WALKING ON TWO LEGS:

A DEVELOPMENTAL AND EMERGENCY RESPONSE
To HIV/AIDS among Young Drug Users
in the CEE/CIS/BALTICS Region

A REVIEW PAPER

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Executive Summary

Overview

1. The region is facing an HIV/AIDS emergency. Two epidemics are interacting – one of HIV/AIDS and a second epidemic of drug use. The HIV/AIDS epidemic in the CEE/CIS/Baltic region is the fastest growing in the world, spreading across and within countries. The epidemic of drug use has created conditions that leave the region open to a massive HIV epidemic unless urgent and large scale action is taken.

2. Young people are at the centre of both epidemics – and are exceptionally vulnerable to their interaction. They are vulnerable as a direct result of continuing social and economic crisis in the region: unemployment, rising poverty, rapid change in values and breakdown of communication within families. They are also vulnerable because few services are tailored to the needs of young people. Among those that are available, even fewer address substance use, sexuality, and ways to avoid transmission of HIV/AIDS. The most vulnerable of young people are those who inject drugs, or those who sell sexual services, young sex workers. Most vulnerable of all are those who do both, a vulnerability made much greater by social attitudes of exclusion, rejection, and hostility to drug users and sex workers.

3. High levels of HIV among injecting drug users (90% in Russian Federation, 70% in Ukraine; 80% in Belarus) are the driving forces of the epidemic. In certain countries, up to 40% of injecting drug users are under 25yrs old and 25% are teenagers. The age of starting injecting drugs is becoming lower – at 12 or 13 yrs among both boys and girls. Levels of HIV infection among young people are already high - reaching 5% in certain oblasts in the Russian Federation. It is this extraordinary level of vulnerability among young people that gives the HIV/AIDS epidemic in the region its special features and call for an urgent response focusing on young people.

4. This paper – commissioned as part of UNICEF’s regional HIV strategy development - provides a framework of action that embraces both the developmental and emergency aspects of the crisis. A developmental approach is needed that can address underlying causes of vulnerability – the social dynamics that have left young people disoriented and without the skills and knowledge they need for life. This includes Life Skills training and social policy that tackles poverty and exclusion and provide opportunities for young people’s participation. Such efforts, however, necessarily represent long term investments and are unlikely to impact on the current epidemic. An emergency response is also needed that is based on what has been found to be effective in reducing HIV infections – and focuses on the most vulnerable groups, now.

5. The focus of the paper, then, is on what has been learned – both within the region and outside – about what works in HIV prevention among injecting drug users (IDUs), and what we know about reaching young injectors and young sex workers. The main message is that experience in the region shows that such groups can be reached by a mix of outreach and service delivery. Coverage levels of such interventions, however, remain very low – too low to have an impact on HIV transmission in most countries. The critical issue is one of obtaining government ownership for such efforts, and the need to tailor interventions much more to client
needs in expansion of services and referral.

6. Mounting effective interventions among IDUs becomes even more important as the epidemic begins to make its move into the heterosexual population. Experience from other parts of the world underline that unless attention is given to stemming new infections among IDUs, efforts to address heterosexual transmission can be rapidly undermined and lead to a resurgence of the virus. With scales of vulnerability evident in the region, a continuing IDU-driven HIV epidemic could easily be hidden yet fuel heterosexual spread, making prevention efforts among the general population much more difficult. The very close interaction between injecting drug behaviours and sexual risk behaviours of young people make the dynamics of this epidemic potentially very fast. It is the same group of people who are at risk on both counts.

7. An emergency response in this region must include targeting explicit IEC materials to young IDUs and sex workers, outreach programmes providing sterile needles and injecting equipment and links to IDU-‘friendly’ services. Each city or oblast is likely to need a mix of services specific to behaviours and practices found to be current amongst young people in their setting. Three phases of interventions with injecting drug users are identified. The key element across all phases is the link between government and local programs – and the advocacy needed to make this ownership significant. Experience suggests it may well take at least 7 years for such efforts to become fully established; an early start to interventions in countries that as yet may not have high HIV infection levels becomes critical.

8. The main part of the paper concentrates on what the role of UNICEF could be in the context of this fast moving epidemic. It looks to find where UNICEF’s comparative advantage in the region lies – what it does best - and how these strengths could be brought to bear on a response to HIV/AIDS. It concludes that UNICEF - using its position with government and NGOs, between national policy and local practice - could have a major role in advocating for a response that addresses both the developmental and emergency aspects of the crisis. This is laid out as a combined strategy of ‘walking on two legs’. UNICEF should continue its work on longer term primary prevention – though in the face of the drug epidemic this too cannot be business as usual - while at the same time move strongly to promote the emergency response required.

9. The real questions (and genuine difficulties) facing UNICEF as it decides on role, however, are not technical but ones of deciding on focus and of ensuring capacities. Lessons from UNICEF’s earlier work in HIV/AIDS are considered along with where UNICEF’s mandate and other regional objectives point to priority UNICEF engagement Three major issues emerge as critical in deciding UNICEF’s future role in working with highly vulnerable young people:

- First, whether there are political costs (and how high these are) of UNICEF entering a field as sensitive and at times controversial as injecting drug use among young people.
- Second, whether UNICEF is not better engaged in staying in areas related to primary prevention where it has established itself and is more comfortable in its relations with government – in Life Skills promotion and information for young people; and
- Third, the question of UNICEF’s own capacities- what can it realistically commit itself to and what are the choices that have to be made in terms of...
opportunity costs of pursuing work in this as opposed to other areas?

10. Whatever decision UNICEF takes, it is emphasised this should be one taken with a full understanding of implications and risks. It is recognised that in some country settings, controversy around work with injecting drug users will make the environment more complex. However, partners in national governments have made it clear that work by UNICEF on IDU issues will not cause problems for UNICEF’s other work. UNICEF’s work must be based on evidence of effectiveness. Risks can be mitigated by careful choice of strategy and by sharing risk with partners such as WHO, UNDCP and international NGOs.

11. Should UNICEF focus on what it feels it know best? Life skills promotion and communication of knowledge to prevent HIV among young people already represents a huge proposition if taken to scale. But unless action is taken to stem the epidemic among young IDUs now, a generation may be lost before the primary prevention work begins to make a major impact. Many of the heterosexual infections among young people will continue to be directly or indirectly from IDUs or sex workers. And with the IDU-led epidemic still at very its early stage in the region, there are large numbers of young people who are presently uninfected but, given what we know about the explosive nature of epidemics in such groups, could easily become so.

12. Capacities are central to the debate. Many UNICEF offices in the region are small, lightly staffed, and already have considerable commitments. There is a real limit in terms of what they can take on. We agree. The approach proposed will need HIV-dedicated staff in every office. And resources. We suggest financial resources need to be channelled to both developmental and emergency responses – on a 50-50 basis. A set of internal management indicators to track progress towards the goals set for UNICEF in this area are identified in the paper. The main role that is proposed for UNICEF is one of advocacy for governments to take up strategies on the scale needed. Support to service development should be very limited – focusing on young people’s needs - and very specific to support policy advocacy. New capacities will be needed – but they need not be all found in house. UNICEF, working closely with sister UN agencies, can engage in ‘strategic partnerships’ with other more technical agencies – including INGOs such as Medecins Sans Frontieres (Holland) and the Open Society Institute (OSI) – so as to ensure the technical support needed.

13. In sum, it is argued that UNICEF is uniquely positioned to make a critical contribution, one that is feasible and closely positioned around its mandate. And that if a decision is taken, capacities can be built swiftly. A draft mission statement for UNICEF’s work with young injecting drug users is proposed:

Unicef’s mission with respect to young injecting drug users should be focussed around advocacy for a combined developmental and emergency response to HIV amongst young people. This should

- within the developmental approach, give support to and advocate for change in factors that contribute to vulnerability to drug use and drug related risk among young people
- simultaneously advocate for an effective emergency response to the current HIV crisis in the region by focusing on young IDUs and commercial sex workers and promoting evidence based interventions so that they can reach a high percentage of
14. This would be consistent with UNICEF’s strong rights approach to its work with young people – promoting interventions that address the causal factors of young people’s vulnerability; acting on the immediate life saving measures needed to protect the lives of large numbers of young people; and at the same time ensuring that the rights of the most vulnerable young people are not overlooked and are given equal consideration.

15. Entry points for UNICEF should be based on country by country assessment and the different phase of response in place. It could include:

- ensuring that information/communication on HIV prevention and Life Skills promotion takes substance use as one of the central issues facing young people in the region, and is consistent with insights and messages drawn from harm reduction.
- expanding Rapid Assessment and Response (RAR) activities, building on the work already underway but giving further emphasis on initiating a response and building local capacities in each setting.
- modelling of services for young people that reach marginalised young people
- encouraging/breaking barriers around participation of young people – through peer to peer approaches, ensuring young people are on NGO organising committees etc, and finding mechanisms for young IDUs to participate in programme design
- making its work on prevention of mother to child transmission of HIV (PMTCT) ‘targeted’ to the needs of young women who may also be drug users. The goals of PMTCT stay the same in terms of increasing access to quality ANC. The specific needs of women who are IDUs or are partners of IDUs need to be met innovatively through using outreach workers of Harm Reduction networks, or through use of rapid testing diagnostics for women who arrive at time of delivery without prior ANC contact. Strategies to meet the psycho social needs of such women (going beyond health into legal and employment issues and care) open up a continuum of care needed for HIV positive women and children. This needs to include UNICEF urgently addressing the protection rights of abandoned HIV positive infants- many of whom at present are condemned to grow up in hospital wards...
PREFACE

This paper has been prepared as an input into the preparation of UNICEF’s regional strategy for HIV prevention in the CEE/CIS/ Baltic and Central Asia. It aims to lay out choices for UNICEF’s work with young injecting drug users (IDUs) and young sex workers. And, in the context of the broader strategy being developed, identify feasible strategies in working with such highly vulnerable groups – ones that will have greatest impact on the epidemic as well as fall within the mandate and capacities of UNICEF to carry these through effectively. (Terms of reference for this work appear in Appendix vii).

Development of the paper involved a review of the epidemiology of HIV, especially among young people, in the CEE/CIS/ Baltic region; and a review of the evidence for effective methods of addressing HIV/AIDS among young injecting drug users (IDUs) and sex workers - the two groups most affected by HIV and most vulnerable to HIV in the region at present. In addition, a series of key informants were contacted to solicit their views of where UNICEF’s comparative advantage related to this area of work lies; visits were made to selected countries and UNICEF supported programmess; and a questionnaire was sent to all UNICEF country offices in the region to ascertain views and further information from the national level.

Information from all of these sources has been collated to present in this paper an overview of the current situation; a brief review of effectiveness data for activities to address HIV among young IDUs and CSWs (Appendix i); an overview of UNICEF responses to HIV/AIDS in the region (Appendix iv); suggestions to UNICEF about its role in addressing these issues; and suggestions for operationalising these suggested roles.

While much is known about what works in interventions to prevent the HIV epidemic in IDU populations, less is known about reaching highly vulnerable populations who are young and represent a growing part of the region’s vulnerability to HIV. This is one of the key features of the HIV epidemic in this region and becomes a focus of the paper’s discussion. The question of UNICEF’s role – finding where and how it can have greatest impact with the limited resources available – is a classic one of organisations that are involved in a wide range of activities. To this challenge is added the urgency of an HIV epidemic that is moving very fast. This question is approached in the context of UNICEF’s mandate for young people’s health, development and protection, identifying what it does best and seeking to focus these strengths on the problem. Within such a wider approach, however, it is argued that HIV requires a sharp focus on interventions that can be shown to work.

Throughout the preparation of this review paper, we have been asked by UNICEF staff for more technical information – about the kind of epidemic emerging and best practice in interventions – and tools to help country teams analyse their situation. We hope this document – with further background in annexes - will help meet that need.
The problem: HIV/AIDS and injecting drug use in CEE/CIS/Baltics

The HIV epidemic in Eastern Europe is the fastest-expanding in the world. HIV is spreading rapidly in Russian Federation (RF) and Ukraine, with burgeoning epidemics in neighbouring countries in Eastern Europe and Central Asia. There is a wide diversity in numbers of HIV positive people across the Central and Eastern Europe/ Commonwealth of Independent States and Baltics (CEE/CIS/Baltics). The region includes countries approaching generalized epidemics (where more than 1% of the general population has HIV) such as Ukraine, to countries with high HIV rates (more than 40% infected with HIV) in concentrated groups such as injecting drug users (including the Russian Federation, Belarus, Moldova, Kazakhstan, Poland, and likely to soon include Latvia and Estonia), nascent epidemics with very few cases of HIV (such as the Czech Republic, Slovak Republic and Hungary), and unknown situations (in most Balkan countries).

While there is a range of levels of HIV infection in the region, there are similarities of the conditions that allow such epidemics to occur. Transmission of HIV among injecting drug users (IDUs) remains the driving force behind all major HIV epidemics in the region. In all countries (with and without major epidemics), injecting drug use is increasing (as it has been globally among most developing and transitional countries for the past decade); drug trafficking occurs across the region; and injectable drugs are available in all countries. Drug policies tend to be based on law enforcement rather than health approaches, driving IDUs underground and away from HIV education and prevention services. This is exacerbated by societal attitudes to drugs and drug users. Few countries provide resources to effectively prevent HIV among IDUs, and few countries carry out comprehensive programs likely to have a major impact on drug use itself.

These factors leave all countries in the region open to massive HIV epidemics in the near future.

1.1 HIV among IDUs drives HIV epidemics

“In regions like Eastern Europe...we could effectively stop the development of large-scale (HIV) epidemics through strong efforts targeting injecting drug users.”
Peter Piot, Executive Director of UNAIDS, June 2001.

Of the large and rapidly increasing epidemics, IDUs make up around 90% of the estimated 600,000 or more people living with HIV/AIDS (PLWHA) in the Russian Federation (RF); more than 70% of PLWHA in Ukraine; 80% in Belarus; 83% in Kazakhstan; and 84% in Moldova. Also, in countries with smaller epidemics, 9-
19% of IDUs are HIV positive in Armenia; while 40% of PLWHA in Azerbaijan are IDUs; 70% in Georgia; 90% in Kyrgyzstan and Uzbekistan.

Epidemics among IDUs in the region began as recently as 1995-96 so it is likely that there will be many more infections among IDUs. On average across several studies of cities and countries in Eastern Europe and Central Asia, about 1% of national populations are IDUs, with levels as high as 5% in some cities. The level appears to be lower in Central Europe and relevant information and research is scarce in South-Eastern Europe, but drug trafficking routes criss-cross the region (including many of the countries which now have nascent HIV epidemics) and HIV among IDUs has been shown in Asia to follow drug trafficking routes. Across the region, IDUs form a massive, young, mobile pool of people with extremely high vulnerability to HIV infection with the potential to transmit HIV both geographically and through sexual partners to all parts of CEE/CIS/Baltics societies.

Increasingly, heterosexual transmission is also becoming more significant in the region, and it is believed that IDUs who also do commercial sex work, or commercial sex workers (CSWs) who also inject drugs, may be playing a significant role in the region’s epidemics. Research in this area is lacking but recent studies have found that in Moscow (RF), 31% of CSWs are also IDUs; and in Vilnius (Lithuania) 25% are IDUs. Sexual transmission is also occurring from IDUs to their sexual partners. For example, studies have found 8% of sexual partners of HIV-positive IDUs have now been infected in the Russian Federation; 6% in Ukraine and a similar percentage in Belarus. This figure is likely to increase dramatically in coming years: a study in North-East India found that 45% of the regular sexual partners of HIV-positive IDUs acquired the virus over a six year period.

Ethnic minorities are likely to be disproportionately affected by HIV in the region: for example, Roma IDUs in the region have been shown to be at higher risk of HIV infection than non-Roma IDUs in Central Europe. Most countries in the region have also reported rapid increases in sexually transmitted infections in recent years: these are likely to propel HIV epidemics from IDUs and CSWs to the remainder of the general population.

Lessons learned from Asian HIV epidemics are relevant to CEE/CIS/Baltics, as most Asian epidemics started six years or more earlier than the major epidemics in Eastern Europe. The greatest rises in HIV among IDUs in most south-east Asian countries (and South Asian countries such as India, in its North-Eastern States) occurred in the late 1980s and early 1990s, and these were followed by large-scale heterosexual epidemics in several countries. In 2001, despite the large number of heterosexual transmissions of HIV, most Asian countries now acknowledge that HIV transmission among IDUs remains one of the most important problems to be overcome in bringing the regional epidemic under control. In several countries, HIV rates are now more than 50% among IDUs (as high as 80-90% in some parts of India, China, Vietnam and Myanmar) so that HIV prevention among IDUs will now be a much more difficult and more expensive process than it would have been in the early 1990s. The Asian experience clearly shows both the value of addressing HIV among IDUs as early as possible, and the need, no matter which direction the epidemic takes, to keep these issues in sight.
Responses to these epidemics and potential epidemics of HIV among IDUs by governments and other agencies have generally been slow and sporadic. Since the early 1990s, good evidence has existed of the effectiveness of various responses to HIV epidemics among IDUs. However, effective responses have been either lacking or carried out at too small a scale in the CEE/CIS/Baltic region (with the possible exceptions of Czech Republic and Lithuania) to have an impact on current or future epidemics. In all countries of the region, there has been a reluctance to implement these effective strategies.

HIV epidemics among IDUs tend to move faster than countries can mobilize resources to prevent the epidemics: for example, HIV infection rose in Odessa (Ukraine) from 0% to more than 30% in one year; in Svetlogorsk (Belarus) from 18% to more than 50% in two months; among New York injectors from 9 to 27% in one year; in Edinburgh from virtually 0% to 40% in one year; Bangkok from 2% to 47% in the same period; and Manipur in India from introduction of the virus to more than 50% in six months.

A recent study showed that the Russian Federation epidemic could have been prevented if sustained implementation of effective prevention programs had begun in the year before the first HIV-positive IDU was identified in the country. Given that HIV-positive IDUs have been identified in almost every country in the region and responses are currently not sufficient to prevent spread of HIV among IDUs, action is urgently required to prevent massive HIV epidemics throughout the region.

The situation at present in CEE/CIS/B demands an emergency response. Any attempts to deal with the HIV crisis in this region need to be based on effective strategies to prevent HIV transmission among IDUs and, increasingly among sex workers and their clients.

1.2 Youth are the most vulnerable IDUs and CSWs

“In the eyes of the majority, the teenagers who start practising substance use are automatically not ‘our children’ any longer, but our enemies...People want to treat them or put them to jail “for their own good”, which actually means not to see them. Not to hear them. Not to remember them.” Moskovsky Komsomolets, Moscow daily newspaper, RF (2000)

“Now, in general, young people are injecting at 12 years, at 15. Yesterday I saw a little girl injecting. And a 12 year old lad who has not yet done military services, who should still be studying, and he is already injecting! I even felt sorry for him.”

IDU interviewee, Togliatti, RF (2001)

Young people in this region engage in two of the highest risk behaviours – sharing injecting equipment among IDUs and unprotected sex among CSWs and their sexual partners – at a higher rate than in many other parts of the world. They are consequently over-represented in HIV statistics in many countries. The region is at serious risk of losing a high proportion of its current generation of youth, a generation that most CEE/CIS/Baltic countries are relying on to assist in their transition towards more effective social and economic systems.
In 2001, up to 5% of young people in Moscow oblast (province) are now believed to be HIV-positive. HIV is concentrated among those aged 18-30 throughout the Russian Federation, and the average HIV-positive IDU is 24 years old. In Belarus, an average of 10% of new HIV infections between 1997-2001 have been aged 15-19, and more than 15% of new infections each year have been among those aged 20-24. One-third of all HIV cases in Latvia and two-thirds in Belarus are among people under the age of 25. In Uzbekistan, 30% of HIV-positive IDUs are aged 15-24. In a 1999 review of HIV and age data from the region, 5-20% of those diagnosed as HIV-positive in CEE/CIS/B countries by that year were under 20, and 20-40% were 20-24 years old. In countries where IDUs account for the majority of cases, such as Moldova and Belarus, PLWHA are younger than in Czech Republic and Turkey, where (homo- and hetero-) sexual transmission has so far been more important.

Research among different (largely HIV negative) injecting drug user populations also shows that in some cities up to 25% are teenagers, and another 40% are young adults 20-25 years old. In Central Asia, it is estimated that 70% of IDUs are aged under 25, and 20% of IDUs in Kyrgyzstan are 16-20 years old. The average age of IDUs in Bulgaria is 19. In one estimate, up to 6% of children and young people in Georgia are injecting drugs. Over 50% of IDUs in Moldova are aged under 24. Roma IDUs also tend to be younger than non-Roma IDUs in countries such as the Czech and Slovak Republics and Hungary.

Sex workers tend to be younger than IDUs. Data collected from different sources revealed that up to 80% of sex workers in the region are under 25. Also, 58% of CEE women trafficked to the Netherlands and 55% of Roma sex workers in Bulgaria were younger than 20 years old. In Moscow, the average age for girls to enter prostitution is about 16. In many CEE/CIS/Baltic countries, there are several “tiers” of female sex workers. The lowest tiers are “street girls” usually very young girls from rural areas who charge low prices ($0.50 in parts of Kazakhstan, Kyrgyzstan and Uzbekistan; and under US$2.00 in Ukraine). Members of this group are in a very poor negotiating position; injecting drug use rates are high; condom use tends to be low or (in some countries) non-existent. These girls and women often have little or no access to sexually transmitted infection (STI) services. Syphilis rates in the general population in the region have increased most dramatically among 20-25 year old women, but increases among adolescents of both sexes have also been substantial.

The reasons for such high percentages of young people becoming IDUs and sex workers are complex and under-researched. Part of the cause appears to lie in the process of transition from a centrally planned economy to a more-or-less market economy. Many countries in CEE/CIS/B have suffered huge socioeconomic upheavals since the break-up of the Soviet Union in 1991, with rising unemployment and generally destabilized economies directly affecting poverty levels, mobility, sex work and social attitudes towards sex and sexuality. While these upheavals have affected almost all segments of society, young people have been hit particularly hard. Falling quality of schooling and general disillusionment have adversely affected behavior patterns and young people’s attitudes towards drugs and risky sexual behavior—all of which are leading risk factors for HIV and STIs.

The vulnerability of young people in CEE/CIS/Baltics to HIV injection itself warrants an emergency response if a generation of youth is not to be lost. The response needs to be specifically targeted to young IDUs and CSWs as these are
the most likely to be infected with HIV. Addressing the root causes of drug use and sex work requires a systematic and comprehensive approach to employment, participation, poverty alleviation, education and recreational opportunities among young people and their families. This process will take years (most likely decades) in most countries of the region.

1.3 Most countries lack the capacity to respond effectively

“One guy died in a house entrance (pod’ezd) – his parents kicked him out of the house – he was a junkie and (HIV) positive. He stayed in this pod’ezd, nobody would approach him. Once some person brought out some food for him in a tea bowl – the way they put out food for dogs. He died there in the pod’ezd…” HIV positive woman, early 20s, Ukraine (1999)

Many countries in the region can be classified as having developing or transitional economies. In general, this implies that countries have little capacity to deal with large-scale HIV/AIDS epidemics. Levels of production in some countries in the CEE/CIS/Baltics remain below those of 1989; and poverty levels remain high in much of the region. Household surveys in Armenia and Kyrgyzstan in 1999, for example, indicated that 55% and 71% of the respective populations had an income below the poverty line. In Eastern Europe and Central Asia (except the Baltics), GNP has fallen by 50-80% in the past decade.

Most countries in the region have begun comprehensive reform programs of health and other sectors, but reform efforts have been seriously hampered by economic constraints. Especially in Eastern Europe and Central Asia, health service personnel are often not paid for months at a time; incomes of doctors and nurses are below those of equivalent professional groups; there is generally low morale and motivation among health staff. Lack of public funding of health services from taxation or social insurance has led to a deterioration of most countries’ health services and diminished access to services.

At their current state of development, few countries in the region will be capable of quickly instituting the changes needed to prevent their young people turning to drug use and sex work. Many countries will also find it difficult to implement effective emergency strategies to prevent HIV transmission among IDUs and CSWs and their clients at the scale needed to successfully prevent or control HIV epidemics. Partly this difficulty stems from competing priorities in each country: it is always a difficult task for a politician or a health worker to defend the provision of needles or methadone to a drug user when pensioners are struggling to survive or ordinary citizens have to pay for their health needs.

However, unless these tasks are undertaken, many countries in the region will soon be facing not only their present problems but the added and overwhelming impact of a massive AIDS epidemic. People with AIDS will require expensive medical, hospital and other treatment, including Highly Active Anti Retroviral Therapy (HAART). Unless they are brought under control, AIDS epidemics increase poverty, reduce national productivity and tie up ever-increasing percentages of Gross Domestic Product in health care costs. All other current problems (from poverty to health care access) will be exacerbated by AIDS.
For these reasons, it is recommended that a developmental strategy be implemented to reduce the vulnerability of children and young people to drug use, sex work and related HIV infection; and to assist countries to improve the quality of life for young people living with HIV/AIDS. Because this will take years or decades to achieve, it is also recommended that an emergency response be implemented to ensure that preventable epidemics are prevented and to bring current epidemics rapidly under control before they reach the general population, substantially reducing the impact of HIV/AIDS in the region.

2. What works? Addressing HIV/AIDS among young IDUs

“I was so surprised that the outreach workers were friendly. Normally we are treated with disgust. I was happy to give out the syringes and leaflets as they asked.” Needle exchange volunteer (female IDU) late teens, RF (2000)

Addressing HIV/AIDS among and from injecting drug users requires a framework of harm reduction policies - strategies and activities that aim to limit or reduce the nature and extent of adverse consequences of drug use. Harm reduction activities have been extensively evaluated and are the only proven effective means of preventing HIV epidemics among IDUs or controlling and reducing large IDU-related HIV epidemics.

Harm reduction is one of the three complementary approaches to addressing drug issues, the others being supply reduction and demand reduction. Supply reduction includes seizing drugs through customs operations and assisting drug producers to stop growing, for example, opium poppies and substitute these with other, legal, crops. It also includes arresting drug traffickers and breaking up supply routes for illicit drugs. Demand reduction is a complex of measures, usually provided by social, education and medical services, to promote a healthy lifestyle free from drugs, and to assist drug users to stop using and achieve medical and social rehabilitation. Every country that has introduced harm reduction programs also carries out supply and demand reduction activities.

2.1 Principles of harm reduction work with IDUs include:

♦ Avoidance of increasing harm: for example, a law enforcement only-approach to illicit drug use may slightly decrease illicit drug use but increases the likelihood of HIV epidemics among IDUs;

♦ Emphasis on short-term pragmatic goals (such as preventing HIV transmission) over long-term goals (such as overall reduction in drug use);

♦ Emphasis on dignity and human rights of all members of society, including IDUs;

♦ Establishment of a harm reduction hierarchy (see below) to provide small, achievable steps which can be encouraged by harm reduction programs;
Use of multiple strategies to achieve goals, working at multiple levels from the street or the school (on risk behaviours for HIV transmission) to the provincial and national governments (on laws and other elements of a supportive environment for harm reduction);

Involvement of IDUs in the planning and implementation of programs designed to address drug use and HIV/AIDS among IDUs.

2.2 A TYPICAL HARM REDUCTION HIERARCHY FOR PREVENTING HIV TRANSMISSION AMONG IDUS IS AS FOLLOWS:

The most effective way to prevent transmission is to never start or to stop using drugs: if you do not use injectable drugs, you cannot catch infections through sharing needles and syringes and other drug preparation or injection equipment.

If this overall goal is not achieved for a specific individual, the drug user should be encouraged to use drugs in any way except injecting: if you do not inject drugs, you cannot catch infections through sharing drug preparation or injection equipment.

If this goal is not achieved, the drug user should be encouraged to inject with new/sterile injecting equipment every time and to not share preparation equipment: if you use new equipment every time, you cannot catch viral infections such as HIV.

If this goal is not achieved, the drug user should be encouraged to re-use his/her own injecting/ preparation equipment every time: if you re-use your own equipment every time, you cannot catch viral infections such as HIV (unless someone else has used your equipment without your knowledge).

If this goal is not achieved, the drug user should be encouraged to clean needles/syringes and other equipment by an approved method. There is some risk of HIV transmission after equipment cleaning, but cleaning in an approved manner will reduce the likelihood of transmission.

As this risk hierarchy shows, many different groups and activities should be involved in harm reduction, from drugs prevention campaigns to drug treatment agencies to outreach workers to drug users themselves. The hierarchy provides small steps which drug users can be encouraged to take to reduce and hopefully eliminate HIV risk behaviours. Ultimately, harm reduction programs collaborate with drug demand reduction efforts to assist drug users to stop taking drugs.

2.3 HARM REDUCTION ACTIVITIES, RELATED TO HIV PREVENTION AMONG IDUS, INCLUDE:

Increasing the availability of needles and syringes, other injecting equipment and condoms for IDUs, including needle and syringe provision or exchange, to provide the tools needed to reduce the sharing of injecting equipment and to reduce the risk of sexually acquiring or transmitting HIV;
♦ Production and distribution of explicit, specific information for IDUs about ways to protect themselves from infection and to prevent transmission of HIV, to motivate and assist them to use the above tools regularly;

♦ Delivery of the above services by credible, trusted workers – often peers including ex or active IDUs – in attractive, accessible formats such as outreach, mobile services and drop-in centers or fixed site needle and syringe programs (NSPs) to reach IDUs driven underground by fears of police and society, and to assist them into drug treatment when desired;

♦ Provision of substitution drug treatment in which methadone, buprenorphine or similar drugs are used for long-term maintenance of opiate users to reduce injecting and drug use;

♦ Provision of low-threshold drug treatment (including substitution treatment where possible) to retain drug users in voluntary treatment as long as possible, to allow entry and re-entry to treatment when desired to reduce injecting and drug use;

♦ Harm reduction drug education, together with enhanced life skills, linked with structural changes to reduce the likelihood of children starting to use drugs;

♦ Empowerment of IDUs through IDU groups to advocate for IDUs’ involvement in HIV and other programs, and to assist in changing social norms among IDUs towards safer behaviour;

♦ Development of links and referrals between NSPs, drug treatment programs, STI services and other health, medical, legal and social services for IDUs to re-engage them with social systems and provide multiple opportunities for effective education on HIV prevention.

Harm reduction activities have been shown to delay epidemics among IDUs in Nepal; prevent epidemics among IDUs in Bangladesh, Australia and the UK; and bring large epidemics under control in Brazil, parts of the USA and Italy. While these activities have been shown to have substantial impacts on HIV risk behaviours, HIV incidence and ultimately HIV prevalence among IDUs, they have not had as great an impact on IDUs’ sexual behaviour.

**Due to the controversial nature of harm reduction activities, they have been more closely studied than any other HIV prevention activity. The evidence for the effectiveness of these activities is overwhelming: this has led to endorsement of these activities by all significant agencies involved in global efforts to prevent or control HIV epidemics. (The evidence for the effectiveness of harm reduction activities is included in Annex (ii)**

Harm reduction activities for sex workers have received less attention in the research literature but there is sufficient anecdotal evidence to suggest that harm reduction activities are useful at least for CSWs who inject drugs and that these can be combined with other proven effective techniques to prevent or reduce epidemics of HIV among CSWs and their clients.
2.4 Effective measures to prevent HIV spreading among CSWs include:

- Provision of free/cheap, accessible STI services to prevent and treat STIs which are often co-factors in HIV transmission both to and from CSWs: these should be linked to voluntary testing and counselling services to encourage testing and use of test results for promoting safe practices;

- Implementing 100% condom promotion campaigns (including at least targeted media campaigns, condom distribution and enhanced safe sex negotiation skills) to assist all CSWs to insist on condom use at least with all clients to reduce the risk of sexually acquiring or transmitting HIV;

- Increasing the availability of needles and syringes, other injecting equipment to CSWs who inject drugs, including needle and syringe provision or exchange, to provide the tools needed to reduce the sharing of injecting equipment;

- Production and distribution of explicit, specific information for CSWs about ways to protect themselves from infection and to prevent transmission of HIV, to motivate and assist them to use condoms regularly;

- Delivery of the above services by credible, trusted workers – often peers including ex or active CSWs – in attractive, accessible formats such as outreach, mobile services and drop-in centers to reach CSWs in safe, “sex worker friendly” premises which allow conversations and counseling on a wide range of issues of interest to the target group, and assistance into alternative employment when desired;

- Empowerment of CSWs through CSW groups to advocate for appropriate legal and police treatment, and to assist in improving CSWs’ negotiation skills to protect themselves;

- Development of links and referrals between NSPs, drug treatment programs, STI services and other health, medical, legal and social services for CSWs to re-engage them with social systems and provide multiple opportunities for effective education on HIV prevention.

As can be seen, there is significant crossover in activities that will effectively address HIV prevention among IDUs and CSWs. It is also important to note that it is only when a set of these services is delivered at a scale large enough to cover a large majority of IDUs and CSWs in any specific area that a HIV epidemic among these groups will be prevented or brought under control.

Specific harm reduction programs for young people (including adolescents) are under-researched but recent work by the World Health Organization has found that the activities outlined above are as effective for young IDUs (including teenagers) as they are for older drug users. Effectiveness of programs for young people appears to be enhanced by employment of peer staff (of a similar age or slightly older than the target group) and youth-friendliness of IEC materials, premises and staff: this has included use of youth culture symbols in IEC materials and as posters in premises, involvement of young IDUs in designing and producing IEC materials and in planning and implementing programs, and staff training to understand the needs and culture of young IDUs.
2.5. ADDRESSING STRUCTURAL AND SOCIETAL FACTORS THAT INCREASE YOUTH VULNERABILITY

In addition to these emergency responses, work is needed on the structural and societal factors that increase youth vulnerability to HIV infection. Evidence for the effectiveness of activities to address these issues is generally unavailable because of the difficulty of researching such long-term processes. But some principles have been developed from work on these issues in many countries and some activities seem more likely to lead to decreased youth vulnerability.

As UNICEF has pointed out, addressing the structural factors that increase the vulnerability of children and adolescents to HIV/AIDS involves the reduction of poverty, especially as it impacts on young people. Principles include the need to:

♦ Integrate and simultaneously address economic and social rights
♦ Ensure government funding for services is based on integration, equity and efficiency
♦ Promote community participation in managing the delivery of an integrated package of social services and special protection for vulnerable children
♦ Reduce the enhanced HIV risks faced by girls through structural efforts to prevent the coercion of girls into sex and sex work, to increase economic opportunities for girls apart from sex work: this must be done in conjunction with educational and structural programs targeting young men as the risk behaviours of the two groups are intertwined
♦ Reduce adult legal drug use to reduce modelling of addictive behaviour for youth

Activities which are believed to be effective in reducing youth vulnerability include:

♦ Advocating for increased spending on basic social services and child protection
♦ Expanding effective sex education (including HIV/STI education) and drugs education (within a framework of healthy lifestyles and life skills) at various institutional levels and throughout the community: this process needs to involve both health and education professionals as well as community and peer educators
♦ Increasing opportunities for participation among young people especially peer education about HIV transmission and prevention
♦ Integrating community and peer education with accessible services for young people
♦ Increasing employment and/or other opportunities for young people as a realistic alternative to drug-taking
3. What will work here? Towards an effective mix of interventions

The emergency response to HIV prevention among young IDUs and CSWs in CEE/CIS/Baltics requires a mix of services based on their risk behaviours and needs. The specific mix and level of services will be different in each city, province and country but the development of these services is likely to proceed through several phases, in each of which international organizations such as UNICEF can play an important role.

3.1 A ‘State of Youth Vulnerability to HIV/AIDS’ in each country:

Given the striking, and in some settings increasing, levels of vulnerability of young people in the region to HIV, such a developmental and emergency response needs to be underpinned by a set of indicators and targets (based on best practice) that will capture current levels and trends in youth vulnerability. This needs to based on the specificities of the region. Such an analysis on the ‘State of Youth Vulnerability to HIV/AIDS’ in each country could include indicators such as:

**STRUCTURAL**
- youth unemployment rates and trends, ratio of adult: youth unemployment;
- child poverty rates;
- % youth ever injecting,
- % ever engaged in sex work;
- youth leaving institutions w/out homes

**MEDICAL/HEALTH**
- access of youth to free medical/ health care in especial areas of concern viz. drug treatment (including substitution drug treatment),
- access STI services (especially access by IDUs and CSWs),
- access to HIV Voluntary Counselling and Testing,
- access to HIV treatment and care services,
- medical care for HIV+ youth; and youth-friendliness of these services

**MEANS OF PREVENTION**
- access of youth to condoms,
- condom use at first sexual contact
- access to needles and syringes and associated injecting equipment
- coverage rates of Needle and Syringe Programmes among young IDUs
- presence of legal restrictions on interventions,
- restrictions through pharmacies/ shops

**INFORMATION/EDUCATION/COMMUNICATION**
- reach of IEC campaigns among youth,
- coverage of NSP outreach programmes,
- reach of Life Skills education
- % life skills that address substance use
reach of explicit targeted specific communication on HIV prevention among young IDUs and CSWs

**EMPOWERMENT**
- rates of participation by youth in management of youth-specific services,
- participation by young IDUs in drug user organizations and other harm reduction services, and young sex workers in sex worker organizations and other CSW-specific services

These indicators (put up suggestively here) and a set of targets to match them should be developed as a collaborative process between UNICEF, UNAIDS, WHO, UNDCOCP, UNFPA, relevant international and other NGOs, and expert consultants. Targets should be developed with national partners. Much of this data would be gathered through regular surveys of youth, with specific sampling of young IDUs and CSWs, and should be included in Rapid Assessment and Response questionnaires. These could become a powerful variant of the MONEE reports, providing regular analysis of trends and issues surrounding young people’s vulnerability to HIV/AIDS

**3.2 A phased introduction of services**

The most effective set of interventions for young IDUs and CSWs would include: targeted explicit IEC for young IDUs and CSWs; outreach (and, if possible, targeted IEC interventions) to many different IDU and CSW networks, including employment of peer educators of a similar age and gender to the target groups; needle and syringe programmes (NSP) and increased availability of injecting equipment through government institutions such as polyclinics, accident and emergency units in all parts of a city and province. It should also include IDU and CSW-friendly STI services; low-threshold, respectful, voluntary drug treatment (including substitution treatment) based on clients’ needs with specific attention given to the needs of adolescent drug users. Access to IDU- and CSW-friendly general and HIV-related medical/health services (including HIV voluntary counselling and testing (VCT) and maternal health services); empowerment organizations of CSWs and IDUs; access to IDU and CSW-friendly psychological, legal and social services to meet clients’ needs are also needed. Advocacy for introduction/ expansion of these services, for a supportive environment for these services; and for structural changes to improve social and health circumstances of IDUs and CSWs (including legal reform where needed) is urgently required.

In most countries in the region, few, if any, of these services are in place or are operating at a level sufficient to prevent or control HIV epidemics. The phased introduction of these services requires an assessment of the speed of effect of each intervention on HIV transmission among IDUs and CSWs, as well as the speed with which needed changes, training, and other activities can take place to allow activities to be implemented.
Phase 1: Where there are no, or very few, emergency response programs:

- Undertake Rapid Assessment and Response (RAR) programs using WHO methodologies (which have been developed to examine potential transmission among IDUs, sex workers and youth). These should be carried out to identify risk behaviours, scale of the problems, possible locations for services, and to begin the process of designing needed services and service links. RAR processes should be carried out in all cities/provinces likely to experience substantial HIV problems related to young IDUs and CSWs.

- These should be followed by the development of pilot programs (of 3-5 years duration) with technical assistance and evaluation for translation of results into policy. The highest priority for these new services should be outreach/youth health centers (YHCs) to find and educate IDUs and CSWs (if NSP can start immediately, then NSP should be combined with outreach/YHC), targeted explicit IEC for IDUs and CSWs (including, where possible, specific adaptation of Life Skills training for these target groups), substitution drug treatment (where possible and legal), and targeted STI services for CSWs and IDUs.

- In all these services, client-centredness should be encouraged, basing services on the self-identified needs of target groups and encouraging participation of young IDUs and young sex workers in planning and implementing interventions (for example, through participation on management or advisory boards).

- Advocacy is also needed for this emergency response, for raising the priority of HIV prevention as a political and governmental issue, for addressing HIV among IDUs and CSWs as the highest or a very high priority in HIV prevention, and for the need for specific activities (outreach/Youth Health Clinics, NSP, substitution treatment, targeted STI services) which may be politically and socially controversial. Countries in this position may include some countries in south-eastern Europe, southern Central Asia and the Caucasus.

Phase 2: Where there are small scale emergency response program(s) in one or more locations:

- Undertake RAR programs to identify the appropriate mix of services needed to prevent or control HIV epidemics among IDUs and CSWs, as well as to identify locations with needs but no services, and start new programs in these locations (using phase 1 priorities).

- The range and reach of programs should be expanded in those cities/provinces with program(s), ensuring that targeted explicit IEC is reaching various networks of young IDUs and CSWs, outreach/YHCs are offering appropriate services to meet the demands of the target groups, NSP (including increased availability through government institutions such as polyclinics, accident and emergency units) is reaching at least 60% of IDUs
on a regular basis, youth-friendly STI services are affordable and easily accessible, low-threshold youth-friendly, voluntary drug treatment (including substitution treatment) based on clients’ needs is available on demand, sufficient access is provided to friendly general and HIV-related medical/health services (including VCT and maternal health services), sufficient access to friendly psychological, legal and social services are provided to meet clients’ needs, empowerment groups are established.

- Client-centredness of services should continue to be encouraged and advocacy should continue as in Phase 1.

Most countries in the region are in this phase, to a greater or lesser degree. Many countries have a single needle exchange and/or methadone program; some have youth friendly health clinics and STI services but none has a comprehensive range of services.

**Phase 3: Where an appropriate mix and level of emergency response services is in place, at least in one or more locations in the country but many of the services have been established with the help of UN or other international NGOs:**

- In this phase, the government of each country needs to take over leadership of the comprehensive response and ensure that State budgets are used to fund these prevention efforts.
- At first, handover of the mix of programs in one or more locations to State financing is required. Actual activities may be carried out by government and/or NGO services as the government desires, but governments should be encouraged to provide funding for at least some services to be delivered by NGOs: highest priorities among these should be outreach services, empowerment groups of IDUs and CSWs and production of explicit IEC materials.
- State financing should also lead to introduction of an appropriate mix of services in all sites where they are needed throughout the country.
- Advocacy becomes an enormous task at this point to gain governmental approval for its own funds to be used for this work. Also, advocacy is needed to ensure that those aspects of services which have been vital to their success – especially client-centredness and youth participation – are not removed during the handover process.

### 4. What role for UNICEF?

The strategy outlined above is one around which all partners need to rally. Having an impact on HIV, however, will require large scale interventions by government and beyond the resources of any one individual agency. It is also going to be a long-term battle. Defining a role for UNICEF that is both clear and strategic, then, is critical.
4.1 Making sure the choice is “strategic”

How do we make sure that the role is indeed close to UNICEF’s strengths and are within its capacities to deliver on any commitments made? Here we identify five criteria that should guide that decision making:

1. the ‘closeness of fit’ between UNICEF’s mandate, its role and the structures that are either already in place or could be mounted swiftly and sustainably.
2. complementarity with what other organisations/partners are doing (matching their strengths and needs)
3. the ‘fit’ between any new activity and other components of UNICEF’s HIV prevention strategy. Does it reinforce and integrate well with these efforts?
4. the feasibility of interventions having an impact on HIV transmission among the target population – in this case highly vulnerable populations
5. resources that are available (or could be available) to UNICEF for this purpose (financial, human and organisational)

Given the sensitive nature of any work in the field of drugs in the region at this time, to these five we should add a sixth ‘political risk factor’

6. the impact on UNICEF of taking on board an area where societal acceptance and tolerance (in this case of working with drug users – even for harm reduction) is, at present, extremely low.

4.2 Comparative advantage – as others see UNICEF and as UNICEF sees itself

First, though, it important to know where UNICEF’s comparative advantage lies as a development organisation in the region. Where has it shown it can have an impact?

UNICEF is still a relatively new organisational presence in the region - with country offices established as recently as 1997. In one sense this is an advantage. It allows UNICEF to focus its work without having to disentangle itself from a history of long engagement in fields that may no longer have priority for the region. A disadvantage is that UNICEF does not enjoy the level of policy access that long standing cooperation and trust has given UNICEF in other parts of the world. This may change (or indeed be changed by a concerted effort) but is part of the present working programme environment.

Key informants were asked what their perceptions were of UNICEF’s strengths as well as its weaknesses. The same question was asked internally to UNICEF staff at country level (with an emphasis this time on finding their views on possible obstacles to working with young injecting drug users). Both sets of responses remain, of course, perceptions. They do give, however, a sense of what UNICEF is
doing well, and where it has been less effective\(^1\). And perceptions can be important in their own right either blocking or facilitating action. Observations have been left as verbatim quotes and are commented on only to bring out the roles that UNICEF is currently playing, or could play, effectively.

<table>
<thead>
<tr>
<th>(a) GOVERNMENT  Strengths</th>
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<tr>
<td>‘It is easier to work with UNICEF as a partner as the Ministry of Health is the national level partner and UNICEF understands the national policy framework. Other outsiders don’t always understand our system and laws….’</td>
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<tr>
<td>‘As professionals, we are a conservative group, we find it easier to work with UNICEF…’</td>
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<tr>
<td>UNICEF ‘combines world experience with local understanding of needs and mentality – this is really important to us’</td>
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<tr>
<td>‘Without UNICEF, we could still do the same work, find out information etc, but our work would be local, and limited…’</td>
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<table>
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<tr>
<th>(a) GOVERNMENT  Weaknesses</th>
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<tr>
<td>‘Its internal procedures are different from national ones – this creates problems…’</td>
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<tr>
<td>‘UNICEF needs more protective links at a high level – especially when it deals with socially controversial areas’</td>
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<tr>
<td>‘If it becomes difficult, UNICEF sometimes drops an issue it is working on, leaving us on our own…’</td>
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Government officials in the region appear to see UNICEF as what they describe as ‘a natural national partner’, often a stable reference point when governments themselves change frequently. UNICEF’s counterparts in government did not appear to have fixed ideas about what UNICEF should or should not be doing. UNICEF was frequently described, though, as an authoritative source on experience of work in areas such as with young people or on preventing mother to child transmission (PMTC). Professionals working in the health sector particularly appreciated access to international experience through UNICEF’s collaboration – reflecting their strong sense of earlier isolation from international experience and a desire to stay abreast of recent developments.

\(^1\) It should be noted that the views quoted below are drawn from discussions with partners and staff from a limited number of countries and those working most closely around the HIV/AIDS field.
(b) LOCAL NGOS Strengths

- ‘UNICEF was important in giving an early push to get things going…’
- ‘When it is learned that UNICEF is supporting this activity, doors that were otherwise closed, open…’
- ‘Financial support is important, particularly as the state is only giving limited support to young people services…’
- ‘UNICEF is permanently here and visible – it has been able to articulate its voice.’
- ‘There are some donors who give the money but are not closely involved in what happens; Others give the money but want to control everything. With UNICEF, it is on a partnership basis’
- ‘UNICEF played a protective role re negotiations we had with the local police’

(b) LOCAL NGOS Weaknesses

- ‘If UNICEF becomes involved in harm reduction, its name won’t help. It will need someone here in its office who can have a dialogue with the government at a high level…’
- ‘We like what we get, but we need much more…’

Local NGOs have become a key partner for UNICEF as it increasingly works on young people’s issues. They are few in number, and still lack capacities in depth. They value UNICEF in a key mediating role with a partner they also have to deal with, government, and with whom, for them, relations are not always easy. Capacities of NGOs to implement reflect their very recent emergence across the region – and UNICEF’s support in supporting them early in their development has left its mark. The relationship of NGOs with UNICEF often appears to be based around individuals rather than organisationally driven – which is perhaps to be expected at this period of civil society evolution. The numbers of NGOs working with very marginalised young people (or which UNICEF is supporting on HIV prevention directly) is still very small – much below what is needed. And is driven by funding availability that itself creates special sets of problem and some dependency. Any future expansion of cooperation with NGOs will need an intensive capacity building effort. UNICEF itself has not had extensive experience in this kind of building of civil society organisations. Others do.

(c) UN FAMILY and BILATERALS Strengths

- ‘UNICEF has both leverage with government and policy access - especially with other sectors such as the Ministry of Education…’
- ‘UNICEF is an agency with a mandate for working with young people – and can do something serious in primary prevention’
- ‘It can break down barriers between sectors…’
- ‘UNICEF has exceptional fund-raising capacities; these can be used strategically’
Partners in both the UN family and bilaterals see and openly recognise the importance of UNICEF’s working contacts with government. Especially with sectors that they themselves may not have linkages with such as Education - but which are vital for the kind of inter-sectoral approaches needed for HIV/AIDS prevention. These are seen as UNICEF’s strengths – as well as its having staff on the ground in almost all countries. Some of these voices are also critical (openly or tacitly) of UNICEF’s seeming to distance itself from what they see as the critical issue in stemming the epidemic - working directly with injecting drug users and of whom most are young. UNICEF is seen as having made the difficult transition from working on the very young child to adolescents but is still seen as more comfortable with an area such as life skills promotion (as is government) while decidedly less comfortable with the more threatening role models involved in working with young people and injecting drugs. While frustration has been on both sides, it is clear that the potential role of UNICEF in HIV prevention is considered by this group of partners to be high - much greater than the role at present.

**(d) INTERNATIONAL NGOS  Strengths**

- ‘UNICEF has an ability to reach younger age groups which we cannot’
- ‘We are only now looking at what is needed around young people. UNICEF is a potential partner’

**(d) INTERNATIONAL NGOS  Weaknesses**

- ‘Part of the UN bureaucracy!’
- ‘UNICEF has difficulties supporting small funding which is where there is a real need’
- ‘We have difficulty working with its internal culture - the person you deal with is never empowered to take a decision - he/she always has to get approval higher up. Things don’t move...’
- ‘UNICEF is a big machine- it is difficult for it to be flexible – like every UN ...’
- ‘UNICEF came, promised, and never came back....’

Many of the INGOs working on HIV/AIDS in the region (such as MSF(H) or OSI) till now have had relatively little contact with UNICEF, occasionally meeting in larger meetings but rarely taking part in a concerted joint activity. UNICEF is not seen by them as engaged in HIV prevention in the same areas as they are. After three to five years of working at the difficult end of the epidemic, however, INGOs are now concerned about sustainability and are looking for partners. Such partnerships may not be automatic: both UNICEF and INGOs tend to set their own terms on how such a partnership should function. INGOs are not without
their own views of the UN system for whom they have a healthy if sometimes critical and irreverent respect. Importantly, at this critical moment in the response, a hand is being offered towards UNICEF to see whether a partnership can take root.

**UNICEF STAFF Strengths (Country office staff)**

- ‘Our role is very different from what it was two years ago. It started with funding NGOs directly. Now we are focusing on building links between Government and NGOs’
- ‘capacity building of local authorities is the critical point and bottleneck of implementation at the moment. Often all they need is ideas and moral support from UNICEF…’
- ‘Young people in general are definitely where we need to be. This is a region where kids do get immunised, where there is still quasi-universal access to education. In all of these areas, UNICEF has a role to play – in improving quality…The one area where our work is cut out for us and will continue to grow is in protection (of young people). This has to include the most vulnerable, but how?’
- ‘Starting this programme will need high political involvement, of the Regional Director, of Carol Bellamy…. This will give us the top level access needed to open up this work…’
- ‘There is a risk (in working with young IDUs…) but we have to take it. I feel we have the mandate; but we cannot do it alone.’

**UNICEF STAFF Weaknesses**

- ‘I don’t know how it (harm reduction) will work in our country’
- ‘Harm reduction is a new area for UNICEF; we have to take into account realities…’
- ‘We can have our own initiatives – but these need to be systematised as part of a wider UNICEF approach. HIV is work for the whole office!’
- ‘We still need a clear sense of priorities…”
- ‘Please write your report so that we receive funds- that’s what we really need…”

UNICEF staff in the field have seen their role changing over a short period. In some settings, they have found themselves moving into ground closer to that of NGOs - facilitators and active movers on issues with local counterparts. The role they see UNICEF playing is one of supporting innovation in mainstream services. Young people is clearly an area where they see growing priority need – both for policy reform and new services. The question that is being seen as posed is ‘how can the organization re-engineer itself to focus on adolescence?’. And as it does so, how should it approach work with very vulnerable groups?

There is still evident uncertainty among field staff about the prospects of moving into a new programme area such as harm reduction – especially in offices which had not yet initiated work in such areas. It was seen as taking UNICEF into ‘murky’ territory that it doesn’t know well. The other concern most often expressed was doubts about technical capacities available. In HIV/AIDS at the national level, there has often been a vacuum of external technical assistance and UNICEF has found itself in a quasi technical role, filling that vacuum. Country teams are stretched to respond to this need, and do not feel they receive sufficient technical support from outside (or within UNICEF…). They are not against taking on new programme areas if these are felt to be important, but they do have difficulty squaring this with existing commitments…. They see themselves as over-stretched in the areas they are already working on.
This brief survey of key informants underlines the wide range of roles seen by UNICEF's partners. Traditionally organisations work most effectively when they have fewer roles and develop the most important of these very strongly. But the space that UNICEF is operating in is one that needs multiple roles – ones that allow it to work on the interface between inside a country and outside and between government and civil society structures. But is important to see what those are and strengthen them consciously.

4.3 From there to core strengths

There are always some roles for an organisation that are more important than others (or particularly significant at a certain time). Which these are in the region for UNICEF and whether they can be carried over to its future role in support of HIV/AIDS prevention among young people is a key question. Despite its recent arrival, UNICEF appears to have established itself as a trusted and stable partner- particularly with government professionals. UNICEF’s role in giving access to experience outside of the country (either in Europe or other parts of the region) is one that has been particularly appreciated – especially in countries still experiencing the difficulties associated with transition. Giving access to international best practice and trying to work out approaches in local settings (while keeping in mind national policy) appears to be UNICEF’s core strength in the region.

And although UNICEF is working across the lifecycle with the very young child (and is recognised for that), it is in its work with young people that UNICEF’s mandate appears to resonate most strongly, corresponding to a perception of a serious gap in services and policies for this age group. International NGOs working on HIV prevention have not been a major part of UNICEF’s horizons but represent a relatively unexplored opportunity. Success in working with and within the UN family has been more elusive.

Interestingly, ‘advocacy’ has not been identified as an area where partners see UNICEF having made a visible contribution, either in HIV/AIDS or in other areas. That may depend on what one defines as advocacy. Scope for more high profile advocacy on a political level is beginning to crystallise at the level of oblast governors or mayors. But it is not yet a core strength for UNICEF at high national levels.

What is of more concern is that the roles adopted seem to have emerged in an ad hoc fashion, dependent on the skills and interests of the local UNICEF office head, are different in each country in response to individual situations, and there does not appear to have been a strategic frame in which they have been developed or supported across the region. This is a weakness rather than a strength.

4.4 Lessons from UNICEF’s work on HIV in the region

UNICEF’s work on HIV/AIDS in the region also only dates from the mid/late 1990s. Reflecting the pattern of the epidemic at that time, the approach was not uniform across all countries. There was a realisation already that the Russian
Federation, Ukraine, and Belarus (RUB) had an epidemic of spiralling proportions on their hands with national responses largely still in denial. Offices in other parts of the region, however, were opening, hardly thinking of HIV/AIDS, concentrating on more traditional areas of MCH and young child services; or finding themselves caught up in mounting responses to complex emergencies that were still present across the region.

As it looked for where it could best contribute as an organisation, UNICEF concluded that what really mattered at that particular moment in time was to address denial and get political recognition of the danger that the HIV epidemic posed. Putting HIV on the political agenda, then, became UNICEF’s first, internally set, objective. Initial focus was strongly on information and media, using UNICEF’s experience on communications and contacts with journalists to increase awareness among the public and policymakers on the risks of ignoring the epidemic.

A second strand in UNICEF’s HIV work developed as UNAIDS entered into the regional picture, and UNICEF began to look at how it should work as a Cosponsor. A strategic planning process among the Cosponsors led to the identification of three major and shared priorities for the region: injecting drug use; sexually transmitted infections; and vulnerable young people. Among these, UNICEF saw itself as being in a unique position to situate HIV prevention as part of services for young people. Lifeskills promotion- aiming to build skills and attitudes that protect and build self-esteem among young people - became the major intervention supported by UNICEF in schools (and increasingly out of school settings) across the region.

A third strand, linked to the above, has been to support efforts towards innovation in services for young people, in setting up ‘youth information centres’, youth clubs or supporting ‘youth friendly’ health and other services.

Together these form the centre of UNICEF’s current approach – focusing on young people’s health, protection and development as a set of holistic responses to HIV but including importantly other aspects such as alcohol and substance abuse. These issues are all seen as closely connected and needing to be addressed in a common framework of promoting and protecting the rights of young people.

Drawing clear lessons from what is still very recent experience is premature. Lessons that do emerge however include:

- the impact of the effort centering on information and media was not decisive. Despite the large amount of resources used for this purpose, and the amount of awareness created by mass media, levels of stigmatisation – around HIV, around injecting drug use - remain just as strong or almost as strong as they were.
- work on life skills promotion among young people has earned a leadership role for UNICEF, along with WHO, encouraging/piloting new methods and approaches. Targeted peer-education has become an accepted strategy, opening the perspective of system wide work with education ministries and other partners. The scale of action in relation to need, however, remains still very modest in most settings.
• programmes developed with local youth organisations, mainly for information and IEC, and services for young people have broken into new ground. But the models of ‘youth friendly’ clinics etc have not always been easy to expand, often facing high unit costs. This has remained promising ground but still to find its critical direction or mass.

UNICEF has not been involved in a major way in the region in working with young injecting drug users. As an organisation, UNICEF didn’t feel it had either the expertise or clear mandate for support in this field. In a few countries though – mainly those faced with burgeoning HIV epidemics among young IDUs - UNICEF responded locally with support to harm reduction interventions (Ukraine and certain Central Asian countries). This was largely directed through NGOs’ outreach efforts with UNICEF providing links with local authorities, and using UNICEF’s ‘convening’ power to support NGOs in their work with government. In the most recent period, UNICEF has also begun to model approaches to create a network of services for marginalised young people that includes information, drop in centres, harm reduction NEP, and counselling (Ukraine).

Lessons derived from this very location specific experience include

• the importance of the link with local authorities for institutionalising responses. In situations of budget shortage and decentralisation, local authorities have held the key to sustainable community outreach efforts.

• support to Rapid Assessment and Response (RAR) methodologies has been a major learning initiative. The RARs have offered an entry point to change the environment in which prevention among hard to reach groups can be launched, contributing to local understanding of the scale and nature of drug use among young people and helping underpin advocacy among policy makers. But RARs are costly and need to be organised in ways that lead to programme interventions as quickly as possible and local capacity building built into the design of the RAR.2

Very little work has been undertaken with young sex workers either in prevention of HIV, other programme delivery or advocacy. Trafficking of young women is becoming a major issue in different parts of the region (and taken up as a cross-border issue by IOM) but activities within countries are few and far between. Strategies to address the needs of ‘young’ sex workers are still missing. Similarly, the protection side of HIV/AIDS – what happens to HIV positive children in society - has not yet been in focus. UNICEF has been prominent in calling for attention to reform of institutional care of children – many of whom emerge with extremely poor life skills and find themselves having to turn to sex work for survival. This opens areas that could be critical for HIV prevention interventions, but the link is still not there.

How do these experiences fit with the developmental and emergency response described in the first part of the paper? The work on lifeskills and participation of young people clearly falls strongly within the developmental response. Much

2 The use of RARs is currently being evaluated as it is implemented in SEE sub region.
understanding has been gained in working with adolescents, forming a solid base for future scaling up UNICEF’s work in primary prevention.

UNICEF’s work on interventions with vulnerable groups is much less developed. Feedback to the questionnaires to country offices on work with young drug injectors (viz. Annex (iv) ) highlighted that for many offices the major reason why UNICEF had not engaged in this area was the absence of any regional or global position on UNICEF’s approach to young IDUs. There was also an emphasis on current lack of technical knowledge (knowing what to do), and the lack of human and especially financial resources to carry out interventions successfully. Any intervention by UNICEF on the emergency response will need to address these gaps.

The questionnaires also highlighted two striking facts. The first was the rapid rate of change of drug use among young people being observed in almost all countries in the region. The second was that in assessing ‘priority’ for UNICEF of work with injecting drug users, most offices saw it as ‘one priority among many’. Clearly the winds of the need for an emergency response on HIV and understanding how quickly the epidemic can move are not yet being felt in-house.

4.5 What are others doing?

The scale of interventions needed across the region – both for mounting a full developmental response and responding to the emergency calls for much more money, more people, more partnerships than any one organisation will have.

The opening part of the paper referred to the path breaking work of INGOs. The possibility of a ‘strategic partnership’ with UNICEF was picked up in the second part on comparative advantage. What INGOs have not yet been able to do is to get governments on board, or to channel the funds and capacity building needed for the next stage of building the national response. Taking what is known can work to scale is the key challenge at this moment in time.

Very little work has gone on young people as IDUs. Very little work has gone on ensuring access to services for marginalised young people.

The UN system and major bilaterals are moving towards a common platform – around the goal of raising coverage of outreach programmes to 60% of vulnerable populations. But in many countries the individual UN agencies do not have the presence or do have not the policy weight to influence government in these areas. Together, it is possible they could.

Among the Co-sponsors, UNICEF and UNFPA have taken young people as the focus of their responsibilities in HIV prevention. At country level that joint commitment is still to take strong shape. There is still only a beginning of the recognition that the epidemic in this region is still at an early stage, with a huge number of young injectors still vulnerable to infection, with effective interventions possible.
On the positive side, the countries of the region are rich in human resources that could be deployed to prevent the epidemic, and once engaged many will be able to sustain such efforts. The crucial challenge is one of engaging policy makers in the difficult but urgent task of HIV prevention among highly vulnerable groups while simultaneously fashioning a longer term response. It is challenge of advocacy and commitment.

4.6 A draft mission statement for UNICEF’s work with young drug users

On that note, and in order to facilitate the discussion, we have formulated a draft mission statement for UNICEF’s work with young injecting drug users, building on the core strengths that UNICEF has shown in the region. It aims to build on and complement existing work rather than represent a new direction in itself:

‘UNICEF’s mission with respect to young injecting drug users should be focussed around advocacy for a combined developmental and emergency response to HIV amongst young people. This should

- within the developmental approach, give support to and advocate for change in factors that contribute to vulnerability to drug use and drug related risk among young people

- simultaneously advocate for an effective emergency response to the current HIV crisis in the region by focusing on young IDUs and commercial sex workers and promoting evidence based interventions so that they can reach a high percentage of these highly vulnerable groups

Advocacy is used here in the broadest sense. In certain settings, this could include policy advocacy at the highest level; in others this might be through illustrative modelling/programming, or exposure to regional or international experience. Each country may well have a different situation and different need. The main goal however is one of obtaining full government ownership of a response that has both elements strongly present, supported and evidence based.

4.7 How close to UNICEF’s mandate?

How central is this draft mission statement to UNICEF’s mandate? The mission statement aims to centre itself on UNICEF’s strengths as an organisation – its ability to advocate for critical issues affecting children and young people, recognise the need for long term development strategies; as well as a proven ability to mobilise resources swiftly and effectively in emergency situations.

That may not in itself be enough. There are many areas where UNICEF could work with the same strengths but chooses not to. For this to be a contribution that has an impact, and justify engaging major resources of time and money, it has to be an area where UNICEF feels its mandate is strongly engaged.

The commitments undertaken by governments and all the UN family at the recent UN General Assembly Special Session on HIV/AIDS set the context for all UN system support. They call for strategies that tackle the ‘stigma, silence,
discrimination and denial that continue to undermine prevention efforts and block access to care and treatment’. In setting targets for 2005, and calling for similar time bound targets to be established at regional and national level, the UNGASS Declaration of Commitment gives an explicit focus to young people and HIV prevention among ‘most vulnerable’ groups. The specific target for 2005 includes ‘ensuring a wider range of interventions aimed at reducing risk behaviour including ... expanded access to condoms, sterile injecting equipment, and harm reduction efforts related to drug use’. There is also a clear recognition in the declaration of the importance of participation of People Living With HIV/AIDS (PLWHA) and among young people as a major strategy in itself.

The Convention of the Rights of the Child (CRC) has quickly become the major influence in interpreting UNICEF’s mandate and a reference point for decisions on which issues should engage UNICEF strategic priority. At the time the CRC was being drafted, HIV/AIDS was still only on the horizons of most countries. It nevertheless establishes key principles. Article 33 focuses on drug prevention – largely in educational terms and as an issue of protection of young people from the effects of drug abuse and exploitation – and underlines how varied and complex are the reasons behind drug use among young people. It also reminds that placing harsh custodial penalties on children is an ineffective form of protection. And that criminal aspects of the problem should not obscure the fact that those involved are also children – often very vulnerable children.

Read with other articles of the Convention, the right to health and access to services by all young people (non-discrimination), and the right to survival, there is a strong call in the CRC for finding effective interventions that will save lives; ones that are based on a full understanding of the problem and address underlying causes. The rights of those young people who, for one reason or another, are excluded from society are given the same importance as those of any other young person. In terms of the unfolding epidemic in the region, this equal basis and treatment of rights becomes crucial.

The CRC is part of a wider body of thinking on human rights that have given new insights into how issues raised by HIV/AIDS should be tackled. These have argued persuasively that interventions directed to HIV prevention through information and education alone are unlikely to be successful unless the factors that cause vulnerability are also addressed. They also remind of the normative importance and potential of legal environments – enormously important around HIV and injecting drug use – as well as the protection of confidentiality.

Perhaps most influential of these contributions has been the recognition of the famous ‘HIV-paradox’. That, counterintuitive still for some policy makers, it is only through respect and protection of the rights of marginalised groups that public health goals such as HIV prevention can be achieved. Too easily, denial of rights leads to those most urgently in need of information and services being driven underground and made unreachable. This insight has changed the paradigm of public health - especially in work with highly stigmatised groups such as IDUs, CSWs and HIV-positive individuals. It is an insight urgently needing to be promoted across the region.

UNICEF’s new Medium Term Strategic Plan (MTSP) reflects this global shift of UNICEF’s thinking. It lays out a rights basis of UNICEF’s work making HIV/AIDS

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1 Quoted often by South Africa’s Supreme Court Judge Edmund Cameron
prevention one of the 5 corporate priorities for the organisation. As highlighted in the draft regional HIV strategy paper, the MSTP identifies explicitly information on HIV prevention for young people (‘the right of every adolescent to know…..’), life skills education, and prevention among vulnerable groups along with Prevention of Mother to Child Transmission (PMTC) as the core areas of UNICEF’s global effort.

4.8 Consistency with other objectives in the region

The MTSP sets the major goals for UNICEF’s future work but they still have to be translated into regional context and priorities. Does taking up the challenge of HIV prevention amongst young IDUs or young sex workers ‘fit’ with UNICEF’s other major objectives in the region? The CEE/CIS/Baltic region has already identified young people as central to its mission, recognising that the costs of economic and social transition have fallen disproportionately on young people. And the rising epidemic of STIs, drug use and HIV among the young is seen as one of the consequences of this disorientation and loss of purpose.

HIV/AIDS is one among a series of goals given special priority in the Region- IDD elimination, addressing education and early child development systematically in UNICEF programmes, the reform of institutional care of children. All are important. They have different time badges on each priority however. IDD as a highly feasible goal in the immediate future that has been carried over from earlier cycle. HIV/AIDS is the most fast moving goal and where urgency is felt. One goal is seen as critical for all the others. That is to see UNICEF move into greater engagement with young people themselves, promoting young people’s participation in all aspects of UNICEF’s work in the region, eventually leading to peer review of programmes by young people.

Evidence of the HIV epidemics continued rise and threat across the region opens the way for a fresh round of thinking of what UNICEF’s role and strategy should be. Whatever that should be, UNICEF is looking for a role and intervention that it can hold itself accountable for. Within HIV/AIDS, the region will still have to make choices; focus on a few things; and say no to those it cannot resource.

A priori, then, the case for UNICEF working on both developmental and emergency response to HIV is strong - from its mandate and falling within the ambit of regional priorities. But in practice, there are still apprehensions.

4.9 Bottom-line concerns

Three major concerns remain in UNICEF staff minds with respect to the prospect of UNICEF expanding its work with young injecting drug users.

‘A ‘hot’ political issue’. Projects of harm reduction are often centred on or closely associated with needle and syringe exchange (though we saw in the first part of the paper that harm reduction is a wider concept than needle and syringe exchange programmes). And in societies where drug use is heavily stigmatised, and where economic difficulties have led to collapse of other services, the idea of harm reduction has been a difficult one to explain and communicate. ‘Spend money for a few druggies. Don’t think about it!’ This is
how they respond’ says Vadim Pokrovski Director of the RF Federal Institute of HIV Prevention. ‘Why should public money be given to help such people while we do not have syringes in our health centres? ‘You are telling drug users to continue injecting but make it safe. This cannot be allowed’ are all views that are often heard and widely held. Local harm reduction projects have to live with a repeated need to explain their objectives to each incoming newly elected local government or police chief. At times there has been highly visible and negative backlashes; although in other settings, communities have learned to understand, tolerate and actively support such initiatives.

- UNICEF staff – especially at country level - are acutely aware of the potentially difficult and sensitive nature of issues involved in working with injecting drug use generally and particularly with young people. There is a fear that negative reactions in this work will carry over into the areas where UNICEF is already working to build effective partnerships. UNICEF’s ‘brand image’ is precious and could quickly be undermined with the very people who are crucial for success in other equally important areas of its work.

Is this really our work? – aren’t we best concentrating on building up life skills as our contribution to primary prevention? A second -not unrelated- view is the pragmatic one of surveying the risks involved in working with injecting drug users and concluding that UNICEF’s best interests are to concentrate on the tasks it has already started related to primary prevention – working with young people on the crucial life and livelihood skills they all need. UNICEF should be careful not to get embroiled in an area in which it is not comfortable, it doesn’t have capacities, and has high risks....

Is there capacity to deliver?’ A third genuine concern is one of capacities. Almost every office in the region at present is small in terms of staff numbers and/or depth of professional expertise. Yet UNICEF’s programme involvement is already across a wide range of activities each potentially needing considerable input of time and programme management. In this context, the idea of adding further areas of work represents to many office managers a move in an all too familiar direction – yet another priority where there are already too many! This also jibes with their sense of capacity constraints and the lack of technical resources. How can UNICEF work in this field when it has so little technical experience in a difficult area? One of the most frequently heard messages from heads of office was ‘do not commit us to what we cannot deliver on’.

These three concerns are important reflections of the (sometimes unspoken) views of UNICEF managers. And each of them need to be carefully addressed in any discussion or decision on a future role with HIV prevention with young injectors.

Of course, there are no easy answers. Perhaps the most important factor in helping thinking through a response is the HIV epidemic itself. Unless action is taken urgently to stem a current and future epidemic among injectors – the majority of whom are young and getting younger - investments in longer term education are just going to be undermined. They will be found to be too little, too...

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4 Quoted in Le Monde ‘La Russie demunie face au sida’ 29 Nov, 2000
late.

This argues for a strong linkage between development and emergency response as laid out in the first section of the paper. Working on the emergency arm of the response actually strengthens the longer-term investment in behaviour change.

Secondly, one comes back to the extraordinary vulnerability of young people themselves in this region. It would almost be unthinkable for UNICEF not to engage itself in addressing the immediate life-threatening risk faced by this group. In this region, a lot of young people fall into this group. Can their needs – and rights even if they are drug users - be ignored even if terrain does prove difficult?

In many country settings, it comes down to a judgement of what is possible – and how strong is the political sensitivity in that setting. In the interviews carried out during field visits for this paper, key informants – mainly government counterparts – were asked ‘Do you feel UNICEF’s taking up work with injecting drug users represents a risk for UNICEF in political terms?’. With only one exception, there was a uniform response in the negative. On the contrary, it was said that this would be seen as UNICEF responding to its mandate of protecting young people. ‘Would it be to the detriment of UNICEF’s work in other areas?’ Again, overwhelmingly the response was ‘No. It could change perceptions of UNICEF’s role but not negatively. In fact this could strengthen UNICEF’s work’. This perception was remarkably similar across country settings. This may not settle the question decisively but it does suggest there is substantial support in countries if UNICEF decides that this is the right way to go. The key question remains how to be effective in its interventions and how much of UNICEF’s time and resources should be given to this vis a vis other pressing concerns - issues of priorities and capacity. We turn to that now.

5. How to do it – A UNICEF response

5.1 First steps – A decision on role and strategy

Whatever position the region adopts in relation to working with young injecting drug users, it is important that UNICEF country offices and teams have a common position, which everyone rallies behind. This is particularly important if UNICEF moves strongly to support the emergency component of the response outlined. The first step then is a decision on role and strategy. The implications of that choice need to be mapped out as accurately and in as much detail as possible (both in terms of opportunities and difficulties). If UNICEF in the region does decide to engage in this field, it should do so with its eyes fully open.

The Regional Management Team (RMT) is the right forum for such a debate and decision - especially as it will be heads of country offices that will have the task of translating the decision into action. It is also important that debate does not stop there. As staff attitudes towards injecting drug use are likely to reflect the values of society in which they live and work, it is important that every staff
member –from top to bottom – understands why the organisation is moving in the direction it has chosen, why such interventions are important, and what is the evidence for their support. Without such an individual buy-in, the effectiveness of UNICEF’s role in addressing these issues can easily be undermined. Having this debate is important in itself.

5.2 Walking on two legs: development and emergency

An approach that combines a long-term developmental goal while simultaneously mounting an emergency response to the epidemic is what we are calling ‘walking on two legs’. Each leg supporting the other and moving forward together. In effect, this allows UNICEF to work at two speeds – one focussing on behaviour change in the medium and longer term, the other in a more urgent immediate mode, addressing the epidemic as it is unfolds dramatically in the region.

Investing in behaviour change amongst young people –through providing life-and livelihood skills in schools and non-formal education channels – should remain the major contribution that UNICEF can make to primary prevention. This already has become a part of UNICEF’s work in all countries and needs to be given continued support. The strategy is broader than HIV alone and seeks to change norms in relation to young people’s perceptions of themselves and others and reduce vulnerability to risk situations. Given the overwhelming presence of substance abuse in issues affecting young people, it will have to ensure approaches are effective, consistent with evidence of what works, and generally not shied away from. With a strong emphasis on participation of young people themselves, this could be the core of the ‘developmental’ arm of UNICEF’s response.

It should be recognised, however, that such an effort is one of generation change and will take a considerable time to put in place. It represents a long-term investment in each cohort of young people. It is equally urgent to act simultaneously on the current threat to young people through reducing vulnerability to infection of those groups of young people who are among most vulnerable to infection – current and future injecting drug users.

The emergency response needs to be built quickly and contextually, recognising that on average it takes at least 5-7 years to build sustainable interventions among such highly vulnerable groups. UNICEF’s role should be centered on its mandate for the protection and participation of young people – all young people and the special vulnerability of this group. If this emergency element is not taken up effectively, there is a risk that the longer term work of building life skills among young people will be overwhelmed by an epidemic that will continue to be driven by IDU sub epidemics that are still to occur in most countries in the region.

The links between these two complementary types of response needs to be emphasised. A long-term developmental response needs to base its work on a sure understanding of the realities of life among young people (and understanding the pressures that surround those who are injecting). Interventions taken up under the emergency response can provide that insight and inform the messages and approaches adopted.
Similarly, the emergency response will not be effective over time unless it incorporates elements of developmental thinking. Outreach programmes need to be put on a sustainable footing and build linkages with services for its target group. Sustainability and high coverage require stronger ownership by government with linkages between NGOs and local authorities need to be institutionalised. Young people’s participation (both IDU and non-IDU) has to be built into strategies.

At the same time, there is no way that emergency responses will be able to address structural issues that are contributing to the rising wave of drug use amongst young people. A developmental perspective needs to be an explicit part of its strategy – often missing in the day-to-day difficulties encountered in organising projects.

Bringing this development perspective into the more short term emergency response (ensuring a two way flow of relevant experience for longer term behavioural change) is one of the key areas where UNICEF, with its links across sectors- and its ability to bring divergent groups together - has a unique role to play.

5.3 Ensuring the crucial bridge to a state-led response

Much of the early work in establishing outreach and harm reduction activities in the region has been spearheaded by international NGOs (OSI, MSF (H), MDM...). They deserve the credit for demonstrating that interventions for hard-to-reach populations such as IDU’s are indeed feasible within the region notwithstanding often extraordinarily high levels of stigmatisation. Many of these are now working with local community groups and have the open or tacit endorsement of local authorities.

While successful in breaking into new territory – often in difficult environments - coverage of these interventions remains far below levels needed to have an impact on HIV transmission. Interventions of a much greater scale will need the engagement of governments to put their own resources behind such efforts. So far, this has only occurred in very limited number of locations. Very little work is underway explicitly to reach young sex workers who are injectors.

In many countries the crucial capacity bottleneck at the present time is funds for existing interventions and limited capacities of NGOs to expand the geographic spread of interventions to all major cities - especially in relation to the target goal endorsed by WHO/UNAIDS of 60% coverage for harm reduction measures.

Definitional problems still remain – how to establish the reference population, how precisely to measure coverage etc. Yet the overwhelming need of the hour is for governments themselves to take responsibility for taking these interventions to scale. This requires budget lines from government itself – even if initially modest - external funding, and mechanisms to work with NGOs in many more settings across each country. We see UNICEF having a major role in supporting the process of policy advocacy. UNICEF’s does not have the technical experience to argue strongly for one kind of model rather than another. This expertise lies in the domain of sister agencies such as WHO or among the INGOs. However in terms of drawing attention to the evidence of what works and what needs to be
made available to young people in vulnerable situations, UNICEF’s voice could be vital.

Three different roles can be envisaged - none of them heavily technical, all of them facilitating.

- **Catalysing adoption of strategies** UNICEF can draw on its ongoing relationship with government to help strategise on exactly what approaches will work best in their settings. This is a classic UNICEF function, and falls within what we saw as UNICEF’s comparative advantage in the region, encouraging counterparts to look at successful initiatives in other countries (or other parts of the country), and come to their own conclusions as to what approaches they should adopt. UNICEF can provide a platform to accelerate the process of making experience from other countries available.

- **Focusing on the link between Government and NGOs.** A second focus could be on the mechanisms that can ensure effective and smooth working relations between government and Non Governmental organisations. These are often points of friction and bottleneck and yet UNICEF’s work with both partners’ gives it considerable experience in helping systematise and streamline such relationships. UNICEF’s role here is one of being able to listen to and understand both sides of the table and assist them come up with workable solutions that they themselves identify. Here UNICEF will be in an ‘honest broker’ role but doing so with an aim to and focus on institutionalising solutions.

- **Encouraging sharing of regional experience.** If there is one area that government officials and NGO workers feel the need for in the region it is to learn from others experience. Study tours take time to set up and are intensive for good preparation but they can be extraordinarily valuable especially for local policy makers or project workers who otherwise have little opportunity to travel to see with their own eyes what other projects are doing. In this area, seeing is believing. Although normally UNICEF might well look askance at the value of study tours, at this stage in building an epidemic response, their value is weighed in gold.

UNICEF’s contribution will, then, include accelerating access to international or regional experience, and providing a platform for different partners to come together. But its main concentration should be in ensuring, and assisting in the creation of, an environment for a state-led and owned response.

### 5.4 Working “together” with partners

Work on both the developmental and emergency responses will require special kinds of technical support. They will also require targeted and at times hard-hitting programme advocacy. UNICEF does not need to build all of these capacities in house. Through partnerships with other agencies, complementary strengths can be brought to bear. We have entitled this section ‘working together with partners’ - rather than the more frequently used language of ‘building’ partnerships - in order to capture the kind of ongoing and mutual working
relationships that will be required.

- **With NGOs:** Much of the initial experience in launching interventions in this field has been gained by INGOs – and in many countries they are likely to continue playing a major role in building NGO and government capacities for implementation of outreach and other services, and preparing the ground for larger scale approaches. UNICEF can learn from that experience. Indeed collaboration with INGOs could form the basis for a strategic partnership with UNICEF providing a focus on young people – an area which has been relatively neglected in the first phase of launching activities- and the INGOs providing technical ideas and support to innovation at the grass roots level. This has the appearance of a partnership from which all sides, UNICEF and its partners in government, and the INGOs, can gain. In practice of course, such marriages cannot be taken for granted, and there will need to be mutual adjustments in style and understanding – and a lot of communication. This often works spontaneously around individual relationships at country level. It could also be supported and facilitated at a regional or higher level.

- **The UN family and the bilaterals** (DFID, USAID, CIDA, SIDA..., ) are the other key partners. WHO’s work in reviewing evidence for and systematising best practice in these fields makes it a key technical resource for programming and advocacy. This could be in areas such as promoting ‘Youth Friendly’ harm reduction and other services, PMTC, drug treatment and legal issues. The latest series of 12 ‘Evidence for Action’ reviews on effective approaches to HIV/AIDS among IDUs will be available early in 2002. Making these quickly and widely available in local languages could be carried out as a joint initiative. UNDCP is a second important partner to ensure wider issues of supply and demand reduction are conducted within the same framework and goals.

- **The collective voice of the UN system** can be particularly important in raising and addressing otherwise strongly controversial areas. The Theme Group, with the help of the UNAIDS Secretariat, can be used as a much more dynamic platform than is often the case, setting common advocacy goals and bring support around common positions. Making sure that roles are clear and understood by all players is the best recipe for making UN co-operation work in the way it should.

In this field in particular then, partners represent a way of expanding capacities for UNICEF. There needs to be a way to ensure that these partnerships are mutually beneficial and are supported. They cannot just be marriages of convenience. UNICEF’s special position is that it will be working with both sets of partners – its counterparts in government and external groups. This mediating role requires the same skills that UNICEF has deployed successfully in other areas of its work.

### 5.6 Entry points

A number of these have already been identified. Each country needs to looks at its own situation and in doing so, identify where it stands in relation to the three phases of programme development identified in the first section of the paper.
There are a number of specific entry points merit special attention

- **Ensuring Information and Life skills are’ young- IDU friendly’**
  Approaches to information campaigns and life skills education can be strengthened by incorporating insights from outreach programmes to young IDUs. The messages used in these areas need to be supportive of harm reduction principles and consistent with educational messages being developed in the emergency response. Too often these remain in separate compartments, and do not synergise. But such large percentages of young people engaged in some form of drug use, life skills work is faced with a particular challenge.

- **Rapid Assessment and Response (RAR)** techniques have proved successful in preparing the ground for launching a response – especially in areas where responses do not exist or limited. UNICEF support for the RAR – its design under local conditions, training of interviewers in focus group techniques in ways that build trust among drug users etc) can become entry points for building UNICEF’s own staff capacities.

- **Modeling services for young people** In situations where there are no INGOs, or where government is still unsure about what course of action to take, there may be a need to support ‘start up’ interventions. These could be straightforward outreach programmes, or involve modeling approaches that bring services for young people into a network that meets the needs of marginalised young. Becoming directly involved in launching initiatives will require technical support from one source or another. Here is where INGOs and UNICEF could come into a mutually- supportive alliance. Funding of service delivery is an option that might be considered under certain circumstances. But this should be in the framework of ensuring the move towards a state-led response.

- **Promotion of participation of young people in design of interventions**
  One of the key features of successful outreach programmes has been involvement of peer educators and ex IDUs in shaping activities. Young people are only rarely given a voice in organisational decisions of NGOs and decision-making functions. UNICEF has a key role in encouraging participatory processes and models among such groups as part of its wider goals in the region but also in terms of ensuring effectiveness of interventions in reaching young populations of IDUs.

- **A ’targeted’ Prevention of Mother To Child Transmission (PMCT).** In this paper we haven’t discussed how the epidemic’s early concentration on the vulnerability of injecting drug users gives a special angle and importance to the implementation of PMTC. Most of the women who are HIV positive in early stages of the regions epidemic are going to be IDUs or partners of IDUs. Many will not be registered for antenatal services and so could easily fall outside the net of regimens of AZT that depend on drug compliance. The goal of PMTC remains the same as in other countries – aiming to encourage access to quality ANC care early on. This could be built into project activities through involvement of Harm Reduction outreach workers. There are also options to deal with female IDU who arrive for delivery but not knowing their HIV status. Use of rapid HIV diagnostics tests and Nevirapine are being explored by NGOs in such settings. But even more importantly, provision of psycho-social
support to mothers post delivery – counselling on understanding their HIV status, advice on legal issues, and contacts for later treatment care and support – can all be given by community workers- often ex IDUs or IDUs themselves. In an IDU- driven epidemic, PMTC becomes a crucial entry point for the continuum of care.

In a number of countries of the region, infants born to IDUs and found HIV positive have been abandoned by their mothers. Many of these have been growing up - refused by orphanages - in hospital wards. Children of 4 years and older have had the hospital ward as their life – no stimulation except what the health workers are able to give, no education, nothing, just the life of the ward. If UNICEF cannot change this situation, there is little point in it going much further in promoting PMTC. Survival but abandoned to this kind of life is not a life at all.

The key message from this section is that there are important linkages across a number of interventions that UNICEF is already working on and these have potential for synergy.

### 5.7 Ensuring UNICEF selected role is matched by internal capacities

‘UNICEF should only enter into a difficult area if it is willing to create the capacities to do the job well and have an impact’. This is the strong and repeated message from heads of offices across the region. We can only endorse and underline this up-front declaration of minimum support needs.

What sorts of capacities are required? At the present time, UNICEF is starting from a point where one of the legs is significantly ahead of the other. Capacities in building the developmental approach have grown over the last two years, giving UNICEF a presence and knowledge base on young people’s health development and protection that is already showing its effect. The kind of processes that have been launched to create knowledge networks and programming tools in these areas need to be continued.

For working on HIV prevention among young injecting drug users, four additional internal capacities need to be built

- **A knowledge base on harm reduction.** This should include awareness of what does and what does not work and the evidence that backs up the adoption of specific best practices. The theoretical underpinning of this analysis should be part of the working knowledge of any staff engaged in either programming or advocacy. At present few UNICEF staff are fully cognisant of harm reduction principles and experience. These numbers need to be built up rapidly.

- **Experience in mounting ‘developmental’ and emergency interventions.** There is a strong ‘hands on’ element of learning by doing in both sides of the two prong strategy. Knowledge of peer to peer outreach and education are particularly important in the
developmental arm. The goal of the emergency response should be to build a network of services while expanding the client base of interventions.

- **Working with local groups/local administrations** If UNICEF is concentrating its role on the government-NGO nexus, then this itself should be the specific subject of capacity building and facilitation. Civil society organisations are still very new in the region and often need individual tailored support. Governments have not been used to working with NGOs on common projects. This interface should be a niche area for UNICEF programmes.

- **Advocacy.** This is where UNICEF teams could well find themselves tested to achieve the draft mission statement. Advocacy associated with injecting drug use in the region has in the past been mined with explodables. Which is why Country Representatives are rightly concerned about political risks. There are advocacy approaches to difficult issues, however, that have been found to work (and do not necessarily involve experiencing putting ones head into a lion's mouth). Advocacy strategies can be successful through exposure of key policy makers to successful experience elsewhere or through visits to countries that are seeing the consequences of not being able to mount effective or early enough prevention efforts! The HIV epidemic can be used as a way of de-fusing otherwise highly sensitive issues on drugs. Organisations of HIV positive groups (PLWHA) are often themselves the best spokespersons for policy change and can be involved in changing attitudes.

Local situations will vary and will need carefully thought out and locally tuned strategies. What is often needed is well designed powerful presentation packages that can catch the interest of top policy makers in the few minutes that may be available to the Office head. It is also often important in highly sensitive situations, however, is that risks are taken and are shared. Between organisations, between UNICEF country and regional staff. Sometimes the only way to proceed will be through risk sharing and support among UNICEF Regional and Executive Director. Advocacy is going to be at times difficult. UNICEF has in the past taken on other difficult advocacy tasks. The lesson from success in these areas is that the organisational position is clear and leadership given from the top.

So yes, additional capacities are needed – but they can be built relatively quickly if a concentrated effort is made around a small number of core competencies. Other capacities can be brought in from partners or outside.

### 5.8 Two other capacities that still need to be discussed – financial and human

Given UNICEF’s current level of programme development around young people’s health and development and HIV prevention we would propose
A 50–50 target for allocation internal HIV resources. Such a target would eventually bring both the developmental and emergency response onto par with each other in terms of UNICEF commitment to both areas of action. Of course individual countries may start at different division of financial resources. The goal would be to move these towards an approach where both elements were seriously supported.

A 100% ‘jump- start’ for the emergency response. Most UNICEF country programmes are yet to enter into working with the components of an emergency response. Since the levels of financial resources are currently so low and the urgency of moving ahead so strong, a 100% increase would not be very large in real terms. But it would send a message of seriousness that UNICEF is determined to address this fast moving situation.

Additional funds. There is no way that this work can be done with existing levels of resources. Large scale funding is likely to soon become available through bilateral or through the new Global Fund for HIV/AIDS, TB and Malaria. There will be an important role here for UNICEF to help countries prepare the ground for such funding through helping preparing project proposals. These are likely to be results based - along the lines of GAVI. Other donors may also wish to support UNICEF’s strategy of walking on two legs – as it corresponds to a philosophy of addressing both development and immediate needs.

Financial resources are going to be important – and will need focused fund raising strategies. Given the urgency of the task, these resources just have to be found.

Human resources come last but they are often the most important contribution UNICEF makes (not reflected always in PROMS!). Without staff on the ground very little of the above will prove possible. In order to give UNICEF in the region the push forward on HIV prevention articulated in the MTSP, it is recommended

A separate project levels staff member each for the developmental and emergency responses. Country situations will differ in needs and current structures. It is clear however that both kinds of response will be heavily time intensive – especially in the early stages of engagement by UNICEF. To make a significant contribution in either field, talented, well-qualified full time staff will be needed. These do exist in the region and could be mobilised quickly.

Technical support networks. There has been good experience of strengthening HIV technical support in- house at the sub regional level (at the Area office level). This allowed activities to move ahead where countries were still to recognise HIV as a major threat. In terms of future strategies, a similar approach could be adopted elsewhere. But it is costly. And between the Area and Regional office, it is the Regional office that is best situated to strengthen networking and backup to all country offices. Strengthening the networking and knowledge base of the whole system is where enhanced support is first needed.
Capacity building takes time and will require a clearly developed plan over at least a 3-4 year time horizon. This should be the minimum time frame for both programme and capacity building.

The main message from this section is that financial and human resources are key issues but they should not be seen as binding constraints. They represent over the medium term resources that can be found if there is a determination to do so. But the level of programme activity does need to follow the rhythm of the availability of these resources.

5.9 Steering by indicators – monitoring internal commitment

For UNICEF to track its depth of engagement in this new area, a set of internal management indicators needs to be put in place, e.g.:

- % of CPRs with component addressing injecting drug use among young people or young sex workers
- proportion of financial resources disbursed in each of the two developmental and emergency responses
- no (%) of country offices with both HIV staff in place
- number of networking meetings explicitly for HIV programme experience sharing within the region
- scale and quality of advocacy activities around HIV and vulnerable groups
- no of public statements of Regional Director and /or Executive Director that explicitly refer to IDU among young people in the region etc

6. Risks

What are the risks of not achieving the goals set?

- **If the developmental approach is taken up**, through life skills education, encouraging the development of networks of youth friendly services, **but is not effective**, the risk is much wider than HIV/AIDS alone. Large numbers of young people will continue to enter their adult lives poorly equipped to identify and avoid risk behaviours or situations. There are risks that the approaches adopted towards promoting prevention of substance abuse are not evidence based and if limited do schools, do not build the life skills of highly marginalised young people. The critical risk for the developmental approach, however, is that efforts will remain at the pilot level and not go to scale.

- **If the development approach is taken up successfully**, and goes to scale **but without the emergency component**, there is a risk that the prevention gains in terms of improved lifeskills for young people will
take too long to have any serious impact on the epidemic. There is a risk that these benefits will be overwhelmed by an HIV epidemic that will have acquired major proportions if allowed to proceed unchecked. The cost in terms of young people lives will be high.

- **If the emergency approach is taken up alone, focusing on young injecting drug users, but is not effective**, either through inability to reach hidden populations, through continued low coverage of outreach and related services or failure to mount large scale interventions through government- the risk again is one of an epidemic that continues to spread both among drug using and among heterosexual populations. Under this scenario, health services will find themselves overwhelmed with the prospect of a massive ongoing drug using HIV epidemic occurring in many countries of the region. Young people will be amongst the most vulnerable groups affected. Many will die.

- **If UNICEF engages strongly in both developmental and emergency responses, but encounters strong criticism from governmental circles for its involvement with young drug users** in that country, then the risk is that UNICEF will no longer be seen as fully supportive of national sentiments in all areas. It may come to be seen as a ‘critical partner’. Much will depend on UNICEF’s stance is on other issues, and in communicating UNICEF’s position. In the case of young people and HIV/AIDS, this may not be such a bad outcome as the chances of stopping the epidemic will have been higher.

### 7. Conclusion

This review concludes that there is a role for UNICEF in addressing the increasing epidemics of HIV among young injecting drug users and sex workers in the CEE/CIS/B region, should UNICEF choose to accept it. This is an epidemic that directly threatens young people. No other agency has the capacity or the in-country expertise to ensure that the full range of issues related to these vulnerable groups are addressed. In collaboration with true partners, UNICEF can bring its advocacy and programming experience to bear on the most important factors affecting the spread of HIV in the region. The work it is already engaged in, in longer term primary prevention of HIV, should remain – and continue to expand taking into account the seriousness of actual and potential drug use among young people. But in the exceptional circumstances of the epidemic in this region, and the way social conditions have created such a large vulnerability for so many young people, it is important that UNICEF keeps looking afresh at where it can strengthen its work. And in this case, move rapidly to also address the immediate threat.

We have argued that UNICEF’s response needs to be tailored very closely to the way the epidemic has and will evolve in the region, recognising that the region’s epidemic is different from almost any other in the world today. It is also important to recall that most of the region has not yet experienced the full force of the IDU led infections - even as the heterosexual epidemic begins. Many young
people are still vulnerable to infection from this explosive channel of the epidemic.

The region is also, however, different from other regions in the way it is rich in human resources which if mobilised could establish effective and large scale interventions. This gives UNICEF a unique role in helping engage that strength on both the emergency front - early enough to avoid many thousands of infections - as well as through strengthening longer term approaches.

Despite the challenge, we do know what will work in reducing HIV infections in these highly vulnerable groups of young people. What is needed is that these interventions are taken to scale rapidly and with government support and ownership. We also know how long it takes a country to get ready for mounting an effective response in such areas. UNICEF has the ability to shorten that time-span and ensure that young people's needs are central to that response. If it can 'walk on both legs' – with a strong developmental and emergency response – it could bring enormous benefit to the youth of the region, not only now but for years or decades to come.
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Injecting drug use prevalence in Central and Eastern Europe and Central Asia (per 1000)

Source: Dehne 2001
Heroin trafficking routes through Eastern Europe and Central Asia

Source: Dehne 2001
Annex II: WHAT WORKS? ADDRESSING HIV/AIDS AMONG YOUNG IDUS

Background

Effective approaches to HIV/AIDS and injecting drug use need to include a range of public health responses. The Ottawa Charter of Health Promotion is the foundation document of such public health approaches (WHO 1986). It states that five activities must be undertaken together for effective promotion of public health:

♦ Promoting health through public policy
♦ Creating a supportive environment
♦ Reorienting health services
♦ Strengthening community action
♦ Developing personal skills:

While the Ottawa Charter places great emphasis on the social and community aspects of public health, individuals also play a major role in looking after their own health. Four main groups need to be targeted for the development of personal skills for HIV prevention among injecting drug users (IDUs) (Ball 1998):

♦ Injecting drug users
♦ Sexual partners, families and friends of IDUs
♦ Doctors and other health care workers (such as psychologists, nurses, social workers, etc.)
♦ Outreach workers and peer educators.

The United Nations Drug Control Program also notes the importance of public health approaches to drug control, especially in those countries seriously affected by HIV/AIDS among drug users (UNDCP 1997)

UN agencies and WHO recommend that these public health measures be carried out in a framework of harm reduction: policies, strategies and activities that aim to limit or reduce the nature and extent of adverse consequences of drug use, including:

♦ health: including HIV and other communicable disease transmission
♦ social: including social effects of (usually) young IDUs dying of AIDS
♦ economic: including costs of treating people with HIV/AIDS,
♦ legal: including detection, arrest and imprisonment of IDUs.

Harm reduction activities have been extensively evaluated and are the only proven effective means of preventing HIV epidemics among IDUs or controlling and reducing large IDU-related HIV epidemics (Burrows et al 1998).

Harm reduction is one of the three complementary approaches to addressing drug issues, the others being supply reduction and demand reduction (Crofts et al 2000). Supply reduction includes seizing drugs through customs operations and assisting drug producers to stop growing, for example, opium poppies and substitute these with other, legal, crops. It also includes arresting drug
traffickers and breaking up supply routes for illicit drugs. Demand reduction is a complex of measures, usually provided by social, education and medical services, to promote a healthy lifestyle free from drugs, and to assist drug users to stop using and achieve medical and social rehabilitation. Every country that has introduced harm reduction programs also carries out supply and demand reduction activities.

Harm reduction activities for IDUs carried out in parts of Western Europe, North America and Australia in the 1980s and 1990s were proven to either prevent an epidemic from occurring (if implemented early enough and on a large enough scale) or to control and reduce such epidemics (if carried out on a large enough scale) (Des Jarlais et al 1998; Des Jarlais 2001). These activities have now been implemented in most of Western Europe, North America, Australia and New Zealand, and have been shown to be effective in parts of Asia, Latin America and CEE/CIS/B.

**Needle exchange and distribution**

The riskiest activity for HIV infection during injection is frequent sharing of injecting equipment with strangers (Ball 1998). Needle exchange or distribution prevents or reduces this practice. There are now 134 countries worldwide reporting the practice of injecting drugs for recreational or non-medical purposes. Of these countries, 114 have reported HIV infection among IDUs, with 46 countries implementing at least one needle and syringe provision or needle and syringe exchange program (Strathdee et al 2001).

Needle and syringe exchange programs (NSEPs) have been studied in many different countries and in great detail due to the controversy surrounding their introduction. US government reports (quoted in Lurie et al 1996) have found that, following the introduction of needle exchange to a city or country, there is:

♦ No increase in the number of drug injectors
♦ No increase in drug use.

No reports have contradicted these findings. An evaluation of Australian needle and syringe exchange programs found that these programs had saved an estimated 3000 lives in a single year at a cost of about US$200 per life saved (Feacham 1995). The savings in HIV treatment costs were estimated to be about US$150 million.

NSEPs have proven highly effective in preventing HIV transmission among IDUs (Lurie et al 1996; Lindesmith Centre 1997). A worldwide survey (Hurley et al 1997) found that in:

Cities **with** needle exchange:

- HIV seroprevalence among IDUs **reduced** by 5.8% per year

Cities **without** needle exchange:

- HIV seroprevalence among IDUs **increased** by 5.9% per year

Specific effectiveness studies have mainly been conducted in the USA, and have concentrated on the effects of NSEPs on both risk behaviours for HIV infection (especially the sharing of needles and syringes) and the effects of NSEPs on HIV incidence and prevalence. Among the first group of studies, findings include:
Frequent use of a NSEP is associated with reduced needle sharing in studies from California, Maryland and NY: the NY study found the number of study participants who shared needles and syringes dropped from 26% to 8% after the first visit to a needle exchange, then to 3% after 8 months of attending the needle exchange (Watters et al 1997; Vlahov et al 1997; Paone et al 1999)

The number of times a syringe is used was reduced by more than half after IDUs started attending NSEPs in three US cities (Heimer et al 1998)

Studies examining the effects of NSEPs on HIV incidence and prevalence among IDUs have found:

- The prevalence of HIV in syringes collected by a NSEP in Connecticut fell from 66% to 43% within three months of the opening of the NEP (a reduction of about 33%) (Heimer et al 1997)
- A 70% reduction in HIV incidence when comparing NSEP participants against non-participants in NY (Des Jarlais et al 1996); and a reduction in prevalence among NY IDUs from 50% to around 30%, believed to be mainly due to the effects of NSEPs (Des Jarlais 2001)
- A 15% to 70% reduction in HIV incidence in a range of US cities, using three different mathematical models (the difference between these results may be largely explained by the level of reach of NSEPs – the greater the reach, the greater the likely effect on HIV incidence) (Lurie and Drucker 1997)
- A reduction of HIV incidence from 4% to less than 2% nationally in Australia (where 50-60% of IDUs attend NSEPs) (Loxley et al 1997)
- HIV prevalence among IDUs in Dhaka, Bangladesh (where NSEPs have reached around 80% of IDUs) remained below 5% despite rapid rises in many other cities in South Asia (Jenkins et al 2001).

Only two studies from Canada appeared to show little positive or even a negative impact of NSEP on HIV transmission (Bruneau et al 1997; Strathdee et al 1997). However, a recent review of all of the above evidence by several leading US epidemiologists showed that the Canadian results were most likely due to the NSEPs in Vancouver and Montreal not reaching sufficient numbers of IDUs at highest risk for HIV infection, or not providing sufficient equipment and other services to meet the varied risk reduction needs of their clients (Vlahov 2000; Des Jarlais 2000; Strathdee et al 1997).

Reach of NSEPs

The complex issue of the reach of NSEPs is becoming increasingly important around the world. In the USA, it has been accepted for some years that more than half of a city's IDUs need to be reached by NSEP services to have a substantial impact on a HIV epidemic. In the most recent paper on the situation in NY (the first city with a large epidemic of HIV among IDUs), it is suggested that at least 50% of IDUs in the city needed to directly participate in NSEP services to bring the epidemic there under control, though secondary exchange (assisting or allowing IDUs to take needles and syringes to distribute to their friends or social contacts) may also have been needed, and the level of secondary exchange needed to bring the epidemic under control is unknown (Des Jarlais 2001).
This problem has also been studied by examining the situation in Kathmandu Nepal, where a NSEP had been in operation for 10 years yet there was a sudden rise in HIV among IDUs. Reynolds (2000) found that Kathmandu IDUs were injecting on average 16 times a week or about 70 times a month, while they received only an average of five needles and syringes a month from the NSEP. This means that a sterile needle and syringe was only used for one out of every 14 injections. He found that this was the most likely reason for the rapid spread of HIV among IDUs in the city.

Other concerns have been expressed about the level of coverage that NSPs have nationally. Wiessing (2001) found that most national NSPs in the European Union are providing fewer than 100 needles and syringes per drug user per year, though the UK provides 556 per drug user per year (through a combination of NSPs and pharmacies). Even this is not enough to meet the current Western European target of a new needle and syringe for each injection. In France and UK, it was estimated that IDUs inject, on average, 2.2 times per day, meaning that a saturation program of needle distribution would need to provide (or provide access to) 803 needles and syringes per drug user per year.

In the UK, where the largest needle exchange system exists, approximately 27 million syringes were distributed through NSPs and pharmacies in 1997 but there were significant regional differences, with the number of syringes distributed per drug user in England and Wales about three times higher than in Scotland (Parsons et al 2001). NSPs in the USA have grown rapidly in recent years, from 68 programs in 1994 to 131 in 1998 (the last year for which figures are available). By 1998, these programs were exchanging 19.4 million needles and syringes per year; and each program operated an average of 4.85 sites (fixed or mobile) per week for an average of 20.45 hours per program per week (McKnight et al 2001). Given that there are estimated to be 1.3 million IDUs in the USA, these programs are probably only reaching a small minority of the country’s IDUs (Stimson and Choopanya 1998).

Several features of NSPs have been shown or are generally believed to increase their effectiveness. A properly organized NSEP unit, stationary or mobile, is the centre of access to a hidden group of drug users, who might never otherwise access medical or social services. Provision of sterile needles and syringes, collection of used needles and syringes, provision of sterile swabs, condoms, booklets and other explicit targeted education materials, contact information about relevant services, consultations on various questions (not only medical) are integral activities of exchange programs (Burrows 2000b).

The siting of NSPs is important: locating the NSEP so that it is convenient to large numbers of IDUs may be critical for effective HIV prevention (Rockwell et al 1999, Burrows 2000b). Continuity of service is also important. An evaluation of Italian NSPs found that continuity of funding and service was vital to the programs’ success in attracting and maintaining relationships with IDUs (Sabbatini et al 2001). Nigro et al (2001), looking at this same issue in the Italian province of Catania, made a similar observation as several NSPs had begun in 1996, closed down later that year and re-opened in 1998. The researchers noted that each time a project was re-started, "a lot of energy, time and effort are dedicated simply to re-establishing old contacts and...rebuilding a relationship with previously contacted users". The closure of a NSEP can also have a serious impact on HIV risk behaviours among IDUs. When a US NSEP was closed in 1997, significant increases were found in the percentage of IDUs re-using
syringes more frequently and sharing needles and syringes (Broadhead et al. 1999).

As well as risks from sharing needles and syringes, there are added HIV transmission risks in drug preparation, manufacture and purchase (such as purchase of liquid drugs in syringes that may not be sterile). NSEPs and educational programs also need to address drug users’ sexual behaviour through prevention education (use of condoms, negotiation of safe sex) and condom distribution. Focus groups, in-depth interviewing and the use of ethnographic methods such as observation (and the use of video for recording drug preparation and manufacture) can identify HIV transmission points and an understanding of the social nature of drug users’ lives. NSEPs and educational programs also need to address drug users’ sexual behaviour through prevention education (use of condoms, negotiation of safe sex) and condom distribution. On the basis of this information, education programs can develop appropriate prevention strategies (Ball 1998).

The goal of such strategies must be to change the social norms surrounding drug injecting and sexual behaviour (Friedman et al. 1994). By encouraging a large percentage of injectors to switch to safer behaviours, HIV prevention becomes the norm. Accompanying a change in social norms, each individual drug user must decide to protect his/her health: many IDUs do not worry about HIV infection, despite the realisation that HIV infection will cause serious physical problems and will likely lead to death (especially in transitional and developing countries). This appears to be the result of internalisation of negative attitudes towards drug users expressed by parents, media, health care workers, militia and the general community (Burrows et al. 1999b, Burrows 2000c).

**Outreach**

Outreach work for HIV prevention among IDUs has also been extensively studied. In Chicago, a large outreach program achieved a reduction in risky behaviours from 100% to 14% over four years and the rate of HIV infection fell from 5% to 1% per semester by the last six months of the study (Choi and Coates 1994). Under the National AIDS Demonstration and Research (NADR) project, the US National Institute on Drug Abuse (NIDA) funded outreach projects in 68 cities of the country. Published results of the outreach work in 20 cities found dramatic decreases in risky behaviour among program clients. For example, the proportion of clients judged to be at high risk of infection with HIV through shared injecting equipment fell from 62% prior to receiving outreach to 31% at a 6-month follow-up interview, and similar decreases (16% to 8%) were noted in the proportion of clients judged to be at high sexual risk (Sloboda 1998).

Outreach work is usually needed to identify networks of IDUs, introduce them to the program’s services, build up trust between program staff and IDUs, (in some cases) distribute sterile injecting equipment and educational materials, and/or carry out research on the needs of IDUs. However, outreach work (whether or not it is connected to a NSEP) is unlikely to reach sufficient numbers of IDUs across a wide range of social networks in a short enough period to prevent fast-moving HIV epidemics. Social norms of injecting will only change with the active involvement of IDUs themselves (Friedman et al. 1987; Friedman et al. 1989; Burrows 2000b). This involvement can take many forms but most commonly at outreach programs, it involves peer education and/or peer support.
In peer education, active IDUs are trained to educate other IDUs about HIV risks, safer injecting and safe sex practices (Burrows 1995a). A study of Australian NSEPs found that peer education was regarded as an essential element in their work (Burrows 1998) and a European study of 2554 IDUs in Greece, France, Italy, Portugal and Spain found that educational materials were much better accepted by IDUs when they were distributed by "friendly contact" from another IDU, rather than from a counsellor or other professional (Volpicelli et al 2000).

In peer support, this process is broadened so that IDUs are involved in all aspects of defining what issues need to be addressed, what types of educational and other strategies should be employed, as well as carrying out the education and other processes and, in some cases, evaluating and reporting on their work (Burrows 1995b). Peer support programs began in the 1980s in the Netherlands and quickly spread to Germany, the UK, Norway, Denmark, France, Belgium, Italy, Spain, Australia and New Zealand (Burrows 1994). More recently, peer support groups are being established in the transitional and developing world in countries such as India, Brazil, Bangladesh, Slovenia and the Russian Federation (Siqueira DJ 1999; Faruque et al 2001; van Dam and Grebenc 1999; Melnikov and Gouwe 2001). Fostering peer support is increasingly being regarded as an important part of effective NSEP practice.

Finally, there is a strong need to reach IDUs at highest risk for acquiring HIV. Specific programs may be needed to target women IDUs (especially those who are sex workers); gay and lesbian IDUs; street youth (whether injecting or pre-injecting); and IDUs of specific ethnicities who are often marginalized such as Vietnamese in Australia, Roma in Eastern Europe, North African in France, etc.

Women IDUs who are also sex workers are increasingly regarded as the main nexus of injecting-related and sexually transmitted HIV epidemics. This group should be at least as high a priority as male IDUs, especially in those countries where a significant proportion of female IDUs are also sex workers (such as Eastern and Western Europe, North America and Australia, and some cities or countries in Asia and South America).

**Drug treatment**

Drug treatment programs have been found to be effective in assisting drug users to reduce or stop injecting, especially where substitution drug treatments are used (Ward et al 1998). Methadone programs are the most widely used type of substitution drug treatments but others include buprenorphine, pethidine, heroin, morphine and tincture of opium. Substitution therapy has been developed since the 1960s. The increase in numbers of heroin users in the US led to the development of new narcological hospitals, where doctors could prescribe their patients narcotic drugs as a substitute for heroin. This approach pursued a number of objectives:

♦ To establish contacts between heroin users and social services;
♦ To prevent illicit drug distribution;
♦ To prevent the increase in crimes, associated with heroin use;
♦ To assist in social adaptation of drug users.

Methadone and other substitution therapies have more recently been found to be very effective HIV prevention measures. US studies, for example, have found that
participants in a methadone program were half as likely to be infected with HIV as drug users who were not on a methadone program (34% against 70%). In most methadone programs, the dose of methadone is selected for each individual separately and the client takes it in syrup once a day (methadone blocks for 24 hours the need for other opiates). Usually the drug is received in a specially equipped office, where each client has to tell his/her personal code, which is given when enrolling in the program and this code defines the personal dose. In another US study, researchers found that those who were not enrolled in methadone treatment used heroin 97 times more often and were imprisoned 53 times more often than those on substitution treatment.

**Care and support of injecting drug users**

While harm reduction programs often are established to prevent HIV transmission among IDUs, they now play an increasing role in care and support of IDUs living with HIV/AIDS (HIV+ IDUs). In areas where a substantial proportion of IDUs are HIV positive, harm reduction programs are usually the only agencies that IDUs will turn to for care and support to treat HIV and/or other illnesses.

In a global review of literature on care and support of HIV+ IDUs, Burrows (2000b) suggested that the Continuum of Care concept developed by World Health Organization and UNAIDS (WHO 1995) to care for people living with HIV/AIDS (PLWHA) be adapted to meet the specific needs of HIV+ IDUs. This continuum of care would involve currently existing health and social institutions as well as a group of new services (possibly offered by NGOs) in a comprehensive range of care services, all linked by discharge planning and referral processes.

Currently existing institutions which could be involved in this continuum of care include:

- AIDS Centres (where they exist)
- Infectious diseases hospitals especially AIDS wards (where they exist)
- General hospitals, polyclinics and ambulatory clinics
- Narcological hospitals and dispensaries
- Needle and syringe exchange, outreach and peer education programs (where they exist)
- HIV/AIDS focused NGOs, especially PLWHA groups (where they exist)
- Sexually transmitted infection clinics
- Social services (such as social services for youth)
- Ambulance services

New services that may need to be started include:

- Needle and syringe exchange, outreach, peer education programs and HIV/AIDS focused NGOs, especially PLWHA groups (where they do not exist)
- Multidisciplinary teams to provide enhanced home care

Co-ordination of care services should ensure that:

- As a matter of principle, HIV treatment is not refused or withheld simply because someone is a drug user
The therapeutic regimen of HIV treatment is adapted to the needs of the individual, rather than require the individual to adapt to a preconceived clinical ideal

- A network of physicians with experience in providing care and treatment to HIV+ IDUs is developed
- Simpler HIV drug regimens are investigated to make adherence easier
- Medical and psychosocial needs of HIV+ IDUs are assessed
- Staff working with HIV+ IDUs are appropriately trained: so that drug treatment staff have an adequate understanding of issues affecting HIV+ IDUs and HIV treatment staff understand HIV+ IDUs' drug use and drug treatment concerns.
- Appropriate protocols for HIV/AIDS treatment of ILWHA are in place
- Discharge planning and referral processes are widely understood and used
- Medical care and HIV/AIDS treatments are available to HIV+ IDUs (to the same level as to other members of the community)
- HIV treatment services are provided in ways that maximise the ability of HIV+ IDUs to access them (including linking HIV treatments with substitution therapy programs where available, other drug treatment programs, outreach and enhanced home care)
- All programs in the continuum address the specific needs of women HIV+ IDUs both as recipients and providers of care
- All medical programs address the issue of pain relief for HIV+ IDUs both within and outside healthcare settings
- Substitution therapy is included in inpatient care (where possible) as a basic method of preventing withdrawal and its associated symptoms, and provide adequate pain relief for HIV+ IDUs
- Psychosocial issues of HIV+ IDUs are addressed within and beyond medical settings
- HIV+ IDUs' palliative care needs are addressed.

In addition, NGOs focused on injecting drug use and HIV/AIDS (such as needle exchanges and outreach programs) and/or NGOs focused only on HIV/AIDS (such as counselling programs and PLWHA groups) may need to start a new set of services (or adapt existing services) to ensure that:

- Information is provided to HIV+ IDUs on HIV/AIDS, course of the disease, symptoms, treatments (including complementary therapies), ongoing drug use and drug treatment, psychological and social aspects of being a HIV positive IDU, and dealing with discrimination (especially by healthcare institutions and staff): the information needs to be written by or with HIV+ IDUs to ensure that the language is appropriate to the target group, and the final materials tested with HIV+ IDUs to ensure that the design is attractive to HIV+ IDUs
- Regular publications and other educational materials are produced on specific aspects of HIV/AIDS, identified as important by HIV+ IDUs
- A training program is provided for HIV+ IDUs, their families and friends, both on home care and on peer HIV/AIDS counselling on both treatments and psychosocial aspects of the disease, and on ways to work with treatment providers (including both HIV and drug treatment) to stay as healthy as possible
- A manual on home-based care of HIV+ IDUs is produced and distributed to families and friends of HIV+ IDUs
- New models of support are developed, which are suited to HIV+ IDUs' lifestyles, accepting of IDUs' choice to use drugs, and able to
accommodate those HIV+ IDUs who are afraid of disclosing either their HIV status or their drug use.

**Harm reduction programs and the community**

The experience of establishing and running harm reduction programs in many countries around the world has confirmed the vital importance of gaining – and maintaining – support from local authorities and communities. Research has shown that such programs are most likely to work effectively if they are well managed, sufficiently financed, free from police harassment and linked with health and other social services (Heimer 1998). Many techniques are used to ensure that the local community accepts the program’s services and, eventually, supports the program’s work (Burrows 2000b).

However, in almost every country, there are serious difficulties between the operation of harm reduction programs and law enforcement activities directed towards preventing drug selling and buying and, in some cases, drug possession and use. This is a seldom-researched topic, though it is often discussed by harm reduction practitioners. The research which has been done suggests that hostile police activities can have devastating effects on a program’s work: for example, client contacts fell by 40% in an Australian NSEP one month after a sustained police operation targeting drug users in the local area around the fixed-site NSEP (Fitzgerald et al 2000).

It is useful to note that harm reduction programs can have an important impact on police behaviour towards IDUs. For example, an advocacy project by the SHAKTI NSEP in Dhaka, Bangladesh in which local police were targeted with orientation and advocacy materials. Prior to the project, 84% of NSEP clients had been arrested by the police (which fell to 12% after the project) and assaults on clients by police fell from 56% prior to the project to 30% afterwards.

Social factors, such as housing and employment, which lie outside the usual purview of harm reduction programs are also being seen as increasingly important. One study of IDUs who stopped injecting in Montreal (almost 20% of the 901 IDUs studied) found that the most important factors in ceasing injecting – either to switch to non-injecting drug use or ceasing drug use – were the IDU’s belief that he/she could change behaviour, having fewer risky practices (such as needle sharing and unsafe sex), and stable housing. Recent involvement in drug treatment was not associated with ceasing injecting (Bruneau et al 2001).

Several programs in Asia provide work skills training and, sometimes, jobs for active drug users, believing that stable employment will assist IDUs to control, reduce and ultimately cease drug use. SHARAN and Mukti Sadan Foundation in India provide various pathways to work in its many HIV and drugs programs as well as assistance with computer training and finding other work (Kapoor and Samson 2001), while NorthNet Foundation in Chiang Mai Thailand has started a bakery to assist drug users to upgrade their skills and to generate income for their families (Zarina Mulla: Personal Communication 2001). Increasingly, harm reduction programs are becoming involved in many of these non drug-related aspects of their clients’ lives.
Harm reduction among adolescents and young people

Ball 2000 has defined some differences between younger and older IDUs, stating that few studies have been carried out in this area but these studies show that young IDUs think and behave differently to older injectors. The main differences are that young IDUs are:

♦ Likely to have less HIV/AIDS knowledge than older injectors
♦ Less likely to identify themselves as IDUs and may be harder to reach with education messages
♦ More likely to deny they are at risk of HIV both through sharing injecting equipment and through unprotected sex
♦ More likely to initiate injecting as part of casual experimentation with wider drug use
♦ More likely to be intermittent users and to use a broad range of drugs
♦ More likely to be novices, with limited experience of injecting and limited contact with other injectors
♦ More likely to include a higher ratio of females than among older injectors
♦ Likely to have more frequent sex with more sexual partners
♦ Less likely to have well-developed sexual identities and more likely to experiment with different sexual practices, including same-sex relationships
♦ Less aware of where and how to access HIV prevention and treatment services and more reluctant to use such services
♦ Less access to prevention and treatment services, including restrictions because of their age.

Specific harm reduction programs for young people (including adolescents) are under-researched but recent work by the World Health Organization (Roy et al In Preparation) has found that the activities outlined in this paper are as effective for young IDUs (including teenagers) as they are for older drug users. The researchers stated:

"We can therefore summarize our review by saying that first, so far, the priority of most projects has been to reach young IDUs and therefore the main model of intervention that was used was peer outreach; second, the interventions consisted mostly of education, referral for HIV testing and for basic needs, and the provision of safe materials (condoms, bleach, needles...). In terms of results, first, one of the key components of interventions aiming at preventing HIV among young IDUs seems to be outreach offering services that respond to youths’ needs and concerns; second, peer involvement is a good way to do that but strong mechanisms to support peers need to be put in place; third, outreach is also a good means to link youth to other health and social services; and fourth, provision of syringes, and other injecting equipment, is an important component of a program aiming at reducing risky drug injecting practices." (Roy et al In Preparation)

Effectiveness of programs for young people appears to be enhanced by employment of peer staff (of a similar age or slightly older than the target group) and youth-friendliness of IEC materials, premises and staff: this has included use of youth culture symbols in IEC materials and as posters in premises, involvement of young IDUs in designing and producing IEC materials and in
planning and implementing programs, and staff training to understand the needs and culture of young IDUs.

**Impact of harm reduction in CEE/CIS/Baltics**

In the CEE/CIS/Baltics region, there have been no evaluations yet of the impact of harm reduction programs on HIV epidemics among IDUs. However, there have been studies on the effects of some activities on IDUs’ risk behaviours. Initial data was released earlier this year from several projects that are evaluating the introduction of NSEPs in Russian Federation. Grund et al (2001) provided preliminary data from a large evaluation undertaken in 1999/2000 of NSEP clients in Nizhny Novgorod, Pskov, Rostov-on-Don, St Petersburg and Volgograd. This data showed "substantial reductions in previously identified injection risk behaviors, such as needle sharing, from the time prior to using the exchanges and generally low rates of the same behavior while using the exchanges. The percentages of respondents reporting receptive syringe sharing - perhaps the most widely used measurement in judging the effectiveness of (NSEPs) - are comparable to those in effective syringe exchange programs in other countries. Based on these data we recommend that syringe exchange and other HIV prevention programs in Russia should be expanded." The authors also found that some risk behaviours remained unchanged after the opening of NSEPs.

The study looked at behaviours in a 30-day period prior to the NSEP opening (called "prior") and in a 30-day period several months after the exchange opened (called "NSEP"). A total of 1076 IDUs were interviewed and, on average across the five cities:

**Table 1. IDU Behaviour in 5 RF Cities before and after attending NSEP**

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Prior</th>
<th>NSEP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily injection of at least 1 drug</td>
<td>53%</td>
<td>53%</td>
</tr>
<tr>
<td>Receiving a used syringe (receptive syringe sharing)</td>
<td>38%</td>
<td>11%</td>
</tr>
<tr>
<td>Injected at an anonymous injecting venue</td>
<td>45%</td>
<td>28%</td>
</tr>
<tr>
<td>Bought drugs in syringe</td>
<td>12%</td>
<td>3%</td>
</tr>
<tr>
<td>Used blood in preparation of drugs</td>
<td>8%</td>
<td>4%</td>
</tr>
<tr>
<td>Saw others use blood in drug preparation</td>
<td>27%</td>
<td>8%</td>
</tr>
<tr>
<td>Injected in a group</td>
<td>91%</td>
<td>86%</td>
</tr>
<tr>
<td>Shared utensils (eg, vial)</td>
<td>82%</td>
<td>73%</td>
</tr>
<tr>
<td>Syringe mediated drug sharing (SMDS) – use of syringes to share drugs between several syringes in group injecting</td>
<td>58%</td>
<td>48%</td>
</tr>
</tbody>
</table>

The authors pointed out that these final three behaviours are tied closely to the group preparation of liquid drugs. It is yet to be determined how the widespread introduction of heroin to RF cities will affect these behaviours. Grund et al also recommended increasing use of secondary exchange of needles and syringes, finding that, on average, 44% of the clients interviewed were already involved in passing on new injecting equipment to their friends.
Preliminary data from a study in Sverdlovsk oblast showed similar results. Power (2001) carried out a baseline survey (IDUs I; \(n = 663\)) prior to the opening of NSEPs in Sverdlovsk, then compared this data with two groups: those IDUs who had been attending an NSEP for at least three months (NSEP IDU; \(n = 241\)) and those who had never attended a NSEP (IDUs II; \(n = 122\)). Some preliminary results are below:

Table 2. IDU Behaviour in Sverdlovsk before and after attending NSEP

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>IDUs I</th>
<th>IDUs II</th>
<th>NSEP IDU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only use own syringe</td>
<td>32%</td>
<td>33%</td>
<td>72%</td>
</tr>
<tr>
<td>Only use own needle</td>
<td>40%</td>
<td>32%</td>
<td>75%</td>
</tr>
<tr>
<td>Only use own filter</td>
<td>37%</td>
<td>38%</td>
<td>69%</td>
</tr>
<tr>
<td>Only use own drug solution</td>
<td>36%</td>
<td>26%</td>
<td>68%</td>
</tr>
<tr>
<td>Purchase ready-made drug</td>
<td>17%</td>
<td>11%</td>
<td>13%</td>
</tr>
<tr>
<td>Syringe mediated drug sharing</td>
<td>65%</td>
<td>52%</td>
<td>32%</td>
</tr>
</tbody>
</table>

Power found that purchasing ready-made drugs was virtually unchanged by NSEP attendance, and that the effects of the NSEP on numbers of IDUs adding blood to drug solution was the opposite of the intended effect. Again, this is likely to change due to changes in drug use patterns, but this finding echoes Grund et al’s statement that NSEPs need to concentrate on the social nature of drug preparation and use. Power also found little effect on condom use among NSEP clients, suggesting that further work is needed to reduce sexual transmission among IDUs.

The UNDCP/UNAIDS Case Studies Booklet – Lessons learned on drug abuse and HIV/AIDS: Central and Eastern Europe and the Central Asian Republics covers the whole CEE/CIS/B region, and finds that the following challenges must be overcome if measures to prevent the spread of HIV among IDUs are to be successful:

♦ "Comprehensive coverage of the entire targeted populations is essential." For prevention measures such as NSEPs to be effective in changing the course of the epidemic in a country, it is essential that as many individuals in the at-risk populations as possible are. No single approach can be acceptable to all drug users, as indicated by the coverage rates cited in the case studies (estimated rates vary between 2 and 33%). In order to reach a substantial part of the population, a wide availability of services is needed.

♦ "Drug abuse treatment needs to be easily available to contribute to preventing HIV infection." Longer retention in treatment, as well as completion of treatment, are correlated with reduction in HIV risk behaviours or an increase in protective behaviours. But, to reach their target population, treatment services need to be readily available and flexible. Treatment applicants can be lost if treatment is not immediately available or readily accessible. Treatment systems need to offer a range of treatment alternatives, including substitution treatment, to respond to the different needs of drug abusers.

♦ "Capacity building in HIV prevention and treatment needs to be encouraged within the existing system of health services."
"Systematic project planning, monitoring and evaluation need to be further strengthened."

**Prioritising and phasing harm reduction activities**

From the evidence, the most effective SINGLE intervention for HIV prevention among IDUs, including young IDUs (in order of speed of effectiveness and evidence for effectiveness) are:

- NSP (preferably provided through outreach as well as fixed sites and mobile services and necessarily accompanied by explicit, targeted education). For maximum effectiveness, this activity should be delivered to at least 60% of IDUs in a city/district on a regular basis, and should involve IDUs in IEC preparation and production, in planning and delivery of services (at least through consultation during planning and, if possible, through employment during implementation). Can impact on HIV epidemics within one year.

- Substitution drug treatment (preferably offered through a range of modalities, voluntary, respectful of clients rights, non-punitive). Maximum effectiveness in HIV prevention terms comes through retention on the program and offering this treatment to all IDUs who desire it. Can impact on HIV epidemics within one year.

- Outreach education (targeted, explicit) coupled with whatever equipment can be provided (apart from needles as that would be NSP) including condoms, swabs, etc. Maximum effectiveness comes through use of close peers, penetration of a variety of networks until virtually all networks are accessed, IDU involvement as in NSP above. Can impact on HIV epidemics within one year.

- Improved STI services for IDUs (especially CSWs who inject) which are easy to access, free (or cheap), respectful and appropriate. Maximum effectiveness appears to come from affordability and ease of access (often through outreach, especially for CSWs). Can impact on HIV epidemics within one year.

- Low-threshold (non-substitution) drug treatment such as detoxification camps which are easy to access, free (or cheap), respectful and based on clients' needs. Maximum effectiveness comes from being able to offer, as much as possible, treatment when and where IDUs want it, offering a range of treatment options which can be matched to IDUs' expressed needs, and allowing IDUs to go through treatment as many times as they feel it necessary. Can impact on HIV epidemics within several years.

- Harm reduction drug education where young people are encouraged not to use drugs, but are fully informed about both the positive and negative aspects of drug use (including legal and illegal drugs) for individuals and societies, together with enhanced life skills, linked with structural changes to education and employment (among others) to reduce the likelihood of children starting to use drugs. No evidence yet of speed of impact on HIV epidemics.

The most effective set of interventions for young IDUs (including CSW IDUs) comprises: targeted explicit IEC for young IDUs and CSWs; outreach (and, if possible, targeted IEC interventions) to many different IDU and CSW networks,
including employment of peer educators of a similar age and gender to the target groups; needle and syringe programmes (NSP) and increased availability of injecting equipment through government institutions such as polyclinics, accident and emergency units in all parts of a city and province. It should also include IDU and CSW-friendly STI services; low-threshold, respectful, voluntary drug treatment (including substitution treatment) based on clients' needs with specific attention given to the needs of adolescent drug users. Access to IDU- and CSW-friendly general and HIV-related medical/health services (including HIV voluntary counselling and testing (VCT) and maternal health services); empowerment organizations of CSWs and IDUs; access to IDU and CSW-friendly psychological, legal and social services to meet clients' needs are also needed. Advocacy for introduction/ expansion of these services, for a supportive environment for these services; and for structural changes to improve social and health circumstances of IDUs and CSWs (including legal reform where needed) is urgently required.

As well as speed of effectiveness, speed of implementation must be considered. For example, outreach and NSP services can be established within 1-2 months (unless legal changes are required), though ongoing training (for example of outreach workers) will be needed. With appropriate resourcing, NSPs and outreach can achieve the necessary scale within 1-2 years (though this may take longer in closed drug scenes where drug use and selling are very carefully hidden). Development of IEC materials can be done very quickly but, to involve IDUs in their design and production means gaining trust and (usually) outreach activities, so they are likely to take 6 months to 1 year, but can reach scale as quickly as they can be distributed through NSPs and outreach programs.

Substitution drug programs require substantial infrastructural provisions (especially concerning security of substitution drugs in transport, storage and delivery), as well as training and often require legal changes or clarifications. They can normally be implemented within 6 months to 1 year and can reach scale very soon afterwards. Improved STI services normally take considerable time to develop as they often require assessment of current practices, approval of suggested changes to practice, training of staff and implementation of new practices. Even with adequate resourcing, it is likely that such services will require several years to reach an appropriate scale.

Low-threshold drug treatment (apart from substitution treatment programs) can be started fairly quickly but to be effective, they need to use evidence-based strategies and staff must be appropriately trained. Where inpatient drug treatment is mostly used, it is very difficult to achieve scale, even after decades of establishing programs and training ever-increasing numbers of staff. This is because most effective inpatient programs have small intakes (often only 10-20) of IDUs who usually stay for 3-18 months. If a city has even 2000 drug users, 100-200 such centers would need to be started to provide treatment for all drug users. If outpatient methods are used, training or retraining is required on a much larger scale as general medical practitioners, social workers and medical doctors may all need to be involved. However, once a system is established, it may be brought to scale much more quickly than inpatient treatment.

Comprehensive approaches to drug prevention, including life skills and other education and structural changes to employment, education etc. have yet to be carried out at a scale that has led to massive falls in drug use by young people. It is likely such changes would require decades of work.
For these reasons, both developmental and emergency approaches are needed to HIV prevention among IDUs, especially young IDUs, in CEE/CIS/B. In addition, a phased approach is required, in which pilot harm reductions can begin, services can begin to network with each other and, ultimately, governments can see the public health benefits from harm reduction and begin to fund these networks of programs.
Annexe III: DEFINING UNICEF’S ROLE IN WORKING WITH YOUNG IDUS AND YOUNG SEX WORKERS FOR HIV PREVENTION IN THE REGION

- a flow of different steps reviewing in turn:

1. Political and social environment in CEE
2. Review of what others are doing...
3. PERSPECTIVE ON THE EPIDEMIC YOUNG IDU/CSW AS PART EPIDEMIC CONTEXT IN CEE/CIS/BS
4. OBJECTIVES OF UNICEF IN REGION
5. IDENTIFICATION OF ROLES THAT MATCH MANDATE & ENVIRONMENT
6. STRATEGIC CHOICE – FOCUS AND MATCH WITH RESOURCES
7. RE-POSITION/CREATE STRUCTURES TO SUPPORT ROLE
8. ACTIONS PLANS

(Adapted from Sen 1999)
Annexe IV: SYNTHESIS OF RESPONSES TO QUESTIONNAIRES

(A full version of responses from all offices is available as a separate document)

(a) UNICEF RESPONSE SO FAR

Q. Has your office responded programmatically to IDU issues over the last 2-3 years?

<table>
<thead>
<tr>
<th>Country</th>
<th>IDU taken up in dialogue w/govt</th>
<th>Within Theme Gp</th>
<th>Rapid Assessment/Response</th>
<th>Support to HIV prevention Young CSWs</th>
<th>Support to Harm Reduction IDUs thru NGOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albania</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
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<td>o</td>
<td>o</td>
<td>x</td>
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<td>o</td>
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<td>x</td>
<td>o</td>
<td>o</td>
<td>x</td>
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<td>x</td>
<td>underway</td>
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<td>o</td>
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<tr>
<td>Bulgaria</td>
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<td>underway</td>
<td>o</td>
<td>x</td>
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</tr>
</tbody>
</table>
Annexe iv contd.

(b) TRENDS IN VULNERABILITY TO AN IDU-LED HIV EPIDEMIC AND PERCEIVED PRIORITY

Q. Do you see Injecting Drug Use as a major problem affecting Young People’s health, development, protection and participation in your country. If so is this changing?

Q. How much priority do you feel HIV/ AIDS is going to have with the national government over the next 2-3 years?

Q. How much priority do you feel work with IDUs should have in UNICEF’s work in your country?

<table>
<thead>
<tr>
<th>Country</th>
<th>Scale and direction of Injecting Drug Use Among young people</th>
<th>Country HIV as perceived priority of Government</th>
<th>IDU as priority for UNICEF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albania</td>
<td>Unknown/Rising</td>
<td>Not yet considered a public health problem but starting to be on Political agenda</td>
<td>X</td>
</tr>
<tr>
<td>Armenia</td>
<td>High/rising (Estimates 20,000)</td>
<td>Not seen as major Problem/growing. Priority not high</td>
<td>X</td>
</tr>
<tr>
<td>Azerbaijan</td>
<td>Low/Emerging</td>
<td>Seen as emerging Problem Priority not high</td>
<td>X</td>
</tr>
<tr>
<td>Belarus</td>
<td>Important/rising</td>
<td>Increasing but still not reflected Implementation</td>
<td>X</td>
</tr>
<tr>
<td>Bosnia&amp;Herzegovi na</td>
<td>Unknown/Rising</td>
<td>Low. Preoccupation Other priorities Reconstruction</td>
<td>X</td>
</tr>
<tr>
<td>Country</td>
<td>Status</td>
<td>Major importance</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>--------</td>
<td>------------------</td>
<td></td>
</tr>
<tr>
<td>Bulgaria</td>
<td>....</td>
<td>Major importance</td>
<td></td>
</tr>
<tr>
<td><strong>FRY</strong></td>
<td>No data/increase</td>
<td>Not yet a priority</td>
<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>Rising rapidly/Low HIV (estimates 120,000)</td>
<td>Emerging priority</td>
<td></td>
</tr>
<tr>
<td><strong>UN P Kosovo</strong></td>
<td>Significant/Rising (little data)</td>
<td>Low. Preoccupation Other concerns: Security etc.</td>
<td></td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>High/Rising (estimates 50,000)</td>
<td>Moving to high Priority</td>
<td></td>
</tr>
<tr>
<td><strong>FR Macedonia</strong></td>
<td>Significant/Growing</td>
<td>Low/Preoccupation – Other concerns Economic security</td>
<td></td>
</tr>
<tr>
<td>Moldova</td>
<td>Major/Rising significantly</td>
<td>Low to medium</td>
<td></td>
</tr>
<tr>
<td>Romania</td>
<td>Thought to be high /growing</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td><strong>Russia</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Turkey</td>
<td>Low / emerging</td>
<td>Rising priority</td>
<td></td>
</tr>
<tr>
<td>Ukraine</td>
<td>Major problem/thought increasing</td>
<td>Recognised as major Public health issue</td>
<td></td>
</tr>
<tr>
<td><strong>Uzbekistan</strong></td>
<td></td>
<td>Uncertain priority</td>
<td></td>
</tr>
</tbody>
</table>
Annexe iv contd.

(c) **EFFECTIVENESS REQUIREMENTS**

Q. What would you have needed to respond more effectively to IDU issues?

Ranked in order of frequency:

- Funding (Azerbaijan, Ukraine, FRY, Kosovo, FRY Macedonia, Moldova)
- Greater Govt commitment (Armenia, Uzbekistan, FRY, FRY Macedonia, Romania)
- Clear policy and strategic guidance from Region (FRY, Ukraine, Kyrgyzstan, FRY Macedonia, Russia)
- Situation analysis IDUs (FRY, Uzbekistan, Moldova, Romania, Turkey)
- Access to 'lessons learned' working with IDUs (Belarus, FRY, Turkey)
- Changes in Legislation (Armenia, Georgia)
- Experience Life skills for IDUs (Belarus, Bulgaria)
- Training UNICEF staff IDU programming (FRY, Kosovo)
- Capacity building local counterparts (FRY, Kosovo)
- Readiness of agencies to become involved in complementary way (FRY, Russia)
- Technical assistance (Albania)
- Reduced social isolation IDUs (Azerbaijan)
- Knowledge effective approaches to working with young IDUs (Belarus)
- Curricula change in schools (Belarus)
- Experience ensuring access IDU to services (Belarus)
- A clear statement indicating IDUs are a UNICEF priority area (Boznia&Herz)
- Understanding drug prevention programmes (Bulgaria)
- Less polarised debate with UNAIDS on IDUs (Russia)
Annexe iv contd:

(d) OTHER RELEVANT ISSUES

Q. Are there other issues that you consider should be taken into account in developing a regional strategy relating to work with young IDUs?

Ranked in order of frequency:

- Seeing IDUs as part of wider YPH&D framework (Bulgaria, Georgia)
- Negative attitudes in society / fear (Armenia)
- Lack of UNICEF experience implementation outreach IDUs (Armenia)
- Resource shortages in Govt (Armenia)
- Social isolation of IDUs (Azerbaijan)
- Rehabilitation programmes for drug users (Belarus)
- Design of harm reduction programmes by peer educators (Belarus)
- Better coordination drug policies (Belarus)
- Life skills based education for drug users (Belarus)
- Gender issues in drug abuse (Belarus)
- Need to build human capacities (across UNICEF, NGOs, Policy support etc) to respond needs IDUs (B&H)
- How to link work with IDUs to CRC (B&H)
- Improved working relations sister UN agencies (B&H)
- More cost benefit analysis harm reduction (B&H)
- Legal issues re IDUs (B&H)
- Clarity of UNICEF’s position re IDUs> 24yrs (FRY)
- Attention to social rehabilitation IDUs (FRY)
- Widen the range of IEC (Georgia)
- Whole issue of young people’s participation (Kosovo)
- Need to strengthen advocacy (socio economic arguments..) (Kyrgyzstan)
- Need for a comprehensive strategy for IDUs (Kyrgyzstan)
- More intensive exchange experience between countries this area (Moldova)
- Concentrate on providing info to all young people on life skills, create youth friendly space etc (Moldova)
- Advocacy for harmonisation of legislation across the region (Romania)
- Develop regional standards of care (Romania)
- Develop integrated package of services for this group (Romania)
- Take holistic view (Turkey)
- Programming activities for young people (Georgia)
Annexe V: SOME USEFUL INTERNET SITES DEALING WITH DRUG USE AND HIV/AIDS

- UNAIDS: http://www.unaids.org
- WHO HIV/AIDS Dept: http://who.int/health-topics/hiv.htm
- WHO Substance Abuse: http://who.int/substance_abuse/
- Harm Reduction Coalition (US): http://www.harmreduction.org/
- International Association of Physicians in AIDS Care: http://www.iapac.org/
- CDC [statistics on HIV/AIDS]: http://www.cdc.gov/hiv/stats/
- HIV InSite: http://hivinsite.ucsf.edu/
- European Center on AIDS: http://www.ceses.org/aids.htm
- European Monitoring Centre for Drugs and Drug Addiction: http://www.emcdda.org/
- HIV InfoWeb: http://www.infoweb.org/infoweb/
- Addiction Research Foundation (Canada): http://www.arf.org/isd/bib/harm.htm
- Asian Harm Reduction Network: http://ahrn.net/
- Canadian Foundation for Drug Policy: http://www.cfdp.ca/
- Centre for Harm Reduction (Australia): http://www.chr.asn.au/
- International AIDS Economics Network: http://www.iaen.org/
- International Harm Reduction Development (US/CEE): http://www.soros.org/harm-reduction/
- The Lindesmith Centre Online Library (US): http://www.lindesmith.org/library/lib2.html
- UNDP Regional Programs on HIV/AIDS in Asia/Pacific: http://www.hivundp.apdip.net/
- RAR archives: www.rararchives.org
- Centre for Research on Drugs and Health Behaviour, London: http://www.med.ic.ac.uk/divisions/64/about.asp
- Drug Abuse Treatment Outcome Studies: http://www.datos.org/
- European Cities on Drug Policy: http://www.ecdp.net/newslett.htm
- International Harm Reduction Association: http://www.ihra.org.uk
Annexe VI : ORGANISATIONS CONTACTED

(a) Global

- World Health Organisation (Dept HIV/AIDS)
- UNAIDS
- UNDCP
- USAID
- DFID
- Open Society Institute IHRN
- HIV/AIDS Alliance

(b) Regional

- UNAIDS IATF
- UNICEF Regional Office for CEE/CIS/Baltics

(c) National

Russian Federation
- UNICEF Area Office
- UNAIDS
- USAID
- Medecins Sans Frontieres Holland
- OSI
- NGO
- Kaliningrad Infectious Disease Hospital
- Kaliningrad HIV/AIDS Centre
- Kaliningrad City Social Services
- Kaliningrad Regional Narcology Hospital
- NGO Ex IDUs Kaliningrad 'Overcoming'
- Youth Friendly Clinic, Kaliningrad
- City sub-district Counselling Centre, Kaliningrad

Ukraine
- UNICEF Country Office
- UNAIDS
- UNDP
- MSFH (Kiev, Odessa)
- State Centre for Social Services for Youth
- Kiev City Centre Social Services for Youth
- State Centre for Social Research
- District Youth Services Odessa
- NGO ‘Faith Hope and Love’ Odessa
- NGO ‘Our children’
- Odessa Medical University & Childrens Hospital
- PLWAs Odessa
Kosovo
- UNICEF office
- WHO
- Institute of Health/ National HIV/AIDS Programme Manager

FRY Serbia
- UNICEF Area Office
- UNICEF Country Office
- State Addiction Centre
- Public Health Institute
- Medecins Du Monde
- UNAIDS

Bosnia& Herzegovina
- UNICEF Country Office
- UNDCP
Annexe vii
TOR FOR DEVELOPMENT OF A UNICEF WORKING PAPER TO INFORM PROGRAMMING ON YOUNG PEOPLE IN THE CEE/CIS & BALTICS WHO INJECT DRUGS

Background

An estimated 700,000 people were living with HIV/AIDS in the CEE/CIS & Baltics region by end of year 2000, compared with 420,000 one year earlier. Despite the explosive spread, the epidemic is still at an early stage. All epidemiological evidence suggests that the very high levels of injecting drug use and sexually transmitted infections against a backdrop of socio-economic turmoil, can, in a few years, lead to larger scale and generalised epidemics.

The vast majority of reported HIV infections in the region are found among injecting drug users, most of who are young people. Russia, Ukraine and parts of Central Asia - where an estimated one percent of the population injects drugs - have some of the highest rates of IDU prevalence in the world. Region-wide, the majority of IDUs are still uninfected but are at increasing risk of contracting the virus. Clearly, efforts need to be made to strengthen HIV/AIDS prevention programs and provide services for this group. It is estimated that (e.g.) in Ukraine, at present only 5-15% of IDUs have access to HIV prevention services. In cities where sentinel surveillance has been conducted, between 20 and 60% of these IDUs are already HIV+.

Certain sub-groups of IDUs such as sex workers have witnessed rapidly increasing HIV prevalence – around 15% in some sites in Russia, Ukraine and Belarus. This not only at least partially reflects the large proportion of sex workers who inject drugs, but also delineates them as an especially highly vulnerable group to HIV infection with the potential to provide a bridge to a more generalised HIV/AIDS epidemic. Over and above the highly vulnerable group of sex workers who inject drugs, other cohorts of IDUs themselves are young and highly sexually active. The alarmingly high level of STIs indicate a high level of unsafe sex and increased vulnerability to HIV infection also outside the highly vulnerable groups.

The number of agencies and sectors involved in supporting harm reduction (including) prevention programs is increasing. However, with such a limited coverage so far, and considering the apparent size of the problem, there is an urgent need for a clearer delineation of who should do what and which mutual efforts should be supported in order to maximise the impact of limited resources.

There is a consensus amongst UN, bilateral and NGO partners that HIV prevention among IDUs, combined with drug demand and supply reduction to reduce the number of (often very young) IDUs exposed to HIV should therefore have a high priority in the region.

The Response
The regional response by a range of partners is extensive but not systematic. Coverage of harm reduction programs are presently estimated to be reaching less
than 5% of IDUs. Monitoring and evaluation of these programs in terms of quality and impact, remains an on-going challenge. Whilst a technical support network exists for NGOs and other agencies working with IDUs, there remains little systematic work around the advocacy required to overcome the heavy stigmatisation, which has led to commensurately little commitments by governments to tackle the problem or create a facilitative environment in which to address the problem.

Scope of Activities in the CEE/CIS & Baltics
Efforts to document the scope of initiatives of the main international partners and local NGOs in the region have been made by the Open Society Institute in collaboration with the Harm Reduction Network. At a glance, the scope of activities are wide and varied. They include:

- advocacy and involvement of Young People and parents of IDUs in harm reduction initiatives
- advocacy for drug legislation as well as juvenile justice reform and decriminalisation of IDU for young offenders.
- integration of HIV and reproductive health planning and services including better use of existing services, development of youth friendly approaches and outreach
- technical support and training for ongoing and new harm reduction projects managers and field staff
- drug education in the context of peer and lifeskills education and the training of peer leaders of beneficiary groups
- needle exchange programs including expanded needle-syringe marketing through the pharmacy system
- social marketing of condoms
- targeted research and action with vulnerable groups
- design of media activities and information materials
- treatment and rehabilitation for IDUs
- referral systems, linking outreach needle-exchange to treatment and rehabilitation services
- substitution therapy
- information/training materials for social workers dealing with IDUs
- publishing of bulletins and newsletters specifically designed for national and local decision-makers
- harm reduction in penitentiary institutions

What Role for UNICEF?
UNICEF both at a country level and at a regional level has supported many of the initiatives outlined. This has been either through direct support at a country level, or through Interagency Task Forces. Clearly, the biggest investment UNICEF has made relates to broader-based interventions around peer and lifeskills education, services for young people and advocacy for young people and their rights.

UNICEF’s is in the process of finalizing HIV/AIDS global Medium Term Targets for 2002-2005. The ICPD goals and strategies to reduce HIV infection amongst young people remain central to this (although IDUs are not identified explicitly in ICPD). In the CEE/CIS & Baltics region, UNICEF has been engaged in a process to reach consensus about regional priorities for HIV/AIDS and young people for
the period 2002-2005. Within this framework, globally and regionally, the UNICEF response to IDUs needs greater focus and strategic direction.

In the CEE/CIS & Baltics region, there is consensus on the need to define both a regional strategy for HIV/AIDS, that includes a focus on young people and addresses the needs of high risk groups; and also to develop a strategy for young people’s health, development and protection that makes the linkages between the different components of the 2002-2004 MTSP.

The UNICEF draft commitment in the CEE/CIS & Baltics is to achieve the following 3 things by 2005, through support for governments and working with a range of national and international partners:

1. Information for all YP!
   Identify/quantify levels of knowledge amongst young people and key duty bearers and ensure that in every country a communications strategy is developed and implemented to achieve ICPD targets, that aims to ensure that 90% of young people (10-19 years) have the knowledge to protect themselves from HIV/AIDS

2. Information and life skills for all YP in schools!
   Ensure that all schools are systematically developing and providing quality life skills education and information on HIV/AIDS and related issues

3. Information, skills and services for especially vulnerable YP!
   Identify/quantify groups at high risk of HIV infection and ensure that at least 60% of young IDUs and CSWs have access to information, adolescent friendly services and opportunities to develop their skills, in order to protect themselves from HIV/AIDS and to minimise its impact

Balanced priorities: High Risk Groups and Young People at large

Clearly, the 3rd commitment remains inextricably linked to the 1st and 2nd. A major challenge for UNICEF is to find a balance in terms of a range of competing priorities, and to appreciate that in general these are not either-or options. Balance needs to be achieved between focusing on the problems and/or the solutions (the symptoms and/or the causes) and designing interventions for all adolescents and/or those that are specifically directed to the most vulnerable and/or disadvantage?

The question is thus not should we be addressing the needs of high-risk groups of young people like IDUs and sex workers, but what should we be doing in terms of comprehensive approaches to young people’s health, development and protection and what are the additionalities required to deal with high-risk groups like IDUs and sex workers.

UNICEF acknowledges its limitations in terms of available financial and human resources and technical capacity to respond to these challenges. At the same time, UNAIDS cosponsors as well as bilateral partners, governments and NGOs in the CEE/CIS & Baltics are increasing their expectations of the role that UNICEF will play in the regional response to HIV/AIDS, particularly as it relates to young people. This underscores the need for UNICEF to be very specific about what it can and cannot hold itself accountable for, especially with respect to addressing high-risk groups.
What needs to be done?
UNICEF needs to delineate its role in working with IDUs, sex workers and other high risk groups of young people. It needs to review its own experience and capacity both in the region and in regions like SE Asia where the bulk of IDU and sex workers experience lies. It needs to look at the range of other actors work and look at what works and what does not. It needs to look at what needs to be done and on the basis of its comparative advantage, decide what part of that UNICEF can commit to.

This area of working with young IDUs is not one that UNICEF could hope to address unilaterally. At the present time the major actors are the members of the International Harm Reduction network, with civil society organisations such as the Open Society Institute (OSI) playing a leading role at an operational level in many countries of the region. The process of UNICEF developing its own strategy is also one of catalysing co-ordinated action amongst key partners working on IDUs and is important in its own right. The review process needs to be supportive of this goal.

Based on the evidence gathered in the first phase of the Review, UNICEF needs to develop a working paper on IDUs and high risk groups like CSWs that proposes possible goals and programming approaches for UNICEF country programs in CEE/CIS & Baltics; and proposes possible technical support mechanisms which need to be developed to support the work.

Major Output
A policy working paper defining UNICEF’s role in programming for harm reduction for IDU’s and sex workers who inject drugs. The paper should be no more than 30 pages, (excluding annexes but including a comprehensive executive summary), and should outline:

a) rationale/situation analysis in CEE/CIS & Baltics
b) state of the art and experience to date (including in SE Asia
c) UNICEF experience in the region
d) Considering UNICEF’s MTSPs and comparative advantage in relation to regional strategic planning on HIV/AIDS and other agencies on-going activities, proposed UNICEF:
   - Strategic roles/Goals
   - Possible targets and programming entry points 2002-2005
   - Broad programming approaches
   - Suggested operationalization and next steps
e) Risks, concerns, gaps

Annex – technical guidance and suggestions for development of technical support mechanisms.

Modalities/Tasks of the consultants
The deliverables described below require a range of experience and specific inputs from consultants. Although a wide variety of key resource people will be consulted, two principal consultants will undertake the review:

- one Consultant (A) with a strong knowledge of UN and international organisations, and more specifically UNICEF’s rights based policies and approaches, global HIV/AIDS issues, and UNICEF’s comprehensive
approaches to addressing HIV/AIDS in the context of Young People’s health
development, protection and participation,

- a second Consultant (B) having extensive knowledge and experience of
working on ongoing interventions for Injecting Drug Users and a broad
knowledge of Harm Reduction, lessons learned both globally and specifically
in the CEE, the CIS and Central Asia region. This consultant should have
close contacts with the network of harm reduction partners and the
operational programme environment in the field.

Both consultants should have proven analytical skills in being able to synthesise
experience, identify lessons learned, and formulate recommendations on effective
strategies.

In order to be able to draft the paper, the consultants will develop a process that
will bring in the views and experience of UNICEF country staff in the region and
review the work of a number of key partners* work and engage them in
developing a future collaborative response.

It is suggested that the consultant should visit selected sites in at least 3 of the
following countries: Russian Federation, Ukraine, Belarus, Kazakhstan, one
Balkan country and one Baltic country. This should include
1. Review of key partners’ work in the region in the area of drug prevention
and HIV prevention among young injectors
2. Review UNICEF’s experience with drug demand and harm reduction in the
region and elsewhere (through a desk study, especially SE Asia)
3. Develop, with inputs from major partners, a framework of strategic choice
for UNICEF work with IDUs and CSWs
4. Describe key entry points and suggested strategies for UNICEF’s action
that have been identified
5. Recommend first steps towards the operationalization of UNICEF’s
priorities on Young People who Inject Drugs in the context of the 3 identified
CEE/CIS & Baltics HIV/AIDS medium term strategic priorities
6. Make recommendations on what and how UNICEF country office technical
capacity can be strengthened and possible mechanisms to do this.

* including MSF, AIDS East–West-Foundation (AEWF), OSI, British Council,
HIV/AIDS Alliance, European Commission, Dutch Trimbos Institute, Social Services
for Youth, UNFPA/UNDCP/WHO and other UNAIDS cosponsors, bilaterals such as
DFID, USAID and other agencies and NGOs in the Harm Reduction Network.

Outputs Consultant A (Gordon Alexander)
Consultant A will have overall responsibility for major outputs described above
and guiding the consultative process. This includes overall responsibility for all
outputs identified below and specifically include:

1. Analysis and review of the program environment and institutional setting
for a response to IDUs, including a contextual examination of UNICEF’s MTSPs
on Young People and HIV/AIDS; rights based programming approaches and
policies etc.
2. Review of UNAIDS cosponsor policies, priorities and strategies in relation
to young people and HIV/AIDS
3. Development of strategic choices for UNICEF in relation to future work
with young IDUs, taking into account UNICEF comparative advantage in the
region and the work of other partners (particularly UN, UNAIDS, bilaterals and NGOs)

4. Recommendations on how UNICEF should respond within its regional medium term strategic priorities and its rights based framework

5. Recommendations on specific programmatic approaches to working with IDUs and the capacities needed to be developed to implement such approaches (including technical support mechanisms)

6. Facilitate an informal round table on the Review and Recommendations with key partners and senior UNICEF managers

7. Production of final report

Outputs Consultant B (David Burrows)
The consultant will bring global and regional harm reduction experience to the process, provide insights into possible opportunities and feasible program choices in a process of continuous consultation over the contract period. The consultant will coordinate closely with Consultant A in the development of the overall review framework and help develop key sections of the report. Specific outputs include:

1. Synthesis of current thinking and best practices on harm reduction amongst IDUs, in consultation with the Regional IDU Task Force members and International Harm Reduction Network members in the region and at a country level.

2. A similar synthesis of best practices and current responses for young commercial sex workers who inject drugs

3. Feedback from and engagement of partnership networks and major global fora on IDUs including the ICAP Conference in Melbourne, October 2001, Harm Reduction Conference New Delhi, March 2001 etc.

4. Participate and facilitate discussion in Melbourne with global partners on the process underway in the CEE/CIS & Baltics; and participate in a roundtable with key partners in Geneva, to discuss the first draft of the UNICEF working paper

5. Review of key partners' work in the region in the area of drug prevention and HIV prevention among young injectors and young CSWs identifying opportunities for strengthening these partnerships

6. Recommendations on key entry points and suggested strategies for UNICEF's action that are identified during the Review.

7. Recommendations on first steps towards the operationalization of UNICEF's priorities on Young People who Inject Drugs in the context of the 3 identified CEE/CIS & Baltics HIV/AIDS medium term strategic priorities; and how UNICEF country office technical capacity can be strengthened to do this.