‘Choices and Opportunities Fund 2011-2014’, Theme – Harm Reduction, Project number 23389

International HIV/AIDS Alliance
Progress Report 2011
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ACRONYMS

AFEW – AIDS Foundation East-West
AIDS – acquired immunodeficiency syndrome
APT – assessment and planning technique
ARV – antiretroviral
ASEAN – Association of Southeast Asian Nations
ATS – amphetamine-type stimulants
BCC – behaviour change communication
CAHR – Community Action on Harm Reduction
CDC (in China) – Centre for Disease Control, a primary healthcare setting
CUT – Collectif Urgence Toxida
GFATM – Global Fund to Fight AIDS, Tuberculosis and Malaria
HBV – hepatitis B virus
HCI – Health Connections International
HCV – hepatitis C virus
HIV – human immunodeficiency virus
HRI – Harm Reduction International
IDPC – International Drug Policy Consortium
IDUF – Indian Drug User Forum
IEC – information, education, communication
IHRN – Indian Harm Reduction Network
INPUD – International Network of People who Use Drugs
KANCO – Kenya AIDS NGO Consortium
M&E – monitoring and evaluation
MAC – Malaysian AIDS Council
MMT – methadone maintenance therapy
NACO – National AIDS Control Organisation (in India)
NADA – National Anti-Drug Agency (in Malaysia)
NS/EP – needle syringe/exchange programme
PCB – Programme Coordinating Board at UNAIDS
PID – people who inject drugs
PILS – Prevention Information et Lutte contre le Sida
PMTCT – prevention of mother-to-child transmission
PPS – psycho-social support
SRHR – sexual and reproductive health rights
ST – Substitution Therapy
STI – sexually transmitted infections
TB – tuberculosis
VCT – voluntary counselling and testing for HIV
Executive Summary

Community Action on Harm Reduction (CAHR) is a multi-country harm reduction programme for people who inject drugs (PID) in China, India, Indonesia, Kenya and Malaysia. As a global partnership of independent locally governed organisations, the International HIV/AIDS Alliance used its partnerships as well as its good practice programme standards to inform the programme’s approach.

In the start-up stages of the first year of project implementation, teams of local and international experts carried out in-country assessments and planning for project activities in all five of the CAHR project countries. Participatory methods were used, which led to context-relevant, evidence-based programme design in all five countries. The management structure and approach of each country programme was established - management is carried out by dedicated programme managers in the project countries with support and oversight from experienced managers from Alliance Ukraine, allowing for regular exchange and technical advice.

A research and evaluation agenda was developed with standardised instruments to include both an international and a local focus. The scope of CAHR’s policy and advocacy related activities was shaped, in collaboration with international and local counterparts, to address common advocacy issues across the countries.

After a year of operations, the CAHR programme has developed a strategy, is fully functioning and providing services to PID in four of the project countries (India will be starting in March 2012). Baseline research has been conducted in five countries and a policy and advocacy agenda has been developed to inform a global advocacy campaign. Harm reduction programming has been launched in Kenya, and a pilot methadone psycho-social support intervention been rolled out in Indonesia. VCT for PID with rapid tests in China has scaled-up, and behaviour change communication interventions implemented in Malaysia.
Introduction and Project Overview

The International HIV/AIDS Alliance (IHAA or the Alliance) Dutch government funded programme, Community Action on Harm Reduction, began on 1 January, 2011. The project operates in five countries – Kenya, India, Malaysia, China and Indonesia – and the programmes in the five countries are implemented through partnerships with Alliance Linking Organisations:

- The International HIV/AIDS Alliance (UK) Kunming Office (Alliance China),
- The International HIV/AIDS Alliance in India,
- Rumah Cemara, Indonesia,
- Kenya AIDS NGO’s Consortium (KANCO), Kenya
- Malaysian AIDS Council (MAC).

Technical expertise in programming, management and global advocacy support is being provided by a team of national and international partners: The International HIV/AIDS Alliance in Ukraine, AIDS Foundation East-West (AFEW), International Drug Policy Consortium (IDPC), Harm Reduction International (HRI), International Network of People who Use Drugs (INPUD) and Prevention Information et Lutte contre le Sida (PILS). Health Connections International (HCI) were working with the CAHR project, but unfortunately left the programme in 2011, citing internal constraints. The Alliance hopes that it might be possible for the partnership with HCI to resume at a later stage.

The project has four objectives against which it reports:

1. Access to HIV prevention, treatment and care, sexual and reproductive health rights (SRHR) and other services for PID, their partners and their children is improved in China, India, Indonesia, Kenya, and Malaysia.

2. The capacity of civil society and government stakeholders to deliver harm reduction and health services to PID, their partners and children is increased in China, India, Indonesia, Kenya, and Malaysia.

3. The human rights of drug users, their partners and children are protected in China, India, Indonesia, Kenya, and Malaysia and advanced in global institutions.

4. The learning about the role of civil society in harm reduction programmes is increased and shared in China, India, Indonesia, Kenya, and Malaysia and globally.
Objective 1. Access to HIV prevention, treatment and care, SRHR and other services for PID, their partners and their children is improved in China, India, Indonesia, Kenya, and Malaysia

In early 2011 a desk-mapping exercise of the PID context, service availability, policy and advocacy environment and local partner organizational capacity was conducted in each of the five CAHR countries. This preliminary information gathering exercise helped to formulate the initial activities in advance of the more in depth field-based assessments.

Each CAHR country project was developed following an on-the-ground assessment and planning process that was specifically developed for CAHR. This assessment and planning methodology involved the application of a set of simple tools in order to develop a detailed plan for a new area of programming. The methodology was developed as a management tool rather than a research instrument, to assist managers in starting up new programmes.

On-site assessments in each country were conducted by a team of experts in four technical areas:

- HIV prevention services for people who inject drugs,
- HIV and drug related policy and environment,
- organisational development issues and,
- monitoring and evaluation of interventions.

The assessments were focused on the lead partners implementing of the CAHR project, their main sub-recipients, and the overall in-country situation in each specific technical area.

In order to establish the current situation in relation to each of the status questions/statements, the assessment and planning team analysed existing information as well as collecting new data. Various data collection methods were employed including a literature review, interviews, focus group discussions and direct observation. The participants included some of the key international and local stakeholders such as people who inject drugs, representatives from relevant governmental agencies, multilateral and bilateral agencies and donors, and key implementers of major HIV/AIDS programmes, such as those funded by the Global Fund.

Some of the findings from each country assessment are provided within this report. A separate document sharing the results of all the country assessments is planned for publication in 2012.
Malaysia

Lead Organisation: Malaysian AIDS Council (MAC)

- Estimated number of people who inject drugs: 205,000¹
- Adult HIV prevalence among people who inject drugs: 10.3%²
- Number of people living with HIV: 100,000 [83,000 - 120,000]
- Adults aged 15 to 49 prevalence rate: 0.5% [0.4% - 0.6%]
- Deaths due to AIDS: 5,800 [4,500 - 7,200]
- Most popular drug: heroin with amphetamine-type stimulants on the rise³

Key assessment findings

The services that are available in Malaysia for people who inject drugs include: needle exchange drop-in facilities, VCT, ARV, PMTCT, TB testing, TB treatment, STI testing and treatment, HBV vaccination, HCV treatment (three courses provided per year per clinic), and MMT. These services mostly take into account the needs of opioid users, with limited services provided to specifically address amphetamine type stimulant (ATS) use. Direct HIV service delivery to drug using populations is carried out by two key groups of service providers - healthcare professionals and trained outreach workers. Outreach remains the frontline of harm reduction interventions, operating in predetermined areas and strictly appointed places where drug users are expected to be located.

The availability of IEC materials is sufficient, but skills in development of such materials with regard to their content and design require strengthening. Counselling is often considered a professional activity restricted to trained healthcare and other specialized professionals, although peer education (which service beneficiaries refer to as ‘counselling’) does in fact take place during outreach activities, and is integral to outreach or needle and syringe programming. In addition to addressing the specifics of drug users’ behaviour and health, ‘counselling’ provided by the trained staff at the VCT sites also includes advice about testing, treatment and appropriate health care referrals. As in many harm reduction programmes working with opiate users, the sexual and reproductive health components of programmes in Malaysia has been fairly weak and is limited to condom distribution, and cultural taboos about sex-related topics complicate condom promotion and safer sex counselling.

In 1983 the Malaysian government introduced the Drug Dependents Act which promotes a zero tolerance policy to drugs, including a 2-year mandatory treatment and rehabilitation sentence for individuals who are considered drug dependent. In 2000,

Malaysia committed to achieve a drug free society by 2015 (Bangkok Political Declaration in Pursuit of a Drug Free ASEAN) which resulted in an even more punitive approach. In response to the rapid spread of HIV amongst people who use drugs, in 2005 NADA started to introduce harm reduction services and has been developing community based treatment alternatives. In this complex policy environment, people who use drugs report widespread police violence and harassment and very high rates of incarceration for drug-related offences.

Despite the fact that heroin is the most commonly used drug in Malaysia, it is generally believed that overdose cases are quite rare, and there is no data with respect to overdose cases.

**CAHR project outline**

The Malaysian AIDS Council (MAC) has designed a project which will deliver national-level scale-up of HIV prevention programmes among PID, support to four new sites which have no current services and for new services in addition to the current scope in four existing sites (including rapid testing for HIV, HCV, HBV, STI, legal services and family support) to start in 2012.

The new sites will be:

Expansion sites:

In each year of the project, operational research will be carried out, followed by a pilot project dedicated to some of the key programmatic exploration areas, which include: women who inject drugs; PID in prison settings; and pharmacy-based interventions.

The policy and advocacy plan for MAC includes further drug policy sensitization activities to promote drug law reform and updates of existing governmental operational procedures on MMT and NSEP.

By 2014, it is planned that the project will reach 23,600 people who inject drugs which will equate to an increase in the national-wide annual coverage of this population by approximately 25%.

**Progress in 2011**

Preparatory activities took place in 2011. Guidelines for the implementation of the CAHR project were developed; partners identified through a competitive process; IEC materials were printed which included information materials for BCC, including guides and hint cards for outreach workers; and procurement of commodities was initiated.

Data from the Ministry of Health suggests that women constitute just 2% of the PID population of Malaysia, but this very small percentage reflects the fact that female drug use is very hidden as a result of strict cultural norms, and is not a reflection the true situation. To uncover some of the characteristics of female drug use, the Malaysian AIDS Council contracted the Centre of Excellence for Research in AIDS at University of Malaya to conduct a pilot
study among women who use drugs in Kuala Lumpur, with the aim of piloting a female PID project in 2012. The main objective of the study was to identify the major health needs among women who use drugs, their risk factors associated with drug use and HIV transmission, barriers to treatment, and other experiences that affect female users. The pilot will be conducted in 2012 and will consider: drug management services/MMT/NSP; reduction of sex work related risks; SRHR services; child management provision; raising self belief; personal care, hygiene and grooming; positive life; lifelong income generating programmes; and advocacy support.

In collaboration with MAC, Behaviour Change Communication training for PID programmes was conducted for all outreach workers. The new BCC protocol was designed to improve the effectiveness of HIV prevention and harm reduction communication, and will be rolled out across the programmes in Malaysia that are funded by CAHR, the government, and also the Global Fund. Across MAC projects, 2,268 PID benefited from the improved BCC activities of outreach workers.

A need to improve data tracking systems was identified a priority area, and a particular focus was made on automatisation of data recording and unification of data from projects funded from different sources. The SyrEx database that was developed in Ukraine was adapted for Malaysia with technical support from International HIV/AIDS Alliance in Ukraine.

In September 2011 a meeting was held with the training division of Royal Malaysian Police with the aim to develop a strategy - in line with advocacy priorities - to facilitate the integration of key public health and drug policy issues into the Malaysian national law enforcement curriculum. As an immediate result of the meeting, a workshop took place at the end of September 2011 for 56 participants, focusing on the sensitisation on harm reduction programmes in Malaysia. This workshop also included a session highlighting the importance and need for police involvement in successful programmes.

**Selected results from women and drug use in Malaysia pilot research**

A total of 104 women participated in a cross-sectional survey between October 2011 and January 2012. Participants were recruited via convenient sampling at the PT Foundation, the National Anti-Drugs Agency Cure and Care Centre, the WAKE shelter home, and other NADA facilities.

The majority of study participants were aged between 31 and 50 years, ethnically Malay, and had received some secondary school education. Almost two out of ten women engaged in sex work. Nearly all the women interviewed had been detained in the past, the majority of whom were detained by police. The main substances reported as used by study participants were methamphetamine (78.8%), alcohol (74.0%) and heroin (71.2%), followed by cannabis and ecstasy. A quarter of participants were on methadone.

Half of the participants had male partners, and more than one in ten reported female partners: crucially, seven out of ten women reported having sex without condoms. 44.2% of the women sampled have had a pelvic examination in the last 3 years, however, only a minority of women received their pap smear tests at government hospitals or clinics and, critically, almost one in three women who needed the tests were not able to access them, with drug use seen as a barrier to receiving the testing. Almost 27% of women in the survey had been sexually molested as a child (under the age of 18), and one in five had been forced to have sex. One in five women also reported having been physically threatened.

These preliminary results highlight serious health and social support needs among women who use drugs. It is clear that women who use drugs are especially vulnerable to sexual violence, and have limited resource to seek help.
Indonesia

Lead Organisation: Rumah Cemara

- Estimated number of people who inject drugs: 219,130
- Adult HIV prevalence among people who inject drugs: 42.5%
- Number of people living with HIV: 310,000 [200,000 - 460,000]
- Adults aged 15 to 49 prevalence rate: 0.2% [0.1% - 0.3%]
- Deaths due to AIDS: 8,300 [3,800 - 15,000]
- Most popular drug used: heroin, amphetamine-type stimulants

Key assessment findings

In 1994, in response to the HIV/AIDS epidemic, Indonesia established a National AIDS Commission (NAC) to focus on preventing the spread of HIV and coordinating the efforts of government, non-governmental organizations, the private sector, and the community. The areas of HIV response that were prioritised by the government were the prevention of HIV among vulnerable populations, ARV treatment and VCT. A governmental Harm Reduction Programme was initiated in 2003, in order to reduce the incidence of HIV transmission, and focussed primarily on syringe exchange, condom distribution and voluntary counselling and testing.

The non-governmental efforts in Indonesia are extensively donor driven, and dominated by the Global Fund, AusAID, and USAID. Although partnerships between the major donors is regulated by a memorandum of understanding, tension between organisations can be observed which creates difficulties for programme planning and coordination.

The services that were present in Indonesia at the time of the assessment were: ARV treatment, TB treatment, Community Health Centres, HBV vaccination, HCV testing, HCV treatment, HIV voluntary counselling and testing, hospital-based rehabilitation, IEC, MMT, NSP, PMTCT, referrals, STI testing and STI treatment. Services are mainly provided in local health clinics, outreach and hotspots that operate till 2:00pm. The number of distribution materials is limited to 3 syringes, 3 condoms and 3 alcohol swabs.

A number of services are provided by district health clinics, such as voluntary counselling and testing, which is widely available in 547 clinics, with all sites giving an option of laboratory or rapid testing at a cost of 3.87 USD. Testing for STIs (excluding hepatitis C) as well as free treatment is also available in the region for a fee of 0.33 USD; free STI and TB treatment is supported by the Global Fund grant; ARV treatment is provided for free but the registration fee to start treatment is provided at a cost of 1.70 USD. These fees for services are in many cases a significant barrier for vulnerable populations. People who use drugs also report high levels of discrimination in health services.

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According to the 2010 UNGASS report, the HIV prevention programme in Indonesia is traditionally targeting male opiate users, whilst women represent less than 5% of people reached. Sexual and reproductive health is heavily underserved in the country and focuses mainly on condom distribution, and in addition, for cultural reasons, SRH is a sensitive issue to address. The majority of staff working in harm reduction projects are self-trained and programmes are often planned based on their personal experiences, which can lead to some programmatic gaps, such as reaching out to drug users who are use drugs other than opiates, work with women using drugs, or reaching the under 25 drug using population.

2009 legislation decriminalised drug use in Indonesia which represents an important legal change compared to previous 1997 legal provision. At the same time Indonesia retains the death penalty for drug offences.

CAHR project outline
Geographic coverage of the project encompasses the West Java province towns of Bandung, Bogor regency, Cirebon and Sukabumi, which are areas that are most affected by HIV. In 2012, an expansion to Bali and Lombok will take place following the results of assessments of potential partners in Sulawesi, Sumatra, Kalimantan, Bali, and Lombok.

Over the course of the CAHR project, Rumah Cemara will be extending basic harm reduction services (syringe, alcoholic wipes, condom, information material and peer counselling) to Bogor regency (West Java), Bali and Lombok, areas where these services are not currently provided. The CAHR project will also provide pre-release support to PID who are preparing for release from prison in Bandung, Bogor, Cirebon, Sukabumi and Bali.

Pilot interventions around psycho-social support for MMT clients, and service expansion to young drug users (under 25) will be conducted in Bandung. Local level advocacy to improve the human rights of PID and promote diversion, will be conducted by holding regular meetings with local police, judges, prosecution in Bandung, Cirebon, Bogor and Sukabumi; trainings on advocacy and human rights for implementing partners in the four cities once every two years; and documentation of best practices in advocacy and human rights in Indonesia.

Rumah Cemara is aiming to reach 3,541 PID over the course of four years with harm reduction and psycho social support services.

Progress in 2011
In 2011 Rumah Cemara prioritized the expansion of basic harm reduction services in the Bogor Regency area in West Java; a pilot of psycho-social support for MMT clients in Bandung to address the high dropout rates among MMT clients that result from very limited availability of psycho-social support services; and pre-release support to imprisoned PID in Bandung.
Prison pre-release activities by Rumah Cemara

One of Rumah Cemara’s focal points for the project in Bandung is to provide services in Banceuy Prison. Banceuy is one of only a few prisons in Indonesia which only detains prisoners with drug related offences. It is therefore vital that Banceuy meets the needs of its inmates in order to increase their quality of life and deal with issues related to drug dependency and basic health care.

Rumah Cemara has been working with Banceuy since 2004; the partnership began with informational sessions for inmates based on Cognitive Behavioural Therapy modules and understanding of HIV.

In 2007, based on the needs of Banceuy inmates, Rumah Cemara assisted them in developing a peer support group for HIV-positive inmates. The development of this group has created opportunities for participants to develop a programme that is tailored to their needs. With ongoing support, the group has become a forum for HIV-positive inmates to share their thoughts, worries, feelings and experiences related to their HIV status and, most importantly, to provide support to each other.

The CAHR project in Banceuy focuses on providing pre-release support to inmates who are in the final month of their prison term. Rumah Cemara works together with the counselling department at Banceuy to develop the capacity of the staff delivering services and to provide an effective pre-release intervention.

The intervention involves:

- capacity building for inmates in the context of bio-pyschosocial support services related to drug dependency, HIV/AIDS and life skills,
- referral information for services, support groups and shelters outside the prison,
- capacity building on HIV and harm reduction for prison staff.

The inmates feel that through the pre-release project each individual becomes more aware of his surroundings and better equipped to navigate new situations upon release and possess the information and knowledge they may need to deal with any social problems that they might encounter following their release, and they know where to go to seek support. Through this project, they are able to rebuild their confidence, maintain social relationships and avoid repeating the same mistakes again.

Working with prison staff, the CAHR project has made significant progress in helping them to fill the gaps in their capacity and awareness in order to ensure effective delivery of the pre-release programme.

Every month, ten inmates participate and benefit from the services in this programme. Every three months, ten members of the prison staff are provided with training and information to increase their capacity to deliver the services. It is expected that this programme will be sustained beyond the life of the CAHR project and become an independent and key component of the prison programme.

The CAHR project has also been able to provide additional CAHR funds to Rumah Cemara in order to cover a funding gap in Cirebon, Bandung and Sukabumi, that occurred as a result of a delay in the Global Fund. In recognition of the strong progress being made by Rumah Cemara, this additional funding was granted and the extra
activities began on November 1st 2011. It is expected that this additional support will facilitate the integration of the CAHR technical developments, and will lead to improvements in the quality of service delivery within the Global Fund programmes, as well as the additional benefit of increasing the geographic reach of CAHR work in Indonesia.

In 2011, 991 PID accessed services and estimated 6000 people accessed harm reduction information and indirect services through CAHR in Indonesia.

As part of its advocacy activities, Rumah Cemara organized a Human Rights and Documentation training in August 2011, which involved 18 participants from four of Rumah Cemara's CAHR partners. In addition there were several representatives from the West Java District Police Department and Lembaga Bantuan Hukum (an advocacy consultant institution) in Bandung. The objective was to build and develop organizational capacity in understanding issues relating to human rights, in particular law assistance for drug users; the formulation of standard operational procedures for case documentation; effective tools for database construction; standardised formats for recording/documenting cases; and systems for learning in terms of assisting drug users facing human rights violations. As a result, human rights violations are now being documented and activities are taking place to address them.

**CAHR MMT psycho-social support pilot in Bandung**

In 2007 PID in Bandung were provided with a new program of Methadone Maintenance Therapy (MMT) by the government, working together with the hospital.

Although the MMT program reinforces existing HIV interventions, particularly amongst the PID community and their partners and children, the government only provides the medical component, and additional services are required in order to improve the quality of life of service users and improve retention rates.

Rumah Cemara, through CAHR, works together with the MMT clinic to fill the gap of psycho-social support.

The activities conducted within CAHR include:

- A group counselling session twice a week with a maximum of 15 MMT clients,
- individual counselling sessions for MMT clients,
- individual assessments of MMT clients through Addiction Severity Index (ASI) carried out by a drug addiction counsellor,
- a self-help group for MMT clients,
- case-management of MMT clients in collaboration with the MMT clinic team,
- a coordination meeting between stakeholders and MMT client representatives.

As a result of these activities, a better relationship has been developed between clients and MMT clinic officers. MMT clients are now able to organize themselves independently to take part in HIV interventions. 40 clients from 70 registered in MMT clinics received psycho-social support services and maintained their therapy.

There is a strong need to maintain a good relationship between the psycho-social and medical support programmes in order to increase the quality of life of MMT clients. This support needs to be provided on an individual case-by-case basis at the beginning of the MMT programme. In addition, the involvement of the community is crucial, including health service providers and family members.
China

Lead Organisation: Alliance China

- Estimated number of people who inject drugs: 2,350,000
- Adult HIV prevalence among people who inject drugs: 12.3%
- Number of people living with HIV: 740,000 [540,000 - 1,000,000]
- Adults aged 15 to 49 prevalence rate: 0.1% [0.1% - 0.1%]
- Deaths due to AIDS: 26,000 [24,000 - 49,000]
- Most popular drug: heroin (87.6%), ketamine and amphetamine-type stimulants

Key assessment findings

China’s efforts to tackle HIV/AIDS among PID have mainly consisted of concentrated MMT programmes. Government programs are supported via AIDS Bureaus and Centres for Disease Control (CDCs) which were established in 2001 and focus on HIV/AIDS education, prevention, treatment, surveillance, and pilot programs for high-risk populations - according to the national programme on HIV/AIDS, the drug using population also has access to syringes.

The range of services available for PID in China is increasing and the government has made efforts to make them more accessible, but considerable barriers still exist. According to ‘Regulations on the Prevention and Treatment of AIDS’, and China’s ‘National Action Plan (2006-2010) for Reducing and Preventing the Spread of HIV/AIDS’, the Chinese government enhanced its policy framework and started providing extensive free antiretroviral treatment, prevention of mother-to-child transmission services, free schooling for orphaned children, and economic assistance and care to affected households. At the same time, access to general healthcare in China is based on a cost-sharing principle meaning that services such as routine examinations, MMT provision, an examination to receive ARVs and drug-free rehabilitation are available only at a cost to the patient. This makes it difficult for PID to access medical services that go beyond their basic needs.

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The majority of HIV prevention services are provided at methadone maintenance treatment and needle and syringe exchange sites and include: condom provision, HBV vaccination, IEC materials, lubricants, MMT, needle/syringe exchange, overdose prevention and response, peer counselling, PMTCT, psychological support, rehabilitation, STI treatment, TB testing, TB treatment and VCT. Providing a broad menu of services for PID means that services are not always specifically tailored to individual clients’ needs, and the services available are also mainly designed to meet the needs of male opiate users and do not take account of the different types of drugs used. Regular HIV testing in China is not always anonymous; the test is often performed through laboratory tests in the local health consulting centres, and results are provided after several days. These procedures often de-motivate drug users from taking an HIV test.

Despite the fact the prevalent mode of HIV transmission is through sexual intercourse, sexual and reproductive health services are not readily available to vulnerable populations and are usually limited to providing access to abortions and condom distribution. Little attention is paid to providing information about hepatitis B and C to drug using populations and HCV testing and treatment in China is available only via a number of private insurance companies.

At the time of the assessment, China received assistance from a variety of foundations, civil society groups, corporations, and international organizations which included the Global Fund to Fight AIDS, Tuberculosis and Malaria and USAID/PEPFAR. Non-government HIV service providers are underrepresented in China, as most CBOs are actually owned by the government. Those that are independent have relied on USAID and Global Fund resources. As these two donors retreat from China, the civil society landscape will change. Fewer independent community groups will survive.

CAHR project outline

The CAHR project in China focuses on outreach activities in three sites in Sichuan, and the introduction of pilot interventions such as rapid blood testing and the enhancement of basic harm reduction package to include changing drug using situation. Substantial


\[13\] A basic harm reduction package is considered as a minimum set of services that should be provided to every client. For example, the basic package would include the distribution of syringes, IEC materials and peer or professional counseling. Together with a basic package there may also be an extended package which would be provided less frequently including additional services, such as: rapid testing for HIV, legal counseling and others.
effort will be dedicated to ensuring the documentation and replication of piloted and proven community led interventions in other sites.

M&E systems strengthening will be achieved through the introduction of a unique client identifier system (client code) for NSP services (which will be based on personal client data (in order to create unique codes) without breaching confidentiality requirements); standardized data collection forms; and a client database for implementing partners which uses code-based information.

China’s policy and advocacy agenda will prioritise:
- the development of clear objectives/working indicators for harm reduction within the overall evaluation system for local government’s response to HIV/AIDS prevention and control,
- capacity building on advocacy in the field of HIV/AIDS for partners and CBOs/peer groups,
- improvement to the anonymity in rapid test and provision of services to PID.

It is planned that at least 3,030 drug users are reached by the project by end of 2014, with an average of 1,325 clients accessing the project’s services annually.

**Progress in 2011**

China has focused on outreach activities in Jin’niu, Chenghua, and Chengdu in Sichuan (where there is poor coverage of HIV prevention programmes for drug users), as well as the introduction of harm reduction interventions that are new to China, such as rapid HIV testing among PID. The activities on the ground started in mid-November 2011.

Outreach work with people who use drugs in two of the partner CDC is organized through peer workers that have drug-using experience, who provide peer education, group activities, counselling services and distribute syringes, condoms and IEC materials to PID. These activities take place in the Methadone Maintenance Treatment Clinic and Needle and Syringe Exchange Centre.

By the end of 2011, with the involvement of experts at the Yunnan Institute of Drug Abuse, qualitative research into stimulant use in Sichuan had been carried out, the results of which will be used to inform further interventions in Sichuan in 2012.

Findings of the research revealed that:
- different ATS drugs have been popular at various times in Chengdu city: from 2002 to 2003 ketamine was very popular, from 2004 to 2005 Ephedrine (‘Magu’) was prevalent, and ‘Ice’ started being from 2008 and remains the dominant drug of choice,
- there is a substantial poly-use practice of methadone, ATS and heroin in different combinations. Alcohol use often accompanies ATS use,
- high-risk sexual behaviour occurs in ATS users due to practicing multiple homosexual or commercial heterosexual relations, increased libido and risky sexual practices without using condoms.

In China, more than 3,000 people benefitted from CAHR provided services in 2011, including 631 PID.
Piloting rapid HIV testing in China

Regular HIV testing in China is not anonymous, and is performed through laboratory tests in the local CDC, with the results provided several days later. This often de-motivates drug users from taking an HIV test. Alliance China, through the CAHR project and in partnership with two CDCs in Chengdu city, piloted rapid anonymous HIV testing in November-December 2011 in outreach settings.

Technical support for the pilot has been provided by the International HIV/AIDS Alliance in Ukraine, which has extensive experience of VCT and rapid testing. Training was provided for representatives of CDCs in Chengdu in August 2011, and VCT guidelines were developed to guarantee the quality of rapid testing. The intervention design involved a peer worker, a medical doctor and a nurse to carry out client motivation, rapid testing with result in 10-15 minutes’ time and counselling. The testing was carried out at needle exchange points, community centres and during outreach.

In a period of less than two months 350 rapid tests have been carried out by two partner CDCs with the involvement of peer workers. The intervention has been greatly appreciated by project clients and medical staff. It has saved resources (time and effort of PID and medical personnel) and involved PID who are currently out of the reach of the CDC. Further development of the project will include the development of internal and external quality management of rapid testing within China, standard regulations and procedures, wider promotion of outreach testing (publication of leaflets to motivate more people to get tested), and further development of follow-up measures for HIV-positive clients for necessary treatment.
India

Lead Organisation: Alliance India

- Estimated number of people who inject drugs: 164,82014
- Adult HIV prevalence among people who inject drugs: 11.15%15
- Number of people living with HIV: 2,400,000 [2,100,000 - 2,800,000]
- Adults aged 15 to 49 prevalence rate: 0.3% [0.3% - 0.4%]
- Deaths due to AIDS: 170,000 [150,000 - 200,000]
- Most popular drug: cannabis, opiates16, pharmaceuticals

Key assessment findings

The National AIDS Control Programme-III (NACP) in India is headed up by the Secretary and the Director General of the National AIDS Control Organization, and the Department of AIDS, under the Ministry of Family Health and Welfare. The Secretary and the Director General provide overall coordination of the national response. There are also non-governmental local organizations working in the region, mainly supported by international donors or the government.

The range of HIV/AIDS prevention services available in India includes: HIV voluntary counselling and testing, ARV treatment, STI testing, STI treatment, oral substitution treatment, a detoxification and rehabilitation programme led by the Ministry of Social Justice and Empowerment (MOSJE), needle and syringe exchange, TB treatment, IEC, HBV testing, HBV treatment, HBV vaccination, STI testing, STI treatment, STI presumptive treatment, PMTCT, Core Advocacy Groups (CAG) and others. Despite the impressive scale of the number of services, they do not meet the needs; services as HIV testing and counselling, ARV treatment, STI testing and treatment, OST, detoxification programme are available in some parts of the country, but they are not connected to each other and are inaccessible for people who inject drugs without the supervision of an outreach worker. The government claims to support referral systems across the country, but the system has significant gaps and creates considerable barriers for the clients (for example, ART counselling is only provided to people who have made the decision to stop using drugs). The referral system functions better in big cities but is almost non-existent in smaller areas.

The data around the size of the PID population is distorted in India because the standardised governmental approach to programming and budgeting is strictly linked to size estimation (which leads to frequent overestimation in order to increase funding sources). Harm reduction programmes are present in India, but they remain fragmented, are of low quality and are often unavailable in certain geographic areas. The number of substitution therapy sites is also limited, causing a major challenge for people who use drugs in accessing them. Treatment of hepatitis C is not affordable for people who use drugs and there are no nationally or internationally funded programmes or activities (including counselling and IEC) addressing the issue.

Services provided for PID are generic for all types of drug use and gender appropriateness is limited to simply separating women and men in the place of service delivery. The number of syringes given out to a client daily is limited (usually 1 or 2) and, although syringes are also available over the counter, their price is relatively high when compared to local living costs: 1 syringe costs about 7 rupees (0.12 USD), the same price as enough bread to feed three people. IEC materials provided by outreach workers and peer educators usually lack practical information – but this is partly due to the low level of literacy within the population.

Aside from one or two organisations that provide relevant services, overdose prevention and response services are not available in most locations and PID avoid calling ambulances for incidences of overdose as it usually means involving the police which they would prefer to avoid. In response to this, some organizations, such as SASO, have created emergency teams whose representatives go immediately to an overdose situation to provide an injection of Naloxone, if it is needed. Because, in India, Naloxone is a prescription drug this approach cannot be recognized as legal, but government institutions do not object.

Although India has significant experience in HIV prevention, the programmes mostly focus on testing, treatment and prevention of mother-to-child transmission. The concept of harm reduction is not new to India, but it is not widely used or accepted and is often seen as an approach that should lead to complete abstinence from drugs.

CAHR project outline

The CAHR project in India has been planned in order to be complementary to government programmes, focusing on providing services that go beyond the minimal harm reduction package (assuming that the latter is provided by the government). In response to the lack of government programmes, the CAHR project will operate in the following states:

- Haryana 16 PID projects,
- Uttarakhand 7 PID projects,
- Bihar 14 PID projects.

These efforts will provide an enhanced approach, alongside the more experienced organisations in Manipur - SASO - and in Delhi - Sharan - which will lead as piloting and coaching sites.

The project will begin with a situational assessment of all sites in Haryana, Bihar and Uttarakhand carried out by Alliance India, in collaboration with the Indian Drug User Forum (IDUF) and the Indian Harm Reduction Network (IHRN). Capacity building programme activities of civil society organisations in the three starter states will then be provided.

Innovative activities in Manipur and Delhi may include: overdose management and prevention; general medicine support for PID and families; home based care (proving training to caregivers); increased ART/OST access and improved adherence and compliance among PID; SRHR; legal aid; education, testing and referrals for HCV and HBV.

By the end of 2014 India CAHR project plans to reach 10,255 PID.

**Progress in 2011**

The India CAHR project has experienced delays in its start-up as a result of the slow approval from the National AIDS Control Organisation for the activities that are planned. The explicit endorsement of NACO has always been a priority for the Alliance India team, who are planning from the beginning for programming that will be sustained and ‘owned’ by the Government of India into the future. Following a series of meetings with NACO, the PID team suggested some adjustments to the geographic scope of the project. The adjustments included adding the regions of Haryana, Bihar and Uttarakhand (where technical capacity to deliver harm reduction is very limited and projects are relatively new) in the first or second year of implementation, and an increase in the activities that will be carried out in Delhi and Manipur. Potential management challenges arising from this more widely dispersed programme will be monitored carefully. It is expected that the projects will start on the ground by March 2012; preparatory discussions about the project scope with partner NGOs and some induction activities have already taken in 2011.
Kenya

Lead Organisation: Kenya AIDS NGO Consortium (KANCO)

- Estimated number of people who inject drugs: 30,264 to 231,231
- Adult HIV prevalence among people who inject drugs: 42.9%18
- Number of people living with HIV: 1,500,000 [1,300,000 - 1,600,000]
- Adults aged 15 to 49 prevalence rate: 6.3% [5.8% - 6.5%]
- Deaths due to AIDS: 80,000 [61,000 - 99,000]
- Most popular drug: injecting and non-injecting heroin that is used by 1.9% of the population19

Key assessment findings

The HIV/AIDS response in Kenya is regulated by the Kenya National HIV and AIDS Strategic Plan, which is arranged around four primary strategies: health sector HIV service delivery; sector mainstreaming of HIV; community-based HIV programmes; and governance and strategic information20.

Kenya has extensive experience in HIV prevention within a generalised epidemic, focussing prevention efforts on the general population. The same methods can be relevant to most at risk populations, but in Kenya, the more specific needs of those key populations are overlooked. In order to scale up the HIV and harm reduction programme beyond what is possible with CAHR funds, other resources will be necessary, and this is a key part of the KANCO/CAHR effort - to make the case for resources for a national harm reduction effort. Some resources from Global Fund Round 10 should flow to harm reduction, and it is hoped that the change in US govt policy in support of harm reduction efforts for PID will result in USG resources being made available in Kenya.

At the time of the assessment a large number of organisations were working in the areas that will be focused on by the CAHR project, but there remained a lack of specific services for drug using populations, for example, there are very few materials available providing information about safer drug use - injecting and non-injecting practices; lack of mobilisation of the community of people using drugs; and poor engagement of PID in programme planning and implementation.

After many years of working to tackle HIV/AIDS in Kenya, there are many HIV-related services available in the country including ARVs, Community Health Centres, condom supplies, drop-in centres, family counselling and planning, HBV vaccination, HCV testing, HCV treatment, HIV Voluntary Counselling and Testing, hospital-based rehabilitation, IEC on general HIV prevention, prevention of mother-to-child transmission, referral for VCT and rehabilitation services, reproductive and sexual health programs, STI testing, STI treatment, and TB screening and treatment.

Unfortunately, many of these services are unavailable for people who use drugs because of a high level of stigmatization towards PID and the requirement to pay for services; STI treatment available in government clinics costs 2.50USD, and rehabilitation in one of six centres is provided at a cost of 335USD. Few PID are accessing the services they need; according to a PID reference group, of 308,000 patients on ART in 2009, only 38 were

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PID (PID reference group, 2010). The services that are available do not include important PID needs, such as methadone maintenance treatment or overdose prevention and response programmes.

Whilst the range of HIV services in Kenya is impressive, knowledge and understanding of a harm reduction approach to drug use and HIV is very low. Many services require drug users to be drug free in order to use those services.

Community-based syringe exchange services are not available, either from non-government or government providers: syringes can be only bought in the pharmacy at a cost of 0.10USD but are often sold for three to four times more to people who inject drugs.

There are no specific services for women who use drugs, and the suggestion is that the proportion of women among drug using community is as low as 5-10%, but as there is very little reliable data on drug using populations in Kenya, this number might be significantly underreported.

CAHR project outline

The Kenyan element of the CAHR programme will advocate for the adoption of harm reduction approaches in the Kenyan national response to HIV; will build the capacity of civil society organisations to develop, deliver and scale up harm reduction services to PID; and will facilitate collaboration between stakeholders: government agencies, civil society, public and private services and researchers.

KANCO, the Alliance’s strategic partner in Kenya, will support harm reduction activities in Nairobi and the coastal region of Kenya to five sub recipients: the Omari project in Malindi, the Muslims Educational Welfare Association (MEWA) in Kilifi, Teenwatch in Ukunda, Reachout Centre Trust in Mombasa and the Nairobi Outreach Services Trust (NOSET) in Nairobi. These partners will provide counselling; distribute IEC and supply
injecting commodities (needles, syringes, dry and alcohol swabs, cookers, injecting water and filters).

The CAHR project’s policy and advocacy agenda in Kenya will focus on positioning harm reduction as an important part of the Kenyan national HIV response, targeting drug users who are most vulnerable to HIV infection. It will include advocating for legal and policy changes in order to enable key harm reduction interventions, the development of operating policies and procedures, and the creation of collaboration mechanisms between service providers, law enforcement, and coordination and decision making forums. A particular priority will be to bring greater coherence between law enforcement and public health approaches to HIV and drug use.

**Progress in 2011**

The schedule for implementation of the CAHR project in Kenya was brought forward in recognition of the combination of greater than anticipated need and excellent opportunities. With the preparatory work completed, including the composition of the harm reduction package developed; five implementing partners selected; a monitoring approach developed; training and instruction to implementing partners conducted; and outreach training conducted, the start of implementation on the ground began in December 2011.

By the end of 2011, 180 PID had been reached by two of the five CAHR implementing sites.

During a networking and advocacy workshop organized by IDPC and HRI alongside the International Conference on AIDS and Sexually Transmitted Infections (ICASA) 2011, which was attended by a number of civil society representatives from Sub-Saharan Africa, one of the main themes of discussion was around harm reduction programming in the region. One of the key outcomes of these discussions was to establish a regional harm reduction and drug policy networking mechanism, and KANCO agreed to host and coordinate this network under the leadership of the CAHR project manager. Quarterly meetings of representatives from Kenya, Uganda, Seychelles, Mauritius, Senegal, Morocco, Nigeria and Ethiopia will be a starting point of broader regional collaboration on harm reduction.
The New Dawn in Kenya

By Cosmus W. Maina, the founder and project coordinator of the Teens Watch Rehab Centre in Diani on the south coast of Kenya.

As the beautiful Diani sun goes down, I watch from my outside perch at the Diani beach café. What a place to be at such a time when the ocean is calm and golden as it reflects the sunset. I always pass by this joint to reflect on a hard day’s work. Just as I have my first sip of the best natural made strawberry yoghurt, I can’t miss spotting a group of beach boys seated under a line of palm and coconut trees. They are smoking weed and most of it is being blown my way. As I look at the six beach boys, youth that sell different items to tourists on the beach including drugs, I can’t help but to remember that my first drug of choice was cannabis. The smell seems not to have changed. I can recall being in class six then, introduced to marijuana by classmates.

Little did I know that I would try harder drugs in the future. Thinking about it now that I have been trained on harm reduction by the Kenya AIDS NGO's Consortium (KANCO), I think about the harm these boys are putting themselves in. In my day, we used to roll the marijuana on a used newspaper or any other wrapping paper available. You can imagine all the chemicals we used to inhale.

When I finished high school and came to Mombasa, I graduated from booze to harder drugs, the main one being heroin. We rolled it with a mixture of tobacco to create a cocktail. Imagine the harm done - we never used filters in the joint as the cigarettes we preferred were the stronger ones that had no filters.

In Kwale County, we have an estimated five thousand plus drug users. About four hundred of them are injecting drug users (IDUs). I meet them often and witness the harm they put themselves in on a daily basis. They use one needle and syringe to inject two to three people depending on the way they shared the cost of buying the stuff (heroin). Usually the person who contributed the most money starts shooting first, followed by the second and then the third. Economic circumstances make sharing a necessity. A single sachet of heroin here in the south coast fetches up to 180-200 Kenyan Shillings (approximately $2 USD). These boys use a minimum of two to three sachets daily. With some IDU being HIV positive, you can imagine how the virus spreads like a bushfire here.

When I started the rehabilitation centre in 2000, there were only three IDUs in Diani. It seemed like a harm reduction approach was the only way forward. As I take another cold sip of my favourite drink and the sun goes down, I notice the boys drift off slowly. The drug has taken its toll on them. Another couple, a white guy and an African girl, strolls down the beach and sits in exactly the same spot under the coconut and palm trees. It’s a romantic union, and as they kiss and embrace, Celine Dion's song “The Power of Love” gently pulses from the speakers mounted on the roof. I am reminded of the fact of that many sex workers in Diani, boys and girls, report being able to earn a higher fee for sex work if a client wishes to have sex without a condom (UNICEF child Sex Tourism Report 2004).

As I finish paying my bill, I recall the words of a speaker at a recent IDU technical working group meeting. He was a senior official from UNODC. He said, “The people in this room should be proud to know that we are setting history on community action on harm reduction. It’s a new dawn”. As I walk out of the Diani villas beach site café, I too am fully convinced that even as the sun sets on my evening out, a new dawn has come.
Objective 2: the capacity of civil society and government stakeholders to deliver harm reduction and health services to PID, their partners and children is increased in China, India, Indonesia, Kenya, and Malaysia

An initial meeting of technical and advocacy partners was held in November 2010 to discuss the key project parameters and clarify potential technical inputs. Following negotiations with the CAHR international technical partners, the final scopes of work of IDPC, INPUD, HRI, AFEW, PILS, and the Alliance Ukraine Kyiv Hub were finalised. The final roles were established as a ‘global policy partners’ comprising INPUD, HRI, IDPC and a ‘technical partners’ group including PILS in Kenya; the Alliance Ukraine Hub around harm reduction service organization and delivery and M&E in all countries; and AFEW around prison programming in Malaysia and Indonesia.

Grant agreements have been signed with all partners except for HCI who resigned from the project in September 2011 citing internal constraints, and PILS who, in collaboration with their partner organization Collectif Urgence Toxida (CUT), have contributed to programme design in Kenya by hosting an exchange visit for the Kenyan implementing partners who were also attending the National Harm Reduction Conference in Mauritius. PILS/CUT will be providing more systematic technical input supporting further developments in Kenya in 2012.

In order to plan local level technical support for each of the countries, the situation assessment and planning was used as the main source of information which led to development of 2011 technical support plans of CAHR project. Based on the needs identified, substantial technical support has been provided to all CAHR country partners. The most extensive technical support in 2011 was provided to Kenyan organisations. KANCO was launching needle syringe programme in Kenya and needed assistance with development of prevention package for people who inject drugs and training of staff from local organisation to deliver services to PID.

In collaboration with PILS and CUT, Alliance Ukraine Kyiv Hub assisted in organising a visit for representatives from Kenya to attend the 2nd Conference on Harm Reduction: Towards a Client Centred Approach that was held 20-22 September 2011 in Port-Luis, Mauritius. Representatives from Kenyan non-governmental and governmental organisations participated in the Conference and visited harm reduction programmes run by CUT, the first NGO to implement needle exchange programmes in Mauritius. Kenyan practitioners and stakeholders participating in the Conference learnt from representatives of African and Atlantic Ocean regions and got acquainted with harm reductionists from these areas for future collaboration. Together with attending the Conference, they visited outreach, mobile and fixed sites run by Mauritian organisations, had an opportunity to ask practical questions on how to start and manage the needle exchange programme and got inspired with an opportunity to launch harm reduction programme in Kenya.

KENYA

In September 2011, the Alliance Ukraine Hub, together with KANCO, organised and conducted a workshop to develop a locally appropriate combination of HIV prevention services for people who use drugs in Kenya. Eleven participants from local NGOs have strengthened their understanding of harm reduction principles, methods and approaches to HIV prevention service delivery to people who use drugs, and have designed a framework for the introduction of needle and syringe exchange programmes. For most of the participants it was the first introduction to the harm reduction approach and the
workshop raised many burning questions with regards to project design and implementation issues, and existing policy and local environmental factors that may influence the programme. Although most participants were familiar with each other and had already met at local events, it was the first formal meeting of local partners involved in the CAHR programme and it has built a good grounding for future cooperation and networking. Following on from the workshop KANCO received follow-up technical assistance to develop terms of reference and templates for a call for proposals.

To evaluate local partners, KANCO was assisted in carrying out a capacity needs assessment. Technical support providers provided suggestions on how to adapt assessment tools to make them suitable for the evaluation of an organisation’s readiness to start needle exchange. The visit that took place in November 2011 was followed up by a workshop for local partners aimed at giving feedback on the results of the assessment and the project proposals submitted to KANCO. A team from Ukraine together with staff members from KANCO visited organisations in Nairobi, Mombasa, Malindi and Ukunda, and met their staff and clients in order to assess their technical support needs and understand how the systems and procedures employed by organisations could be improved and used in harm reduction projects. While assessing the capacity, the team shared the experiences of a Ukrainian organisation, giving examples of methods and tools used by Ukrainian practitioners.

During the workshop that took place in November in Mombasa, participants received feedback on the results of a capacity needs assessment in four areas: governance and program management capacity, technical harm reduction issues, monitoring and reporting capacity, and financial management and systems. It helped them to understand how to improve overall management, administration and monitoring in their organisations.

During the assessments, some gaps were identified in the area of monitoring and evaluation and one of the aims of the workshop was to present the M&E systems used by Ukrainian projects. The technical support team facilitated a discussion about how M&E systems in Kenyan NGOs could be improved based on the experience of Ukrainian organisations. Participants were particularly interested in developing a unique clients' coding system and considering the introduction of the SyrEx database which might help their organisations to calculate clients' coverage more accurately. Individual sessions with participants held in the end of each day of the workshop gave an opportunity to provide feedback on project proposals submitted to KANCO and answer questions about their finalization.

Taking into consideration the results of the capacity needs assessments and discussions during the workshop, the Alliance Ukraine Hub developed practical guidelines to help Kenyan organisations to set up monitoring and evaluation system in harm reduction projects.

In order to launch effective needle and syringe exchange programmes in Kenya, there was a need to train local outreach workers. As it was very time consuming and costly to provide the training for all outreach workers involved in service provision, it was decided to conduct a training of trainers and scale up the training on a local level in the future. In November 2011 a training of trainers Harm reduction and outreach among injecting and non-injecting drug users took place in Nairobi, Kenya which aimed to improve the training skills of participants and raise their skills and knowledge about harm reduction and outreach. A team of 22 future trainers from different parts of Kenya, consisting of outreach workers, outreach supervisors, addiction counsellors and managers from non-governmental organisations received skills and knowledge training that will build their capacity to conduct further training of outreach workers at a local level.

Over the course of the training it became apparent that although all participants had taken part in prior training activities, had experience of carrying trainings themselves and
some of them had taken part in training for trainers earlier, they were actually more familiar with an academic approach to presenting information during training and, as participants themselves remarked, were not as familiar with group work or other interactive exercises and had never been asked to prepare training sessions on their own. Training participants were very motivated to learn from Ukrainian trainers and they demonstrated a great creativity in preparing their own sessions.

**Malaysia**

The Malaysian AIDS Council received technical assistance around the introduction of behaviour change communication approaches and the improvement of monitoring and evaluation systems. The training on BCC was conducted as a training of trainers in order to reach all outreach workers collaborating with MAC to scale up BCC in the Malaysia. Training took place in Kuala Lumpur in July which developed the skills of Malaysian trainers in outreach counselling within the BCC framework, and practical skills around how to use BCC when providing outreach services for drug users. In addition to addressing the methods and approaches of HIV prevention among people who use drugs, participants of the training were trained in how to pass on the training, in order to scale up this type of the educational activity in the country. BCC experts from Ukraine developed a training module and a package of training materials that can be used by local trainers in the future. The new BCC protocol was designed to improve the effectiveness of HIV prevention and harm reduction communication. This protocol will be rolled out across not only for CAHR programme in Malaysia but also projects funded by the government and the Global Fund.

The Malaysian data tracking system was improved introducing SyrEx (service delivery monitoring software) into all Malaysian AIDS Council supported projects. This was a particularly important assignment as it improves the entire client tracking system of MAC programmes and took place within the context of Round 10 GFATM negotiations. These changes therefore have the capacity to influence all HIV prevention programmes among vulnerable groups in Malaysia. The team of Ukrainian experts adapted the database taking into account recommendations from MAC to make it suitable for Malaysian harm reduction projects. The SyrEx software has been adapted to suit MAC monitoring and reporting needs and a locally adjusted user manual has been developed. The distant follow up support was available to support full scale introduction of the software in January 2012.

**India**

Technical support assistance has been provided to India International HIV/AIDS Alliance in October 2011 in order to strengthen their monitoring and evaluation system. During the exchange visit of M&E specialist from Alliance India to Ukraine, there was a meeting with representatives of Alliance Ukraine monitoring and evaluation department. The representatives from India have been introduced with the main elements of Ukrainian M&E system, unique client coding and rating system. The English version of SyrEx database has been presented during this visit as well. The specialist from India had an opportunity to visit non-governmental organisation in Kyiv, see primary documentation
used in harm reduction project and the database in action. That was a good chance to ask practical questions and receive a better understanding of the database opportunities. As a result of the visit Alliance India decided to request further technical assistance on database adaptation for the country.

**China**

Results of the country on-site assessment showed that stimulants use is increasing in China and rapid testing for HIV is not accessible to the vulnerable population. Technical support around stimulant user programmes and rapid testing for HIV and STI was delivered to Alliance China in order to facilitate the introduction of relevant activities by the partner CDCs. In August 2011 two Ukrainian experts conducted three practical workshops, several individual meetings with the representatives of local CDC centres, community based organisations (CBOs) and vulnerable communities. The workshops addressed the issues of rapid testing, overdose prevention and work with stimulant drug users. During the meetings with CBOs technical support providers discussed opportunities to introduce rapid testing for people who use drugs and assisted in developing the implementation plan to launch rapid testing in the country. They also provided guidance on rapid testing, overdose management and stimulant user programming. As a result of this technical support event, a VCT instruction on was developed to guarantee the quality of rapid testing in outreach settings. After the visit 2 local CDCs started HIV anonymous testing in outreach settings using rapid tests.

**Indonesia**

One technical support visit was made to Indonesia in September 2011 to advise Rumah Cemara on improvement of psychosocial support (PSS) programme for clients receiving MMT. The visit included a meeting with Rumah Cemara staff, methadone users’ community members, KOMET to discuss the issues around MMT programme and PSS component specifically and a field visit to HIV/AIDS and methadone clinics. During the visit strengths and weaknesses in service provision were assessed and a set of recommendations developed to improve the PSS component. Rumah Cemara staff received feedback summarizing the main findings and recommendations on the last day of the visit and written suggestions on how to improve PSS component.

Based on situation and planning activities conducted within CAHR, AIDS Foundation East-West conducted survey assessing the needs for technical support. As a result 2 countries were identified for provision of technical assistance for prison health activities. AFEW consulted with the Malaysian Aids Council and Rumah Cemara and decided to have a first training in 2011, introducing the two partners in the matters of Transitional Client Management. Transitional Client Management is a service offering help, care and support to prisoners two to three months before their release, and three months to ex-prisoners (after their release).

The national partners selected the training candidates based on a terms of reference. The training was conducted in December 2011 in Kuala Lumpur. Ten participants attended the training. AFEW’s specialist trainer in Transitional Client Management conducted the training which was received well and eventually good evaluated. At the end of the training AFEW expert assisted partners to develop work plans of activities for 2012. As a follow up of the training and on request of the partners some documentation about health policies in prisons was sent.

As a result of the training a pilot project on prison programming may be developed in Malaysian AIDS Council in 2013 and some adaptations made to the existing work on pre-release conducted by Rumah Cemara. During 2012-13 AFEW will be continuously supporting CAHR partners in Malaysia and Indonesia to conduct prison-related work.

Overall, more than 600 days of technical support in different areas were provided within CAHR in 2011.
Objective 3. The human rights of drug users, their partners and children are protected in China, India, Indonesia, Kenya, and Malaysia and advanced in global institutions

CAHR policy work is conducted both at the national level through implementing partners, and globally, with strong support from the International Drug Policy Consortium, the International Network of People who Use Drugs, and Harm Reduction International.

These partners are leading international advocates for issues including HIV, harm reduction and the rights of people who use drugs.

International policy priorities include:

- Full and meaningful participation of people who use drugs in policy and programme design,
- a strong commitment to protecting the human rights of people who use drugs,
- drug and HIV policy which is evidence based.

In April 2011 the CAHR project was represented at the International Harm Reduction Conference, held in Beirut, and was made visible through various forums. A separate one-day meeting prior to the conference was organised for project partners to discuss plans, progress and global policy. Throughout the conference, the CAHR project partners participated in numerous multilateral activities to promote harm reduction and the rights of people who use drugs, including signing the Beirut Declaration, a joint civil society statement on harm reduction which was used as an advocacy tool during the New York High Level Meeting on HIV in June.

The CAHR project increased the capacity for a strategic engagement with respect to the protection of rights of people who use drugs in the following key high level meetings:

- Commission on Narcotic Drugs – March 2011 (Vienna),
- High Level Meeting on HIV – June 2011 (New York),
- UNAIDS Programme Coordinating Board (PCB) – June 2011 (Geneva),
- UNAIDS PCB – December 2011 (Geneva).

In December 2011, INPUD held their first ever side meeting at the high-level PCB meeting of UNAIDS, entitled ‘HIV, Legal Issues and Drug Use’ and during which drug user activists from Russia, Afghanistan and Portugal gave testimony to the range of experiences of HIV, legal issues and drug use, from the most negative to the most progressive. INPUD lobbied around Decision Points on the removal of criminal sanctions from people who use drugs, valuable preparation for the dissemination of CAHR advocacy points over the coming year and a concrete demonstration of the principle that successful global advocacy is built on the involvement of people who use drugs at a local level.
INPUD and the regional drug user networks have been contributing to both regional consultation events in advance of the High Level Meeting on HIV and the on-going Global Commission on HIV and the Law (GCHL). INPUD is also represented on the Technical Advisory Group for GCHL.

INPUD has made positive progress in supporting and resourcing the development of regional networks of people who use drugs. Initially the only regional network was in Asia where development funding had been secured from AusAID by the Australian national drug users network (AIVL). INPUD, through another Dutch funded consortium, is planning to strengthen regional networking in Asia, Eurasia and MENA, which will help realise the potential of these new networks of people who use drugs.

Drug policy assessments in all of the project countries took place during the assessment and planning exercises, with significant technical inputs from HRI and IDPC on the policy aspects of the assessment development. IDPC participated in the Malaysian, Indonesian and Kenyan assessment exercises in the first half of 2011. As a result of the Malaysia assessment and planning exercise, IDPC produced a Policy briefing paper on harm reduction and drug policy in Malaysia (full version available on CAHR website: http://www.cahrproject.org/resource/policy-responses-to-drug-issues-in-malaysia/).

IDPC supported important developments in political context of harm reduction work in Malaysia, Indonesia, and Kenya.

A policy visit was conducted by IDPC in November to Malaysia with the following outcomes:

- a plenary presentation on effective and evidence based drug treatment services at the IFNGO conference, Kuala Lumpur,
- a symposium in partnership with MAC ‘On the policy for the successful treatment and care for people who use drugs and HIV prevention’ attended by over 30 participants from government, legal experts, civil society, and media,
- an HRI and IDPC meeting with Law Minister, Nazri Aziz,
- an HRI and IDPC meeting with Nancy Shukri, an MP from Sarawak and Chairman of Malaysian Women’s Parliamentary Caucus,
- a Civil Society Drug Policy Advocacy workshop with Malaysian and Indonesian participants (25 participants), focusing on how to advocate for drug policies based on evidence, human rights and cost-effectiveness.

In December 2011, IDPC visited Indonesia and organised:

- Meetings to discuss CAHR project and drug policy in Indonesia with participants from Rumah Cemara, HIV Cooperation Programme for Indonesia (AusAID), UNODC Indonesia office, BNN National Narcotics Authority (Badan Narkotika National - BNN), Ministry of Health, AIDS Resource Centre in Atma Jaya University (ARC), Joint meeting with Jangkar, Rumah Cemara, PKNI and IAAC, Performa and Stigma and the People’s Alliance for Drug Policy Reform, National AIDS Commission (KPA), FHI, Attorney-General’s Department (Kejaksaan Agung), CLAI- M (Community Legal Aid Institute Masyarakat), ASEAN Secretariat.
- A planning meeting with civil society partners to strategise on key opportunities in 2012. It was agreed to move forward on the issue of diversion from the criminal justice system to evidence-based and humane drug dependence treatment.

IDPC and HRI organised a joint networking and advocacy workshop in the margins of the ICASA meeting in Addis Ababa (December 2011), which brought together three Kenyan civil society participants (all partners of KANCO). IDPC, HRI and KANCO also jointly organised a satellite event at ICASA to present the recommendations of the
Global Commission on Drug Policy, promoting a harm reduction and human rights based approach to drug policy in Africa. The event was attended by over 70 participants.

HRI contributed to the development of a training package on using international human rights mechanisms to promote harm reduction (developed via support from another funder), which has been shared with relevant partners in the CAHR project to assist in preparing in-country human rights-based work and trainings.

Preparatory discussions in 2011 have led to the decision by the International Drug Policy Consortium, the International Network of People who Use Drugs, Harm Reduction International, and the International HIV/AIDS Alliance to launch in 2012 the Support Don't Punish campaign to call on governments to put an end to drug policies that lead to damaging health, social, economic and human rights outcomes. The statement of the campaign can be found here:


This statement will constitute the basis for CAHR’s advocacy work at national and international level.

CAHR partners will continue working together to combine their global advocacy efforts with specific support to the national leads and their local partners aimed to develop and implement pragmatic and expedient policy solutions at the national and local level.
Objective 4. The learning about the role of civil society in harm reduction programmes is increased and shared in China, India, Indonesia, Kenya, and Malaysia and globally

M and E
The CAHR project’s M&E and research framework has been successfully developed and used in all the countries for routine data collection. The M&E framework has been provided to the Dutch government and will be fully completed after baseline data has been entered into the document.

A particularly important achievement of CAHR is the development of methodology and initiation of conduct of baseline collection in all of the project countries. An initial tool was developed and piloted in China and was followed up by training on a baseline study for country M&E specialists and partner research institutions in Malaysia in September 2011. As a result the data collection tool was refined, a sampling approach was developed, and the assessment launched in November 2011.

The decision was made to add a qualitative element to the baseline evaluation methodology through the introduction of small qualitative cohorts in each of the implementation countries. The qualitative instruments will be drafted in early 2012, and applied in countries in mid-2012. The London School of Hygiene and Tropical Medicine has been commissioned to conduct qualitative longitudinal research in Kenya. Professor Tim Rhodes is leading the research and is training local Kenyan outreach workers to conduct fieldwork. Fieldwork will commence in September 2012. The London School is currently developing proposals to seek additional research funds to extend and complete this research beyond phase one. Plans are also underway to extend the methodological guidance and data collection training to other CAHR partners, to seek to inspire small scale qualitative studies elsewhere.

Value for Money
In June 2011 the Alliance facilitated a four day workshop with CAHR partners which included one day around Value for Money work within CAHR. The group discussed VFM basic principles for CAHR and mapped out an action plan for the programme. Participants of the workshop made a decision to pilot the development of a costing tool for CAHR partners, with a generic approach to establishing cost centres for community based harm reduction programming, using service statistics and data from the programme sites.

A detailed costing spreadsheet has been developed, and tested with data from Kenya’s CAHR reporting and finance systems. Cost centres have been identified, although the tool itself is currently in draft format. Over the course of 2012 the tool will be to the other CAHR countries, with the intention for all CAHR partners to use it. Once sufficient data has been gathered for all centre costs the next stage will be to implement a strategy for ensuring cost efficiency and look for areas of saving that have no impact on service quality. A repeat of the costing analysis at the end of the program will allow us to determine if cost efficiency measures have been effective.

Horizontal Learning
Country partners have been working on producing project start-up stories. So far, case studies about the China programme, the Kenyan drug use situation, and Indonesian
CAHR activities have been written and shared.\textsuperscript{21} Key Correspondents training in Kenya was temporarily postponed, but is planned for February 2012.

One horizontal learning exchange took place in December 2011 when representatives from MAC travelled to Ukraine to explore options for refining their technical support system. All CAHR country representatives have become part of the Harm Reduction Community of Practice, a forum of practitioners moderated by the Alliance Secretariat, which regularly discusses harm reduction activities and challenges in order to develop understanding and learning.

The Alliance’s Good Practice Guide on HIV and Drug Use has been translated into Chinese and published in China. The circulation will include local CDCs, peer groups, national and international partners working in the country.

Several project coordination meetings have also taken place throughout 2011. The initial meeting in February 2011 to prepare for country assessments and planning was the first meeting where all country representatives were present. In April, at the pre-conference meeting in Beirut both country and international technical partners were able to come together to discuss each others’ progress and focused on policy themes. The third and most grounding event was the review and replanning meeting in Kyiv which took place in October.

The review and re-planning meeting of CAHR partners in Kyiv was dedicated to summarising the results of the project to date, and planning for 2012. CAHR partners from Malaysia, Kenya, Indonesia, India, Ukraine and the UK (including the Alliance Secretariat and IDPC) attended the meeting and were able to observe the implementation of harm reduction in Ukraine, visiting syringe exchange points, outpatient clinics, community centres for people who inject drugs, and harm reduction operating pharmacies and exchange their own experiences. As a result of the meeting the 2011 scopes of activities were reviewed and considered, next year’s planning initiated, and knowledge sharing and global policy activities were discussed and conceptualised.

A large number of the CAHR global team will be attending AIDS 2012 in Washington, and will be sharing the achievements and lessons learned from the CAHR project.

\textsuperscript{21} All are available on CAHR project website: http://www.cahrproject.org/category/resource-types/case-studies/
Annex A: Preliminary results of 2011 baseline research in CAHR countries

Goal and objectives
The goal of the baseline assessment was to capture the changes in attitudes, knowledge and behaviour of PID that are anticipated in all five countries as a result of CAHR project. The baseline assessment was carried out at the end of the first year of the project and an end-of-project evaluation will be conducted in the fourth year.

The guiding questions for the baseline survey and end-of-project evaluation are:

- What is the effectiveness (added-value) of additional wrap-around services (additional community-oriented interventions other than the nine interventions included in ‘comprehensive package’ of HIV and harm reduction endorsed by the World Health Organization) for PID and their families?
- To what extent are the services provided demand driven? What are the key factors that make the service attractive/not attractive to the clients?
- Knowledge/attitudes/behaviour of PID in relation to HIV/AIDS before and after project implementation.
- Well-being and quality of life of PID before and after project implementation.
- Relations with police; compulsory rehabilitation/detoxification centres.

A local research agency was selected in each country to carry out the survey, with close coordination and quality control by monitoring and evaluation officers within the implementing partner organisations.

Sampling Methodology and Study Design
A specific sample of PID from selected geographical locations was surveyed within each country based on the set quotas of ‘new’ and ‘old’ clients and in accordance with the determined sampling methodology. The baseline figures and the desired target for the key variable of interest (‘percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected’) were used to establish the sample size. The resulting sample sizes were: Kenya – 186, Malaysia – 206, Indonesia – 186, India – 181, China – 177.

In order to capture the difference between PID previously reached by prevention services (before the start of CAHR project) and those who received prevention services for the first time through the CAHR programme, the sample within each country was composed of both of these sub-groups with no less than one third of the sample size per country to be composed of ‘old’ project clients, and no less than one third was to be composed of ‘new’ clients, who presented for services for the first time.

The sample for this assessment was achieved through the following process:

- The sample size per country was distributed between the established geographical locations for sampling (selected out of the CAHR sites).
- Within each selected location the sample size was further distributed between ‘old’ and ‘new’ clients.
- The sample of ‘old’ and ‘new’ clients was selected based on the following methodology:
  - For recruitment of ‘old’ clients, simple random sampling without replacement was used to ensure that all existing clients in a recruitment site at baseline have an equal chance of selection.
Convenience sampling was used for recruitment of 'new clients': to ensure the attainment of sufficient number of new clients within the determined timeframe each new client was invited to participate in the survey.

Inclusion criteria for participation in the study included being a PID (an interviewer asked a number of set questions to ascertain this); living, studying or working in the given geographical area; and a willingness to participate in the survey and to provide data for the respondent identifier code (RID). Informed consent was obtained from each respondent before the beginning of the interview.

Field Coordinators from the selected research agencies carried out data collection quality checks of by means of direct observation (of at least 10% of all interviews conducted at a given location) and control for double inclusion of the same respondents into the study. Additional independent quality checks were conducted by the Alliance implementing partners by means of direct observation and exit-polls.

Site selection

In Malaysia three sites were selected based on their geographical location (North, South and East Coast) as drug users in each of these areas participate in varying practices of drug use. Existing implementing partners of NSEP were present in all three sites. One of the partners was in the process of identifying and opening a new site that would cater for all new clients this study and the other two sites provided services for a combination of new and existing clients.

Kenya identified three CAHR project sites for the survey based on evidence of the spread of injecting drug use in the country. The three sites were Nairobi, and the coastal areas of Mombasa and Kilifi County, where the main concentration of drug users consuming heroin - the most commonly injected drug – are found. A study carried out by the National Agency Campaigning Against Drug Abuse (NACADA) established that 56.3% of drug users in the coastal areas, and 50% in Nairobi were consumers of heroin, differing from other regions where heroin consumption is less than 30%.

In India the three selected sites were Delhi, Manipur and Haryana. In Manipur drug use is highly prevalent (mostly heroin), as the free trade between the border with Burma enables drugs to cross over to the state on daily basis. It was the first state in South East Asia to adopt harm reduction as state policy in 1996, which led to a significant reduction in HIV prevalence from 75% to 22%. Nonetheless, additional prevention efforts are necessary to sustain these impressive results. In Delhi state the concentration of PID is very high, and there is a very high prevalence of HIV among the PID population, which is mostly mobile in nature. Drugs used among PID in Delhi are mostly pharmaceutical products which are easily available over the counter. Haryana is another important site for the study, as limited information is currently available on drug use practices in this area (although it is known that drug use is prevalent).

In China, Chenghua and Jingniu districts of Chengdu were selected as baseline assessments sites because they have a high HIV/AIDS burden and a significant number of PID; there were few international prevention programmes; both these sites are in the downtown of Chengdu; and they had some services for PID available before CAHR.

Indonesia selected three sites for both project implementation and the study, based on the lack of harm reduction services covering the bio-psycho-social needs of PID. The three sites are Bandung (the capital city of West Java province), Bogor, and Sukabumi, all located in West Java province. The first two sites are existing locations for prevention service delivery, while the third is new. Different drug users and practices of drug use are prevalent in each site, Bogor and Sukabumi has a greater proportion of heroin users, whilst PID in Bandung are moving towards injecting buprenorphine use.
**Preliminary Results**

The final results of the baseline assessment study will be reported in 2012. Some preliminary results are available below.

**Social and demographic characteristics**

The total sample accepted for analysis for this study was 648 respondents (119 in China, 123 in Kenya, 183 in India, 108 in Indonesia and 115 in Malaysia). A number of completed questionnaires were excluded from the analysis as incomplete or because of the presence of mistakes. The distribution of 'old' and 'new' clients was as follows:

- China: 67% 'old' clients/33% 'new' clients
- Kenya: 66% 'old' clients/34% 'new' clients
- India: 100% 'old' clients (no 'new' clients were recruited due to the last minute change of the CAHR resulting from a government partner’s suggestion)
- Indonesia: 57% 'old' clients/43% 'new' clients
- Malaysia: 56% 'old' clients/44% 'new' clients

Overall, 79.9% of respondents were male and 20.3% were female. In India all respondents were male (despite the random sample, no female PID were selected).

36% of the respondents reported having 'occasional earnings', 27% were unemployed, 12% were permanently employed, and the rest indicated 'other' as their main occupation. Only a little more than 1% of all respondents were students. The highest number of unemployed respondents was reported in China where they made up 66% of the country sample. The percentage of respondents who do not have means to support themselves varies from 2.1% in Indonesia to 15.5% in Malaysia.

The lowest level of education was reported in Kenya, where the majority of the respondents indicated primary education (58%), and the highest in Indonesia: 48% indicated completion of high school, and 46% partial or completion of college/university education.

On average, about 38% of all respondents reported having a spouse or a permanent sexual partner. The highest reporting of this characteristic was in Indonesia and China (more than 50%). About 34.2% respondents did not have sexual partners, this was greatest in Malaysia with about 60% of all respondents not having sexual partners.

**Drug injection practices**

The type of injecting drugs most frequently identified in all countries were opiates (98%-100%), and within this group 89.5% of respondents indicated using heroin. An exception to this was India, where 'pharmaceuticals' was the most frequently named drug (66.7% of all respondents as well as 50.1% indicated using heroin). Liquid buprenorphine was indicated as a drug used by 39% of the respondents in Indonesia and 18% of the respondents in India (0% in other countries). Stimulant use was highest in Malaysia (42.7% of the respondents), whilst only 5.8% of drug users in Indonesia indicated using stimulants, 1 person in China, and none in Kenya and India. 0% of the respondents in Kenya and 17.9% in Indonesia indicated using sedative drugs, such as Diazepam, Calmipose and others.

About 50% of the respondents had injected drugs every day over the past 30 days, with the lowest frequency of drug use in Indonesia (only 12% injected every day), and the highest in Malaysia (78%). The average number of injections per day of injecting was 2.3, with the lowest in India (1.7) and the highest in Kenya (3.1).
Approximately one third of respondents indicated receiving substitution therapy (ST) (34.3%) with huge differences across countries: more than 70% of respondents in China indicated receiving ST and only a little more than 5% in Kenya.

Opiate overdoses were reported by almost 30% of the respondents with, again, the largest variations from the mean value indicated in China (10%) and Kenya (about 50% of the respondents).

**Risky injecting behaviour**

18% of respondents indicated using somebody else’s syringe during the last injection (ranging from 5.3% in Malaysia, 7.3% in China, 9.0% in Indonesia, to 21.3% in India and as high as 48.4% in Kenya). 21.7% of all respondents indicated having used a previously used syringe during the last 30 days. The two main reasons for not using a clean syringe given were: ‘no clean syringe/needle available’ (67.1%) and ‘I was using the needle/syringe after a person I trust’ (14.2%).

The reports of other risky behaviour are even more concerning, including practises such as participating in blood-filling and sharing injecting equipment. 81.2% of respondents indicated having at least once in their lives participated in blood-filling, and 46% indicated having shared injecting equipment (spoon, cup, cotton, filters, water, etc.) during the last 30 days (ranging from 17.5% in China to 60% in Kenya). The rate of injecting oneself using a preloaded syringe during the past 30 days was 12.1% with the highest numbers being in India and Indonesia (19.7% and 16.8% respectively) and the lowest in Malaysia (6.3%).

**Police and Law**

64% of respondents had been arrested for drug-related crimes such as using, possessing, buying or selling drugs, ranging from 25.7% in India to as high as 94.2% in Malaysia. 34.6% of the respondents reported having ever been kept in a compulsory drug detention centre (ranges from 10% in Indonesia to 69% in China).

**Sexual behaviour**

53.0% of all respondents indicated not using a condom during the last sexual intercourse (35.4% in India, 44.5% in Indonesia, 57.7% in Kenya, 68.8% in China, and as many as 70.8% in Malaysia). Condom use did not differ much between sexual intercourse with permanent or casual partners: 59.7% of the respondents did not use a condom with permanent partner, and 53.3% did not use a condom during the last incidence of intercourse with a casual partner. Condom use was higher with commercial sexual partners, 32.2% of the respondents indicated not using a condom during the last incidence of commercial sex. 64% indicated not using a condom at least once during a sexual intercourse during the last 30 days (with any type of partner).

Reasons for not using a condom included: (i) ‘using a condom lowers senses’ (27.2%), (ii) ‘I did not consider it necessary (21.5%), (iii) ‘no condom at the moment when it was needed’ (13.4%), (iv) ‘my partner insisted on not using a condom’ (13.2%).

**Knowledge about HIV/AIDS and safe injecting**

In response to 13 questions/scenarios around knowledge about HIV/AIDS and safe injecting, 83.8% of all respondents provided correct answers to all the questions. The lowest rate of correct responses was to question #9 (If someone is suffering overdose they should be put in a tub of cold water) – 60% of the respondents gave a correct answer to this question. The other main misconceptions were that HIV cannot be transmitted from an HIV-positive mother to her child during pregnancy (74% gave a correct answer) and that a mosquito’s bite can infect with HIV (77% gave a correct answer).
**HIV testing**

90.6% of respondents knew where to go to get an HIV test (China demonstrated the lowest rate across countries with only 73%). Only 55.6% of the respondents would be able to get an HIV test completed anonymously (the lowest response was in Kenya – 26.3% and the highest was in Malaysia – 76.2%). 86% of respondents have ever had an HIV test (the lowest average response was in India – 76% and the highest was in Kenya – 97%), and 70% of respondents had received an HIV test in the last 12 months.

95% of those who had had an HIV test received their results, with 31.0% of these being HIV-positive (with the highest in Indonesia 57.0%, 28.2% in Kenya, 21.8% in Malaysia and 15.1% in India (the data on this question for China were not completed correctly)), 58.5% were HIV-negative, and others were not willing to respond to this question.

Only 19.1% of all respondents who reported being HIV-positive stated that they are registered with an ART-provision centre (1.6% in Malaysia to 43.0% in Indonesia). The majority of respondents did not provide an answer to this question (70%). The assumption is that the question was possibly not understood by the respondents.

As these are just preliminary findings, the final report on the results of the baseline assessment will also contain sections around access to and satisfaction with services, and well-being and quality of life of PID. The report will also attempt to establish linkages, where possible, between the receipt of different types of services and quality of life and knowledge and risky behaviour in respect of HIV. It is expected that the baseline results will provide a solid basis for fine-tuning within the CAHR project to ensure efficient high-quality service-delivery. Analytical, country-specific reports are also being developed within countries aimed at analyzing the results obtained, as well as providing specific recommendations for the improvement of programmatic activities within CAHR.