

A close-up photograph of a hand holding a metal spoon. The spoon contains a small amount of a white, crystalline substance that is being heated, as evidenced by a bright orange and yellow flame rising from the spoon. In the background, a discarded syringe is visible, and the ground is littered with debris, including a piece of white paper and a discarded orange cigarette. The overall scene suggests the process of injecting drugs.

Spreading the light of science

**Guidelines on harm reduction
related to injecting drug use**



International Federation
of Red Cross and Red Crescent Societies

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Foreword

When the International Federation of Red Cross and Red Crescent Societies was founded in 1919, a major goal was to 'spread the light of science and the warmth of human sympathy into every corner of the world', particularly in the field of health care. Today, the message of the International Federation is the same as it was 84 years ago.

Sound scientific evidence and human compassion must be the guiding force in our response to the humanitarian challenges we face. But sadly, political imperatives, donor demands, and ignorance and fear continue to impede the work of preventing and alleviating suffering and protecting human dignity.

Nowhere, is the gap between a humanitarian response based on compassion and scientific evidence and the inadequacies of actual practices, more evident than in the inhumane treatment of injecting drug users. These people are in need of care and compassion, and real alternatives. Instead, they routinely face harassment, stigmatization, violence and social exclusion. The stigma attached to drug use is causing further marginalization of this most vulnerable group and this is directly impeding efforts to prevent the spread of HIV.

Forcing people who use drugs further underground and into situations where transmission of HIV/AIDS is more likely, and denying them access to life-saving treatment and prevention services is creating a public health disaster. This happens even though the evidence from scientific and medical research on best practices and cost benefit analyses is overwhelmingly in favour of harm reduction programming. This includes needle exchange, drug substitution treatment and condom distribution as part of the response to HIV/AIDS.

The message is clear. It is time to be guided by the light of science, not by the darkness of ignorance and fear. If we are to put a stop to this trend, communities need to treat drug users in a more humane way, respecting them as people with rights and needs. The Red Cross and Red Crescent is well placed to advocate for the just treatment of drug-users and for harm reduction in general. Our respected name and emblem enable us to reach a wide audience the world over and our compassion and concern for human health and dignity have earned us the trust of the most marginalized groups.

From this perspective, it is very appropriate that the theme of the International Conference of the Red Cross and the Red Crescent in 2003 is Protecting Human Dignity. The Agenda for Humanitarian Action emerging from that conference is one more step in the promotion of humanitarian values, and building the climate to reduce marginalization so the risk and impact of HIV/AIDS and other infectious diseases can be reduced. It demonstrates that the Red Cross and Red Crescent values every life by extending humanitarian assistance to where it is most needed, without discrimination.



Juan Manuel Suárez del Toro Rivero
President
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Contents

Abbreviations	_____	3
Introduction	_____	4
Background	_____	6
Chapter 1 Injecting drug use	_____	8
1.1 Injecting drug use and HIV epidemiological data	_____	8
1.2 Increases in injecting drug use	_____	12
1.3 Sharing needles and syringes	_____	13
1.4 The most affected populations	_____	14
1.5 Effective responses	_____	16
Chapter 2 Rationale for harm reduction	_____	18
2.1 Harm reduction	_____	18
2.2 Humanitarian rationale	_____	19
2.2.1 Humanitarian action, National Societies and injecting drug users	_____	19
2.2.2 Humanitarian action, National Societies and injecting drug users in prisons	_____	20
2.3 Public health rationale	_____	21
2.4 Human rights rationale	_____	22
2.4.1 Human rights, health and injecting drug users	_____	22
2.4.2 Human rights, health and injecting drug users in prisons	_____	24
2.5 Cost effectiveness of harm reduction programmes	_____	25
Chapter 3 National Society response	_____	27
3.1 Principles and strategy formulation	_____	27
3.1.1 Guiding principles	_____	27
3.1.2 Strategic directions	_____	28
3.2 Programme development	_____	28
3.3 Areas of intervention	_____	29
3.3.1 Outreach	_____	30
3.3.2 Drop in centres	_____	30
3.3.3 Needle and syringe exchange programme	_____	31
3.3.4 Provision of free, good quality condoms	_____	32
3.3.5 Peer education	_____	33
3.3.6 Primary health care services	_____	35
3.3.7 Drug substitution treatment – low threshold programme	_____	36
3.3.8 Injecting drug rooms	_____	37
3.4 Facilitation of programme implementation	_____	37
3.5 Advocating harm reduction programme	_____	38
3.5.1 Changing society views	_____	39
3.5.2 Influencing policy-makers	_____	40
Annex I Bibliography	_____	42
Annex II Drug characteristics and their effects	_____	45
Annex III Press releases	_____	53

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANCD	Australian National Council on Drugs
ARV	Anti-retroviral
CBO	Community-based organization
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human Immunodeficiency Virus
IDU	Injecting drug user
NEP	Needle exchange programme
NGO	Non-governmental organization
PHC	Primary health care
PLWHA	People living with HIV/AIDS
STI	Sexually transmitted infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

Introduction

The purpose of this document is to outline the rationale for harm reduction programmes. It outlines generic approaches that National Societies can adapt to the realities of their countries in the development and implementation of harm reduction programme and in conducting advocacy for the acceptance and realization such programmes.

The guidelines are designed for National Society staff and volunteers working at all levels and for those involved in planning, organizing, implementing and assessing harm reduction programmes, as well as those involved in advocacy. The document also sets out ideas related to programme development, ways to facilitate programme implementation, as well as ways to plan and realize advocacy activities.

These guidelines were compiled at the request of the Governing Board. The request was made at the same meeting at which the board adopted the International Federation's HIV/AIDS policy, in 2002. It is expected that the guidelines will be used to give strategic direction to all National Societies intending to address the challenges of HIV/AIDS among injecting drug users (IDUs). The document is based on an extensive literature review related to the impact of harm reduction programmes and to the lessons learned concerning the implementation of harm reduction programmes by various organizations over the last decade.

These guidelines are part of the International Red Cross and Red Crescent Movement's response to the HIV/AIDS epidemic and should be read in conjunction with other relevant International Federation documents, including:

- the 2003-2005 International Federation global programme: Reducing household vulnerability to HIV/AIDS and other infectious diseases¹, and update 2003;
- AIDS, Health and Human Rights manual;²
- Orphans and other children made vulnerable by HIV/AIDS. Principles and Operating Guidelines for Programming;³
- Community home-based care for persons living with HIV/AIDS: A framework for National Society programming;⁴
- the Fundamental Principles of the International Red Cross and Red Crescent Movement; and
- Operational Guidelines for Planning.

There are other supporting International Federation documents:

- The International Federation HIV/AIDS Policy, 2002, approved by the Governing Board, provides a framework to support National Societies in the implementation of HIV/AIDS related activities. It states, "Guided by sound public health and humanitarian principles, promote and where appropriate facilitate harm reduction strategies for high risk behaviours and traditional practices, including advocacy for law reform as necessary".⁵



Andrew MacCall/Federation

1 <http://www.ifrc.org/what/health/hivaids/vulnerability/index.asp>.

2 Publications, Geneva: International Federation of Red Cross and Red Crescent Societies, Harvard School of Public Health, 1995, available in English, French and Spanish. To order, e-mail guidera@ifrc.org.

3 <http://www.ifrc.org/what/health/tools/index.asp#hivaids>.

4 <http://www.ifrc.org/what/health/tools/index.asp#hivaids>.

5 <http://www.ifrc.org/who/policy/hivaids.asp>.

6 http://www.ifrc.org/cgi/pdf_berlin.pl?health.pdf.

7 <http://www.aprc.net/map2002.htm>.

8 <http://www.ifrc.org/what/health/hivaids/antistigma/declaration.asp>.

9 Millennium Declaration signed by 189 countries, September 2000. www.un.org/documents/ga/res/55/a55r2002.pdf.

10 UNGASS, Paragraph 34 <http://www.unaids.org/UNGASS/>.

11 See footnotes 50, 51 and 52 and text.

12 UN Economic and Social Council, Commission on Narcotic Drugs, forty-fifth session, E/CN.7/2002/L.3/Rev. 1, 12 March 2002.

- The European National Societies Conference in Berlin, April 2002, unanimously supported implementing harm reduction strategies, marking a major step forward to addressing the rapid increase in infection in the region.⁶
- The Manila Action Plan, which concluded the Manila Conference in December 2002, requires all National Societies in the Asia, Pacific and Middle East regions to develop culturally appropriate harm reduction programmes.⁷
- The International Federation 13th General Assembly Declaration of 2001 states, “Recognizing that the HIV/AIDS epidemic is a devastating health and socio-economic crisis; following the Fundamental Principles of humanity, impartiality and neutrality; acknowledging the commitment to serve and involve the most vulnerable people, including people living with HIV/AIDS; and recognizing the need to build partnerships at all levels in order to be successful, the Assembly declared that HIV/AIDS will be confronted through prevention, care, treatment and support, and the promotion of dignity of those affected”.⁸

These guidelines are in conformity with:

- the Millennium Declaration⁹, Goal 6, in which states committed to halting and beginning to reverse the spread of HIV/AIDS by 2015;
- the Declaration of United Nations General Assembly Special Session on HIV/AIDS (UNGASS), 2001, which recognized the work of the Federation. “Further acknowledging the efforts of international organizations combating the epidemic, including the volunteers of the International Federation of Red Cross and Red Crescent Societies in the most affected areas all over the world.”¹⁰ The Declaration also makes specific reference to harm reduction, drug using behaviour, and stigma and discrimination¹¹; and
- the United Nations Commission on Narcotic Drugs resolution on HIV/AIDS and drug abuse which “recognizes that effective prevention, care and treatment strategies require behavioural changes and increased availability of and non-discriminatory access to, inter alia, vaccines, condoms, microbicides, lubricants, sterile injecting equipment, drug therapy, including anti-retroviral therapy, diagnostics and related technologies, as well as increased research and development, encourages Member States to strengthen efforts to reduce the demand for illicit drugs and to ensure that a comprehensive package of prevention, education, treatment and rehabilitation measures are accessible to all individuals who use and abuse illicit drugs, including those infected with HIV/AIDS, and encourages Member States to; implement measures that reduce or eliminate the need to share non-sterile injecting equipment.”¹²

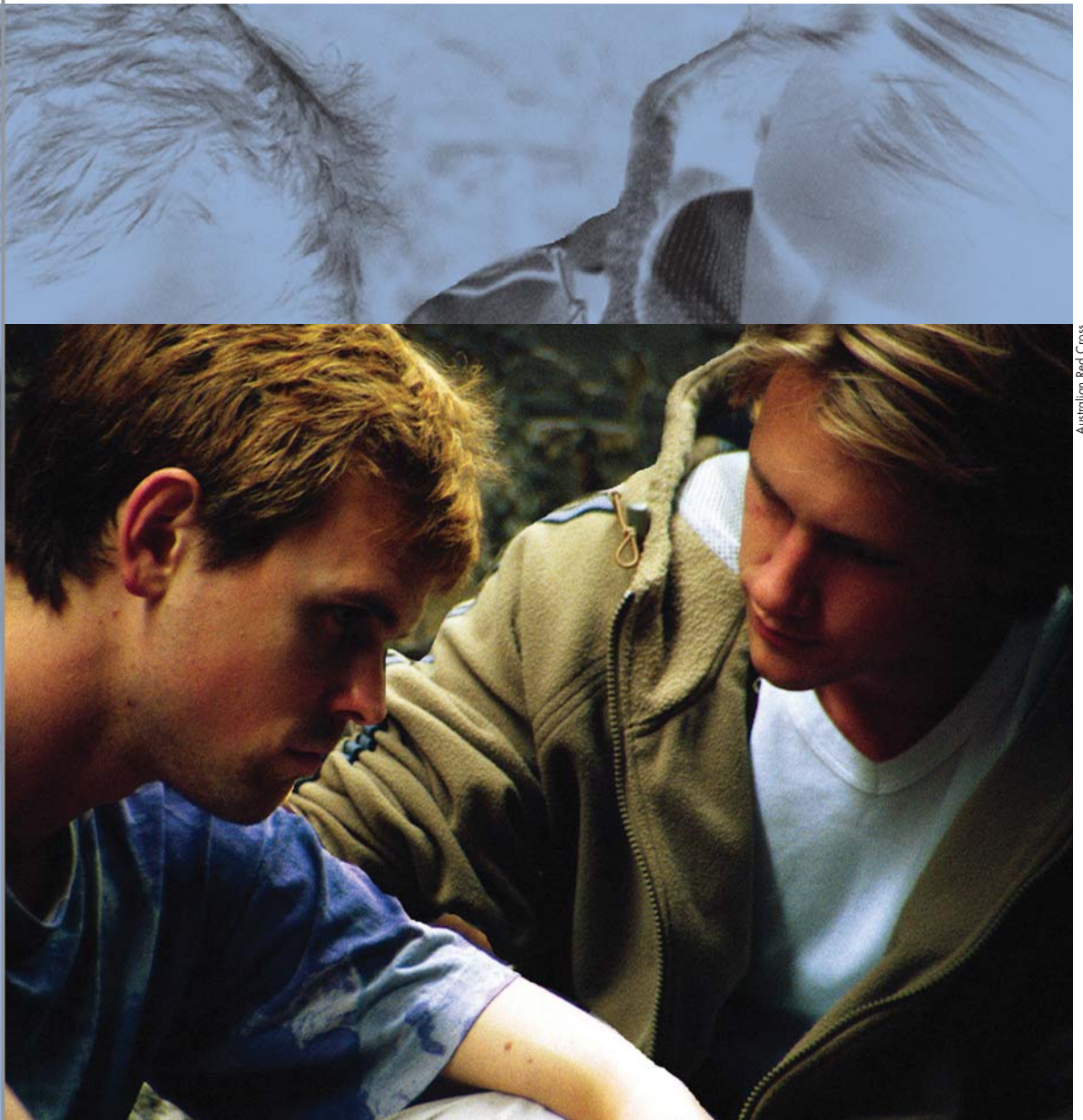
The guidelines outline the epidemiological data concerning injecting drug use and HIV infection; the increasing drug and injecting drug use; and needle sharing. The human rights, humanitarian and public health rationales as well as cost effectiveness of harm reduction programmes are laid out. Finally, information and possible activities for National Societies are outlined.



Background

People have used psychoactive substances since time immemorial. Consumption has been through inhalation or smoking as well as ingestion of fluid or solid substances. Manufactured drugs and modernized methods of administration are relatively new phenomena beginning in the last decades of the 19th century. Needles and syringes are a relatively recent invention, now routinely used to administer drugs in both medical settings as well as for many illegal drugs.

The availability of drugs, human curiosity, pleasure, peer pressure, economic deprivation, social and religious traditions, a lack of objective information on drugs and their effects, psychological illness, and possibly genetic factors, play roles in people's use and abuse of drugs. Substance use and abuse are not isolated behaviours and failure to see them, possibly, as part of larger patterns of risk taking may create barriers to effective interventions. In addition, IDUs are affected by problems such as high rates of homelessness, unemployment, low educational levels and little information on HIV and other health problems associated with injecting drug use.



Over the past century, and increasingly in the last decades, governments in many countries have adopted strict policies against the provision, sale and use of illegal drugs as well as on the possession of drug use paraphernalia.¹³ The objective has been to create a society free of illegal drugs. At the same time, most cultures accept other drugs of addiction such as tobacco, alcohol, quatuor, bettlenut and caffeine. And these are used by governments to raise revenue through taxes, even though conclusive medical evidence exists that some of these drugs can cause serious social and health problems, including death.

Since the early 1990s, the changed geo-political climate has seen the opening of borders which were previously closed, creating new drug trafficking routes and markets, and opening up old ones. The effects of these developments have been enhanced by the globalization of drug markets and distribution networks, and by the increase of informal economies including the drug market as an unwanted by-product of drug suppression activities.

In spite of laws and governmental measures, such as intensive policing, imprisonment and, in some countries, 'war on drugs', illegal drug use is on the increase. This approach, which includes imprisonment and harassment by law enforcement agencies, drive many drug users underground, away from social support services, including health services, making contact, providing HIV education and prevention as well as and health care difficult.

In addition, legalistic approaches and government policies which aim at criminalizing the behaviour of people who use drugs have created and reinforce the stigma and discrimination faced by people who use substances. In some countries, this has been transferred to people living with HIV/AIDS (PLWHA) or specifically to PLWHA who use drugs.

Furthermore, discrimination faced by IDUs can also be found in the medical setting. It has been reported in many countries where there are HIV-positive IDUs, that doctors are refusing to proscribe anti-retroviral (ARV) therapy to IDUs on the basis that they are unlikely to adhere to the complicated drug regimes, which may result in the formation of drug resistant mutations of HIV, which in turn will be transmitted to other drug using or sexual partners. Studies have shown that HIV-infected drug users who receive comprehensive assistance usually have good ARV adherence.¹⁴ Such paternalistic and discriminatory approaches are compromising the health of HIV-positive as many HIV-positive IDUs are delaying HIV treatment much longer than non-users.

Finally, another problem faced by HIV-positive IDUs is pain management, since IDUs usually have a very high tolerance for depressant drugs and need higher, not lower, dosages for effective pain management.

13 United Nations Single Convention on Narcotic Drugs, 1961 aims to combat drug abuse by coordinated international action. There are two forms of intervention and control that work together. First, it seeks to limit the possession, use, trade, distribution, import, export, manufacture and production of drugs exclusively to medical and scientific purposes. Second, it combats drug trafficking through international cooperation to deter and discourage drug traffickers.

United Nations Convention on Psychotropic Substances, 1971, establishes an international control system for psychotropic substances. It responded to the diversification and expansion of the spectrum of drugs of abuse and introduced controls over a number of synthetic drugs according to their abuse potential on the one hand and their therapeutic value on the other.

United Nations Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988, provides comprehensive measures against drug trafficking, including provisions against money laundering and the diversion of precursor chemicals. It provides for international cooperation through, for example, extradition of drug traffickers, controlled deliveries and transfer of proceedings http://www.unodc.org/unodc/un_treaties_and_resolutions.html.

14 IDUs taking part in methadone maintenance programmes have an increased adherence and long-term ARV success. Linking drug therapy programs with ARV treatment and using directly observed therapy where possible may also contribute to antiretroviral success. Providing IDUs with frequent, careful medical and psychosocial follow-up with constant reinforcement of the need for ARV treatment and the ability of the clinician to manage ARV-related side effects and potential toxicities are also keys to success. Mulcahy F, *Antiviral therapy and management of HIV in intravenous drug users*, Program and abstracts of the Fifth Congress on Drug Therapy in HIV Infection, Glasgow, Scotland. Abstract PL3.3, October, 2000.

Chapter 1 Injecting drug use

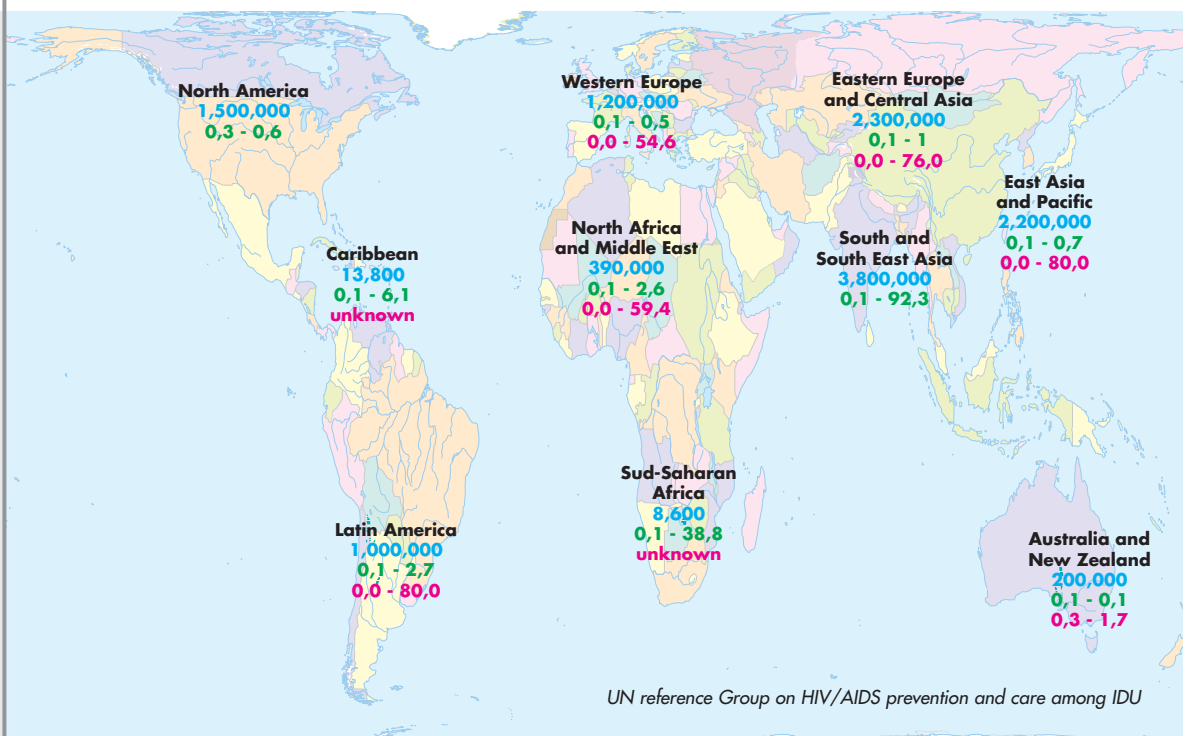
Section 1.1

Injecting drug use and HIV epidemiological data

Many injecting drug users are occasional or opportunistic recreational users. They do not fit the stereotype of the 'drug addict'. However, such delineation does not protect recreational users from HIV infection. Some individuals report being able to regulate their drug use for long periods and maintain work and family responsibilities, and this is referred to in the literature as 'functional drug use'.

Nevertheless, it is clear that many people, even when they are well informed about the risks associated with drug use, continue to use them. Most individuals who are regular IDUs do become addicted over time, and this often adversely affects their own lives, their partner's and the community in which they live. Recovery from drug addiction is at best a long-term process, usually involving relapse. Considerable courage and support is needed to face the pain and personal growth involved. It is clear that this recovery process usually needs to be undertaken voluntarily to be effective and sustained.

Some of the worst public health problems associated with drug use involve the sharing of injecting equipment. Of all the modes of HIV transmission, directly injecting a substance such as opiates like



Estimated global IDU population, 1998/2003 - 12,600,000 IDU
Global HIV prevalence (%) among adults (15-49), in 2001*
and HIV prevalence (%) among IDU, 1998/2003

* UNAIDS Report on the global HIV/AIDS epidemic 2002

heroin, methadone or morphine, or other drugs such as cocaine, amphetamines, barbiturates, anabolic steroids, antibiotics or vitamins contaminated with HIV into the blood stream is by far the most efficient.

The risk of HIV infection or infection with other blood borne viruses such as hepatitis B virus (HBV), hepatitis C virus (HCV) is not through drugs themselves, but rather their mode of administration. Some IDUs, frequently, others, occasionally, share needles and syringes or other equipment used in the process of preparing drug mixes for injection.

The sharing of contaminated drug injecting equipment and drug preparations is a highly efficient means of spreading HIV. Usually, small amounts of blood enter the needle and syringe when drugs are injected. In addition, the blood can then be transferred to other drug injecting equipment such as 'cookers', filters and drug containers, as well as water used for mixing and rinsing.

Only a small amount of infected blood is needed to pass on the virus from one drug user to another, so any type of equipment sharing poses a high risk of HIV transmission. The worst situations for the spread of HIV are when many IDUs are using the same needle and syringe, such as in the 'shooting galleries' of North America and with some 'professional' injectors in Asia, eastern Europe and Latin America, as well as in prisons.

In the last decades, long standing patterns of drug injection in developed countries have been joined by the emergence of injecting drug use in many developing countries. This has occurred even in countries which were thought to be resistant to injecting because of their drug using tradition, cultural behaviours, or religious or spiritual beliefs.¹⁵

In some developing countries, injecting is found in many social groups, in rural and urban areas, and among township dwellers and hill tribes. The spread of injection has been followed by harmful health and social consequences including the rapid spread of HIV infection among IDUs, now reported in 114 countries of the 136 countries which report IDU, HIV transmission to sexual partners and their children, economic costs to families and communities, and loss of liberty or life for drug users from penal or community sanctions.

Currently, it is estimated that there are more than 10 million people globally who inject drugs. Of these, 2-3 million people are estimated to be HIV-positive. This translates to an estimated 10 per cent of HIV infections globally, resulting from shared injecting equipment. In 1992, the number of countries which reported HIV infection associated with injecting drug use was 52. However, by 1999 this had increased to 114.¹⁶

Asia is estimated to have the largest number of injecting-drug-related HIV cases. Injecting drug use is also a major factor in HIV epidemics in North America, western Europe and in parts of Latin America, the Middle East and North Africa. In some eastern European countries, especially in countries of the former Soviet Union, shared injecting equipment is driving major HIV/AIDS epidemics among young people, and many outreach programmes report rising numbers of sexually active teenage drug users.

Injecting-drug-related HIV epidemics do not remain limited to injecting drug users. Most injecting drug users are young, male and sexually active. They are likely to acquire or transmit the HIV virus not only by sharing injecting equipment but also through sexual intercourse with regular or casual partners. Injecting drug use also overlaps profoundly with the sex trade, with users often buying sex or selling sex to finance their drug dependencies.

15 *Report on the Global HIV/AIDS Epidemic*, UNAIDS, 2002.

16 *Report on the Global HIV/AIDS Epidemic*, UNAIDS, 2002.

In 2000, in Hanoi, Viet Nam, 20 per cent of street-based female sex workers reported recent drug injection, while 23 per cent of male injecting drug users bought sex. In Bangladesh, the corresponding figures were 14 per cent and 50–75 per cent, respectively. Similarly, in some cities of the Russian Federation and Ukraine, up to 30 per cent of female injecting drug users are also involved in commercial sex work. More generally, recent studies in Donetsk, Moscow and St Petersburg have revealed HIV prevalence rates of 13–17 per cent among sex workers.

The remainder of this section draws on the findings of the 2002 Joint United Nations Programme on HIV/AIDS (UNAIDS) Report on the Global HIV/AIDS Epidemic.

Asia

Throughout the region, injecting drug use offers the epidemic huge scope for growth. Upwards of 50 per cent of injecting drug users have already acquired the virus in parts of Malaysia, Myanmar, Nepal, Thailand, Indonesia, and in Manipur in India. Very high rates of needle sharing have been documented among users in Bangladesh and Viet Nam, along with evidence that a considerable proportion of street-based sex workers in Viet Nam also inject drugs (a phenomenon detected in other countries, too).

The epidemic in China shows no signs of abating. Serious localized HIV epidemics are occurring among injecting drug users in nine provinces, as well as in Beijing municipality. The most recent reported outbreaks of HIV among injecting drug users have been in Hunan and Guizhou provinces (where sentinel surveillance among users has revealed HIV prevalence rates of 8 per cent and 14 per cent, respectively).



Eastern Europe and central Asia

Eastern Europe and central Asia have the unfortunate distinction of having the world's fastest-growing HIV/AIDS epidemic. In recent years, the Russian Federation has experienced an exceptionally steep rise in reported HIV infections. In less than eight years, HIV/AIDS epidemics have been discovered in more than 30 cities and 86 of the country's 89 regions. Up to 90 per cent of the registered infections have been officially attributed to injecting drug use, reflecting the fact that young people face high risks of HIV infection as occasional or regular drug injectors. Also in the region, 70 per cent of HIV infections in Ukraine, 80 per cent in Belarus, 83 per cent in Kazakhstan and 84 per cent in Moldavia are estimated to be the result of injecting drug use.

The HIV epidemic is growing in Kazakhstan, where a total of 1,926 HIV infections were reported as at June 2001. A more substantial spread of HIV is now also evident in Azerbaijan, Georgia, Kyrgyzstan, Tajikistan and Uzbekistan. In the latter two republics, recent evidence of rising heroin use heightens concerns that they could be on the brink of larger HIV/AIDS epidemics. Already, a steep rise in reported HIV infections has been noted in Uzbekistan, where 620 new infections were registered in the first six months of 2002 – six times the number of new infections registered in the first six months of 2001.

Reported HIV incidence is rising sharply elsewhere. In Estonia, reported infections soared from 12 in 1999 to 1,474 in 2001. Relative to population size, Estonia now has the highest rate of new HIV infections in this region – 50 per cent higher than the Russian rate. A burgeoning epidemic is also visible in Latvia. New reported infections rose from 25 in 1997 to 807 in 2001. A further 308 new HIV cases were registered by the end of June 2002.

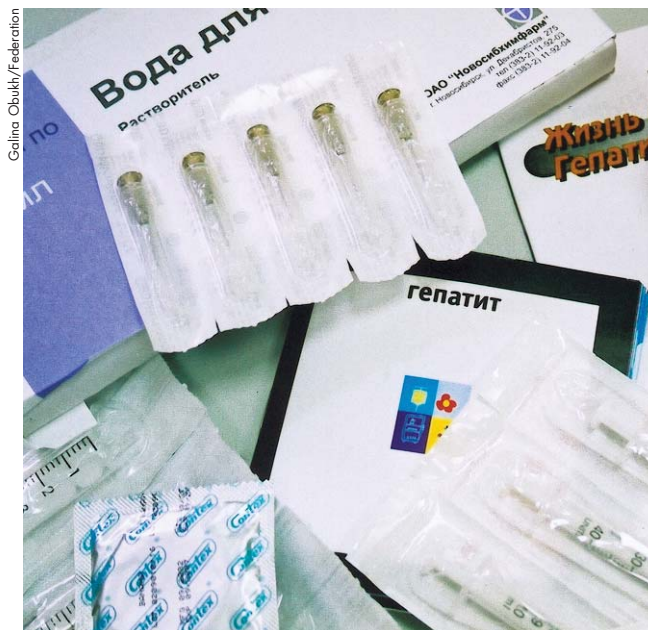
The other Baltic state, Lithuania, experienced a major HIV outbreak in one of its prisons, where 284 inmates (15 per cent of the total) were diagnosed HIV-positive between May and August 2002. This confirms the important and often overlooked role of prisons in the spread of HIV in many countries of the region.

Latin America and the Caribbean

The spread of HIV through the sharing of injecting drug equipment is of growing concern in several countries, notably Argentina, Brazil, Chile, Paraguay and Uruguay (in South America), the northern parts of Mexico, and Bermuda and Puerto Rico (in the Caribbean). Injecting drug use accounts for an estimated 40 per cent of reported new infections in Argentina and 28 per cent in Uruguay. In both countries, an increasing number of women with HIV are either injecting drug users or sexual partners of male drug users.

North Africa and the Middle East

Significant outbreaks of HIV infections among injecting drug users have occurred in about half the countries in the region, notably in North Africa and in the Islamic Republic of Iran.



Galina Obukh/Federation

In Iran, most HIV transmission is occurring among the country's estimated 200,000-300,000 injecting drug users, about 1 per cent of whom are believed to be living with HIV. High-risk behaviour is widespread in this largely male population; about half of the users share injecting equipment, and as many are believed to have extramarital sexual relations. According to some estimates, a significant percentage (more than 30 per cent) of them is married. Yet condom use is very rare. In addition, about 10 per cent of prisoners are believed to inject drugs and more than 95 per cent of them share needles. HIV prevalence among imprisoned drug injectors was 12 per cent in 2001.

Developed countries

Most high-income countries are also contending with concentrated HIV epidemics, including in the United States, where injecting drug use is a prominent route of HIV infection (accounting for 14 per cent of all reported HIV diagnoses). Reported HIV prevalence among injecting drug users in Spain in 2000 was 20-30 per cent. In France, prevalence rates ranged between 10 per cent and 23 per cent. Portugal's serious epidemic among injecting drug users accounted for more than half of the newly diagnosed HIV infections in both 2000 and 2001, though the number of reported HIV infections among injecting drug users declined significantly in 2001.

Sub-Saharan Africa

Injecting drug use is a global phenomenon including, most recently, in Africa, which is also, increasingly being used for the trafficking of heroin and cocaine. According to the 2001 UN Office on Drugs and Crime (UNODC) World Drug Report, the opiate use prevalence in Nigeria was 0.3 per cent. The joint study between the World Health Organization (WHO), the ministry of health and the University of Ilorin on drug abuse concluded that injecting drug use with associated health consequences was an emerging problem in Lagos, Nigeria.

The knowledge base of the drug abusers on HIV was generally low; treatment and rehabilitation services were few and non-affordable. HIV prevalence rate among the total sample of drug users was higher than in the general population (9.8 per cent versus 5.4 per cent). There was no significant difference between the HIV rates obtained for non-injectors and ever-injectors, however, female users were significantly more likely to be HIV-positive compared with their male counterparts, regardless of their injecting status.¹⁷

Injecting drug use has already been described as a major problem in Mauritius. Reports indicate increasing numbers of IDUs in Kenya.¹⁸ And there is strong anecdotal evidence from Tanzania of an evolving drug problem.¹⁹

Section 1.2

Increases in injecting drug use

Coinciding in part with pressure on countries to submit to international restrictions on drug use, illegal drugs are increasingly administered through injection, especially in regions where poverty, homelessness, migration and other socio-economic problems are common. Several factors may be important, including local drug production and transit, and unintended consequences of enforcement activity and drug user migration. Such factors are in turn related to global drug markets, income inequalities between nations, trade and cultural links, urbanization, social dislocation, modernization and internal political conditions.

Other reasons for the spread and increasing popularity of injecting are complex:

- Injecting offers the most cost-effective way of using a drug – a smaller quantity of a given drug is needed to achieve the same effect provided by another mode of administration.

- Injecting a drug is a faster route than other methods for achieving a high.
- Drugs and injecting paraphernalia may be easier to conceal than other methods of taking drugs.
- Injecting is often described as the 'normal' way of taking a given drug.
- Injecting is the only way of using some preparations and there may not be a choice of preparations on the market.
- There is a greater availability of a drug which can be injected.
- Peer pressure to use drugs may occur as the drug-taking rituals can create a sense of social inclusion.
- There is a custom of injection for self medication.
- There is an influence of migratory drug users.
- There is increasing involvement in cultivation and manufacturing drugs.
- People live in proximity to drug trafficking routes.

Efforts to discourage injecting and to avoid the associated health and social costs are hampered by social, structural, economic and political factors. These include:

- over investment in supply reduction rather than demand and harm reduction;
- tough law enforcement against drug users;
- benefits to producer and transit countries from continued production and distribution;
- populations with low levels of education;
- lack of access to media;
- poor transport and communications;
- competing health and social priorities;
- lack of medical and public health resources;
- lack of resources for treatment and harm reduction;
- marginalization and repression of drug users;
- national 'immunity' myths; and
- antipathy towards public health approaches to help IDUs and social costs of drug use.



Section 1.3

Sharing needles and syringes

The extent of HIV epidemics among IDUs and the speed with which a given epidemic spreads within IDU communities, and thereafter into the general population, depends on the degree of social mixing in the population. This includes the number of different people shared with, the degree to which IDUs move between social networks, and how large these sharing networks are.

Given the wrong conditions, the transmission of HIV among IDUs can be rapid, with up to 40-90 per cent of all IDUs in a given community infected in a matter of months. This has happened in places as geographically and culturally remote as New York, Milan, Edinburgh, Bangkok, Santos, Odessa, Ho Chi Minh City, Yunnan Province in China and Manipur State in India.²⁰

17 *World Drug Report*, UNODC, 2001, in *Assistance to country responses on HIV/AIDS associated with injecting drug use by the UN and other agencies*, Report for the Interagency Task Team on injecting drug use, 2003.

18 The prevalence rate of opiate abuse in Kenya is 0.1 per cent, *World Drug Report*, UNODC, 2001, in *Assistance to country responses on HIV/AIDS associated with injecting drug use by the UN and other agencies*, Report for the Interagency Task Team on injecting drug use, 2003.

19 *Assistance to country responses on HIV/AIDS associated with injecting drug use by the UN and other agencies*, Report for the Interagency Task Team on injecting drug use, 2003.

20 Rhodes T, Stimson GV, Crofts N, Ball A, Dehne K and Khodakevich L, *Drug injecting, rapid HIV spread, and the 'risk environment': implications for assessment and response*, 13 (suppl A), *AIDS* 1999; Ball AL, Rana S and Dehne KL., *HIV prevention among injecting drug users: Responses in developing and transitional countries*, 113, suppl:170-181, *Public Health Reports*, 1998; Stimson G, Des Jarlais DC and Ball A (Eds), *Drug Injecting and HIV Infection: Global Dimensions and Local Responses*, London UCL Press, 1998.

Some of the reasons for sharing needles and injecting paraphernalia include:

- lack of information about associated risks of injection and about safe injection;
- sharing behaviour as a form of bonding or as a culturally or socially accepted practice;
- intoxication during injection;
- lack of injecting skills, particularly during the initiation period;
- fear of procuring or carrying injecting equipment because it is illegal or because of police harassment;
- difficulty in accessing new injecting equipment because of prohibition, physical isolation or limited hours in which to procure it; and
- lack of money to buy injecting equipment.

After more than two decades of experience in HIV transmission among IDUs, there are a number of epidemiological, geographical and social factors that are known to contribute to the rapid spread of HIV among injectors. These include:

- the presence of HIV in the population;
- a recent and rapid spread of injecting drug use;
- proximity to drug supply routes;
- widespread unemployment and economic dislocation;
- social change;
- regular sharing of injecting equipment among members of social networks;
- high levels of mixing between social networks of injectors; and
- sale and distribution of drugs in syringes.

The dual problems of injecting drug use and HIV transmission ultimately affect all members of society. In countries with injecting drug use related HIV epidemics, HIV infection rates amongst IDUs, who have shared injecting equipment or had unprotected penetrative sexual intercourse, have risen and continue to rise sharply. In fact, in some parts of the world, injecting drug use has kick started the HIV epidemic. This was the case in Thailand, where during the first nine months of 1988, HIV prevalence rates among IDUs in Bangkok rose from around zero to almost 40 per cent. Before that, there were few people known to have HIV in Thailand. Afterwards HIV prevalence rates increased dramatically, mainly through sex.²¹

This means that countries with little HIV infection but with IDUs can go from few people infected to many thousands in a short space of time, forming an epicentre for further spread of HIV. IDUs who are sexually active may transmit HIV to their sexual partners and their children. This situation is compounded by the involvement of many IDUs in commercial sex work, often to support their drug use. It is also compounded in prisons which mix many different IDU populations, and are also a setting in which drug use and injecting drug use is frequently initiated. Experience has shown, without effective immediate harm reduction programmes, IDU-based HIV epidemics can rapidly become self-sustaining generalized HIV/AIDS epidemics.

Section 1.4

The most affected populations

In general, injecting drug use is associated with pre-existing socio-economic deprivation. Due to the amount of resources necessary to provide drugs, most injecting drug users live in poverty. Many IDUs come from low-income households. When HIV infection leads to illness, this brings reduced income from the person with HIV and often further economic and social costs associated with families caring for their relatives. This in turn leads to further poverty and increased likelihood of other family members engaging in risky HIV behaviours.

In addition, there are some populations particularly susceptible to injecting drug use and HIV infection. Female IDUs are at a higher risk of HIV infection mainly due to drug mixing or commercial sex work²², while injecting drug use is a severe problem among street youth.²³ Migrants, because of their proximity to drug cultivation or trafficking routes, or because of their general situation, are often over represented in drug use.²⁴ Existing data also indicate that indigenous people are often over represented in groups most vulnerable to HIV, such as sex-workers and prisoners. In particular, indigenous people are over represented among inner city IDU communities, including among clientele using needle exchange programmes and counselling or referral sites.²⁵

Injection drug use is also a problem among prisoners (a population whose welfare is specifically within the mandate of the Movement and an area in which the Red Cross and Red Crescent has a comparative advantage). Once in prison, many IDUs continue injecting and prisons are also a setting where many people have their first experience of using or injecting drugs.²⁶ Sex, forced or consensual, is common in prison and is generally unprotected. Another often forgotten aspect of prison life is the past time of tattooing using needles.

In many countries, current prison practices effectively promote the transmission of HIV and tuberculosis (TB) infections within prisons and thereafter into the general community upon prisoner release. Few countries have implemented harm reduction measures in prisons. The main reasons given are that sex and drug use is illegal and that needles and condoms may be used as weapons.

Europe leading the way on needle and syringe exchange programmes in prisons

Needle and syringe exchange programmes are still rare but on the increase. Since the first prison-based syringe exchange programme was set up at the Oberschöngrun prison for men in Switzerland in 1992, studies of similar programmes have confirmed their effectiveness.

Needle sharing has declined dramatically, there have been no reported cases of inmates acquiring HIV, HBV or HCV in any of the programmes, and no serious unintended consequences were encountered. By 2001, sterile needles were being distributed in seven Swiss prisons.²⁷

German and Spanish authorities have also successfully introduced needle exchange schemes in several prisons. HIV prevalence among Spanish prisoners has declined from 23 per cent in 1996 to 17 per cent in 2001, due largely to innovative programmes for heroin users (methadone programmes). Nine of the country's prisons have begun introducing needle and syringe exchange programmes complemented by education, counselling and condom distribution.²⁸

21 Drug Use and HIV/AIDS, UNAIDS statement presented at the United Nations General Assembly Special Session on Drugs, 9 June 1999.

22 Spittal PM, Craib KJ, Wood E, Laliberte N, Li K, Tyndall MW, O'Shaughnessy MV, Schechter MT, *Risk factors for elevated HIV incidence rates among female injecting drug users in Vancouver*, British Columbia Centre for Excellence in HIV/AIDS, St. Paul's Hospital, Vancouver, 166(7) pp. 894-9, CMAJ, 2 April 2002. Barnard M, *Risky Business*, 43 *The International Journal of Drug Policy*, 1993. *HIV/AIDS Among Injecting Drug Users in Canada*, Health Canada, April 2003.

23 For example, one study found that one-third of a sample of Montréal street youth had injected drugs in the previous six months. Among those who were regular injectors, 47 percent had shared needles in this time frame *Risk Behaviours Among Injection Drug Users in Canada*, supra, note 1 at 3, with reference to E Roy, N Haley, J Boivin et al. *Injection Drug Use among Street Youth: A Dynamic Process*. Paper presented at the 6th Annual Conference on HIV/AIDS Research, Ottawa, May 1997. *Canadian Journal of Infectious Diseases* 1997; 8 (Suppl A): 29A (abstract 225).

24 Stimson GV, Adelekan M, Rhodes T, *The Diffusion of Drug Injecting in Developing Countries*, The Centre for Research on Drugs and Health Behaviour, University of London. This article is based on a presentation at the Sixth International Conference on the Reduction of Drug Related Harm, Florence, Italy, 1995. <http://www.drugtext.org/library/articles/96745.htm>.

25 Stimson GV, Adelekan M, Rhodes T, *The Diffusion of Drug Injecting in Developing Countries*, The Centre for Research on Drugs and Health Behaviour, University of London. This article is based on a presentation at the Sixth International Conference on the Reduction of Drug Related Harm, Florence, Italy, 1995. <http://www.drugtext.org/library/articles/96745.htm>.

26 For example, in a federal prison in British Columbia, 67 percent of inmates responding to one survey reported injection drug use either in prison or outside, with 17 percent reporting drug use only in prison. T Nichol. *Bleach Pilot Project. Second unpublished account of the introduction of bleach at Matsqui Institution*, dated 28 March 1996. On file with Legal Network. In the 1995 inmate survey conducted by the Correctional Service of Canada, 11 percent of 4285 federal inmates self-reported having injected since arriving in their current institution. Correctional Service of Canada. 1995 *National Inmate Survey: Final Report*. Ottawa: The Service (Correctional Research and Development), No SR-02 at 138, 1996.

27 *Report on the Global HIV/AIDS Epidemic*, p 98, UNAIDS, July 2002.

28 *Report on the Global HIV/AIDS Epidemic*, p 98, UNAIDS, July 2002.

Generally, refugees and people involved in conflict situations are at an increased risk of HIV/AIDS. In the turmoil that leads people to become refugees, health-care information and related services for HIV prevention usually do not exist. However, injecting drugs by IDUs before an emergency is likely to continue. Given the circumstances, if drugs are available, this is likely to increase. Unfortunately, injecting drug use in emergency settings is little understood.

Section 1.5

Effective responses

Emerging evidence with regard to successful approaches has demonstrated that HIV transmission among IDUs can be prevented. There are three complementary strategies:

- Decrease the social marginalization and the subsequent vulnerability of IDUs.
- Increase the access of IDUs to health and social care, including drug education, comprehensive package of interventions for HIV prevention and treatment services.
- Promote a non-repressive approach to IDUs based on human rights and public health principles.²⁹



In spite of existing proven strategies for curbing the transmission of HIV related to injecting drug use, most countries to date have failed to introduce comprehensive harm reduction programmes. Since the first needle exchange programme (NEP) was introduced in Amsterdam in 1984, at least 46 regions, countries, and territories reported having at least one NEP by December 2000. However, only one-third of countries where HIV has been reported among IDUs, and only 40 per cent of countries where injecting drug use is known to occur, have introduced at least one NEP.³⁰ Furthermore, there are also no cases globally of transmission of HIV or hepatitis as a result of a needle-stick injury from an inappropriately discarded needle and syringe.³¹

The failure to introduce effective HIV prevention measures such as comprehensive harm reduction programmes for IDUs costs lives. For example, it is estimated that for each year without increased access to sterile syringes for IDUs, as many as 12,350 persons in the United States are becoming infected with HIV.³²

Some of the reasons for the lack of an effective response include:

- marginalization and stigmatization and discrimination against injecting drug users;
- antipathy towards public health approaches to reducing the individual and social costs of drug use;
- lack of political will to develop the necessary policy dialogue and programmatic response;
- drug use viewed as a criminal rather than a public health issue;
- failure to recognize injecting drug use as a factor in the HIV epidemic;
- denial of international evidence on effective responses;
- failure to address the legal, ethical and human rights issues concerning IDUs;

29 *Preventing the Transmission of HIV among Drug Abusers*, position paper of the United Nations System, 2000.

30 Steffanie A. Strathdee and David Vlahov *The effectiveness of needle exchange programs: A review of the science and policy*, Vol. 1, No. 16, AIDScience, December 2001.

31 Dolan, K., Topp, L. and MacDonald, M., NSP: *needle and syringe programs: a review of the evidence*. In NSP: Needle and Syringe Programs [Information kit], Canberra: Australian National Council on AIDS, Hepatitis C and Related Diseases, p. 18, 2000.

32 Holtgrave, David R., Pinkerton, Steven D., Jones, T. Stephen, Lurie, Peter., and Vlahov, David., 1998, *Cost and cost-effectiveness of increasing access to sterile syringes and needles as an HIV prevention intervention in the United States*, Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology, 18 (supplement), pp. S133-S138.

33 Steffanie A. Strathdee and David Vlahov *The effectiveness of needle exchange programs: A review of the science and policy*, Vol. 1, No. 16, AIDScience, December 2001.

Strathdee, S. A. et al., *Needle exchange is not enough: Lessons from the Vancouver injecting drug use study*. 11, F59-F65, AIDS, 1997.

34 Tyndall MW, Currie S, Spittal P, Li K, Wood E, O'Shaughnessy MV, Schechter MT, *Intensive injection cocaine use as the primary risk factor in the Vancouver HIV-1 epidemic*, British Columbia Centre for Excellence in HIV/AIDS, St. Paul's Hospital, Vancouver, Canada, 17(6):911-3, AIDS, 11 April 2003.

- lack of easily accessible, quality treatment service;
- insufficient understanding of the impact of HIV on society;
- poor networking and integration between sectors and agencies responsible for drug control and HIV prevention; and
- limited skills, resources (both human and financial) and experience in understanding and responding to IDUs and HIV.

To be effective, harm reduction programmes must fit local conditions. For example, research in Canada has shown that cocaine injectors tend to inject much more frequently than heroin injectors, and therefore require much greater quantities of needles and syringes than usually provided by needle-syringe programmes.³³ In addition, the time to HIV infection was accelerated among regular cocaine injectors independent of concurrent heroin use. Injecting cocaine use was a strong, dose-dependent predictor of HIV seroconversion in this poly-drug using population. Injecting cocaine users remain particularly vulnerable to HIV infection and while treatment options for cocaine dependency remain woefully inadequate.³⁴

Harm reduction programmes that only reach a minority of injecting drug users may yield benefits for those participating but are unlikely to significantly influence the course of the HIV epidemic in a country. For example, Nepal introduced needle exchange programmes in 1991. By 1995, some researchers were claiming that the interventions had averted an HIV epidemic among injecting drug users. But by 1997, almost half the users tested in Kathmandu were infected with HIV. The needle exchange programme was too limited and too localized to have a powerful, lasting impact. Appropriate coverage of all injecting drug users is an important target for national HIV/AIDS programming. To be effective, it needs to include IDUs involved in sex work, living in prisons, from ethnic minorities, migrants and refugees.



Chapter 2

Rationale for harm reduction

Section 2.1

Harm reduction

In public health harm reduction is used to describe a concept aimed at preventing or reducing negative health consequences associated with certain behaviours. In relation to HIV and injecting drug use, harm reduction aims at preventing the transmission of HIV and other infections that occur through sharing of non-sterile injecting equipment and drug preparations.^{35/36} Harm reduction takes a morally neutral stance to drug use, neither condoning nor opposing drug use. It focuses on actual harm and assumes that some people will continue to use injecting drugs despite government repression and therefore they should be given the possibility to do so in an in a way that reduces the risks and causes least harm to themselves and others.

While many governments, organizations and individuals would like to see drug free societies, the role of harm reduction is not to work directly towards this. If individuals who inject drugs go into rehabilitation programmes as a result of contacts made through harm reduction programmes, this is a welcome spin off effect but it is not an aim of harm reduction strategies. Demand reduction is a separate strategy which seeks to reduce the use of drugs. Harm reduction acknowledges drug use without condoning it, and seeks to minimize the harm to the individual and by correlation to the society as a whole.

A hierarchy of objectives for harm reduction has been put forward:

- Enter into drug dependence treatment. Those offering long-term medications such as methadone maintenance are more effective.
- If drug dependence treatment is not an option switch from injecting to non-injecting drug use.
- If injecting continues always use sterile injecting equipment and do not share equipment or drug solutions.
- If it is not possible to use sterile injecting equipment clean and reuse your own equipment and do not share it.
- If sharing does occur, clean injecting equipment between each use (using bleach, for example).
- Do not share 'cookers', drug containers or filters used for injecting, and do not use or share water for rinsing or mixing.
- Avoid unprotected sex. Always use condoms.³⁷

Harm reduction can consist of various measures including:

- needle and syringe exchange programmes;
- the provision of condoms;
- medical treatment using opiate substitutes;
- psycho-social counselling; and
- strategies for reaching out to the most vulnerable populations and those with no access to health care systems.

35 Injecting Drug Use and HIV/AIDS: World AIDS Campaign, UNAIDS, 2001.

36 Harm reduction encompasses a wide range of drug user services including needle and syringe exchange, injecting drug rooms, drug substitution, health education, medical referral and support services.

37 Pecheny, Mario, *Argentina: Discrimination and AIDS Prevention*, in Peddro: Drug Abuse and AIDS – stemming the epidemic, UNESCO, European Commission and UNAIDS, Special Issue, December 2001.

HIV education; voluntary and confidential testing for HIV infection; and adequate pre- and post-test counselling and treatment for HIV infection, including ARV treatments, should all be considered as other interventions which can mitigate the impact of HIV/AIDS on individuals and communities. The creation of safe injecting environments with medical backup as well as the decriminalization of drug use are both strategies that have been successfully introduced to minimize drug related harm.

In many countries injecting drug users are marginalized, stigmatized and discriminated members of the society. Many states have taken punitive measures against IDUs with the objective of preventing illegal drug use, but with little success. International conventions, declarations and humanitarian principles obligate states to respect, protect and fulfil, equitably and in a non-discriminatory manner, IDUs' human rights, which includes comprehensive harm reduction programmes as well as providing treatment, care and support, including anti-retroviral therapy for HIV-positive IDUs, if medically recommended.

In addition, public health imperatives support the introduction of comprehensive harm reduction programmes as a proven way to protect public and individual health. Furthermore, scientific evidence shows that harm reduction strategies including needle and syringe exchange are cost-effective measure to prevent and control HIV transmission, do not lead to higher rates of drug use and protect the individual's right to health.



Section 2.2

Humanitarian rationale

2.2.1 Humanitarian action, National Societies and injecting drug users

Most IDUs are at a high risk of contracting HIV/AIDS, HBV, HCV and other infections. They often suffer stigma and discrimination and face high levels of incarceration. IDUs are vulnerable groups that require Red Cross and Red Crescent support. Too often, the issues of drug use, HIV transmission and harm reduction methods are entangled in political, religious and moral debates to the detriment of prevention and care efforts.

The Red Cross and Red Crescent, as the largest and oldest humanitarian organization established with the objectives of preventing and alleviating human suffering without judgement wherever it may be found, can take an active role in education. It can ensure a clear understanding of the scale of the HIV/AIDS epidemic, and advocate for appropriate and effective prevention, treatment, care and support measures. Of the seven Fundamental Principles of the International Red Cross and Red Crescent Movement, three – humanity, impartiality and neutrality – are particularly important for prevention and for rendering treatment, care and support to IDUs.

At the Governing Board meeting held in November 2002, The International Federation adopted a new HIV/AIDS Policy, which states

“guided by sound public health and humanitarian principles, promote and where appropriate facilitate harm reduction strategies for high risk behaviours and traditional practices, including advocacy for law reform as necessary.”

In April 2002, the European National Societies Conference in Berlin unanimously supported implementing harm reduction strategies, marking a major step forward to addressing the rapid increase in infection in the region. Similarly, the Manila Action Plan, adopted at the Manila Conference in December 2002, requires all National Societies in the Asia, Pacific and Middle East regions to develop culturally appropriate harm reduction programmes.

Several National Red Cross and Red Crescent Societies have already initiated harm reduction strategies in collaboration with governments or other organizations. The Australian, Croatian, Italian, Portuguese, Russian and Spanish National Societies are demonstrating workable programmes. The Vietnamese and Chinese Red Cross Societies also have initiatives underway. Many National Red Cross and Red Crescent Societies have capacities and networks which can be utilized to support IDUs and advocate for the acceptance, introduction and maintenance of harm reduction programmes.

2.2.2 Humanitarian action, National Societies and injecting drug users in prisons

According to the fundamental principle of humanity, the Red Cross and Red Crescent “endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found”. Its purpose is to protect life and health and to ensure respect for the human being.

The role of National Societies has grown from serving as auxiliaries to an army’s medical services in times of war, to include welfare activities³⁸ developed in favour of families and children, the elderly, sick people and people with disabilities (mental, physical and social disadvantaged) in times of peace. The last of these groups includes detainees.

In its efforts to implement the principle of humanity, the Red Cross and Red Crescent pays particular attention to the most vulnerable people. The Red Cross and Red Crescent philosophy and doctrine and its fundamental principles provide basic guidelines for the social welfare work of National Societies in favour of prisoners and their families. The reasons for National Society activity in prisons are individual assistance to the prisoners as human beings; help and assistance to their families; and to assist as much as possible during the period of separation from normal conditions of life.

National Societies are auxiliaries to the public authorities and must maintain their independence, impartiality (non-discrimination) and autonomy in relation to states, and must be neutral and impartial. That is they must be non-discriminatory as to nationality, race, religious beliefs, class or political opinion; and proportional in the manner in which assistance to prisoners is distributed.



Marko Kokić/Federation



National Societies cannot take the place of the state, which has the task of providing assistance to underprivileged individuals since they are the only entity with the necessary authority and sufficient resources to cope with an undertaking of this magnitude.

The provision of health services is the most common activity of National Societies work in prisons. Some National Societies provide care, medicine and other services to sick persons. A few National Societies are providing assistance to drug dependants. Some organize courses such as first-aid training or seminars on HIV/AIDS for health personal and/or prisoners. Some National Societies also provide medical care to family members of prisoners, cover medical costs or conduct campaigns against particular diseases.

There is ample scope for National Societies to build on existing activities in prisons to provide HIV/AIDS related services. National Societies can advocate with governments, prison services and wardens for the acceptance, introduction and maintenance of harm reduction programmes. And giving due regard to its auxiliary role, National Societies may be in the position to facilitate harm reduction measures in prisons.

At the request of National Societies or on its own initiative, the International Federation secretariat can contribute to the activities of National Societies by providing guidance in social welfare, including health service provision and harm reduction measures for IDUs in prisons. The International Federation can also provide information on the activities of the National Societies and promote cooperation and exchange of experience. National Societies requiring background information on mandates for work in prisons are referred to the publication *Activities of National Red Cross and Red Crescent Societies in Prisons* (International Federation and Henry Dunant Institute, 1994).³⁹



Section 2.3

Public health rationale

The sharing of needle and syringes and other drug injecting equipment is the most important factor fuelling the HIV epidemic among drug users. Drug control laws and policies should aim to reduce, not increase, the HIV risk faced by injecting drug users. Popular strategies of suppression or elimination have not contained the fast growth of HIV epidemics. Experience has shown that HIV epidemics among IDUs can be halted, or if IDUs are appropriately supported through a comprehensive harm reduction approach at an early stage, epidemics can be minimized or avoided.

A global review of needle and syringe exchange programmes implemented between 1993 and 1998 in 29 cities has shown that the HIV prevalence rate among IDUs decreased by an average of 58 per cent per year while the number of users did not increase. By contrast, in 52 cities, where similar harm reduction programmes did not exist, the HIV prevalence rate increased by almost 6 per cent annually.⁴⁰

Effective public health interventions to limit the transmission of HIV are required for several reasons:

- Currently, it is estimated that there are more than 10 million people globally who inject drugs. Of these, 2-3 million people are estimated to be HIV-positive.
- The number of countries reporting injecting drug use has increased from 80 in 1992 to 138 in 1998 with 114 countries reporting HIV infection among the IDU population.

38 Social welfare, material assistance, health services, organization and arrangements relating to work in and outside prisons, training, education, entertainment, leisure, sport, special care for young prisoners and children of prisoners, facilitation of contacts by foreign prisoners with their country and families, intervention in favour of nationals imprisoned abroad, development of alternative measures to imprisonment and social rehabilitation and reintegration.

39 To order, e-mail guidera@ifrc.org.

40 UNAIDS.

- The reuse of contaminated needles and syringes by different people as well as the communal use of equipment for injecting preparation are common practices among IDUs.
- HIV and other blood borne infections are efficiently transmitted by sharing injecting equipment.
- HIV can rapidly spread through drug using populations and can stabilize at high prevalence rates. Studies indicate that in the absence of preventive measures the prevalence rate can rise up to 40 per cent or more within 1-2 years of introduction of HIV into a community.
- Transmission of HIV also occurs through sexual contact both between IDUs and with other sexual partners, including through sex work, facilitating the transmission of HIV to their children and into the general community.

Section 2.4

Human rights rationale

2.4.1 Human rights, health and injecting drug users

The right to health is enshrined in international human rights law, even if these rights do not appear under the explicit title of ‘the right to health’. Although subject to progressive realization and resource constraints, this right imposes certain obligations. These immediate obligations include the guarantees of non-discrimination and equal treatment, as well as the obligation to take deliberate, concrete and targeted steps towards the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. This might include the preparation of a national public health strategy and plan of action. Progressive realization means that states have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of the right.

The preamble of the Constitution of the World Health Organization states,

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States. The achievement of any State in the promotion and protection of health is of value to all... Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.^{41/42}

The right of everyone to the enjoyment of the highest attainable standard of physical and mental health, is reflected in Article 25(1) of the 1948 Universal Declaration of Human Rights;⁴³ Article 12 of the 1966 International Covenant on Economic, Social and Cultural Rights;⁴⁴ Article 24 of the 1989 Convention on the Rights of the Child;⁴⁵ and Article 12 of the 1981 Convention on the Elimination of All Forms of Discrimination against Women⁴⁶.

The right to non-discrimination is enshrined in Article 5(e)(iv) of the 1965 International Convention on the Elimination of All Forms of Racial Discrimination.⁴⁷ The guarantees of non-discrimination and equal treatment in the fulfilment of human rights means that everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. This by definition applies to people who inject drugs, including HIV-positive IDUs.

The interpretation of existing human rights treaties confirms this. The resolutions passed by the UN Commission on Human Rights in 1999, 2001 and 2003, invited UN bodies, international organi-

zations and NGOs to take all necessary steps to ensure the respect, protection and fulfilment of HIV-related rights.⁴⁸

In May 2000, the UN Committee on Economic, Social and Cultural Rights adopted a general comment on the right to health which proscribes,

any discrimination in access to health care and the underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.⁴⁹

In the Declaration of Commitment, unanimously accepted at the 26th UN General Assembly Special Session on HIV/AIDS, 2001, states made specific commitments relevant to IDUs.

By 2005, ensure that a wide range of prevention programmes which take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including...expanded access to essential commodities, including male and female condoms and sterile injecting equipment.⁵⁰

By 2003...to promote and protect the health of those identifiable groups which currently have high or increasing rates of HIV infection or which public health information indicates are at greatest risk of and most vulnerable to new infection as indicated by such factors as the local history of the epidemic, poverty, sexual practices, drug-using behaviour, livelihood, institutional location, disrupted social structures and population movements, forced or otherwise.⁵¹

By 2003, all States will have eliminated any laws, policies and practices that discriminate against people living with HIV/AIDS and other highly vulnerable groups.⁵²

41 The Constitution of the World Health Organization was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 states <http://www.who.int/governance/en/>.

42 Governments have made commitments to ensuring progressive realization of the Human Right to Health at nearly every major Conference during the past decades including:

- Ottawa Charter for Health Promotion, First International Conference on Health Promotion, Ottawa, 21 November 1986 - WHO/HPR/HEP/95.1 http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf

- Cairo Programme of Action, Principle 8 and para. 8.6, International Conference on Population and Development, Cairo, 5-13 September 1994. <http://www.iisd.ca/linkages/Cairo/program/p00000.html>

- Habitat Agenda, paras. 36 and 128, United Nations Conference on Human Settlements (Habitat II), Istanbul, Turkey, 3 - 14 June 1996. <http://www.unhabitat.org/unchs/english/hagenda/ist-dec.htm>

- Copenhagen Declaration, Commitment 6, World Summit for Social Development, Copenhagen, Denmark 14-15 October 1999. <http://www.un.org/esa/socdev/wssd/agreements/>

During its session in May 1998, the World Health Assembly endorsed the new World Health Declaration and the new global health policy Health for All in the 21st Century. Health for All in the 21st Century guides action and policy for health at all levels and identifies global priorities and targets for the first two decades of the 21st century. Key values such as human rights, equity, ethics and gender sensitivity should underpin and be incorporated in all aspects of health policy. A key feature is the strengthening of the participation of people and communities in decision-making and actions for health.

Important global "health for all" targets by 2020 include: "... the worldwide burden of disease will be substantially decreased. This will be achieved by implementation of sound disease-control programmes aimed at reversing the current trend of increased incidence and disability caused by tuberculosis, HIV/AIDS, ...all countries will have introduced, and be actively managing and monitoring, strategies that strengthen health-enhancing lifestyles and weaken health-damaging ones, through a combination of regulatory, economic, educational, organizational and community-based programmes".

43 Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

44 The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

45 States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

46 States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

47 In compliance with the fundamental obligations laid down in article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: Economic, social and cultural rights, in particular: The right to public health, medical care, social security and social services.

48 1999/49 of 27 April 1999; 2001/51 of 24 April 2001 and 2003/L.64 of 16 April 2003. <http://www.unhchr.ch/html/menu2/2/sessions.htm>.

49 General Comment 14, Paragraph 18. [http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4,+CESCR+General+comment+14.En?OpenDocument](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4,+CESCR+General+comment+14.En?OpenDocument).

50 UNGASS, Paragraph 52 <http://www.unaids.org/UNGASS/>.

51 UNGASS, Paragraph 64 <http://www.unaids.org/UNGASS/>.

52 UNGASS, Paragraph 58 <http://www.unaids.org/UNGASS/>.

The above outlines the legal basis for states to respect, protect and fulfil, equitably and in a non-discriminatory manner all IDUs' human rights. This includes comprehensive harm reduction programmes as well as providing treatment, care and support, including anti-retroviral therapy for HIV-positive IDUs, if medically recommended.

In keeping with the fundamental principles and the role of the Red Cross and Red Crescent in protecting and promoting the health of the most vulnerable populations, IDUs as a vulnerable population merit the strong and privileged voice of social conscience. The International Federation can advocate governments to fulfil IDUs' right to the enjoyment of the highest attainable standard of physical and mental health.

2.4.2 Human rights, health and injecting drug users in prisons

As with all HIV infection of IDUs, HIV transmission between IDUs in prisons is largely preventable. Furthermore, the principal international human rights documents clearly obligate states to protect the human rights of prisoners.

Article 7 of the International Covenant on Civil and Political Rights (ICCPR) and Article 16 of the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) both prohibit torture and cruel, inhuman, or degrading treatment or punishment, without exception or derogation.

Furthermore, Article 10 of the ICCPR mandates that "all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person". It also requires that the reform and social readaptation of prisoners be an essential aim of imprisonment. Finally, Articles 2 and 26 of the ICCPR contain, respectively, provisions concerning the discriminatory application of the convention and a general right to equality.

Other UN standards applicable to the treatment of prisoners include:

- United Nations Standard Minimum Rules for the Treatment of Prisoners, 1957;
- Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment, 1958;
- Basic Principles for the Treatment of Prisoners, 1990;
- Code of Conduct for Law Enforcement Officials, 1978; and
- Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1982.

With regard to juvenile prisoners applicable UN standards include:

- United Nations Standard Minimum Rules for the Administration of Juvenile Justice, 1985;
- United Nations Guidelines for the Prevention of Juvenile Delinquency, 1990; and
- United Nations Rules for the Protection of Juveniles Deprived of Their Liberty, 1990.

Also applicable is the 1990 United Nations Standard Minimum Rules for Non-custodial Measures. All these instruments are binding on governments to the extent that the norms set out in them explicate the broader standards contained in human rights treaties.⁵³ They clearly reaffirm the tenet that prisoners retain their fundamental human rights.

⁵³ For texts, see <http://www.unhcr.ch/html/intlinst.htm>.

⁵⁴ Principle 5, Basic Principles for the Treatment of Prisoners, Adopted and proclaimed by General Assembly resolution 45/111 of 14 December 1990.

⁵⁵ United Nations Human Rights Committee, General Comment 21, Paragraph 3, 1992. The Human Rights Committee provides authoritative interpretations of the ICCPR through the periodic issuance of General Comments.

⁵⁶ *Ibid.*, paragraph 4; see also *Mukong v. Cameroon* (No. 458/1991) (August 10, 1994), UN Doc. C/51/D/458/1991 (stating that minimum requirements regarding floor space, sanitary facilities, provision of food, etc., must be observed, "even if economic or budgetary considerations may make compliance with these obligations difficult").

The most recent of these documents, the Basic Principles for the Treatment of Prisoners declares,

except for those limitations that are demonstrably necessitated by the fact of incarceration, all prisoners shall retain the human rights and fundamental freedoms set out in the Universal Declaration of Human Rights, and, where the State concerned is a party, the International Covenant on Economic, Social and Cultural Rights, and the International Covenant on Civil and Political Rights and the Optional Protocol thereto, as well as such other rights as are set out in other United Nations covenants.⁵⁴

Endorsing this philosophy in 1992, the UN Human Rights Committee explained that states have “a positive obligation toward persons who are particularly vulnerable because of their status as persons deprived of liberty” and states,

not only may persons deprived of their liberty not be subjected to [torture or other cruel, inhuman or degrading treatment or punishment], including medical or scientific experimentation, but neither may they be subjected to any hardship or constraint other than that resulting from the deprivation of liberty; respect for the dignity of such persons must be guaranteed under the same conditions as for that of free persons. Persons deprived of their liberty enjoy all the rights set forth in the [ICCPR], subject to the restrictions that are unavoidable in a closed environment.⁵⁵

Significantly, the UN Human Rights Committee has also stressed that the obligation to treat persons deprived of their liberty with dignity and humanity is a fundamental and universally applicable rule, not dependent on the material resources available to the state party.⁵⁶

One significant consequence of this framework is that the enjoyment of the highest attainable standard of health is applicable to every human being without distinction as to race, religion, political belief, and economic or social condition. Therefore it applies equally to prisoners and detained persons.

As such, the lack of HIV education; harm reduction measures and voluntary and confidential testing for HIV infection; adequate pre- and post-test counselling and treatment for HIV-infected prisoners; as well as mandatory HIV testing and segregation of HIV-positive prisoners, undermine the public health response to HIV/AIDS, are contrary to human rights and compromises the human dignity of the person.

In addition, one measure of whether states are protecting the human rights of IDUs in prisons is whether they are receiving the same prevention and care measures as IDUs in the general community. For this to be a true measure, IDUs in the community must have access to comprehensive harm reduction programmes. If they are HIV-positive, they must be receiving non-discriminatory access to treatment, care and support, including anti-retroviral therapy, if medically indicated.

Section 2.5

Cost effectiveness harm reduction programmes

An expanded and sustained implementation of comprehensive harm reduction programmes is effective in the prevention and control of the spread of HIV and other blood-borne infections. The Australian National Council on Drugs (ANCD) conducted a study on harm reduction programmes implemented in the ten years from 1990-2000. According to the findings, harm reduction programmes were successful:

- An estimated 25,000 cases of HIV infection were prevented.
- An estimated 21,000 cases of HCV were prevented.
- More than 5,000 lives are estimated to be saved up to the year 2010.
- An investment of almost 150 million Australian dollars has resulted in an estimated return of 2.4-7.7 billion Australian dollars.⁵⁷

In Svetlogorsk, Belarus, an HIV prevention programme included education about safe injecting and safe sex, and provided clean syringes and condoms. In 1997, before the programme began, 92 per cent of those surveyed said they shared syringes. By 1999, this percentage had dropped sharply to 35 per cent, while reported condom use doubled over the same period.

The programme is estimated to have prevented over 2,000 cases of HIV infection by its second year, at a cost of around US\$ 68 per infection prevented; far below the cost of an AIDS case to a family or a health system. The Belarus campaign was bolstered by a change in the law, which made it legal to possess syringes and facilitated the funding and implementation of AIDS education and needle exchange among drug users.⁵⁸

Using data from Australia as a model, the number of HIV infections that could have been prevented by a national needle exchange programme in the United States from 1987-1995 were calculated. Cost calculations were based on the US government estimate of the discounted lifetime cost of treating an HIV infection (US\$ 55,640). It was calculated, conservatively, that the number of HIV infections that could have been prevented ranged from 4,394 (15 per cent incidence reduction due to needle exchanges) to 9,666 (33 per cent incidence reduction). The cost to the US health care system of treating these preventable HIV infections is between US\$ 244 million and US\$ 538 million, respectively.⁵⁹

In 1995, it was estimated that an additional 5,150-11,329 preventable HIV infections could occur by the year 2000 if there was no change in the policy on needle exchange programmes.⁶⁰ Another study estimated that for each year without increased access to sterile syringes by injecting drug users, as many as 12,350 people in the United States are becoming infected with HIV, leading to estimated cost of US\$ 1.3 billion in future medical costs. This study concluded that it is three times more expensive to provide medical treatment for one person ill with HIV/AIDS than it is to prevent one new HIV infection using needle exchange programmes and pharmacy sale of syringes.⁶¹

While governments often fear that programmes that facilitate IDUs access to clean needles and syringes might result in more injecting drug use, the evidence does not support this view. Studies in Australia, Canada, Sweden, the United Kingdom and the United States⁶² have all shown that such programmes – particularly in concert with other interventions – help reduce the sharing of injecting equipment and the transmission of HIV. There was no evidence that they increased either the number of injectors or the frequency of injecting drug use.



Galina Obukh/Federation



57 Australian National Council on Drugs, *Needle and Syringe Programs*, position paper, March 2002 http://www.ancd.org.au/publications/pdf/pp_needle_syringe.pdf.
 58 Kumaranayake, L; Watts C, Vickerman, P; Walker, D; Zviagin V; Samoshkin S; Romantsov V., *The cost-effectiveness of HIV preventive measures among injecting drug users in Svetlogorsk, Belarus* (draft), UNAIDS, May 2000 <http://www.ahrn.net/pdf/Belarus.pdf>.
 59 David R. Holtgrave, Steven D. Pinkerton, T. Stephen Jones, Peter Lurie, and David Vlahov, 1998, *Cost and cost-effectiveness of increasing access to sterile syringes and needles as an HIV prevention intervention in the United States*, Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology, 18 (supplement), pp. S133-S138.
 60 Lurie P and Drucker E., *An opportunity lost: HIV infections associated with lack of a national needle-exchange programme in the USA*, Center for AIDS Prevention Studies, University of California, San Francisco 94105, USA, Lancet. 1997 Mar 1; 349(9052):604-608.
 61 David R. Holtgrave, Steven D. Pinkerton, T. Stephen Jones, Peter Lurie, and David Vlahov, 1998, *Cost and cost-effectiveness of increasing access to sterile syringes and needles as an HIV prevention intervention in the United States*, Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology, 18 (supplement), pp. S133-S138.
 62 In April 1998, the then US Secretary of Health and Human Services, Donna E. Shalala publicly announced that the scientific evidence proved needle exchange programs were effective in preventing the spread of HIV and did not encourage the use of illegal drugs. U.S. Department of Health and Human Services, *Research shows needle exchange programs reduce HIV infections without increasing drug use*, Press release, 20 April 1998.

Chapter 3

National Society response

Section 3.1

Principles and strategy formulation

3.1.1 Guiding principles

The social nature of drug injection, the complex dynamics of sharing injecting equipment, and the interaction of drug use with high risk sexual behaviour, present considerable challenges for designing effective responses.⁶³ It is important to identify core principles underpinning appropriate responses.

The following are some of the major principles that National Societies intending to design harm reduction programmes should consider.

Active involvement of injecting drug users: Developing useful responses to the problems of HIV among IDUs is more likely to be effective if the views of people who inject drugs and the local community are listened to and taken into account when developing responses.

Protection of human rights: People are more vulnerable to infections when their economic, health, social and cultural rights are not respected. Respect for the rights of IDUs creates a favourable situation for addressing the complexities of injecting drug use preventing the sharing of injecting equipment.

Early intervention: HIV prevention among IDUs should start as early as possible. Once HIV is introduced into the community of IDUs the rate of transmission is fast.

Adequate coverage: It is recommended that at least 80 per cent of the target population is covered by comprehensive programming. Interventions should aim at achieving at least 60 per cent change in risk behaviours.

Base line data: The development of programmes should be based on situation assessment to have an in depth understanding of the local drug use pattern and the context. People outside IDU networks often know very little about the extent of the problem, nature of the subculture and the different determinants of the problem. Often prevailing social perceptions are not also well understood. Such information gives useful insights for addressing challenges.

Humane and compassionate response: Drug abuse problems can not be solved simply by criminal justice initiatives. Punitive action drives the people most in need of prevention and care services underground.

Concerted effort: There is a need to develop cooperation at all levels.

Working modality: There is a need for developing service outside traditional settings. Outreach work and peer education outside normal service settings, working hours and other conventional working arrangements are needed to reach IDUs.

⁶³ National Societies requiring background information on how to design and carry out an assessment on HIV/AIDS and drug use are referred to the Aids Alliance publication *Developing HIV/AIDS work with Drug Users – A Guide to Participatory Assessment and Response* (August 2003). <http://www.aidsalliance.org/>

3.1.2 Strategic directions

It is useful to explain the difference between interventions and strategies. In these guidelines, interventions comprise sets of activities and inputs required to achieve the desired outputs and outcomes. Strategy is the method for implementing interventions in identified areas so as to achieve the desired impacts.

In any given society, the prevailing social, political, cultural and economic conditions dictate the selection of interventions for implementation. Strategy assists the realization of planned activities by choosing appropriate interventions, which are supported by the necessary inputs to achieve the planned outcomes to meet the set objective. Several key points need to be considered in the identification of strategies.

Availability of supportive national policy and legal basis: The strategy must be built on a legal framework that can be adapted to allow comprehensive responses.

Awareness: Low level of awareness about the problem of drug use and HIV/AIDS, and inadequate knowledge about prevention leads to marginalization and stigmatization and discrimination against IDUs. It is important to understand this when deciding on strategies.

Multi-sector approach: Strategies that encourage the establishment of broad based alliances of local administration, police, health care providers, representatives of target population and community-based organizations need to be considered.

Local responsibilities: Decision-making powers and allocation of funding are usually centralized. However, for effective impact these powers and resources must be delegated to the local level, as appropriate.

Assessment: The identification of strategies must be based on baseline information concerning IDUs and the social setting. The underlying conditions within the community, particularly the magnitude, trend and dynamics of injecting drug use and the perceptions of the general community as well as decision-making bodies must be taken into consideration in deciding on any given strategy.

Taking these considerations into account, National Societies should develop strategies which promote and where appropriate facilitate harm reduction strategies for injecting drug users including advocacy for law reform, as necessary.

Section 3.2

Programme development

As mentioned previously, the fundamental principles and mandate of the Movement obligate National Red Cross and Red Crescent Societies to take all possible measures to assist injecting drug users.

Depending upon the prevailing conditions in any given country, National Societies can become involved in programmes:

- In countries where supportive policies exist, harm reduction programmes can be developed and implemented.
- In countries where supportive policies do not exist, National Societies can advocate with stakeholders, decision-makers, community opinion leaders and the community at large for changes in laws and policies related to injecting drug use to enable public health interventions.
- In the absence of a supportive legal and policy framework, National Societies can negotiate with governments to undertake pilot harm reduction programmes.

Effective response requires concerted action in which key players are involved in the design of harm reduction programmes. In developing such programmes, it is suggested to consider the several measures.

Active involvement of injecting drug users: More than anyone else, IDUs know well the nature of the problem they face and the types of assistance relevant to them. Therefore, efforts must be made to include them in all phases of programme development. Early contacts with IDUs are useful for establishing relationships which can be broadened through IDU involvement in programme development and implementation.

Lathvan red Cross



Baseline data: In many countries and communities little is known about IDUs. Information about IDUs, their social circumstances, their challenges, community perceptions and prevailing governmental laws and policies need to be compiled, analysed and used as basis for programme development – rapid situation assessment. Much of this information can be gleaned from IDUs if a relationship of trust is developed.

Community involvement: From the onset of programme development, all sectors of society, including relevant individuals, families and the general community should be involved.

Involvement of professionals: Professionals with relevant backgrounds such as social, health, law enforcement and criminal justice as well as International Organizations and NGOs should be involved from the outset.

Pragmatic intervention: To be effective, interventions must be locally oriented and focussed on the need of IDUs with provisions for periodic revision and adjustment when monitoring and evaluation of the programmes suggest that it is appropriate.

Integration: In many countries there are national drug control programmes which focus on demand and supply reduction as well as national HIV/AIDS prevention and control programmes. Harm reduction programmes should be linked to these national efforts.

Section 3.3

Areas of intervention

In the last two decades, some countries have adopted different interventions for reducing risks associated with injecting drug use. Based on the lessons learned, the following interventions have been successful in reducing individual risk behaviour and preventing infection through sharing injecting equipment:

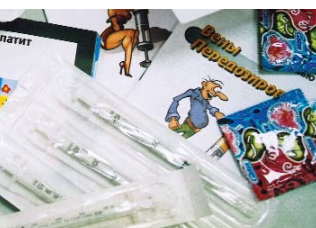
- outreach;
- drop in centres;
- needle and syringe exchange programmes;
- provision of free, good quality condoms;
- peer education;
- primary health care provision;
- drug substitution treatment; and
- injecting drug rooms.

3.3.1 Outreach

In many countries, drug use is illegal and drug users are prosecuted or may be harassed. IDUs can be hard to reach and shun contact with authorities, including health services. In this situation, in order to implement harm reduction programmes, it is necessary for outreach workers to go into the IDU community and make contact in the settings where IDUs live or where they congregate such as at train or bus stations, or in particular streets or parks.

Some features of outreach programme include:

- Outreach workers establish themselves in localities where IDUs meet.
- Establish face-to-face contact with IDUs. Such interaction helps create trust and facilitates acquisition of information regarding the problems and needs of IDUs.
- Provide services such as information on HIV/AIDS, first aid services, provision of condoms, and clean needles and syringes or information on where these can be obtained.
- Network with community groups in order to help integrate IDUs in social structures.
- The people involved in outreach programmes must be given adequate training prior to moving into the IDU community.
- Consider employing people who have experience working with IDUs to undertake outreach work.



Galina Obuklyi/Federation



The above outreach methods are most useful for reaching the more visible IDU's, who are often particularly vulnerable. Consideration should also be given to reaching the larger number of IDU's who are everywhere (such as recreational drug users) and therefore more hidden and often more difficult to identify and reach.

Secondary distribution: Croatia

The Croatian Red Cross has 105 well-structured branches with professional staff. Three syringe exchange projects are being carried out in selected areas based on the number of IDUs. Activities started in 1998 as part of the national strategy and include the distribution of needles and syringes to IDUs, as well as the distribution of condoms and information material at needle exchange points.

One of the main activities is secondary distribution. Clients at drug exchange points are used to further distribute syringes to other IDUs. It is estimated that there are 15,000-18,000 IDUs in Croatia. About 80 per cent of these are male and they are mainly heroine users. Most HIV transmission among IDUs is through unsafe sexual contacts.

3.3.2 Drop in centres

The situation in many countries is such that IDUs are often shunted from one place to the next. As such many IDUs receive little or no governmental, social or family assistance. Drop in centres, sometime known as boutiques, provide a safe space where IDUs can rest, shower, wash clothes, have light refreshments and relax. For such centres to be effective, they must be non-judgemental and not pressure clients.

The services in the drop in centres can include:

- showers;
- shelter;
- provision of washing machine service;
- coffee and tea;
- food;
- first aid assistance for their health problems;
- simple and understandable educational leaflets with contact information; and
- someone to talk to.

Comprehensive harm reduction: Italy

Villa Maraini Foundation was founded in 1976. Of the 140 people working with the Foundation, 50 per cent are ex-IDUs. The foundation has an emergency unit with a help line, street unit, prison and shelter projects – both drop in and for sleeping. The mobile teams operate with the objectives of reducing overdose deaths and the transmission of HIV/AIDS and other infectious diseases as well as assisting IDUs outside of the rehabilitation centre setting. The main tasks include:

- syringe exchange at two locations in Rome;
- distribution of condoms;
- sharing information on drugs, prevention of HIV/AIDS and other infectious diseases;
- finding solutions for housing issues; and
- psychological support.

Villa Maraini



3.3.3 Needle and syringe exchange programmes

Ensuring the availability of sterile injecting equipment so that each injection can be made free of HIV contamination is a fundamental step in breaking the chain of transmission.

Needle and syringe programmes function on the bases of providing sterile needles and syringes accompanied by educational materials, the provision of condoms as well as the collection of used syringes and needles. It is important to ensure that used needles and syringes are disposed of safely.

In many countries, sharp bins or containers are placed in toilets or other localities out of the view of the general public. The inappropriate disposal of needles and syringes is often cited as a fundamental reason why communities reject needle and syringe exchange programmes.

Successful ways for increasing needle and syringe availability include:

- sales of needle and syringes at minimum price through pharmacies and other outlets;
- free needle and syringe exchange programme; and
- providing appropriate means for the disposal of used needles and syringes.

Needle and syringe programme can be organized from:

- fixed, user-friendly drop in centres;
- self-help spaces;
- through outreach workers;
- through peer educators;



Andrew MacColl/Federation



Anne Sterk/UNAIDS

- mobile vans;
- dispensing machines located at places easily accessible to IDUs; and
- injecting drug rooms.

Where needle and syringe exchange programmes are not implemented because of legal or policy restrictions, such as in prisons and detention centres, then bleach can be provided to clean used needles and syringes before reuse. However, such measures are not proven to reliably stop HIV transmission and while better than nothing, must be considered as a compromise second line measure.

Taking every chance: harm reduction in Belarus

The Belarus Red Cross began harm reduction activities when the home care service was significantly curtailed, leaving a large surplus of unutilized disposable syringes. In 2002, the local authorities provided the Red Cross with the premises for a syringe exchange point. The Red Cross visited drug abuse clinics and the police to discuss the importance of introducing harm reduction programmes in light of the growing IDU-related HIV/AIDS epidemic. It also advertised its syringe exchange activities through the local press.

The Red Cross gained the trust of local IDUs and the programme has become popular. Every six weeks sees around 60 syringes distributed by the Red Cross, while the municipal health authorities were distributing the same amount of syringes during a whole year.

New for old: Latvia

Latvia has a population of 2.5 million people, 500,000 of whom live in the capital, Riga. HIV is prevalent among the country's youth. The Latvian Red Cross began syringe exchange activities in Riga in 1997 and outreach work programmes in 1999. In 2002 the syringe exchange programmes were expanded to eight municipalities and included the distribution of education material.

In 2002, about 100-300 new clients were served every month; health education information was updated regularly; and the rate of exchange of used syringes for new was close to 1:1. However, funding support for the programme has been difficult to maintain as the primary partner in Latvia changed organizational priorities.

3.3.4 Provision of free, good quality condoms

Unprotected sexual contact between IDUs and with other non-drug injecting sexual partners is another route for the transmission of HIV. Commercial sex work is often linked to drug use as it is one way in which drug injecting can be financed. This creates the risk of HIV moving from the IDU community into the general population via clients. Also, in prisons, sexual contact between inmates is frequent and IDUs are disproportionately represented in prison populations.

The provision of free, good quality condoms linked with education and information is a low cost intervention which can prevent the sexual transmission of HIV. Condom distribution can be integrated into many other interventions such as self-help spaces, outreach work, drop in centres, needle and syringe exchange programmes, peer education, primary health care provision, drug substitution treatment and injecting drug rooms. They can also be provided by mobile vans and through dispensing machines located in easily accessible places.

Central Asia

The reported number of HIV/AIDS cases in central Asia is progressively increasing, mainly among IDUs, who account for 60-85 per cent of all new infections. All five National Societies in central Asia are actively involved in the distribution of high quality condoms and health information material to targeted groups in the frame of their HIV/AIDS prevention programmes. Current activities are mainly focused on youth peer education. The National Society of Kazakhstan provides a hotline telephone service and anonymous, free of charge, psychological support to different vulnerable groups.

From 2004, the National Societies of Kazakhstan and Uzbekistan plan to involve IDUs and commercial sex workers in HIV/AIDS prevention activities. Home care for PLWHA is also planned.



3.3.5 Peer education

One of many reasons why people become involved in drug use is a lack of objective information concerning the effects and risks associated with drug use. It is important to create environments where relevant, objective information can be provided to drug users and to acknowledge that some people do continue to take drugs when well informed, but are then more likely to manage the risks involved. The use of trusted peer educators is an effective, proven method of reaching people who use drugs in their own environment.

Several features of peer education are worth noting:

- Objective information can be provided to drug users and IDUs in their own environment.
- Educational activities must take place in an environment of trust, which is best created by information being provided by current drug users or IDUs, or ex-drug users or IDUs.
- In the development and design of educational materials and approaches, drug users and IDUs should be fully involved from the outset.
- Printed educational materials can be used to provide information. However, it is acknowledged that its effect on attitudes and behaviours is limited. Such materials should provide service provider contact information.

Supporting injecting drug users: China

The Chinese government has registered more than one million drug users. The actual number of drug users could be 3-8 million and is increasing, as the social and economic structures change faster than many people's ability to adjust. About one half of users inject and most share injection equipment. This drives China's HIV/AIDS epidemics. Nationally, 60 per cent of PLWHA are IDUs. HIV infection rates among IDUs in some areas, particularly remote rural areas, are running at more than 80 per cent.

Despite a 95 per cent relapse rate, government facilities that treat addiction continue to rely on 'cold turkey' detoxification, physical rehabilitation through labour and rigorous physical exercise, and psychological rehabilitation through self-criticism. Harm reduction measures, including methadone assisted detoxification and substitution therapy, are new and implemented as small scale, pilot projects.

The cultural imperative of familial responsibility, rather than individual rights, and society's zero tolerance for drug use, ensure that IDUs are highly stigmatized. IDUs who have been through the government-run rehabilitation centres often express internalized shame and stigma.

Added to the stigma of weakness and degeneracy that attaches to drug users is the stigma of having a (popularly perceived) self-inflicted and fatal illness. While many people in China are aware of AIDS, few understand the routes of transmission and means of prevention. Many people who have correct knowledge of HIV transmission often have incorrect beliefs about non-transmission, and assume that casual contact or proximity to PLWHA can transmit the virus.

Efforts to provide care and support

The Sunshine Homeland for Drug Users in Kunming, Yunnan Province, developed and supported by the Red Cross Society of China and the Australian Red Cross, incorporates peer education, home



Australian Red Cross

care, and job skills training to improve care and support for former drugs users and PLWHA. Thirty recovering drug users have been trained as peer educators, and in the first six months of the project have facilitated 23 workshops for 500 participants in drug treatment centres and in the community.

Nineteen people have attended a basic computer skills course, and fourteen have been trained in first aid. Interviews with

project participants and their families indicate that the project is well-regarded and is, to date, attaining the objectives of discouraging drug relapse, reducing stigma and discrimination by family and communities towards those who have used drugs, as well as improving the self esteem of project participants.

PE+ project in Yunnan and Xinjiang Provinces

PE+ is a Red Cross cooperative project. It is China's first project to support the development of PLWHA as educators and as people who have something to give to their communities. Almost all PE+ educators are former drug users. PE+ trains PLWHA to educate their neighbours, friends, and family about HIV/AIDS as well as caring for those who are infected. In contrast to other Red Cross projects, PE+ is not structured and workshop-based, but relies on PE+ educators finding spontaneous and natural opportunities to talk to others about HIV/AIDS, prevention, and care. Weddings, funerals, mah-jong and card games, tea breaks during farm work – all are used as chances for volunteers to distribute information and discuss HIV/AIDS. For more information, please send an e-mail to <ifrcn12@ifrc.org>.

Involvement is a way forward: Viet Nam

For two years, a person with a history of drug use, who is also living with HIV, was supported by the Red Cross of Viet Nam and the Australian Red Cross, to take the lead in outreach work to IDUs and PLWHA and to bolster a community of support. Involvement in this work did much to repair the self-esteem of this person who entered treatment voluntarily with support from his family.

3.3.6 Primary health care services

Many IDUs do not have access to basic health care services or are afraid to use them even though they may have been exposed to infections prevalent in their communities. IDUs are also susceptible to health problems related to drug injections such as multiple abscess and skin lesions.

In addition, many IDUs are without work and whatever money is available may be used for drugs. As a result many IDUs suffer from malnutrition or are unable to pay for health care. Furthermore, in terms of family background, IDUs may come from dysfunctional families or their addiction has caused their family to cut from them; so that this traditional source of support is also not available.

Primary health care (PHC) services can address health problems including HIV infection. HIV/AIDS related treatment and care aims to help drug users living with HIV/AIDS cope with the infection. Involving IDUs living with HIV in primary health care and/or anti-retroviral treatment programmes provides an opportunity for them to adopt and consolidate safe behaviours and may yield significant HIV preventive effects, and most importantly can delay the on set of AIDS. Prevention aspects apply particularly to HIV/AIDS treatment and care that is provided in the context of specific information and counselling services.

The provision of information about PHC services and the services themselves can be integrated into different harm reduction interventions including educational programmes and materials, self-help spaces, drop in centres, injecting drug rooms, referral by outreach workers and mobile vans. Services can also be provided through the coordination of referrals to health care institutions that provide free medical care, by those working with IDUs.

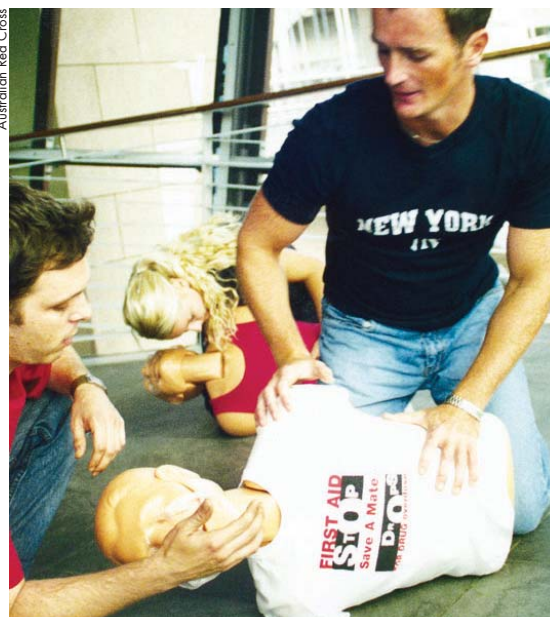
Possible PHC services for IDUs:

- medical care such as draining and dressing of abscesses and treatment of skin lesions;
- treatment of common infections and sexually transmitted infections (STIs);
- screening for TB and treatment;
- provision of, or referral to, voluntary HIV testing and counselling services;
- education on, and the provision of, basic materials to maintain personal hygiene;
- education and the provision of materials to maintain sanitary conditions in the place of residence;
- support, information and food for improving nutrition; and
- vaccination programmes, particularly for HBV, for IDUs and their dependents.

Save a Mate: Australia

In Australia, the misuse of drugs is the sixth largest killer of young people with up to 70 per cent of overdoses witnessed, usually by a friend or family member. The risk of a drug-related emergency is not exclusive to any single age or socio-economic group but traverses the whole of society. The prompt and appropriate intervention by bystanders with the provision of basic life support, cardio-pulmonary resuscitation (CPR), before the arrival of ambulance paramedics is an essential component in reducing the number of deaths resulting from drug overdose.

Save a Mate (SAM) is an initiative of the New South Wales branch of the Australian Red Cross. It is a drug education programme and first-aid course specifically designed for alcohol and other drug-



Australian Red Cross

related emergencies. The programme provides a general orientation to drug and alcohol issues, challenges myths, and teaches how to administer life-saving techniques in drug and alcohol emergencies. SAM is targeted at people considered at most risk of engaging in harmful drug-taking behaviour, and those who live or work in an environment where there is a risk of a drug and/or alcohol-related emergency occurring.

The programme has two components:

1. Drug and alcohol seminar

- What is a drug?
- Classes of drugs
- Routes of administration and physiological dangers
- Rationales behind drug use
- Addiction, tolerance, overdose and harm in relation to drug use

2. First aid for drug-related emergencies

- What is first aid?
- Recognizing drug and alcohol emergencies and dealing with emergency assistance telephone operators
- Emergency action principles (DR. ABC)
- Universal (standard) precautions
- Legal considerations
- Drug and alcohol first aid – CPR

Drug use affects everybody – the user, family members, children, and the wider community. If you live or work with drug issues, the chances are you will encounter an overdose or drop at some point. The skills taught in the SAM programme do save lives. In the event of overdose, people, professionals, friends or family, who are equipped with the knowledge and skills of first aid, which are needed in the vital minutes before medical assistance arrives, can administer CPR – it can mean the difference between life and death.

SAM has taken a traditional Red Cross service, first aid, and customized it to address a relevant contemporary issue, drug use. For more information, visit <www.nsw.redcross.org.au>.

3.3.7 Drug substitution treatment: low threshold programme

Some of the worst public health problems associated with drug use involve those drugs taken through injection and where the injecting equipment is shared. Of all the modes of HIV transmission, directly injecting a substance including opiates such as heroin, methadone or morphine, or other drugs such as cocaine, amphetamines, anabolic steroids, antibiotics or vitamins, contaminated with HIV into the blood stream is by far the most efficient.

In the case of heroin, IDUs can receive medically supervised treatment by drug substitution, which does not give the same effects as the drugs themselves. Substitution drugs take care of the symptoms of withdrawal and craving but do not provide a high. The benefit of substitution drugs is that pharmacotherapy helps stabilize and normalize the lives of drug users. Methadone and buprenorphine are the most commonly used substitution drugs, of which methadone is the best researched.

Some facts about methadone treatment and its uses:⁶⁴

- Methadone is a synthetic opiate without strong sedative effects.
- Methadone can be administered orally in tablet or syrup forms thus avoiding injections and the possible associated risks of sharing needles and syringes and other injection paraphernalia.
- Methadone can cause dependence of a lesser nature than that of other opiates.
- People can stop using methadone by reducing the dose gradually.

- Retention of IDUs in substitution programmes reduces the health and social consequences of drug use and eventually may lead to detoxification and abstinence.
- For effective results, substitution drug treatment must be combined with support for IDUs to reintegrate in society, including employment, which requires support in the work place.



Andrew MacCall/Federation

3.3.8 Injecting drug rooms

Injecting drug rooms are still a controversial harm reduction intervention, but there is little doubt that such direct intervention saves lives. The rooms are in effect, safe spaces for injection with medical personal on hand to provide first aid in the event of an overdose or drop.



Australian Red Cross

Section 3.4

Facilitation of programme implementation

A coherent and smooth implementation of harm reduction programmes requires strong commitment and concerted efforts of national and local policy-makers and public authorities. Moreover, effective and broad-based community responses that involve NGOs, community-based organizations, IDUs and the private sector are also required.

National Red Cross and Red Crescent Societies have much experience in working within communities, with civil society, governments, and international donors and organizations in relief and development related programmes. Harm reduction programmes have been proven to reduce the transmission of HIV and other blood borne infections and increase the overall well-being of drug users and injecting drug users.

Yet the introduction and implementation of these programmes require additional efforts on the part of National Societies, particularly in the field of advocacy. As such, programmes are often high profile and require legal and policy reforms and changes. However, in keeping with the fundamental principles of humanity, impartiality and neutrality, it is part of the Movement's commitment to protect the most vulnerable without discrimination, which includes people who inject drugs.

There are many actions National Societies can take to facilitate programme implementation:

- Educate volunteers and staff about drug use including injecting drug use in the general community and in prisons, HIV/AIDS and harm reduction strategies. Education will also counter the stigmatization of and discrimination against IDUs and PLWHA and will empower National Society members to be informed advocates for the reform of laws and policies related to injecting drug use and to effectively implement harm reduction programmes.

- Organize workshops and seminars on relevant subjects including detainees, HIV/AIDS and the role of the National Society.
- Make an effort to get the support of policy-makers at the national and local levels by explaining the importance of harm reduction programme to senior government officials at all opportune moments and in all forums. For example, the members of the National Society executive committees and boards are often ex-senior government officials or well-respected members of society. These channels should be used to deliver messages on the necessity of introducing harm reduction programmes.
- Advocate for harm reduction programmes through social marketing campaigns, resource mobilization and human resource development programmes.
- The effective implementation of harm reduction programmes partly depends on the active involvement of IDUs. In an environment of repressive laws and policies as well as stigma and discrimination, IDU participation is likely to be minimal. Yet, National Societies can contribute to creating an enabling environment:
 - Organize regular discussion forums with law enforcement bodies such as the police, judges and other judicial officers. Explain the importance of harm reduction programme in the prevention and control of HIV. Such forums can be used to give updates on the implementation of programmes including the successes and setbacks, while seeking their participation in finding solutions to obstacles.
 - Identify key or respected community leaders or members and engage them in the development and design of harm reduction programmes, in regular discussions on the success and challenges encountered in programme implementation as well as ways of addressing stigma and discrimination.
 - National Societies can provide space in their buildings for IDU self-help groups.
 - Establish coordinating bodies including policy-makers, public authorities, service providers, representatives of service users, relevant NGOs and community-based organizations at national and local levels to help streamline the efforts of organizations to avoid duplication of efforts, and share experiences and information for synergy.
 - Incorporate monitoring and evaluation as part of the development of harm reduction programmes. Indicators and systems for information collection and analysis need to be defined during the programme development phase. Effective monitoring will indicate in a timely manner programmatic weaknesses so that they can be addressed and rectified. Such measures positively contribute to the effective, efficient and transparent management of programmes and assist in achieving programme objectives. Such monitoring and evaluation will produce lessons learned and perhaps good practices which can be disbursed across the Movement.

Section 3.5

Advocating harm reduction programmes

In many countries, the transmission of HIV is being fuelled by people sharing injecting equipment. And still, there are no supportive policy and legal framework for the development and implementation of harm reduction programmes. In light of the alarming scenarios seen in eastern Europe and Asia, there is a compelling reason for strongly advocating governments to introduce harm reduction programmes.

National Societies in partnership with other organizations can play a useful role in conducting advocacy for the acceptance, introduction and maintenance of harm reduction programmes. In this process it is important to identify issues that National Societies focus on.

3.5.1 Changing society views

Societies have views about IDUs that do not reflect an understanding of why people become involved in drug use and the associated risks. Negative or uniformed views may be reflected in marginalization or harassment of, stigmatization or antipathy towards, or discrimination against IDUs. To change such views requires:

- conducting a short survey to understand society's views and perceptions of drug use and IDUs; and
- based on the findings of the surveys prepare appropriate messages that can positively influence social views and perceptions, including countering misunderstandings and misinformation. This work aligns naturally with existing work to promote humanitarian values and should involve IDUs.

Galina Obukh/Federation



Possible action that National Red Cross Red Crescent Societies can take:

- Educate volunteers and staff about drug use including injecting drug use in the general community and in prisons. Also educate about HIV/AIDS and harm reduction strategies to promote humanitarian values and counter stigma of and discrimination against IDUs.
- Involve current and ex-IDUs as well as PLWHA in the design and implementation of the advocacy process.
- National Societies can provide space in their buildings for IDU self-help groups.
- Develop key messages on injecting drug use in the community and in prison, and on HIV/AIDS and harm reduction.
- Identify community and government leaders and organize briefing sessions to make them aware of issues faced by IDUs and ways to deal with these, including harm reduction strategies and countering stigma and discrimination.
- Through the oriented key society leaders, and using the key messages, facilitate educational sessions for the community.
- Facilitate ongoing dialogue with community leaders on harm reduction strategies, including with leaders of faith-based organizations and ethnic and marginalized groups.
- Promote dialogue for a supportive policy and legal framework through discussions with key community members and others such as academics and activists.
- Use public forums and, in particular, the mass media to explain what harm reduction is, its benefits, the underlying rationales and its cost effectiveness.
- Disseminate information through the media to the general public about harm reduction programmes during national, regional or global events such as conferences, on 1 December – World AIDS Day, 8 May – World Red Cross and Red Crescent Day.
- Coordinate public debate with professional associations including teachers, lawyers, law enforcement and medical, as well as human rights centres, known activists and NGOs.
- Research which obligations with regards to IDUs and harm reduction the government has ratified freely in human rights treaties. What obligations did the government agree to through the UNGASS Declaration? Did the government undertake obligations in the Ottawa Charter on Health Promotion, 1986, the Cairo Programme of Action, 1994, the Habitat Agenda, 1996, the Copenhagen Declaration, 1999, or other United Nations Conference Declarations? What are the country's obligations derived from the World Health Assembly's Declaration, Health for All in the 21st Century, 1998? What plans or promises has it made in national HIV/AIDS strategies? Make these public.⁶⁵
- Advocate for health services that promote a range of options for people choosing to discontinue drug use.

⁶⁵ See footnotes 42, 50, 51 and 52.

Convey the message: Bosnia and Herzegovina

'Drugs are not having the last word', was the topic of a press conference and round table discussions organized by the Red Cross of Bosnia and Herzegovina on 8 May – International Red Cross and Red Crescent Day. "The subject has been on the Red Cross agenda for the last few years," says Lea Kujundzic, head of the Red Cross international department. "And we use the Red Cross Red Crescent Day to highlight the problem in our country, a problem which is on the way from east to west."

Two video clips aimed at prevention of drug abuse have been developed and shown on the national television. A large ceremony took place for the representatives of diplomatic missions and partners from among NGOs devoted to these latest Red Cross activities.

Confront stigma and discrimination: Viet Nam

The Red Cross in Viet Nam has been including IDUs in the groups of youth receiving education and skill development regarding HIV prevention. It has been a challenge to reach out and include IDUs as the government's 'social evils' approach promotes the idea that IDUs are to be feared and shunned, rather than helped. One community even refused the Red Cross use of the community hall if IDUs were included in the HIV education sessions. Rather than sacrifice the fundamental principles of the Red Cross and Red Crescent, the Red Cross in Viet Nam conducted the session under a tree in the village.



Use the media: Italy

The Villa Maraini, a foundation of the Italian Red Cross in Rome, has been providing treatment to drug users within the framework of the Italian Red Cross for more than 25 years. By advocating for better treatment of IDUs by police forces, it is creating an enabling environment for harm reduction activities to be carried out. And this means less HIV transmission. The foundation advocates for humane treatment to reduce human suffering – respecting that all drug users are

different and that addiction is a disease that requires treatment in just the same manner that other diseases require treatment.

The foundation is fighting the stigma faced by drug users in Italy using the mass media. Five police officers, who are also world or Olympic sports champions, have appeared in advertisements organized by Villa Maraini advocating for the humane treatment of drug users. Now that the police force fully understands the issues that surround drug use, they have been more capable of understanding the harm reduction approach.

3.5.2 Influencing policy-makers

The lack of a supportive legal and policy framework is the greatest obstacle to the acceptance, introduction and maintenance of harm reduction programmes. In many countries, the relationship between the spread of HIV and drug use is ignored, disbelieved or neglected. In some countries, dialogue on policy reform rarely takes place.

Drug policies in many countries do not focus on public health issues such as HIV/AIDS. Conversely HIV/AIDS policies often do not address injecting drug use. Often governments and development agencies place priority on funding long-term solutions to drug use undermining efforts to reduce the more immediate harm caused by the transmission of infections such as HIV through sharing injecting equipment.

Informing policy-maker's views requires several factors:

- Involve current and ex-IDUs as well as PLWHA in the advocacy process so as to present their views and to give a human face to the issues.
- Present evidence that despite repressive laws and policies in some countries concerning the supply, demand and use of drugs over decades, drug use and injecting drug use is increasing.
- Present evidence that drug use is present in the society, including information on the role of injecting drug use in prisons in facilitating generalized HIV epidemics.
- Present the evidence about the role of sharing of injecting equipment increasing the incidence and prevalence of HIV, HBV and HCV in the community and in prisons.
- Present the evidence that harm reduction programmes prevent HIV transmission and other blood borne infections in the community and in prisons.
- Present evidence that harm reduction programmes do not increase the level of drug use in the community and in prisons.
- Present evidence that harm reduction programmes are cost effective.
- Present the government with information on its human rights obligations, particularly in relation to health, which it has freely entered into, and how these relate to injecting drug use and HIV.
- As part of promoting humanitarian values, assert that while an IDU-related HIV epidemic may be less visible than a famine or natural disaster, the government's obligations in the face of human suffering and death are similar.

There are several possible actions National Red Cross and Red Crescent Societies can take:

- Involve current and ex-IDUs as well as PLWHA in the design and implementation of the advocacy process so as to present their views and to give a human face to the issue.
- Gather scientific evidence on harm reduction programmes and their success and present it to decision-makers through all possible channels.
- Gather good practices and lessons learned from other harm reduction programmes in country and from other countries to present to government and communities.
- Advocate with the government to repeal laws on the non-provision of condoms, needles and syringes in the community and in prisons.
- Advocate for the introduction of appropriate drug use and related education programmes for families of prisoners and juvenile detainees.
- Advocate with governments to expand the range of non-custodial sentencing options for persons convicted of drug use and, where appropriate, related charges.
- Support AIDS education, voluntary and confidential testing for HIV infection, pre- and post-test counselling and awareness programmes for IDUs.
- Develop youth peer education programmes and outreach for people who inject drugs.

- Develop peer education programmes specifically targeted at the use of drugs, including injecting drugs, for recreational use at parties and raves.
- Research the human rights treaties the government has ratified; the obligations which it has undertaken in the UNGASS Declaration and Ottawa Charter on Health Promotion (1986) as well as the plans laid out in national HIV/AIDS strategies. Advocate for the government to fulfil its obligations particularly with regards to IDUs and harm reduction.
- Negotiate with governments to undertake pilot harm reduction programmes.
- During international or national events that have wide media coverage, focus on one or two key messages so as to provide a sustained, coherent message. For example, see Annex III, the International Federation press releases from the International Conference on Reduction of Drug Related Harm, Thailand, 6-10 April 2003.



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Annex II

Drug characteristics and effects⁶⁶

Heroin

- First discovered by a British chemist in 1871, heroin or *diacetylmorphine* is produced by bonding opium's active ingredient, morphine, obtained from the opium poppy, with a common industrial acid, acetic anhydride. By the end of the 19th century heroin was being mass produced and used as a broad spectrum pain killer. It was believed to be a safe, non-addictive morphine substitute.
- Heroin can be administered by injection, sniffing (snorting), or smoking and is highly physically addictive and produces lasting psychological dependence.
- Depending on the availability of heroin and the finances of the user, heroin is commonly injected about three times a day with effects lasting from three to six hours.
- Common behaviours following administration include an increased sense of euphoria and sleepiness, lethargy, docile appearance and possibly a shuffling gait.
- Acute withdrawal symptoms commence within 8 to 12 hours after the last dose. Though these are generally not life threatening they can be very severe, including gastrointestinal discomfort, muscle cramps and flu-like symptoms. In some people, withdrawal symptoms can be so severe that when some users obtain heroin, they may inject as rapidly as possible, sometimes without concern for possible HIV, hepatitis B or hepatitis C infection.
- Associated health problems of long term heroin use can be collapsed veins, abscesses, tetanus, HIV/AIDS, hepatitis B, hepatitis C, heart, chest and bronchial problems and constipation. Overdose risk is independent of length of use.

Opium

- The sole source of opium is the opium poppy, *Papaver somniferum*. The psychological and healing effects of opium have been known for around 4,000 years.
- By incising the head of the opium poppy, farmers can extract its sticky brown sap from the egg shaped bulb. The raw opium sap contains 7-15 per cent morphine, which easily can be precipitated from the poppy sap after simple boiling. Raw opium has a characteristic odour which is strong and pungent.
- Opiate receptors in the brain induce high physiological addiction and lasting psychological dependence. Regular use results in increased tolerance and the need for greater quantities of the drug.
- Use of opium in developed countries has decreased substantially but it is still widely used among highland ethnic minorities in China, Laos, Cambodia, Myanmar, Thailand and Viet Nam both for recreational and medical purposes.
- Can produce intense euphoria, a heightened state of well-being, enhanced imagination and speech. Soon after, respiration slows down, imagination diminishes and the thinking process becomes confused. Lethargy, relaxation and deep sleep usually follow.

⁶⁶ The information in this annex is adapted from the *Manual for Reducing Drug Related Harm in Asia*, The Centre for Harm Reduction, Macfarlane Burnet Centre for Medical Research and Asian Harm Reduction Network, 2003.

- Administration is usually by smoking but it can also be chewed and cooked with food for digestion. Particularly in countries of origin, it can be drunk as an infusion.
- The opium pipe has a long thick stem with a bowl at one end. The opium 'pellet' is placed into the bowl, heated and the smoke is inhaled.
- Sediment or the 'dross' left in smoking implements can contain up to 8 per cent morphine, is often used again and is known as black water opium. This form of opium still remains popular in particular Asian countries, i.e. Viet Nam and Cambodia.
- Smoking puts more of the active ingredients of opium into the blood stream faster, by the way of the lungs, so the drug begins to reach the brain in about seven seconds.
- Long-term use results in decreased mental and physical capacities with loss of appetite and body wasting.
- Withdrawal symptoms, similar to those of morphine, include agitation, irritability, anxiety, restlessness, insomnia, and abdominal and muscle pain.

Morphine

- Morphine is a naturally occurring substance in the opium poppy, *Papaver Somniferous*. Morphine is most commonly found as morphine sulfate and morphine hydrochloride. Both are fine white crystalline powders, bitter to the taste. Both are soluble in water and slightly soluble in alcohol.
- Morphine is a potent narcotic analgesic, and its primary clinical use is in the management of moderately severe and severe pain.
- Morphine is administered by several routes (injected, smoked, sniffed, or swallowed); but when injected intravenously, morphine can produce intense euphoria and a general state of well-being and relaxation.
- Regular use can result in the rapid development of tolerance to these effects. Profound physical and psychological dependence can also rapidly develop, and withdrawal sickness upon abrupt cessation of morphine use; many of the symptoms resemble those produced by a case of moderately severe flu.
- Irregular or intermittent users (who are not substituting the drug for another narcotic analgesic) may start and continue to use doses within the therapeutic range (i.e. up to 20 milligrams). However, regular users who employ morphine for its subjectively pleasurable effects frequently increase the dose as tolerance develops. To take several hundred milligrams per day is common, and there are reliable reports of up to four or five grams (4,000-5,000 mg) per day.
- Duration of effect is four to five hours.

Methadone

- German chemists first produced methadone in the early 20th century and it has been used clinically since the end of the First World War.
- It is a powerful synthetic opiate like heroin and morphine but without the strong sedative effect. It can substitute for heroin and is widely used by doctors in the treatment of heroin addiction.
- In its basic form it is a white crystalline powder. It is generally administered as a syrup, mixed with cordial or fruit juice and taken orally. Methadone is also available in an injectable form. Users have been known to inject the syrup which can result in health problems.
- Effects are felt within one hour of a dose, with the peak effect felt at four to eight hours after the dose. The effects of methadone last longer (usually up to 24 hours) than heroin and therefore administration is usually once a day.
- Doses vary for different people and from the commencement of treatment the dose is gradually increased while observing the level of tolerance and avoiding the onset of heroin withdrawal. Once treatment has stabilized, daily dosages can vary from 40 milligrams to over 100 milligrams.
- If the dose is too low opiate withdrawal can occur resulting in symptoms such as abdominal cramps, nausea and vomiting, irritability and back and joint ache. Too high a dose can be indicated by such symptoms as drowsiness, nodding off, shallow breathing and pinpoint pupils.

- Other side effects that can occur but are unrelated to the dose can include, sweating, constipation, aching muscles and joints, decreased sex drive, fluid retention, loss of appetite and tooth decay.
- Methadone can lead to dependence but it is generally considered less serious than heroin and morphine dependence and is easier to treat. People can stop using methadone by reducing their dose gradually, by not setting a time to achieve this goal, and by consulting the counsellor/doctor involved in the methadone programme about what is involved.
- Sudden withdrawal is not recommended as the discomfort encountered can result in people using heroin again regularly.

Cocaine

- Inhabitants of South America have a history of chewing the coca leaf for thousands of years but it has only been known to the Europeans since the 19th century. The coca leaf affects a number of neurotransmitter systems in the brain and is active on various anatomical sites within the central nervous system.
- Cocaine is produced by chemical processing and treatment of the coca plant which transforms the leaves into coca paste. Paste is treated with hydrochloric acid to remove impurities and results in white, crystalline substance, cocaine hydrochloride.
- It is the most potent of the stimulants.
- In the form of leaf chewing or brewed tea the drug is believed to be virtually harmless but it is rarely available in this form outside of South America.
- Disagreements exist among authorities and researchers as to the addictive nature of cocaine. While some state there is a high risk of developing physical and psychological dependence, many researchers suggest that cocaine does not produce physical dependence.
- Methods of administration include snorting by intranasal inhalation (onset of effects two to four minutes); smoking or 'freebasing' (burning the crystals and smoking the vapours; onset of effect 15 seconds); and injection (onset of effect 15-20 seconds).
- Effects can last from 10 to 40 minutes depending on the purity and the route of the administration.
- Typical behaviours during the effect include hyperactivity, exhilaration, increased energy, alertness, confidence and sexual activity. The user may also have unpredictable behaviour, feel invincible and be both quarrelsome and aggressive.
- A fatal condition can result from sensitivity to the drug or massive overdose.
- Several hours after last use, feelings of agitation and depression can occur.
- There is a high risk of HIV transmission since typical IDUs of cocaine require more injections than heroin, and high incidence of sharing of needles and unprotected, prolonged sexual intercourse.

Cannabis

- Cannabis is a psychotropic product from the plant *Cannabis sativa*. It is believed to have been used for thousands of years for medical, religious and social reasons. The stem of the plant (non potent form of cannabis) is used in the manufacture of hemp rope, string, paper, textiles and clothing.
- There are male and female plants. The strongest concentration of the psychoactive chemical, Tetrahydrocannabinol or THC, is found in the flowering shoots of the female plant.
- A widely used drug with a relatively low potential for harm when compared to heroin, alcohol and tobacco.
- There are differing views by authorities on physical dependency of cannabis. Psychological dependency can be associated with frequent cannabis use.
- Three forms of cannabis exist: marijuana, hashish and hashish oil. Marijuana is the dried leaves and flowers of the plant and is usually the least potent of the three. Hashish forms as a sticky oil coating on the flowering tops of the plant which is collected and made into small blocks of dried resin. The concentration of THC is greater thus producing a stronger effect. Hashish oil is the

extraction from the resin of the cannabis plant and is the most powerful of all the cannabis forms.

- Marijuana is usually smoked in hand rolled cigarettes or in a pipe. The concentrated form of hashish or hashish oil is often smoked with ordinary cigarettes or incorporated into food substances such as cakes and biscuits and ingested.
- Effects vary due to a number of factors in relation to the person, method of administration, cannabis form and frequency and period of use. Some effects can include euphoria, relaxation, relief from stress and pain, increased appetite, impaired motor skills, confusion, loss of concentration and decreased motivation.
- Effects normally reach their peak within 30 minutes and can last up to three hours.
- Withdrawal following long-term use can include headaches, anxiety, depression, and sleep disturbance.
- Like other burnt inhalations cannabis contains carcinogens, tar and carbon monoxide. This can result in respiratory complications, cardiovascular effects and cancer. A single cannabis cigarette contains the same amount of tar and other noxious substances as approximately 14-16 filtered cigarettes.

Amphetamine

- Originally synthesized in Germany in the late 19th century amphetamines were not patented until the 1930s. In the 1940s the drug came into therapeutic use for a variety of medical conditions such as epilepsy, depression and hyperkinetic children. Following the Second World War, amphetamines were promoted quite readily.
- Amphetamines have a stimulant action similar to the naturally occurring hormone adrenaline which stimulates the activity of the central nervous system and increases the activity of the brain.
- Amphetamines appear in a number of forms and when manufactured illegally can be found in powder, tablet, capsules or liquid. Administration is by ingestion, injection, inhaled through the nose and smoked when in the form of methamphetamine hydrochloride.
- Most common illicit manufacturing of amphetamine is in the form of methylamphetamine. The most common starting material for methylamphetamine is ephedrine, which is a legal substance, is readily available in tablets or capsules and is sold as a decongestant.
- Self medication with amphetamine is common among truck drivers, students, fishermen, and businessmen to stave off normal fatigue, enabling them to work for days with little sleep or food.
- Effects usually wear off after three to six hours and the user can become suddenly tired, irritable, depressed and unable to concentrate. Methylamphetamine 'ice' when smoked can have an effect of between 2 to 16 hours depending on the amount taken.
- Effects from amphetamines vary and depend on dosage, mode of administration, the individual, and the circumstances in which the drug is taken.
- Low doses can result in a sensation of euphoria, heightened alertness, increased energy and activity, reduced appetite and self confidence. Long-term use can lead to malnutrition, exhaustion, depression and psychosis. Death from stimulant use is rare but is more likely to occur with intravenous injection.
- Tolerance can be pronounced where a long-time user may need 20 times the initial dose to produce the same effect.
- Has a reputation for facilitating social and sexual interactions which has implications for potential HIV risks as enhanced sexuality may not be accompanied by safer sexual practices.
- Withdrawal symptoms during the initial period may be acute exhaustion, and for a regular user, it may be followed by irritability, lethargy, deep depression, anxiety attacks and episodic craving.

Ecstasy or Methylenedioxymethamphetamine (MDMA)

- Although first patented in Germany in 1914 as an appetite suppressant, it was never marketed. In the 1970s it was used by psychiatrists in the United States as a valuable and safe aid to counselling and therapy, until it was banned in the mid 1980s. Since the 1990s it was commonly associated with dance parties and other social activities, including sex.

- Closely related to both amphetamines and hallucinogens it is often described as a psychedelic drug with stimulant properties.
- Appears as tablet (most frequently seen), capsule and powder form.
- Preferred administration is by swallowing although there are reports of experimentation by injection and inhalation.
- Taken orally the effect will commence between 30 to 60 minutes and may last for several hours.
- The immediate effects can be a 'rush' of euphoria, followed by a general sense of peacefulness and heightened sensual awareness. Inhibition can disappear, there is increased self esteem and confidence, and improved trust and communication between friends can occur. Adverse effects can include dry mouth and throat, jaw clenching, increased heart rate and blood pressure.
- Overdose can result from very high blood pressure, increased heart beat and body temperature (overheating). Deaths have been reported from fluid imbalance either by dehydration or water overloading.
- A 'high' can be followed with fatigue, anxiety and a depression which may last several days.
- Tolerance can develop with continued use and some dependence is thought to occur. Little is known about long-term effects but it has been suggested that it may damage some types of brain cells.

Hallucinogens

- Hallucinogens also known as psychedelics, act on the central nervous system to produce significant, often radical, changes to the user's state of consciousness; can distort the user's sense of reality, time and emotions. First synthetically produced in the 1940s to remove obstructive inhibitions in psychiatric cases. Those derived from plants, such as the peyote cactus, have been used by indigenous groups of Mexico for hundreds of years for recreation and religious observations. Other hallucinogens include mescaline (natural product from the peyote cactus), nutmeg and mushrooms (containing the drugs psilocin and psilocybin), dimethyltryptamine (DMT), phencyclidine (PCP) and ketamine hydrochloride.
- Lysergic acid diethylamide (LSD) is the best known of hallucinogens. It is a synthetic drug based on an ergot which has been extracted from a dry fungus that grows on rye grass. The manufacturing of LSD from precursor drugs requires a high level of technical knowledge and expertise.
- LSD is an odourless, colourless and tasteless liquid which is often absorbed into any suitable substance such as blotting paper and sugar cubes or can be incorporated into a tablet, capsule or occasionally confectionery. Its most popular form is on absorbent sheets of paper which are then divided into squares and taken orally.
- Unlike many other drugs, LSD users can have little idea of what they are embarking on and the effects can vary from person to person, from occasion to occasion and the dose.
- Effects can begin within one hour, build up between two to eight hours and slowly subside after about 12 hours.
- For many LSD users the effect can be extremely enjoyable, relaxing and promote a sense of well-being. There are often changes in perception, of sight, sound, touch, smell, taste and space. Negative effects can include loss of emotional control, disorientation, depression, dizziness, acute panic and feelings of being invincible resulting in a person physically placing themselves in danger.
- Long-term use can result in flashbacks of hallucinogenic effects, days, weeks or months after using the drug.
- There is no evidence of physical dependence and no withdrawal symptoms have been observed even after prolonged use. However, psychological dependence can occur.
- Tolerance to LSD can develop rapidly but tolerance can also disappear after five to six days when not used on a regular basis.

Nicotine/tobacco

- Known to be used by Native Americans in religious and social occasions 1,000 years ago. Introduced to Europe in the 17th century where it was used for recreation and medicinal pur-

poses. Tobacco consumption expanded with the introduction of milder forms of tobacco, automatic cigarette rolling machines, massive advertising campaigns and when governments saw its potency as a source of revenue.

- Nicotine, found in tobacco, is one of the most addictive substances known. Nicotine is a central nervous stimulant that disrupts neurotransmitter balance. Physical dependence on nicotine and more importantly, psychological dependence on cigarettes, develops quickly.
- Tobacco inhalation results in nicotine affecting the central nervous system (CNS) in about ten seconds. With the chewing of tobacco, it takes upwards of five minutes to affect the CNS.
- The effect of nicotine when tobacco is consumed in the form of smoking, chewing or as snuff is the constriction of blood vessels, raising of the heart rate, and blood pressure, decreased appetite, producing mild emphysema, partially deadens sensation of taste and smell and irritates the lungs. Prolonged use of tobacco can cause lung, heart and blood vessel damage and cancer.
- The World Health Organization estimates that smoking is responsible for one out of five deaths, or 3 million deaths per year. Research has shown that over 50 per cent of smokers will die prematurely as a direct result of tobacco induced illnesses.
- Tolerance to the effects of nicotine develops rapidly, faster than that of heroin and cocaine.
- Withdrawal, after long term-use can result in headaches, severe irritability, inability to concentrate, nervousness and sleep disturbance. Nicotine craving may last a lifetime after withdrawal.
- For the very physically dependent, nicotine patches are provided in a relatively harmless form avoiding the injurious affects of tobacco smoke such as carbon monoxide, tar, soot and other by products.

Solvents, inhalants and volatile substances

- Since ancient times, people have inhaled the vapours of perfumes, ointment and burning spices as part of their religious ceremonies. Solvent misuse, as we know it, emerged during the 1950s in the United States and has since spread to most parts of the world.
- Three main types of inhalants are organic solvents, volatile nitrates including amyl nitrate – poppers, which are used for sex and dancing, and nitrous oxide.
- Some of the most common inhalants include glue, aerosol spray cans, paint thinner, petroleum products, chrome based paint and felt pens.
- Inhalation is either through the mouth or nose. Often the product is sprayed into a plastic bag or soaked onto a rag and then inhaled or it is inhaled directly from the container.
- Inhalants are absorbed through the lungs into the blood stream, which then carries the chemicals rapidly to the brain. They slow down the activity of the brain and central nervous system. Intoxicating effects are often quick acting (seven to ten seconds), intense and short lived, lasting no more than 30 to 60 minutes (some inhalants only last two minutes).
- Effects can include excitement, dizziness, stupor, disorientated and uncoordinated, visual disturbance and slurred speech. Prolonged use, particularly leaded petroleum products, can lead to brain, liver, kidney, and especially lung damage. Death can arise from respiratory arrest and cardiac irregularities.
- Organic solvents are often readily available, inexpensive and are commonly used by young people in their first few years of secondary schooling.

Alcohol

- Alcohol is the most commonly used psychoactive drug globally and the oldest. Historical references abound in literature, religion and science about alcohol, its effects and its consequences.
- The production of alcohol results from a process of fermentation, in which water and yeast act on the sugars of various types of grains, vegetables and fruit. The psychoactive drug that is produced is ethyl alcohol.
- As a depressant drug, alcohol slows down the activity of the central nervous system and in small doses can result in people being relaxed, with inhibitions being lowered. As the depressant effect takes over, it can slow reflexes, depress respiration and heart rate and disrupt reasoning and judgment.

- Heavy drinkers usually develop a tolerance to alcohol and need to drink more to experience the same effect.
- Regular drinking can result in psychological and physical dependency.
- The long term effects of alcohol on the body, following heavy drinking over a long period of time, are extensive. These can include higher blood pressure, enlarged heart, cirrhosis of the liver, liver swelling and pain, skin bruising, stomach and intestinal ulcers, muscle weakness, loss of memory, loss of sensation in feet and hands and foetal damage if pregnant.
- Behavioural problems are commonly linked to alcohol. Some problems can include family violence, work absenteeism, motor accidents, legal problems and fines associated with violent assaults and financial difficulties.
- A physically dependent person will suffer withdrawal symptoms that can include loss of appetite, irritability, confusion, inability to sleep, cramps, tremors, hallucinations and even death due to seizures.
- Addiction to alcohol is a chronic progressive disease that is distinguished by lack of control over drinking, preoccupation with alcohol use despite adverse consequences and denial. If not controlled it can be fatal. While alcoholism can take years to develop the recovery period can take a lifetime.

Benzodiazepines

- This class of synthetically-based drugs was developed in the late 1940s and 1950s as an alternative to barbiturates. In the West they came into wide clinical use in the 1960s and the 1970s. The drugs were looked upon as an innovation in the treatment of anxiety disorders and sleeping problems.
- Benzodiazepines are a chemical group term and are classified as sedatives or tranquillizers. Benzodiazepines combine with certain parts of the nerve cells in the brain to enhance inhibitory mechanisms. They induce a state of calmness, slowing down physical, mental and emotional responses. When given in large doses they will induce sleep. The increasing number of drugs includes Temazepam, Diazepam, Nitrazepam, Oxazepam, Clonazepam and Flunitrazepam.
- Administration is usually in tablet, capsule or liquid form and taken orally or by injection. The calming effect is evident in about 45 minutes and some degree of sedation can persist for 24 hours.
- Adverse side effects can include lethargy, confusion, mood swings, nausea, dizziness, disturbing dreams and slurred speech. The over prescribing or individual misuse of such drugs can result in increased anxiety, irritability and hostility. Mixed with other drugs they can reduce judgment of time, space and distance and combined with alcohol can result in death.
- After a high dose continued for about two months or a low dose taken for a year or more, withdrawal can be extremely severe and prolonged. Feelings of craving for the drug, anxiety, sleep disturbance and possible hallucinations can occur. Withdrawal symptoms can erratically come and go in cycles separated by two to ten days and may persist for several months after the drug has been stopped.

Anabolic steroids

- Performance enhancing drugs have been documented throughout human history. In the 1920s, testosterone (male hormone) was isolated and by the First World War was being administered to troops to overcome fatigue and injuries. Since the 1950s, testosterone has been synthetically produced and its use was soon associated with athletic performance.
- Anabolic steroids are a group of synthetic compounds which are structurally related to the natural male hormone testosterone. They produce anabolic activity (greater muscular bulk resulting in increased muscular strength) by increasing protein synthesis and androgenic activity (enhanced secondary sexual characteristics).
- Administration is by intravenous or intramuscular injection and orally.
- Injectable forms are designed to be longer acting than orals and are released slowly over time. The high rate of administration via injection has raised the concern and risk of HIV, hepatitis

B and hepatitis C. Primarily taken to increase muscle mass, they can also allow a user to train harder, promote a quicker recuperation phase and increase the healing process for some types of injuries.

- Early effects can include increased confidence and energy, enhance motivation and enthusiasm, increased aggression and sexual appetite. Larger doses can result in a loss of inhibition, lack of judgment and mood swings. Prolonged users frequently become quarrelsome and aggressive. Severe prolonged use can result in heart disease, liver damage, mental disorders and violence.
- Physical addiction is not believed to occur but some users do become psychologically dependent, believing their physical and sporting achievements will be reduced without them.
- Withdrawal symptoms can include severe depression, insomnia, lethargy, loss of appetite, headaches and craving.

Barbiturates

- Barbituric acid, a combination of urea and malonic acid, the base material of barbiturates, was first synthesized in 1863 by Adolph von Bayer. In 1903, barbiturates were first synthesized as a sedative for nervousness.
- Barbiturates are a prescription drug in a white bitter tasting powder soluble in water.
- Barbiturates are swallowed as tablet, capsule or liquid solution. They can also be inserted as a rectal suppository or injected into bloodstream (mainlining) or muscle, or under skin (skin popping).
- Effects include relaxation, peacefulness, sleepiness, pleasurable intoxication, dizziness, inactivity, withdrawal, interrupted thought process, mood swing, excitement, increased pain, hostility, depression, anxiety, confusion, changed vision, increased sex drive, intense emotions, hangover.
- Barbiturates depress the central nervous system and result in a progressive decline in blood pressure, heart rate and breathing. They can produce nausea, vomiting, abdominal pain, alternate pupil constriction and dilation, loss of reflex response, low body temperature and blood temperature, and weak pulse.
- Tolerance builds quickly, which requires increasing the dose to maintain the effects of barbiturates. Craving continues after pleasurable effects disappear and drug use is stopped.

Annex III Press releases

 International Federation
of Red Cross and Red Crescent Societies

Federation news



Red Cross Red Crescent calls on governments to end 'social evil' policies that fuel HIV/AIDS, 5 April 2003.

Governments need to stop treating people who are at high risk from HIV/AIDS as 'social evils' and urgently address the stigma, discrimination and marginalization of these groups if global efforts to combat the disease are to be achievable, said the International Federation of Red Cross and Red Crescent Societies.

The call comes on the eve of the 14th International Conference on the Reduction of Drug Related Harm in the northern Thai city of Chiang Mai, which runs between 6-10 April. The conference, of which the International Federation is a co-host, will address, among other issues, the negative impact of 'social evil' policies on preventing HIV infection. Among the groups generally targeted as a social scourge, are injecting drug users and commercial sex workers.

"We need greater recognition worldwide of the fact that by ostracizing and marginalizing groups of people, they are made especially vulnerable to disease. We know that by being singled out as deserving punishment, the unsafe practices of injecting drug users are being driven underground, resulting in a public health disaster", said Massimo Barra, founder of an Italian Red Cross foundation that assists injecting drug users, and board member of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Southern Europe and communities in North and South America and Australia, have previously experienced explosions in HIV epidemics through the use of shared injecting equipment. Eastern Europe and parts of Asia in particular, are today witnessing alarming rates of HIV infection through shared injecting drug equipment. In Eastern Europe, which has the fastest growing HIV/AIDS epidemic in the world, HIV rates have soared by 1300 per cent since 1996 while in Russia, up to 90 per cent of registered infections have been attributed to the use of shared injecting equipment.

"The only way to reverse this trend is for governments to implement policies that see a deliberate shift from social exclusion to social inclusion of injecting drug users. Reach out to them and make their practices safe. Providing clean needles is a start," added Barra.

Studies show that needle exchange programmes have reduced high-risk behaviour among injecting drug users by as much as 80 per cent, with an estimated 30 per cent or more reduction in HIV infection rates.

"There is clear scientific evidence that needle exchange programmes work. They help contain the HIV/AIDS pandemic, and in a very cost effective way. Evidence is also clear that these programmes do not promote drug use," said Bernard Gardiner, head of the International Federation's HIV/AIDS unit.

The Red Cross and Red Crescent is already implementing such programmes in several countries, including Italy, Croatia, Latvia, Portugal and Spain in collaboration with governments or other organizations, while the Vietnamese and Chinese Red Cross have begun to include injecting drug users in their HIV/AIDS prevention programmes.



International Federation
of Red Cross and Red Crescent Societies

Federation news



Prevent war on drugs becoming war on drug users, says Red Cross Red Crescent, 10 April 2003.

It is becoming more urgent every day for governments to provide efficient and practical measures to help injecting drug users lead healthy lives, such as increased access to treatment and programmes that lessen the harm they are exposed to, the International Federation of Red Cross and Red Crescent Societies said today. Harsh and even violent policies to force individuals to change, only shift the war on drugs to a war on drug users, it added at the closing of the 14th International Conference on the reduction of drug-related harm in Chiang Mai, Thailand.

HIV-rates among injecting drug users who share needles and syringes are rapidly increasing – in many countries the infection rates have exploded to epidemic levels in less than one year. Most injecting drug users are already a disenfranchised population at high risk to HIV infection, and face high levels of stigmatization, discrimination and even incarceration.

Support to these groups is imperative, said Dr. Massimo Barra, who founded an Italian Red Cross foundation that assists injecting drug users, and board member of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

“If we do not recognize, respect and appropriately provide available and proven treatment strategies to people who use drugs, if we react in ways that aggravate the suffering, then we are perpetuating an attitude that goes against the concept of humanity and human rights – as well as against the interests of each nation. Easier access to clean needles and syringes, drug substitution and treatment programmes is a humanitarian gesture, not an act of complicity,” said Dr. Barra.

Hundreds of scientific studies around the world have demonstrated the effectiveness and cost benefit brought about by harm reduction strategies, which often include needle and syringe exchange programmes and drug substitution treatment.

“The scientific evidence is clear: harm reduction works. ‘Social evil’ policies, condemnation, harassment and even incarceration of drug users do not,” said Bernard Gardiner, manager of the International Federation’s HIV Unit. “What is urgently needed are treatment programmes for those who can and want to stop using drugs and effective harm reduction programmes to stop people from dying. The stigmatization and discrimination of injecting drug users, particularly those who are HIV-infected, continues to spread the virus around the world, also among the groups who consider themselves at low-risk.”

Although many countries are already providing quality services to address problem drug use, other governments have instituted policies that hinder practical harm reduction work. A number of Red Cross and Red Crescent societies in Europe, Africa, Asia and the Americas are already running harm reduction programmes in line with the International Red Cross and Red Crescent Movement’s humanitarian mandate. Most of these programmes build on the experiences and views of current and former drug users and HIV positive people, who through these programmes are involved in the betterment of their communities and their own personal growth and human dignity.

The Red Cross and Red Crescent aims to relieve the suffering of people all around the world, and it does this mainly by working in local communities. Red Cross helps people during times of war and peace, and also after natural disasters, all of which today requires working towards protecting the basic social, economic and cultural needs of all individuals regardless of their origin, beliefs or status.

The International Red Cross and Red Crescent Movement plays a unique role in protecting the dignity of persons affected by disease, in particular through efforts to reaffirm the principles - Humanity, Impartiality, Neutrality, Independence, Voluntary Service, Unity, and Universality - and values of international humanitarian law. Discrimination and intolerance continue to cause great suffering that affects individuals and societies. There is widespread lack of respect for international humanitarian law, human rights and human dignity in the world today. Yet no person can be underserving of the protection of the law. Respect for the inherent dignity of the human person is a basic tenet of international law. Moreover, the ultimate aim of any legal order should be to expand the protection afforded to the individual.

States and the components of the Movement are natural partners for humanitarian action. States recognize that National Societies are autonomous organizations that play an auxiliary role in providing humanitarian services side by

side with the public authorities within their own countries. They are jointly responsible for preventing and alleviating human suffering and for preserving the dignity of persons affected by disease and other harmful events or circumstances.

IDUs are particularly vulnerable owing to discrimination, marginalization and social exclusion. Measures are needed to empower IDUs and to strengthen their capacity to respond to and cope with situations that threaten their dignity. In relation to HIV/AIDS, measures to ensure that IDUs have a voice and participate in decisions affecting them, and measures to improve their situation including harm reduction programmes and efforts to reduce the stigma and discrimination which IDUs face, are needed.

Effective partnerships between States, the components of the Movement, civil society and international aid agencies are necessary in order to build capacity and mobilize resources in response to the HIV/AIDS epidemic and in relation to IDUs to implement comprehensive harm reduction programmes and policies, including legal reform.

States and the components of the Movement should look to their commitment to action set out in the Plan of Action of the 27th International Conference in order to raise awareness of humanitarian principles and values, and actively promote tolerance, non-discrimination, non-violence and respect for diversity among all peoples.

 International Federation
of Red Cross and Red Crescent Societies

Federation news



Red Cross Red Crescent welcomes Global Fund move to tackle HIV/AIDS among injecting drug users

A decision by the Global Fund to Fight AIDS, TB and Malaria (GFATM) to finance HIV/AIDS prevention and care programmes among injecting drug users in Thailand and Russia, has been welcomed by the International Federation of Red Cross and Red Crescent Societies as a significant step in tackling the issue.

In welcoming this move, Dr Massimo Barra, a GFATM board member and veteran of the Italian Red Cross HIV/AIDS and harm reduction response, also called for more programmes that follow humanitarian and public health principles.

“The stigma attached to drug use is causing further marginalization of this most vulnerable group and this is directly impeding efforts to prevent the spread of HIV. Forcing drug-users further underground and into situations where transmission of HIV/AIDS is more likely and denying them access to life-saving treatment and prevention services, is creating a public health disaster,” he said.

“This happens even though the evidence from scientific and medical research on best practices and cost benefit analyses is overwhelmingly in favour of harm reduction programming”.

The International Federation sees programmes tackling the transmission of HIV/AIDS through shared needle use and the stigma and discrimination associated with it, as essential to the battle against the pandemic. Red Cross societies in Europe, including Russia, have begun such initiatives, including needle exchange and drug treatment.

The approval of the a US\$ 1.38 million grant for Care Thailand and US\$ 88.7 million for a non-governmental organization (NGO) consortium in Russia came at a meeting of the GFATM board in the northern Thai city of Chiang Mai. It is the first time that the Global Fund has backed harm reduction efforts in South East Asia, parts of which are witnessing an HIV/AIDS epidemic fuelled by injecting drug use.

Injecting drug user groups and NGO's have participated in efforts to develop country specific programmes for Global Fund financing around the world, but have found it difficult to convince some Ministries of the need for programmes to tackle HIV transmission through needle sharing. This despite injecting drug use being the main factor in the HIV/AIDS epidemic in areas such as Eastern Europe.

The grants to Thailand and Russia was one piece of positive news emerging from this latest GFATM board meeting. The Fund is still dramatically short of money promised by rich countries to scale up the HIV/AIDS battle as agreed at a special UN General Assembly (UNGASS) two years ago in New York. In this funding round, fewer people will be given access to anti-retroviral treatment through Global Fund money than on previous funding rounds, particularly in Africa. This despite global targets to increase the number of people with access to HIV/AIDS treatment.

“This is just not good enough. The Fund should be growing – not shrinking,” said Bernard Gardiner, manager of the International Federation's global HIV/AIDS programme. “At UNGASS, all countries agreed to specific objectives to stop HIV/AIDS. It is not only time to honour those promises to keep people alive, but imperative to do so.”

MINUTE
ADOPTED AT THE CONFERENCE

APRIL 4, 1919

We are assembled at the invitation of the *Committee of Red Cross Societies* to assist in the task for which that Committee was constituted, namely: « To formulate and propose to the Red Cross societies of the world an extended program of Red Cross activities in the interest of humanity. » In addressing ourselves to this task we desire to express our belief that while every measure should be taken to repair the ravages of war and to prevent all wars, it is no less important that the world should address itself to the prevention and amelioration of those ever present tragedies of unnecessary sickness and death which occur in the homes of all peoples.

This world-wide prevalence of disease and suffering is in considerable measure due to causes which science has not yet disclosed, but a great part of it is due to wide-spread ignorance and lack of application of well-established facts and methods capable either of largely restricting disease or of preventing it altogether.

It is clear that it is most important to the future progress and security of civilization that intelligent steps be taken to instruct the peoples of the world in the observance of those principles and practices which will contribute to their health and welfare.

In the accomplishment of these great aims it is of supreme consequence that the results of the studies and researches of science should be made available to the whole world; that high standards of practice and proficiency in the prevention of disease and preservation of health should be promoted and supported by an intelligent and educated public opinion; and that effective measures should be taken in every country to secure the utmost co-operation between the people at large and all well directed agencies engaged in the promotion of health.

We have carefully considered the general purpose of the *Committee of Red Cross Societies*, whereby it is proposed to utilize a central organization which shall stimulate and co-ordinate the voluntary efforts of the peoples of the world through their respective Red Cross Societies; which shall assist in promoting the development of sound measures for public health and sanitation, the welfare of children and mothers, the education and training of nurses, the control of tuberculosis, venereal diseases, malaria, and other infectious and preventable diseases; and which shall endeavor to spread the light of science and the warmth of human sympathy into every corner of the world and shall invoke in behalf of the broadest humanity not alone the results of science but the daily efforts of men and women of every country, every religion, and every race.

We believe that the plans now being developed should at the earliest practicable moment be put into effect and placed at the disposal of the world. In no way can this be done so effectively as through the agency of the Red Cross, hitherto largely representing a movement for ameliorating the conditions of war but now surrounded by a new sentiment and the wide support and confidence of the peoples of the world equipping it to promote effective measures for human betterment under conditions of peace.

We are confident that this movement, assured as it is at the outset of the moral support of civilization, has in it great possibilities of adding immeasurably to the happiness and welfare of mankind.

The Fundamental Principles of the International Red Cross and Red Crescent Movement

Humanity

The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples.

Impartiality

It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Neutrality

In order to enjoy the confidence of all, the Movement may not take sides in hostilities or engage in controversies of a political, racial, religious or ideological nature.

Independence

The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

Voluntary Service

It is a voluntary relief movement not prompted in any manner by desire for gain.

Unity

There can be only one Red Cross or Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

Universality

The International Red Cross and Red Crescent Movement, in which all societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.



The *International Federation of Red Cross and Red Crescent Societies* promotes the humanitarian activities of National Societies among vulnerable people.

By coordinating international disaster relief and encouraging development support it seeks to prevent and alleviate human suffering.

The Federation, the National Societies and the International Committee of the Red Cross together constitute the International Red Cross and Red Crescent Movement.