REPORT

FOURTH PARTNERS MEETING ON HIV PREVENTION AND CARE WITH INJECTING DRUG USERS

10-12 November 2005
Kunming, China

Manila, Philippines
July 2006
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Convened by
World Health Organization
Regional Office for the Western Pacific

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NOTE

The views expressed in this report are those of the participants in the Fourth Partners Meeting on HIV Prevention and Care with Injecting Drug Users and do not necessarily reflect the policies of the Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of Member States in the Region and for those who participated in the Fourth Partners Meeting on HIV Prevention and Care with Injecting Drug Users from 10 to 12 November 2005 in Kunming, China.
ABBREVIATIONS

AIDS Acquired immunodeficiency syndrome
ATS Amphetamine-type stimulants
ARHP Asia Regional HIV/AIDS Project
CHR Centre for Harm Reduction, Melbourne, Australia
GFATM The Global Fund to Fight AIDS, Tuberculosis and Malaria
FHI Family Health International
HIV Human immunodeficiency virus
ICG WHO Inter-country Contact Group on Harm Reduction
IDU Injecting drug use
MMT Methadone maintenance treatment
MOLISA Ministry of Labour, Invalids and Social Affairs
NGO Nongovernmental organization
NSP Needle and syringe programme
OI Opportunistic infection(s)
PLHA People living with HIV/AIDS
UNAIDS Joint United Nations Programme on HIV/AIDS
UNAIDS-RST UNAIDS Regional Support Team for Asia and the Pacific Team
VCT Voluntary counselling and testing
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Keywords: Acquired immunodeficiency syndrome – prevention and control / HIV infections – prevention and control / Substance abuse, Intravenous/Harm reduction.
1. INTRODUCTION

The Fourth Partners Meeting on HIV Prevention and Care with Injecting Drug Users was held in Kunming, China, from 10 to 12 November 2005. The meeting was organized by the WHO Regional Office for the Western Pacific.

1.1 Objectives

(1) To review the latest epidemiological and surveillance information on HIV and drug use, and country responses, including access to HIV/AIDS treatment;

(2) to review progress and proposals for the expansion of HIV prevention targeting injecting drug use to achieve effective coverage; and

(3) to consider regional initiatives to ensure access to HIV/AIDS treatment and care, and make recommendations on how those infected through needle and syringe reuse should obtain equitable access.

1.2 Participants

Thirty-five participants attended the meeting, including country participants from Cambodia, China, Malaysia and Viet Nam; partner organizations, including the Asian Harm Reduction Network (AHRN), the Australian Agency for International Development (AusAID), the Centre for Harm Reduction (CHR), the Department for International Development of the United Kingdom (DFID), Family Health International (FHI), T Issues Consultancy, the Joint United Nations Program on HIV/AIDS (UNAIDS) Regional Support Team for Asia and Pacific, United Nations Office on Drugs and Crime (UNODC), and the United States Agency for International Development (USAID). The WHO secretariat included staff from WHO Headquarters, the Regional Offices for South-East Asia and the Western Pacific, and from country offices in Cambodia, China, Malaysia and Viet Nam. Temporary advisers for the meeting were drawn from the affected and vulnerable communities: drug users and people with HIV.

The list of participants, temporary advisers, consultants, observers/representatives and secretariat staff is attached under Annex 2.

1.3 Organization of the meeting

The meeting was held at the Rotunda Ballroom of the Harbour Plaza Hotel in Kunming, China, from 10 to 12 November 2005. Methods used in the meeting included plenary sessions, presentations and small group discussions.
2. PROCEEDINGS

2.1 Opening ceremony

Mr Gray Sattler (Technical Officer, HSI, WHO Regional Office for the Western Pacific), welcomed participants and introduced Dato' Dr Tee Ah Sian (Director, Combating Communicable Disease, WHO Regional Office for the Western Pacific).

Dato' Dr Tee Ah Sian delivered the opening address on behalf of Dr Shigeru Omi, WHO Regional Director for the Western Pacific (see Annex 3). Dr Tee welcomed the Director of the UNAIDS Regional Support Team for Asia and the Pacific and the UNODC Representative for East Asia and the Pacific. She spoke of the high importance of and need for, effective programmes to reduce HIV transmission; the need to provide care and treatment to all those who have HIV or AIDS; and the need to reduce discrimination against those who are infected. She also outlined the impact and focus of the previous harm reduction meetings and wished the participants well for the meeting.

Dr Prasado Rao (Director, UNAIDS Regional Support Team for Asia and the Pacific) also addressed the meeting. Dr Rao spoke of the need to work with local authorities to develop partnerships to combat HIV and provide high quality treatment and care.

Mr Akira Fujino (Representative of UNODC, East Asia and the Pacific Regional Office) spoke of the extent of HIV transmission among injecting drug users across the region and its significance for an HIV pandemic in Asia. He stressed the need for the effective integration of HIV/AIDS and drug policies.

Mr Lenny Ng Yoon Chong (Project Manager IKHLAS Drug User Project) spoke of the need to encourage injecting drug users to come forward and participate at all levels in the planning and delivery of the response to HIV/AIDS in order for it to be successful. He confirmed the importance of ensuring that the vulnerable community has a voice at meetings such as the WHO Partners Meeting. He noted that there is evidence that those working in HIV/AIDS prevention and care are beginning to recognize and acknowledge the community and to accept the importance of their involvement in HIV/AIDS programmes.

Dr Wu Zunyou (Director Division of Health Education and Behavioural Intervention, National Centre for AIDS Prevention and Control) spoke on behalf of the host country, China, and welcomed the opportunity to host the important meeting. Dr Wu presented an overview of the importance of partnerships to the success of HIV/AIDS prevention and care efforts.

Mr Ziang Changan (Deputy Director, Yunnan Province AIDS Prevention Office) welcomed the participants to Kunming and gave an overview of HIV/AIDS in Yunnan Province, where injecting drug use accounts for over 67% of HIV infections. He also outlined the programmes that are in place to combat HIV in the Province.

2.2 Country updates on epidemiology and harm reduction initiatives

Presentations by participating countries:

The PowerPoint or Word documents provided by speakers are included with the soft copy of this report. This can be obtained from the WHO Western Pacific Regional Office website, at http://www.wpro.who.int/health_topics/harm_reduction/ or can be ordered on CD by contacting
the Responsible Officer, Mr Gray Sattler on sattlerg@wpro.who.int. Notes below summarize key points of the speakers' presentations.

2.2.1 China

Mr Li Yuanzheng (Director, Ministry of Public Security, National Narcotics Control Commission)

- Approximately 45% of injecting drug users share needles. There is a significant rate of infection among injecting drug users.
- Work is being done to establish a ‘win-win’ situation by:
  - reducing the number of new injecting drug users;
  - preventing injecting drug users from sharing needles; and
  - introducing comprehensive intervention programmes with injecting drug users to reduce harm.
- There is close working collaboration between the Ministry of Health and the Ministry of Public Security to implement these actions.
  - Significant guidelines and policy have been established.
  - Key activities include national prevention education programmes, drug-free communities, methadone maintenance treatment (MMT), screening in closed settings, and training doctors and officers in closed settings.
- There is strong government support. President Hu Jintao has called for a real “people’s war of drug control and AIDS prevention.”
- There are problems with discarded needles. A commitment has been given by both the Ministry of Health and the Ministry of Public Security to solve this problem, and pilot programmes have begun.
- At the end of 2004, people who had injected drugs made up 43.2% of people with HIV/AIDS.

Dr Wu Zunyou (Director, Division of Health Education and Behavioural Intervention, National Centre for AIDS Prevention and Control)

- It is estimated that China had 1.14 million drug users in 2004.
- In 2004, there were 47,606 people with HIV, and a further 23,955 with AIDS newly reported. Of the reported HIV cases, 43.2% were injecting drug users.
- The framework for China’s response, the ‘4 Frees and 1 Care’ Policy is a significant step forward for those with HIV/AIDS in China.
- There is close collaboration within and between government and non-government services.
- The Chinese response is based on four themes:
  - primary prevention of drug use;
  - provision of drug treatment;
  - MMT; and
  - needle and syringe exchange.
- The MMT programme is notable because a comprehensive programme is now in place. There are already 35 clinics in operation, and a further 93 have been approved. Further expansion is planned over the next three years.
2.2.2 Cambodia

Dr Kaoeun Chetra (Vice Chief of AIDS Care Unit, National Centre for HIV/AIDS, Dermatology and STD, Cambodia)

- Cambodia is experiencing an increase in the use of illicit drugs, first reported in 2000 and still increasing.
- Amphetamine-type stimulant (ATS) use is more commonly reported than heroin use, which appears to be decreasing.
- It would appear that the rate of injecting drug use is low.
- Most injecting drug users are 18 to 25 years old.
- Seventy-seven per cent of people use substances alone.
- Priority targets for education and prevention programmes are youths and labourers.
- There is legislative support for harm-reduction-based interventions, and the HIV/AIDS Strategic Plan includes an illicit drug component.
- Multilateral support is provided by both WHO and UNODC.
- Cambodia is providing both treatment for opportunistic infections (OI) and antiretroviral therapy (ART), with some 9000 people currently receiving treatment.

2.2.3 Malaysia

Dr Rohani Ali (Principal Assistant Director, AIDS/STD Unit, Ministry of Health, Malaysia)

- Epidemiology:
  - To date there have been 64,439 HIV infections, 9,442 cases of AIDS and 7,195 AIDS deaths.
  - 2002 was the highest year for infections.
  - Seventy-five per cent of infections in Malaysia are in injecting drug users.
  - There are an estimated 900,000 injecting drug users in Malaysia. The number of new addicts detected in 2004 was 38,672, 33% of whom reported using heroin.
  - Eight per cent of drug users are HIV-positive.

- Government response:
  - UN Millennium Goal 6 is strongly supported by the Government.
  - The National Drug Agency was established in 1996.
  - There are 28 drug treatment centres across Malaysia (12,000 residents), and 56 private centres. Relapse rates are high.
  - In 2004, the decision was taken to use MMT.
  - The Action Committee on Treatment and Testing has been established.
  - A pilot MMT programme is in place in a number of centres across the country until Oct 2006. It is planned to expand the programme to introduce many more centres in the future.
  - The Ministry of Health announced in June 2005 that a needle and syringe programme (NSP) and condom distribution programme would be established, targeting injecting drug users. The programme aims to reduce needle sharing, reduce HIV and increase access into drug treatment, etc., and is based on an 'exchange' policy. This is part of a comprehensive health care package, including education, referral, counselling and access to primary health care. It will use fixed
sites and outreach services, and be implemented by nongovernmental organizations in four sites beginning in January 2006.

- Programme needs:
  - trained people at all levels;
  - more NGOs on the ground;
  - laws that are more consistent with the NSP and which do not hinder outreach and operations; and
  - funds for start-up costs.

2.2.4 Viet Nam

Ms Nguyen Thi Than Huong (Nurse in Chief, Drug Abuse Treatment Unit, Bach Mai Hospital, Hanoi)

- HIV prevalence among injecting drug users is estimated to be 28.6%.
- Needle use among users varies from region to region, but up to 30% share needles and syringes.
- Condom use with sex workers among injecting drug users is low.
- It has been estimated that, without effective interventions, the number of HIV-positive people in Viet Nam could be over 300,000 by 2010.
- There is evidence of increased understanding of HIV prevention among the vulnerable communities.
- A range of government programmes has been implemented with support from a number of donors, including the United Kingdom Department for International Development (DFID), the United States Agency for International Development (USAID), the United States Centre for Disease Control and Prevention (CDC), the Ford Foundation and others, including:
  - IEC with injecting drug users;
  - peer education programmes with drug users;
  - safe injecting;
  - NSP (exchange only); and
  - condom distribution.
- There is evidence that harm reduction programmes have reduced infection rates.
- Peer education and condom use promotion are key strategies.
- No MMT is available in Viet Nam yet.
- A major problem is the lack of a legal framework to support harm-reduction-based activities.
2.3 Expansion of comprehensive HIV prevention with drug users

2.3.1 International Context: Moving towards Universal Access by 2010

Dr Andrew Ball (Senior Strategy and Operations Adviser, Department of HIV/AIDS, WHO Headquarters)

Dr Ball's presentation provided an international context for the regional and country programmes.

There have been significant developments over the last five years:

- Definition of the Millennium Goals, which include one for HIV/AIDS
- The United Nations General Assembly Special Sitting on HIV/AIDS (UNGASS) Declaration of Commitment, in 2001
- The WHO Health Sector Strategy for HIV/AIDS 2003-07
- The WHO/UNAIDS Strategy 2004-2008
- Universal Access by 2010
- "3by5". During the period of this programme there have been significant developments including:
  - increased commitment to HIV/AIDS prevention and care;
  - lower drug prices; and
  - new funding mechanisms, e.g. PEPFAR.
  - BUT country action has been slow, hence the 3 by 5 target.
  - WHO involvement is core business
  - The programme is based on five pillars (see attached).
  - Forty-nine counties are being targeted, many in Asia.
  - There has been significant uptake across many countries (up from four countries in 2003 to 40 in 2005).
  - In Asia, 14% of those with a need for ART have access to it. The number of people on treatment in Asia has tripled in the last 12 months.
  - Bottlenecks include capacity to deliver treatment and funding hold-ups. Need to get treatment to those who are most vulnerable.
  - There are still significant prevention gaps.
  - Impact of 3 by 5 on injecting drug users has included acceptance that treatment is for all, but often there is a need to improve access to testing and counselling for injecting drug users.
  - The public health approach has required development of new models for service delivery to injecting drug users through primary health care.
  - Strengthening of the health system is essential (e.g. laboratory services).
  - Supportive policy, legal and social environments are essential.
  - Further improvement in human resource availability is needed, as well as an increase in the range of services.

- In July 2005 the G8 recommended the goal of approaching as near as possible to universal access to HIV/AIDS prevention and care by 2010. The WHO General Assembly, in September 2005, recommended support for this goal as did the United Nations General Assembly. WHO is developing a definition of universal access and a proposal for how it can contribute to achieving this goal.
2.3.2 The Biregional Harm Reduction Strategy 2005-2009

Mr Gray Sattler (Technical Officer, HSI, WHO Regional Office for the Western Pacific) presented the key elements of the WHO Biregional Harm Reduction Strategy 2005-2009.

- The Biregional Harm Reduction Strategy was developed from the Framework adopted by the Third Biregional Partners Meeting in Melbourne, Australia, and is for five years, until 2009.
- The objectives of the Strategy are:
  - to ensure access to the Essential Prevention Package;
  - to ensure access to treatment, care and support services for people who inject drugs; and
  - to create an enabling environment for harm-reduction interventions.
- The Strategy defines the Essential Prevention Package for harm reduction as:
  - information and education that is targeted and developed in consultation with the target population;
  - access to the means of prevention: needles and syringes, condoms;
  - an expanded range of drug-dependence treatments, including substitution treatments; and
  - use of outreach as a key approach to service provision.
- The Strategy recommends service levels for the Essential Prevention Package as follows:

<table>
<thead>
<tr>
<th>HIV prevalence among injecting drug users</th>
<th>V. Low (&lt; 0.5%)</th>
<th>Low (0.5 - 1%)</th>
<th>Med. (1 - 5%)</th>
<th>High (&gt; 5%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential Prevention Package coverage target (%)</td>
<td>30%</td>
<td>30%</td>
<td>50%</td>
<td>80%</td>
</tr>
<tr>
<td>Target % of injections using sterilized or new injecting equipment</td>
<td>70%</td>
<td>70%</td>
<td>80%</td>
<td>90%</td>
</tr>
</tbody>
</table>

- The Strategy also identifies what is required to implement it and what WHO will do at regional and country office levels in the following four areas:
  - political support;
  - resource mobilization;
  - increasing capacity; and
  - measurement.

2.3.3 Developing a programmatic approach to harm reduction: The experience in New South Wales, Australia.

Mr Owen Westcott (NSW Department of Health, Australia).

  - Important aspects of the National Drug Strategy include supply reduction, demand reduction (including the expansion of drug treatment programmes) and harm reduction linked under the heading of 'harm minimization'.
  - The National AIDS Strategy combines population health, health promotion and human rights. The involvement of the affected communities is central to the Strategy. HIV/AIDS has bipartisan political support.
• Description of NSP in NSW:
  o Now 19 years old. Public programme and private programme (pharmacies). Over 50% of needles distributed in the public programme are exchanged; this rises to over 80% in the pharmacy programme.
  o There are an estimated 20,000-30,000 injecting drug users at any one time who inject daily, plus an unknown number of less regular injectors, probably at least 40,000.

• Outcomes include: less than 2% of injecting drug users infected with HIV; fewer than new 20 HIV cases among injecting drug users per year; few cases of secondary infection to non-injecting drug users' partners and children; reduced heterosexual epidemic; HIV largely confined to homosexual and bisexual men.

• Programmatic approach described, including the aim, behavioural objective and operational objectives.

• To achieve a significant prevention effect at population level requires a high level of coverage (comparison with mass vaccination programmes). Achieving high coverage means attracting injecting drug users to the NSP, since their attendance is voluntary.

• Achieving high coverage involves: acknowledging that injecting drug users are a diverse population, that risk behaviour is determined by a range of individual, social and environmental factors and that injecting drug users have a diverse range of needs, among which HIV may not be an issue of particular importance.

• The NSW approach to achieving coverage includes the following:
  o establish trust and rapport with injecting drug users;
  o consult with injecting drug users about needs and services and acknowledge the role of peer-based services;
  o provide needles and syringes through multiple sources;
  o supply needles and syringes with minimal conditions;
  o develop innovative services which include outreach;
  o link effectively with other services; make appropriate referrals to drug treatment and primary health services;
  o provide access to testing, counselling and treatment for bloodborne and sexually transmitted infections; and
  o identify and remove/reduce barriers to access by: developing agreements with the police, consulting with local communities and dealing with concerns (e.g. inappropriate disposal), monitoring and evaluating programme performance through data collection and research.

• Challenges still exist, including:
  o maintaining political support;
  o limited coverage for indigenous communities;
  o limited coverage for certain language groups;
  o lack of effective treatment for ATS;
  o high hepatitis C incidence; and
  o responding to changing patterns of drug use.
2.4 Working group Session 1. What are the next steps in implementing the prevention strategy?

2.4.1 Country-based groups, involving participants, observers and secretariat members, considered current harm reduction approaches and what support WHO might provide in the future. Groups discussed and reported back on three questions:

- Where are we now?
- What are the challenges?
- What support is needed for the next steps, particularly from WHO?

China:

- Where are we now? Strong support for harm reduction across China. Sufficient financial resources to move forward.
- What support is needed? Political support, resource mobilization, increased capacity in health, justice and public security sectors.
- Support that WHO can provide? ART availability and guidelines; monitoring and evaluation; harm reduction workforce development; guidelines to support community-level understanding and implementation of harm reduction approaches.
- Challenges? Planning and priority setting, coordination.

VietNam:

- Where are we now? The group felt that the country presentation made during the first plenary (refer to 2.2 above) adequately reflects the existing situation.
- Challenges?: Significant challenges identified, including:
  - MMT pilot to commence soon. Need to implement on a wider scale.
  - Legislation needs some updating. There are still some contradictions between laws and the harm reduction framework.
  - There is a need for a master plan regarding harm reduction. What can be achieved realistically?
  - Scale and reach of needle exchange programme needs review.
  - Need to link with MOLISA (Ministry of Labour, Invalids and Social Affairs) regarding programmes in drug treatment centres.
  - Harm reduction capacity-building required.
  - There is a need for strong provincial support for harm reduction, promoted by strong central government and political support. There is a need for the Ministry of Health to take a strong leadership role.
  - There is a need to weave separate projects into a joint harm reduction programme. There is no current sense of “a programme.” This will require more collaboration between donors and agencies.
  - Drug treatment models need to be extended. Some community-based models needed.
- Support needed, particularly from WHO? WHO can assist by providing strong technical and financial support and assistance in the management and coordination of services.

Malaysia:

- Where are we now? The group felt that the country presentation made during the first plenary (refer to 2.2 above) adequately reflects the existing situation.
• Challenges:
  o Translating the NSP trial into a countrywide programme. Increased level of staffing and capacity is required to enable this to occur.
  o There is a need for enhanced government oversight of NSP and support for NGOs to deliver it.
  o Increased understanding of harm reduction at a political and community level.
  o Expansion of the whole harm reduction programme. NGO support required.
  o There is a general need for technical support on harm reduction issues.
• WHO can assist by providing:
  o support for harm reduction programmes and how to manage them;
  o ongoing technical support for implementation of the harm reduction programme rather than just for specific projects; and
  o lessons learnt from others who have implemented harm reduction well.

Cambodia:

• Where are we now? Refer to presentation in 2.2 above. There is a high level of policy support, and harm reduction can grow within this. Wide-ranging treatment programmes currently exist.
• WHO can assist by providing:
  o evidence-based programmes;
  o technical and financial support; and
  o cooperation between sectors.
• Challenges: Cambodia requires a more consistent legal framework, technical and financial support, guidelines on best practice, and workforce capacity development.

A large group discussion followed during which the following issues were raised:

• Overall, the requests for assistance from WHO were very broad and clarification about the particular details of what is needed, when and how would need further discussion at the country level. It was suggested that a two-year plan detailing the support required could assist and should be developed. In particular there is a specific need to identify capacity-building and training needs - who needs to be trained and to what end.
• The future of work to address HIV prevention and care with drug users in countries that are not present and how the biregional strategy applies to these countries.
• Resources to provide a harm reduction programme within the existing programmes is required at the in-country and Global Fund level.

2.4.2 The meeting reconvened into small groups to identify issues and needs that should be addressed at the regional level.

The groups reported back on issues and needs that should be addressed regionally by WHO and partners, as well as on some issues of relevance to all countries and hence able to be addressed at country level across the region.

• Issues requiring a regional-level response:
  o Lessons learnt in countries should be shared with other countries, e.g. experience and lessons learnt in adapting legislation to support harm reduction, developing common monitoring and evaluation approaches.
  o Workforce development: training at country level is needed and WHO should assist countries in identifying and meeting training needs.
• Development of a broader understanding of harm reduction: that it is not just needle and syringe programmes and MMT.
• Gathering and sharing of information on MMT services, including costing.
• Clarifying the role of public security agencies and how to work with them in the provision of harm-reduction-based programmes.
• Access to low-cost essential drugs.

• Issues requiring country-level activity across the region:
  o Support for developing and implementing national plans, including donor support.
  o All countries need information at the country level on the costs associated with MMT.
  o Support for the development of community-based organizations of drug users.
  o Harmonization of technical support.

2.5 Treatment, access and integration of prevention and care

The second day of the meeting focused on HIV/AIDS treatments access and integrating prevention and care services for drug users. Three presentations were made.

2.5.1 Overall challenges to treatment access: Presentation by Dr Michel Tailhades (Medical Officer, HSI, WHO Regional Office for the Western Office).

Key issues covered in the presentation included:

• IDU Epidemiology: Growth in number of HIV-positive injecting drug users to 13.2 million people in 136 countries; 3.3 million estimated in South-east Asia. A range of illicit drugs are being used, including amphetamine-type stimulants (ATS), opiates, cannabis and cocaine, and the overall use of illicit drugs is increasing. Injecting accounts for 5% -10% of all new infections globally. If Africa is not included in the data this grows to 30%. Many countries have high HIV infection levels among drug users; these range from 20% in Indonesia to 65% Myanmar.

• Why injecting drug users are at risk of HIV: Sharing of injecting equipment, unprotected sex, multiple health risks are all issues for injecting drug users.

• Important services for injecting drug users include:
  o early detection and access though primary health care services;
  o outreach programmes to contact hard-to-reach users, provide equipment and condoms;
  o detoxification programmes;
  o psychosocial interventions and ongoing counselling;
  o drug dependence treatment, including substitutes (e.g. MMT);
  o social reintegration programmes;
  o integrated treatment and rehabilitation services as part of the health system; and
  o access to ART.

• Issues for injecting drug users that are barriers to treatment include:
  o Attitudes: injecting drug users can benefit from ART as much as anyone. Some people do not perceive this to be the reality.
  o Gaps in service provision, limited services available; location is an issue.
  o Stigma and discrimination. Public attitudes to injecting drug users. Many consider them to be criminals.

• How to help injecting drug users reduce risk:
  o peer education;
o access to medical care;
o needle and syringe programmes; and
o community support and prevention services

- What still needs to be done:
o Sexual behaviour of injecting drug users needs to be addressed.
o HIV and hepatitis C risk needs to be addressed.
o Harm reduction programmes need to be implemented.

Discussion following the presentation raised the following issues and concerns:

- Drug use is treated primarily as a criminal matter in most countries and this affects access to the available treatment options for drug-dependent people.
- There is a need for injecting drug users to be involved meaningfully in programme development and delivery.
- Peer education approaches are felt to be the most useful approach to prevention education with injecting drug users.
- There is a "harm reduction advantage" from having drug-dependent people in treatment, particularly MMT for opioid dependent people, because this offers daily contact with clients, allowing for significant interaction, counselling and education.

The meeting noted the recent WHO Technical Consultation on the Development of HIV/AIDS Treatment and Care Protocols for Injecting Drug Users, held in Lisbon, Portugal. The meeting further noted that, while different HIV/AIDS treatment criteria are not required for injecting drug users, it is important that health/morbidity issues be addressed on an individual patient basis when providing ART.

2.5.2 Community perspectives on challenges to treatment access: Presentation by Mr Ronny Waikhom (CARE Foundation Manipur) and Mr Lenny Ng (IKHLAS, Kuala Lumpur)

Mr Waikhom presented first, using Manipur, India, as an example of the issues facing health services in provision of treatment and care to injecting drug users with HIV/AIDS. Key issues presented included:

- Reducing the incidence of HIV infection among injecting drug users in India at the same time as increasing HIV incidence among women attending antenatal clinics (spouses), children and increasing TB and STI.
- Access to HIV/AIDS treatment is low across India, less than 10% of the 2005 target of 1 million has access to ART. This is consistent with the situation in neighbouring countries. There is a particular issue on the borders, where access is almost nonexistent.
- In Manipur about 30% of those needing ART have access.
- There are a number of programmes aimed at getting HIV-positive people into treatment.
- Because of stigma and discrimination, it is difficult to get PLHA to come out into the open and thus providing treatment is a problem. This is improving, but it provides a particular challenge in accessing injecting drug users.
- Challenges in providing ART to injecting drug users include: poverty, co-infection, drug supply issues, adherence to regimen, no available options for stabilization of drug use, stigma and discrimination, limited clinical monitoring, side-effects and toxicity, lack of primary health care facilities, and almost no continuum of care.
- ART treatment services specifically identify a number of challenges including:
  o too many bottlenecks in the supply of ART;
  o inadequate record keeping; and,
  o a lack of trained service providers, including counsellors, with knowledge of ART.
• In Manipur these challenges are being dealt with by:
  o linking services and providing a continuum of care;
  o monitoring and advocacy; and
  o a state coordinating team.

The Manipur example involves an NGO as the treatment service provider. This places the needs of the injecting drug users to the fore, but limits government involvement. Both user needs and capacity and government involvement are important.

Lenny Ng Yoon Chong spoke in detail on the issues raised in the presentation, adding an additional perspective. Key points raised included:

• The need for the broader community to understand and accept harm-reduction programmes and to be realistic about why services are offered.
• The need for health services to be able to adapt when dealing with injecting drug users on ART and to be as supportive as possible, recognizing the needs of individual clients.
• Injecting drug users on ART often feel helpless and alone and it can be difficult for them to admit they need ART or to sustain their treatment regimens.
• Using substitution therapies is important when these are available, but involvement in drug treatment should not be used as a criterion for placement on ART.
• Care and support: Poor adherence to the treatment regimen is often cited as a reason for not starting people on ART. In these situations there is a need to examine the factors influencing adherence and try to address these. One major factor can be to provide support to the person on ART so that peers, family members etc. work with health care providers to support the person on treatment.

2.5.3 Service providers' perspectives on challenges to treatment access: Presentation by Dr Rohani Ali (Principal Assistant Director, AIDS/STD Unit, Ministry of Health, Malaysia)

Key issues in the presentation included:

• In Malaysia, the integration of HIV management into community health centres facilitates ART provision. Training of family medicine specialists is an important component of the programme.
• Targeting HIV-positive injecting drug users in closed settings is an important objective in Malaysia. The discussion below indicates how the Malaysian pilot programme is structured.
• Case study: The Serendah Project. This project is being piloted in the Serendah drug treatment centre, with a future plan to expand this programme to all the 28 drug treatment centres nationwide and is aimed at providing ART to HIV-positive injecting drug users with a CD4 count of less than 200 in all centres. Treatment continues to be provided on release, and is free for life. Those HIV-positive injecting drug users who do not qualify for ART during treatment are followed up and offered treatment in the community when their CD4 count reaches 200.
• Lessons learnt from this case study include: A high rate of drop-out from the programme [19%]; the programme requires a dedicated team of health professionals to deliver the services so that trust with clients is developed; there are challenging security issues that must be dealt with; there is a need for addiction counselling and better referral to other primary health services.
The project is well supported by the Government and it has demonstrated that it is feasible to provide ART to injecting drug users in closed settings. The project is currently being expanded.

2.6 Working group session 2. Challenges in ensuring access to treatment

2.6.1 This session involved participants, observers and the secretariat in working together in country groups to consider the current approach to treatment and care and what support WHO might provide in the future.

Viet Nam:

The following issues were identified:
• Training of health staff about care and treatment is required.
• Treatment for OI available, some ART available.
• No ART in prisons or compulsory drug treatment centres.
• The two-year plan focuses on raising the capacity of health staff and broadening the availability of treatment.
• Production of ART is a problem. Often standards are not met.
• There is a need to expand treatment facilities and access and to mobilize the community and the families of injecting drug users.
• There is a need for guidelines on treatment issues for injecting drug users.

Cambodia:

The current situation concerning treatment can be summarized as follows:
• There is a good policy environment (MoU, DHA, Strategy Plan)
• Continuum of care for PLHA (30 ART sites, 99 VCCT, 250 HBC Teams). 9000 (45%) PLHA on ART (Q3, 2005) but there is a lack of data on injecting drug user and non-injecting drug user access to OI and ART services.
• Drug users have no access to OI and ART services
• No drug treatment services.

Challenges:
• Integrated training of government, NGOs, and health, social and law enforcement personnel in a comprehensive approach.
• Technical and financial support: Manpower, money for provision of services (outreach, VCCT, ART, detoxification, rehabilitation, aftercare) and capacity building.
• Adapting international best practice guidelines to the Cambodian context.
• Resources mobilization (Government, donors, partners).

In two years, at the national level, Cambodia will:
• strengthen coordination between the Government (AIDS, drugs) and NGOs through a work plan and resources allocation;
• better coordinate law enforcement and health through agreements at national and provincial levels; and
• enhance cooperation between NGOs outreach and mental health programmes and HIV counselling and referral to VCCT and OI and ART services, ATS psychosocial treatment, rehabilitation and community aftercare.
Needs:
• The evidence, to advocate with the Government and partners.
• Drug treatment guidelines and protocols for ATS and opiates.
• The Mental Health programme needs guidelines and a protocol for drug use and referral to VCCT and OI and ART services.
• NGOs need outreach guidelines, protocols and a referral system.
• A comprehensive work plan (who, what, where, when).
• Adapt continuum of care for PLHA to include DU/IDU in the community.
• Funding for pilot activities and ongoing research. ATS treatment on ART and ongoing surveillance.

Malaysia:

The current situation is that:
• Malaysia is committed to providing treatment for injecting drug users.
• For the first time, the provision of ART is free.
• Already Malaysia has achieved solid treatment goals, injecting drug users are accessing treatment in increasing numbers.
• ART for people in drug treatment centres has been expanded from the pilot programme.
• There is seamless movement into community programmes for those on ART.
• There is ongoing capacity building for health service providers.
• There is full support from the Government.

Challenges:
• Link between ART and MMT. Need to overcome the problem of people who drop out of the treatment programme (ART)

Needs:
• “How to” guidelines, especially how to identify, attract and maintain HIV-positive injecting drug users in treatment.

China:

Needs and challenges:
• To provide ART to people living in rural areas, accessibility is the greatest challenge especially with injecting drug users. In China there are over 19,000 people currently on ART.
• To encourage injecting drug users to volunteer for treatment. This is difficult at the moment due to the barriers created by stigma and location.
• An ongoing discussion about the specific aspects of treatment involving WHO regional and country staff and Ministry of Health staff is required.
• Ongoing planning for a more comprehensive and supported approach.

2.7 Closing

The WHO Regional Director, Dr Shigeru Omi, addressed the closing session of the meeting. He welcomed the opportunity to be at the meeting and thanked all those present for their efforts and contributions.
Dr Omi expressed his hope that, through the harm-reduction programme, HIV incidence will be reduced among injecting drug users in the region. He noted that significant resources and individual commitment is being invested in the programme and emphasized the need to focus on the target of reducing the currently high prevalence rates among drug users. Is it possible, he asked? Nothing is impossible as long as we work together.

Dr Omi noted that the region has already reported success in prevention work, for example, the declining rate of transmission of HIV among sex workers in Cambodia. He challenged participants to identify and promote success stories among drug users across the region, and as soon as possible. He again thanked all those who had participated in the meeting for their hard work and wished them well for the future.

2.8 Peer Review of *Inside out: HIV harm reduction education for closed settings*

Day three of the meeting was a facilitated, interactive peer review of *Inside out: HIV harm reduction education for closed settings*. *Inside out* is a prevention education package that has been developed under the regional harm reduction programme. It is particularly for use in compulsory drug rehabilitation and treatment centres. The feedback, comments and suggestions from this session provided the final review and will be incorporated into the final package.
3. CONCLUSIONS

The final working session of the meeting was structured to allow discussion of the meeting outcomes and future activities.

3.1. Outcomes

The meeting noted the following:

- There has been an increase in political support for harm reduction programmes across the Region.
- The evidence suggests that there is also increasing access to clean injecting equipment and substitution therapy.
- There is a need to coordinate resources, training and support, especially regarding treatment and care issues.
- There is increasing engagement with law enforcement and legislation agencies.
- There is a need for the active participation of injecting drug users in decision-making and programme planning.

A range of views were expressed when input was sought from participants on the outcomes of the meeting. Some participants felt that they had benefited from the meeting through the opportunity to learn from the experience of other countries. Others felt that there was a clear need for further work by WHO and donors to support the development of management capacity for a programmatic basis for harm reduction.

3.2 Future activities

The need for, timing and focus of future meetings to support the development of harm reduction based prevention and care with drug users was discussed.

There was overall support for future meetings; however, there were differing views on the objectives for the next meeting, its style and focus. Some participants stressed the need to sustain momentum, noting that the meeting is a useful means of providing guidance for WHO on what Member States require and suggesting that the next meeting should be of a similar style to the Fourth Meeting. Others felt that the opportunity to share and learn from other countries was the most valuable element and they supported a fifth partners meeting focused on sharing of experiences between participants. Still others felt that the next meeting could be more technical in focus, looking at the key challenges from here – where we are and where we should be in two years? It was suggested that other countries should be included in future meetings and that participants from the WHO South-East Asia Region should be encouraged to attend.
## TIMETABLE

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<tr>
<th>Time</th>
<th>Thursday, 10 November</th>
<th>Time</th>
<th>Friday, 11 November</th>
<th>Time</th>
<th>Saturday, 12 November</th>
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<tbody>
<tr>
<td>0830</td>
<td>Opening Ceremony</td>
<td>0830</td>
<td>Report-back from country groups (by CO focal points) and discussion</td>
<td>0900</td>
<td>Overview of HIV in Closed Setting Project</td>
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<td></td>
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<td>0915</td>
<td>Treatment access and integration of prevention &amp; care 1) Presentation on overall challenges to treatment access Q&amp;A, discussion</td>
<td></td>
<td>The Process of Toolkit Development</td>
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<td></td>
<td></td>
<td>0930</td>
<td>2) Community perspectives on challenges to treatment access Q&amp;A, discussion</td>
<td>1020</td>
<td>Key Issues for Discussion Identified through Field Testing  • Issues for use with women residents  • Issues about cleaning of injecting equipment  • Male to male sex</td>
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<tr>
<td></td>
<td></td>
<td>1045</td>
<td>3) Service providers perspectives on challenges to treatment access Q&amp;A, discussion</td>
<td>1130</td>
<td>Key Issues for Discussion Identified by Meeting Participants.</td>
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<tr>
<td>0945</td>
<td>Coffee break (30 m)</td>
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<td>Coffee break (30 m)</td>
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<td>General Feedback on Inside Out including &quot;Introduction&quot; Section.</td>
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<td>1015</td>
<td>Introduction to the meeting</td>
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<td>Treatment access and integration of prevention &amp; care (continued)</td>
<td>1020</td>
<td>Key Issues for Discussion Identified through Field Testing  • Issues for use with women residents  • Issues about cleaning of injecting equipment  • Male to male sex</td>
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<td>Country and regional updates:</td>
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<td>Key Issues for Discussion Identified by Meeting Participants.</td>
<td>1130</td>
<td>Key Issues for Discussion Identified by Meeting Participants.</td>
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<tr>
<td></td>
<td>To include latest epidemiological information, current situation (including planned activity for 2006) for harm reduction based interventions.</td>
<td></td>
<td>General Feedback on Inside Out including &quot;Introduction&quot; Section.</td>
<td></td>
<td>General Feedback on Inside Out including &quot;Introduction&quot; Section.</td>
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<td></td>
<td>30 minutes per country (and RO). Each presentation will be followed by an opportunity for Q&amp;A from the floor.</td>
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<td>Key Issues for Discussion Identified through Field Testing  • Issues for use with women residents  • Issues about cleaning of injecting equipment  • Male to male sex</td>
<td></td>
<td>Key Issues for Discussion Identified by Meeting Participants.</td>
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<td>1230</td>
<td>Lunch (1.5 h)</td>
<td>1215</td>
<td>Lunch (1.5 h)</td>
<td>1200</td>
<td>Feedback on Training/ Resident Education Activities in Inside Out (Sections A and B)</td>
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<tr>
<td>1400</td>
<td>Expansion of comprehensive HIV prevention with drug users Presentations:</td>
<td>1345</td>
<td>Working group session (country based)</td>
<td>1300</td>
<td>Feedback on Use of the Toolkit Section (Sections C and D)</td>
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<td></td>
<td>• The Biregional Harm Reduction Strategy, the Essential Prevention Package, coverage needs and targets.  • Developing a programmatic approach and need for a comprehensive response.</td>
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<td>To discuss and identify responses to challenges in ensuring equitable access to OI and antiretroviral therapy for people infected through contaminated needle &amp; syringe reuse. Output: next steps for government (in collaboration with partners) and what is required of World Health Organization</td>
<td></td>
<td>Feedback on Appendices</td>
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<td>Structured discussion, Q&amp;A, mixed groups.</td>
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<td>Other Issues</td>
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<tr>
<td>1500</td>
<td>Coffee break (30 m)</td>
<td>1500</td>
<td>Coffee break (30 m)</td>
<td>1455</td>
<td>End of peer-review</td>
</tr>
<tr>
<td>1530</td>
<td>Working group session (country based)</td>
<td>1530</td>
<td>Report-back from Country groups</td>
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<td>Country based groups to work on identifying next steps, the needs and what can be sought from the World Health Organization/elsewhere to implement the strategy.</td>
<td>1600</td>
<td>Discussion of needs and regional activity in support of country needs</td>
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<td>1715</td>
<td>Wrap up of day 1</td>
<td>1700</td>
<td>Closing Ceremony: Dr Omi</td>
<td>1730</td>
<td>End of day 2</td>
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ANNEX 2

LIST OF PARTICIPANTS, TEMPORARY ADVISERS, OBSERVERS/REPRESENTATIVES
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DISTINGUISHED PARTICIPANTS, LADIES AND GENTLEMEN.

I have the honour of welcoming you to this important meeting on HIV/AIDS prevention and care. I would like to thank the Government of China for graciously agreeing to host this meeting. I would also like to acknowledge the presence of Mr Prasada Rao, the Regional Representative in Asia and the Pacific for UNAIDS, and Mr Akira Fujino, the Regional Representative for East Asia and the Pacific for the United Nations Office on Drugs and Crime, as well as representatives from various donor organizations, government agencies and nongovernmental organizations.

The strengthening partnership and collaboration indicated by your continued support for these meetings is very encouraging. This partnership is essential because the overlap of HIV/AIDS and drug use creates a complex situation that requires collaboration between the health sector and other sectors of the Government, and between government, nongovernmental and community based-agencies.

There is no need to quote the sobering statistics on HIV and AIDS. We all know the nature and scope of the problem, and it motivates us to work harder than ever to ensure quality services and access for all. It is, however, worth noting that as we face a challenge in ensuring access to treatment and care, we face a similar challenge in prevention: low national HIV prevalence figures mask the very high infection rates in particular communities, particularly among drug users. It is these people who are bearing the greater part of the current burden and our responsibility is to reduce that burden.

The focus for the Fourth Partners Meeting will be on action that contributes to improved national and regional responses to the drug-use related elements of the HIV epidemic, in particular, the need to ensure programmes are comprehensive and integrated. This means providing a range of services that evidence tells us will work, and developing and linking prevention programmes with care and treatment. We hope to develop a continuum of service that overcomes the problems created by the separation of prevention and care, giving us more than each approach can offer on its own.

Without prevention those who use drugs, especially if they inject, face a greater number of health risks. They are among the most vulnerable people in our communities, particularly for exposure to HIV and other blood-borne infections. While there is strong evidence that harm-reduction programmes work and our support for these programmes is clear, less than 3% of injecting drug users have access to harm reduction programmes in this Region. This coverage is too low to have any impact on the HIV epidemic. The Third Partners Meeting supported the development of a strategy for harm reduction in the Western Pacific and South-East Asia Regions, which is now complete. It defines an "Essential Prevention Package" for harm reduction and also recommends necessary coverage levels if we are to be effective. I hope your deliberations will move us much closer to achieving those coverage levels.

The Third Partners Meeting also considered the issue of harm reduction in closed settings, such as prisons and compulsory drug treatment and rehabilitation centres. A package for HIV prevention and education in closed settings was recommended, and I understand you will review the final package at this meeting. We look forward to your comments and to adding the revised package to the range of information and training materials we now offer to support the development of country
programmes. And I hope we will find willing partners to assist in delivering this package in all closed settings.

In 2003, WHO committed itself to a very ambitious goal with the 3 x 5 Initiative, a plan to reach 3 million people with antiretroviral therapy by 2005. More recently, we have lent support to the much more ambitious goal set by the G8, "Universal Access by 2010". The challenge is how to make treatment and care accessible to those infected and how to ensure that prevention services reach people at risk. Universal access means ensuring access to treatment for opportunistic infections, to antiretroviral treatment and to essential prevention services. In the Western Pacific Region, where injecting drug users make up the highest percentage of existing and new HIV/AIDS cases, this also means ensuring access to effective drug dependence treatments.

The stigma associated with drug use and the discrimination drug users face, even when seeking treatment, are the greatest barriers for this community. We must therefore ensure that treatment regimes and delivery modalities ensure accessibility and are suited to this community. So I urge you to consider this issue carefully and propose firm answers to this challenge.

This meeting also will consider how prevention and care services can be integrated, in order to increase access to both. Treatment provides us with new opportunities for prevention, through voluntary counselling and testing and in clinical settings. This may compliment and augment the ongoing community-based work, which must also be expanded. At the same time, prevention services should find ways to improve access to treatment and care for highly vulnerable, yet difficult-to-reach populations.

At the Third Partners Meeting, we decided to invite community representatives to future meetings, and I welcome representatives to this meeting. Your participation is important, and I would encourage you to be actively involved in the meeting. This is one more step in the growing collaboration between WHO and the people most affected by this epidemic. Closer collaboration with communities at risk will strengthen our capacity to support country responses. We encourage the involvement of the vulnerable and affected communities in all stages of programme planning and implementation.

I expect this meeting to provide a platform for shared learning and an opportunity to strengthen the collaboration that is so necessary to success in the response to HIV/AIDS. I trust your deliberations will be fruitful and that you have a very pleasant stay in Kunming.

Thank you.