HARM REDUCTION 2010
IHRA'S 21ST INTERNATIONAL CONFERENCE
Liverpool

DAILY UPDATE

DAY TWO
Tuesday 27 April 2010

Youth Rise lead the call for young people's involvement

LACK OF APPROPRIATE INFORMATION and education is putting young people at risk according to representatives from Youth Rise. Each made the case for non-judgemental interventions, tailored for the youth audience.

Most injecting drug users started practising before the age of 25, yet few HIV prevention programmes focused on youth, said Chantale Kallas, from the Lebanon, *pictured above with colleagues Anita Krug and Lynn Itani*. Local data showed that 72 per cent of IDUs were less than 30 years old and more than 80 per cent shared needles. Risky behaviour was linked to inadequate information and no access to health centres.

Five per cent of all deaths between ages five and 29 were attributable to alcohol use in a 1990 study, and a significant number of the estimated 13.2m IDUs worldwide were young people. Nearly half of HIV infections related to young people aged 14 to 24, and 5.4m young people worldwide were infected with HIV.

Consultation led by UN groups called for a package of confidential adolescent-friendly services that respected the rights of children to be heard and have their views taken into account.

'We need to help children to build resilience and be better problem-solvers,' said Ms Kallas, advising that any initiatives should be appropriate to the overall context of their community. This could be achieved by incorporating peer education and integrating young people's services with other sectors of the community, as well as making sure health providers were specifically trained in youth-friendly approaches.

'It's important that outreach teams go to places where young people hang out,' she said. Talking to them confidentially in their own environment made it more likely they would participate in voluntary counselling and testing for HIV and hepatitis B and C.

'Our Youth Rise experiences have shown we can customise services, she added. 'Youth culture is different from adult culture, so you need to be flexible. Information must be written for a youth audience. It is also important to differentiate between use and abuse – if you get young people involved you will know the best language to use.'

To demonstrate that initiatives for young people were a worthwhile investment, she quoted feedback from a former Youth Rise member: 'Provide resources to us and we will do so much with them.'

HIGHLIGHTS

Tuesday 27 April

PLENARY SESSION

Martin Acuna examines the recent shift towards decriminalisation in drug-related policies in the Argentine Republic and Latin American countries.

Genevieve Harris explores room for manoeuvre in the global drug prohibition regime governed by the UN-based treaty system.

The innovation and evidence that back up the Portuguese national strategy on drugs, presented by **Alex Stevens**.

Steve Rolles tells delegates what an evidence-based drug policy based on public health and harm reduction might look like.

DIALOGUE SPACE

12.30 – 17.30

Beginning with **Jamie Bridge** and **Elie Aaraj**'s talk show *Dogma versus stigma*, there will be lively discussions on a variety of subjects.

FILM FESTIVAL

Showing films from around the world from 12.30 in the cinema, auditorium level, and continuing at 17.15 at FACT movie theatre – see map on the back of the programme.

Lunch break from 12.30 – 14.00

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INTERNATIONAL HARM REDUCTION ASSOCIATION
CONFERENCE CONSORTIUM

Programme changes

TUESDAY 27 APRIL 2010

Sessions

P2: Ann Fordham will be replaced by Genevieve Harris.

P2: Fatima Trigueiros will be replaced by Alex Stevens.

M04: Cheryl White will not present.

M05: Ernest Drucker will not present.

C16: Will be chaired by Bradley Mathers.

C17: Dave Burrows will not present.

C22: Zaw Thein Oo and Raffi Balian will not present.

C22: Brito Irma will present *Before you get burnt: University Peer Education*.

C24: Marie-Claude Couture will be replaced by Lisa Maher.

Bringing the youth audience: Kathrine Jack, staff attorney at the National Advocates for Pregnant Women and her son Om sample the vast array of posters on show on level 3 of the conference centre. You will find a guide to poster presentations in the back of your conference handbook.

Escalating excitement: Monday's delegates break from a morning's hard work to head for lunch.

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Message for Tweeters!
If you are Tweeting from the IHRA conference, please remember to include the 'hashtag'(#)ihra and your message will be added to the Facebook page of www.injectingadvice.com

Calling all doctors
There will be a meeting of IDHDP on Wednesday 28 April at 13.45 at Suite 8, Jury's Inn, 31 Keel Wharf, Liverpool (just opposite the conference centre). IDHDP in the International Doctors for Healthy Drug Policies, an international e-network whose aim is to reduce drug-related harm by supporting doctors worldwide to improve their practice and influence peers and policymakers. Come and be a part of the worldwide voice for healthy drug policies. www.idhdp.com

EuroHRN Launches today
Come along to the launch of the European Harm Reduction Network (EuroHRN) on Tuesday 27 April at 13.30–14.30 to hear about the network's plans and the opportunity to join up. The meeting takes place at Jury's Inn, 31 Keel Wharf, Liverpool (opposite the conference centre). If you can't make the meeting but want to know more, email Maria Phelan at maria.phelan@ihra.net

About the daily update

The Daily Update is produced on behalf of IHRA by CJ Wellings Ltd, publishers of *Drink and Drugs News* (DDN) in the UK. DDN is a free fortnightly magazine circulated to people working in all areas of the drug and alcohol field, and is read worldwide online. The DDN website, which contains current and back issues of the magazine, is freely accessible at *www.drinkanddrugsnews.com*. To advertise in DDN email *ian@cjwellings.com*

Daily updates will be available on Monday, Tuesday, Wednesday and Thursday mornings at the conference, and will include late changes to the programme.

Reporting team: Claire Brown, David Gilliver, Ian Ralph. Design: Jez Tucker. For editorial enquiries or feedback, please email claire@cjwellings.com

HIV interventions must be 'scaled up dramatically'

Bradley Mathers: Only around five per cent of worldwide injecting is done using clean equipment.

INTERVENTIONS TO COMBAT the spread of HIV among injecting drug users need to be scaled up dramatically, Bradley Mathers of the University of New South Wales told delegates in Monday's opening plenary, *Harm reduction: next generation challenges.*

He was reporting on the results of a global systematic review of efforts to expand HIV prevention – 'a stocktake of where we are this far into harm reduction' – looking at how far responses were meeting the needs of injecting drug populations. There were documented reports of injecting drug use in 151 countries, which could add up to as many as 21.2m people, he said. There was an ongoing process of improving the data, but the best estimate of IDUs living with HIV was around 3m, he said, half of whom were concentrated in Eastern Europe and South East Asia.

The review focused on needle and syringe programmes, opioid substitution therapy and antiretroviral therapy. Needle and syringe programmes were confirmed in 82 countries, he said, but this ranged from low to high coverage, the latter defined as 200 needles/syringes distributed per IDU per year. Most of the world fell into the 'low' category, however, of fewer than 100 needles per IDU per year – which meant 'potentially a large amount of HIV risk.' Globally, only 22 needles/syringes were distributed per IDU per year, he said, which meant that only around five per cent of worldwide injecting was done using clean equipment.

Opioid substitution therapy was present in 71 countries, but absent in around 80 countries where injecting occurs. Measuring the coverage of programmes was difficult, but some countries – mainly in Western Europe – were achieving high-level coverage. However, coverage remained low in most places and globally only eight people per 100 IDUs were receiving opioid substitution therapy, he told delegates. Worldwide, only four IDUs received antiretroviral therapy for every 100 HIV-positive injectors, he said.

Interventions needed to be delivered to scale and in combination, he stressed – at present only a minority of countries were delivering them to the scale required. Acknowledging that it was 'easier said than done', he told delegates that 'these interventions work best when delivered together – we need to scale them up, and we need to scale them up together.'

Global training aims to net wider youth audience

HARM REDUCTION TRAINING and services are not being targeted on young people globally, according to Kyla Zanardi, Youth Rise's representative on HIV prevention.

With an estimated 6,000 new HIV infections each day among young people aged 15 to 24, her project aimed to provide free access to training and advocacy resources for young people on HIV and Aids prevention and substance use.

A 'youth engagement approach' was the guiding principle, complemented by adult partnerships, support and advice. Training had to be 'context-specific, flexible and creative', outlining best practice on harm reduction, HIV prevention, sexual health and substance use.

Youth-led training sessions had been held in different countries, to provide tangible guidance. Young people had been recruited for the sessions by using an open call in a newspaper and through word of mouth among local NGOs.

Peer training had proved particularly useful in encouraging participants to volunteer for HIV and hepatitis C testing, and the injecting drug users had been keen to ask for more information after the sessions. Their feedback had included requests for more interactive training so they had the opportunity to share their own experiences, and a call for additional multimedia material such as films and audio clips on overdose and drug treatment – which could be difficult when working with local NGOs with limited resources, commented Ms Zanardi.

With the project continuing its next phase of training in Mexico and Canada, and development of a more comprenhesive education process, a guide would be launched on World Aids Day, 1 December 2010.

Mexican crime drives 'inadequate' treatment

Aram Barra: Poor funding leads to open-minded attitudes to advocacy and support.

AN INCREASE in drug-related violence in Mexico had driven the growth of drug treatment centres but compromised quality of care, according to Aram Barra, a long-time activist who had been working with Youth Rise.

The 'War on Drugs' had resulted in a 'decree', which modified general health law and the federal criminal code and aimed to differentiate between drug users, small time traffickers and the major drug traffickers, he explained. It included a table of maximum amounts that could be carried by a person, providing a compulsory route into drug treatment centres.

These 329 'new life' centres were brand new and in many cases situated in neighbourhoods that were considered 'risky' for drug crime. But fast growth had meant that they lacked funding and had inadequate facilities inside.

'There is no systematic way of recording people coming into the centre, or whether their treatment has been successful,' said Mr Barra. Furthermore, there was lack of pragmatic drug policy and lack of harm reduction policy.

'On a positive note, they are so badly funded that they are open to receiving support and advocacy material,' he added. 'They are willing to collaborate with NGOs in the field and share information.'

Three cents a day – the value of a life

Urgent increase needed in harm reduction funding, says IHRA report

SPENDING ON HARM REDUCTION needs to be increased 'urgently and dramatically', according to a major new IHRA report launched at the conference yesterday. A 'cautious estimate' of the amount invested in HIV-related harm reduction in low- and middle-income countries in 2007 is approximately $160m, equating to $12.80 per injector per year, or three US cents per day, says *Three cents a day is not enough* – resourcing HIV-related harm reduction on a global basis. Furthermore, states the report, this is 'almost certainly' an overestimate of actual spending.

UNAIDS estimates the resources needed for harm reduction for 2010 at $3.2bn, or $256 per injector per year, figures which do not take into account additional resources for antiretroviral therapy, care and support, the report stresses. 'Current spending is clearly only a small proportion of that required and is nowhere near proportionate to need,' it says.

Global funding for harm reduction is provided by 'a handful' of donor countries, the document continues – 90 per cent of the $160m for 2007 ($136m) came from donor contributions, while most major international philanthropic donors remain conspicuous by their absence from harm reduction funding. The report calls for more high-income countries to get involved in funding harm reduction if progress towards the goal of universal access to HIV prevention programmes – something the UN is committed to – is to be achieved for injecting drug users.

Donors should be able to set targets for the proportion of global spending going to HIV-related harm reduction, the report recommends, and IHRA wants to see this global spend properly monitored by UNAIDS and NGOs. Resources for harm reduction and HIV services for drug users should be proportionate to need within countries, it states, and a global community fund for harm reduction should be established to advocate for increased resources. The report also concludes that, given the scale of the funding gap, 'new ways of delivering harm reduction services' may be necessary.

'Rather than coming close to ensuring universal access, the current funding represents about one-twentieth of what is required,' states the document. 'People who use drugs are not receiving the harm reduction services that they need and to which they have a right. At current rates of progress, universal access to HIV prevention for people who inject drugs will not be achieved for decades, let alone in 2010. The scale of investment in harm reduction needs to be quickly and radically increased.'

Three cents a day is not enough, by Gerry V Stimson, Catherine Cook, Jamie Bridge, Javier Rio-Navarro, Rick Lines and Damon Barrett, available from www.ihra.net

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Mat Southwell: 'It cannot be right that in Europe we can have life-saving strategies to protect people who use drugs, while in Russia there are thousands of heroin-related deaths every year'

Drug users now equal partners in harm reduction

EUROPE HAD BEEN A CHAMPION for harm reduction and the catalyst for models of harm reduction that had since gone on to be adopted around the world as best practice, Mat Southwell of INPUD told delegates in the *Harm reduction in Europe* session. The challenge was to scale that up around the world, he said.

'It cannot be right that in Europe we can have life-saving strategies to protect people who use drugs, while in Russia there are thousands of heroin-related deaths every year'. In the fierce debates at places such as the Commission on Narcotic Drugs, the EU was central to fighting harm reduction's corner, such as when 26 countries under the leadership of Germany stated that HIV prevention meant harm reduction. 'It's important that we see the increasing discomfort in what's called the "unintended consequences" of drug control,' he said.

Harm reduction's move to the mainstream did not mean there was not still substantial reticence – while people may accept many of the core harm reduction functions, they could remain ambivalent about things such as consumption rooms, heroin prescribing and crack pipe distribution. 'The evidence of harm reduction is overwhelming,' he said. 'It's dogma that prevents us from implementing it.'

The conference would also see the launch of the European Harm Reduction Network, following the approval of EU funding last year, he said. The network would be driven by science and would share best practice and learning as well as encourage members to challenge each other. Open to individuals and organisations, the network would be supported and coordinated by IHRA, and would have three subregional networks – Northern Europe, Central and Eastern Europe and Southern Europe.

It was essential to spread the real progress that had been made in countries like Spain and Portugal all over the world, as well as to defend harm reduction in those parts of Europe where people were trying to row back. 'As we start to win the arguments on the ground, people will start to co-opt our arguments,' he said. 'We must learn to resist that.

'No longer are we the subject of a network – you trying to help and cure us,' he continued. 'We're sitting at the table as equal partners. This allows us to advocate more strongly and clearly with the EU and governments for harm reduction.' It was also essential that harm reduction did not stand still as drug use was continuing to change, he said, and vital that there was active empowerment to ensure meaningful input of people who use drugs.

ADVOCATING FOR RESULTS

'What's important is that the Global Fund fights the epidemic where it is, and 30 per cent of all HIV infections outside of sub-Saharan Africa occur because of the non-sterile use of injection material.'

'THERE IS NOT ENOUGH MONEY out there for harm reduction' says Urban Weber, The Global Fund to Fight AIDS, Tuberculosis and Malaria's interim director for Eastern Europe, Central Asia, Middle East, North Africa, Latin America and the Caribbean. 'The Global Fund works through countries and therefore people need to engage in the countries that are recipients, so that more applications reach the Global Fund.'

Advocacy for demand creation is key, therefore, he stresses, and so far Global Fund money remains unaffected by the financial crisis. 'Countries apply for programmes for a duration of up to five years and all the amounts approved by the Global Fund are secured at the time of approval.' Replenishment of that money occurs this year, with a pledging conference in October with Ban Ki-moon. 'The Global Fund will not get replenished because of harm reduction,' says Weber. 'It's because we're contributing to Millennium Development Goal number six – fighting HIV and malaria – as well as four and five, child mortality and maternal health. Harm reduction won't be prominent on the agenda, so it's piggy-backing harm reduction onto the larger picture.'

Is that a deliberate strategic move? 'I wouldn't say donors would disregard harm reduction, it's just that we're talking of an amount between $13-20bn for the next three years. What's important is that the Global Fund fights the epidemic where it is, and 30 per cent of all HIV infections outside of sub-Saharan Africa occur because of the non-sterile use of injection material.'

This problem remains acute in Eastern Europe and Central Asia, he says. 'They have largely IDU-driven epidemics. Sexual transmission is increasing, but only because a huge cohort of drug users are infected and they're transmitting it sexually to their sexual networks. We can see the beginning of a spillover effect into the 'mainstream population', let's say, through sexual contact, but if people were to say the nature of the epidemic was changing they would be wrong. It simply means that instead of having one problem, we have two – the sexualisation of the epidemic doesn't mean the underlying problem is going away.'

He's adamant that key players – NGOs and the developmental community – engage within countries, and says it's crucial to remember that the conservative culture and politics of many developing nations mean it's unlikely that spending would come from domestic sources, making international donors vital. 'There's no other way to get money into these countries,' he says. But this money, he stresses, can lead to genuine policy change, citing the Balkan countries and substitution treatment in Kyrgyzstan and Tajikistan. 'Once money is in the countries it starts to talk. Money from international donors can have a catalytic effect in changing policy.'

From 'Che Guevara to Florence Nightingale'

HARM REDUCTION HAD STARTED AS A 'COUNTER MOVEMENT' in the Netherlands and the UK but was now part of the EU mainstream, Franz Trautmann of the Netherlands-based Trimbos Institute told delegates. 'It went from being bottom up to being promoted top down,' he said. 'It's still controversial, but it's an element in the global trend of convergence of drug policies.'

Drug policy expenditure had increased substantially in the last decade in many countries, he said, with harm reduction measures expanding to more nations. Opioid substitution therapy was now even spreading to 'unlikely' countries such as China and Iran, while on the supply side, convergence of policies meant increasing toughness towards traffickers and sellers. Use and possession still accounted for the majority of arrests in most countries, even if they didn't lead to imprisonment, he said, and overall, most drug expenditure still went on supply reduction. 'In all countries – even the famous Netherlands – it's the same trend,' he said.

Harm reduction was now more widely accepted as a guiding principle of demand reduction, he told the conference. 'It's losing its revolutionary aura, moving from "Che Guevara" to "Florence Nightingale". But this also risks turning it into technical management of drug-related health problems with more of a "9 to 5" mentality, moving away from humanitarian commitment.'

'The paradigm that drug use is an illness and not a crime is patronising,' he said. 'We've changed it to something that's a little bit better, but it's still keeping people under.'

Generational shift – the move away from injecting in the Netherlands

John-Peter Kools: 'The challenge of the future is to get route transition onto the harm reduction agenda, not only in richer countries in Western Europe but in transitional and developing countries.'

'AN ENTIRE GENERATION of injectors in the Netherlands switched to non-injecting,' independent drugs consultant John-Peter Kools told delegates in the *Route transition interventions: public health gains from preventing or reducing injecting* session.

Only 9 per cent of problem drug users were currently injecting in the Netherlands, but 20 years ago it had been a very different story. The Dutch 'heroin epidemic' had begun in the mid-1970s with 'bohemians and hippies' before expanding to unemployed youth, Surinamese migrants and people from other European countries with stricter drug laws. By 1985 there were 25,000 people using drugs in the Netherlands, 9,000 of them in Amsterdam. Forty per cent of the Dutch drug users were injecting, he said, along with 70 per cent of the migrants from other European countries. However, just 5 per cent of the Surinamese injected.

There was also 30 per cent HIV prevalence among IDUs in Amsterdam, he said. 'There was a distinct watershed between the injectors, who considered themselves the "real drug users", and the non-injectors, who were seen as "sissies". Health interventions aimed at prevention and cessation of injecting were needed, but the question was could it be done without alienating clients?'

However, the move from injecting to non-injecting did not begin with workers, he stressed – rather it was started among drug users themselves. 'The health promotion workers just recognised it, but it was then strengthened by health organisations.' One organisation even produced a magazine with health advice which contained high quality aluminium foil alongside articles on smoking heroin.

'This was an eye opener to a new trend for the injecting communities,' he said. A range of campaigns began with the objective of enforcing and accelerating existing trends of transition away from injection, with some needle exchange services providing aluminium foil. By 1995, field research showed that half of former injectors had moved away from injecting. 'The reasons were often very practical,' he said. 'Lots of people had vein problems and other logistical problems that led them to other ways of consuming drugs. People preferred smoking for very practical reasons but felt that it brought huge benefits after a while, like self respect and more socialising.' There were also peer support campaigns, such as a mobile counselling programme with outreach workers funded by the Ministry of Health.

'In a decade an entire generation of injectors stopped,' he said. 'It just went on and on. Injection prevalence has halved.' Only 4 per cent of Amsterdam drug users were current injectors, with 20 per cent reporting 'lifetime' use. HIV prevalence had fallen from 8.5 per cent to virtually zero, and the number of fatal overdoses had also drastically decreased.

A key element was the importance of a stable heroin market with stable purity, he said, as well as the presence of the non-injecting Surinamese as role models – 'they were the main street dealers and were considered cool'. Another factor was the increasing popularity of crack – 'an instant hit that can be smoked.'

'Interventions to promote route transmission can be developed,' he told delegates. 'The challenge of the future is to get route transition onto the harm reduction agenda, not only in richer countries in Western Europe but in transitional and developing countries.'

Taking the initiative – preventing initiation into injecting in Eastern Europe

Neil Hunt: 'Overwhelmingly it's the drug market that's the most influential factor for whether the intervention is relevant or feasible.'

'WE KNOW THE FACTORS that influence whether people decide to inject,' drugs researcher and consultant Neil Hunt told the conference. These included learning from, and watching, existing injectors.

He described work he had been involved in investigating whether the *Break the cycle* intervention – designed to prevent initiation of injecting among vulnerable youth – would be appropriate in Serbia, Moldova and Albania. Serbia was 'not a poor country but not a rich one', he said, where 'people were very clear about the incredibly poor quality of heroin' – around 2 per cent. 'Novices would snort for a while, and it wasn't of a grade that was smokable. If you have a drug that can only be injected, you don't have a situation of mixing between injectors and non-injectors like in the UK.' It was also judged unrealistic to try and diminish social exposure among two of the most vulnerable populations in Serbia, street children and Roma.

Moldova, meanwhile, was a poorer country with the main injected drug home produced heroin known as 'shirka'. When the country's borders were first opened injecting was more visible and had carried some kudos, but social exposure to injecting had been reduced as it was now seen in a much more negative light, and there had also been increased police oppression. Initiating others was seen as highly taboo in Moldova – 'it was almost impossible to get people to talk about initiation,' he said. 'It's very unlikely that you're going to get conversations of the sort of quality necessary for the intervention, so it seemed the right decision not to proceed with it, and services had other priorities.'

In Albania, meanwhile, a lot of injecting took place in public areas, and services – while often poorly resourced – had a strong ethos of developing outreach work with peers from the local community. Heroin purity was sufficiently good to sustain sniffing, smoking or injecting, he said, and therefore there was more mixing between injecting and non-injecting heroin users, making it a more appropriate environment to offer *Break the cycle*.

'Transition to injecting is not automatic,' he said. 'We're now in the process of translating the campaign materials and testing them with local injectors.' The project had shown up three very different drug situations, he explained. 'Overwhelmingly it's the drug market that's the most influential factor for whether the intervention is relevant or feasible, and the intervention is by no means applicable in all contexts. Low capacity for core harm reduction work may mean people are less willing to invest in marginal interventions like *Break the cycle*.'

Harm reduction now 'mainstream' EU policy

'THE FIRST THING YOU HAVE TO REMEMBER in terms of drug policy at EU level is that there's a very weak legal basis,' Paul Griffiths of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) told delegates in the *Harm reduction in Europe* session. Most things were done through cooperation, and the EU was keen to act with one strong voice at international level.

Harm reduction was a very different landscape to 10-15 years ago, he said. Politically it was less controversial and there was a lot of EU interest in the topic. EMCDDA had put together a monograph, *Harm reduction: evidence, impacts and challenges*, which showed how harm reduction had developed in the EU throughout the 1980s and 90s initially through public health concerns around HIV. However, harm reduction was now seen as part of EU policy and had very much come into the mainstream.

The question of evidence remained central, however – 'what is it and how do we interpret it'. Within the EU drugs debate, HIV prevention remained important but no longer had the primacy it once had, while debate was less parochial and there was more acceptance of national differences. Harm reduction services remained poorly developed in some countries, however.

There had been an overall decline in new, recorded infections among injectors in the EU and all EU countries now had harm reduction programmes, meaning that around 40 per cent of people with opiate problems now had contact with opioid substitution treatment. Great variation still existed between services, however – 'coverage can be very patchy', he said. In Europe, overdose remained the widest cause of morbidity and a central policy concern at EU level remained what measures could be taken to address overdose deaths.

The political debate in Europe was now moving to focus on new drugs, he told the conference, alongside stimulant use, non-injecting routes of administration and youth recreational drug use. 'How do we respond to new patterns of drug use?' was a key question. It was also difficult to isolate the effects of harm reduction programmes or consider the importance of combined interventions, and there was still a real need for studies of effectiveness, he stressed.

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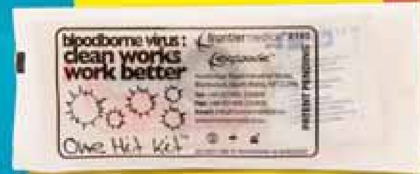

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