Response Beyond Borders


Public private partnerships


International partners and stakeholders

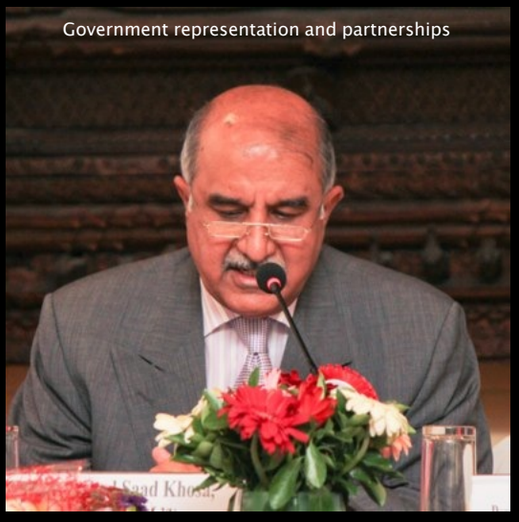

National AIDS Control Programs


Representing networks


UN country level engagement


Representing young people who use drugs


The Global Fund


Government representation and partnerships


Representing women who use drugs

Sub-Regional Consultation on the Prevention of HIV among People who Inject Drugs

Evidence, Engagement and Informed Response

15th - 17th April 2014

Kathmandu, Nepal.

Response Beyond Borders is an Asian movement to seek effective solutions through dialogue and debate to the nexus of poverty, drug use, HIV and AIDS together with Parliamentarians, Governments, UN bodies, Funding agencies, Civil Society, and affected populations and communities.

RBB Goa 2008

RBB Phnom Penh 2009

RBB Kathmandu 2009

RBB Bishkek 2009

RBB ICAAP Bali 2009

RBB Bangkok 2010

R B B

Kathmandu
April
2014

Afghanistan

India

Nepal

Pakistan

Bangladesh

Response Beyond Borders (RBB) grew out of a recognition that the challenges faced from drug use and associated HIV are not homogeneous throughout the world; that international networks and agencies are not on their own, sufficiently equipped to identify or focus on the key challenges facing Asia; and from a recognition by Asian civil society activists that unless national Asian governments take responsibility for both informed policy development and evidence-based interventions, the work currently being implemented is not sustainable.

RBB recognises that drug use knows no borders. Drug practices happening in one city in Asia are likely to migrate to another in a very short time. Consequently the response to drug use and HIV vulnerability should be equally rapid and collaboration across country borders among parliamentarians, government officials, civil society and affected populations is essential to develop knowledge, expertise, accountability and commitment.

RBB is therefore a movement which seeks to find Asian solutions to Asia's problems. In respect of drug use and HIV, simple disease control strategies (advocated worldwide) have limited effectiveness in Asia because of the underlying and crippling poverty of most people trapped in drug use, who are vulnerable to HIV.

The Sub-Regional Consultation on the Prevention of HIV among People who Inject Drugs: Evidence, Engagement and Informed Response is co-organised by RBB, UNAIDS, UNODC and WHO. The objective of this consultation is to ensure consensus on evidence-informed HIV programmatic responses based on multi-stakeholder engagement. Supportive actions will be identified to accelerate efforts in reducing and addressing the consequences of HIV infection among PWID, their partners and children in Afghanistan, Bangladesh, India, Nepal and Pakistan,

This Sub-Regional Consultation seeks to take stock of current status in the HIV response among PWID in countries, to reach consensus on strategic, programmatic and investment priorities, as well as suggestions made to the nationally-defined comprehensive service package in the HIV response among PWID to reach HLM targets, inclusive of health, drug treatment and social protection and to articulate joint actions for scaled-up and effective responses involving government, civil society and community engagement.

Evidence

Afghanistan, Bangladesh, India, Nepal, and Pakistan account for 90% of South Asia's population estimated at a total of 1.7 billion. Despite having comparable development indicators, these countries have contrasting realities including, among others, varying levels of stability, poverty, gender inequities and social conservatism.

As in other sub-regions of Asia and the Pacific (AP), countries in South Asia have concentrated HIV epidemics.

Among the three key affected populations (KAP) - female sex workers, men who have sex with men and people who inject drugs - the highest HIV prevalence continues to be found among PWID.

Prevalence of Hepatitis C among PWID in these countries is also believed to be substantially higher than the prevalence of HIV. There is also evidence linking the epidemiological dynamics of injecting drug use with sexual transmission of HIV, including through unprotected sexual contacts with regular or intimate, casual or sex work partners. In all countries there are significant percentages of PWID having sexual contacts either with female, transgender or male sex workers.

Despite the fact that South Asian countries share similar epidemiological contexts with regard to HIV infection among PWID, there are also marked differences that have evolved over the last two decades in terms of: extent of spread of HIV among PWID across sub-national levels - i.e. across provinces or states, districts and cities of countries. In general, we can detect three epidemiological patterns and trends over time that differentiate between diverse sub-national contexts among PWID in South Asia:

a) **Established concentrated epidemics** - provinces, districts or cities where HIV infection took hold early on among PWID in mid to late 1990s - such as in Kathmandu Valley in Nepal as well as in Manipur and Nagaland states in NE India - and with high levels of infections peeking around the early to mid-2000s and declining substantially since then (e.g. from 68% in 2002-3 to 3.5% in Kathmandu Valley, Nepal: from over 80% to 12.9% in Manipur, India, by 2011 and 2.22% in Nagaland in 2011);

b) **Emerging and expanding concentrated epidemics** - in provinces, districts or cities where HIV infection emerged in the early to mid-2000s **continues to expand to date**. (throughout Pakistan and selected NE (e.g. 12% in Mizoram in 2011) and Northern (e.g. 21.1% in Punjab and 18% in Delhi in 2011) states in India.) The province of Punjab in Pakistan reports the highest number of PWID across all sub-national entities in the five countries, with an estimated 63,500 PWID and HIV prevalence exceeding 40% in a number of districts and cities; and

c) **Low-level epidemics** - provinces, districts or cities that are seemingly at an earlier phase of infection, such as across most provinces in Afghanistan [note: with the exception of high rates of HIV prevalence in Herat in the western part of the country] and numerous districts in Bangladesh, India and Pakistan.

There is not enough known, at this juncture, to confirm whether the epidemic will or will not expand further in these regions.

Based on the more recent surveillance rounds, some countries are reporting either continuing overall **decline or stabilisation in HIV infection** at national level with regard to drug injecting, such as in Nepal and certain states in India, respectively. In Pakistan, however, HIV infection continues to **expand** with no evidence that is it plateauing. Afghanistan is - partly due the limited rounds in surveillance - believed to be at an earlier stage of emergence of HIV among PWID. Once sub-national trends are considered, however, a far from more complex situation arises in countries.

Within all countries, there are significant differences that emerge at sub-national level on epidemiological trends among PWID.

This is clearest in the largest two countries, India and Pakistan, which also have the most detailed HIV surveillance data sets down to selected district or city levels. In India, some previously high prevalence states have experienced considerable declines over time at the same time HIV is emerging among PWID in other states, reaching around or above 20% in certain localities. In Pakistan, a host of districts and large cities have prevalence between 20-40% with some going even beyond that as well.

A range of mega to large cities, linked to each other through key arteries of movement of population, goods and possibly also drugs, now report rising prevalence among PWID across the sub-region, including from west to east, Herat (15.7%), Kabul (3.2%), Peshawar (20%), Lahore (30%), Karachi (42%), Faisalabad (52.5%), Amritsar (45%), Delhi (18.3%) and Kathmandu (6%).

In some of the frontier provinces and districts of these countries, the to and fro cross-border mobility of people is such that there is evidence of a **similar epidemiological and, in some cases, HIV-related service provision across borders**, such as if we follow the road and highway stretching from Kabul to Delhi (i.e. known as NH1 in India starting from the border of Pakistan and going through Punjab, Haryana to reach Delhi). In the eastern provinces of Afghanistan, such as in Jalalabad and from Kabul onwards, for example, persons who are living with HIV seek ART services in Pakistan - specifically in the city of Peshawar but also in other towns [Note: The second largest number of Afghans on ART after Kabul is in the Pakistani city of Peshawar]. Afghan refugees also are found in street drug use settings in the cities of Peshawar, Quetta and Rawalpindi in Pakistan. There is also very notable similarity of the drug use and HIV situation developing in urban and rural areas of Punjab State in India with that of Punjab Province in Pakistan [Note: The recent highest rate of HIV prevalence reported among PWID in India is in the city of Amritsar which is on the border of Pakistan]. Burmese inhabitants in the north west of Myanmar who share community ties with the populations of NE India also seek AIDS-related services across borders in states such as Manipur, Nagaland and Mizoram in India. Mobility in the corridor between Bangladesh-India-Nepal has also been the focus of HIV prevention efforts for the last decade or more.

Response

Comparable economic, socio-cultural and institutional parameters across the countries account for similar contexts in HIV-related vulnerability as well as in policy, programmatic, investment, and implementation aspects of the AIDS response.

Based on the early efforts of civil society organisations (CSOs), including the harm reduction networks and forums representing or working directly with people who use drugs, **governments have now largely adopted harm reduction approaches** to HIV prevention, treatment, care, and support from the guidelines of the comprehensive harm reduction package of services (nine intervention components) as articulated by UNODC, WHO and UNAIDS in 2009 and in the guidance provided subsequently to country target setting in 2011.

Harm reduction has become part of the mainstay of the National AIDS Programs' work-plans mostly relying on the CSOs that have access to PWID to provide services and, where it works, to ensure linkages and referrals to health care, testing, Antiretroviral Therapy, Tuberculosis and drug treatment.

While some countries are progressing albeit slowly on landmark legislative and policy matters with regard to, for example, introducing and expanding Opiate Substitution Therapy (OST) and adapting strategies to ensure Antiretroviral Therapy (ART) and drug treatment for PWID, each of the countries [or selected provinces-sates in these countries] has amassed some **critical achievements and competencies in Harm Reduction** (HR): for example, the organisation of scale-up of Needle Syringe Exchange Programs (NSEP) and OST, combining CSO and public health facility-based OST program models, as well as working with women who inject drugs in India; Reaching partners of drug injectors and 'task shifting' or adoption of community-testing modalities for HIV Testing and Counselling (HTC) and CD_4 testing by CSOs in Pakistan; and lessons learned on effective HR models in Nepal, etc.

In an effort to ensure that countries move more rapidly towards achieving the commitments made at the 2011 High-Level Meeting (HLM) political declaration by 2015 and in the post Millennium Development Goals (MDG) period after 2015 around HIV prevention targets, specifically with regard to HLM Target 2 on **reducing HIV infection among PWID by 50%** it is essential to:

(a) reinforce the allocation of both domestic and external resources for HIV prevention among PWID, as it generally continues to be an underfunded area despite some progress made in recent years in terms of investment of resources on HIV prevention;

(b) identify the current critical shortcomings in effective service-delivery and how to overcome them, including on key issues such as increasing access and adherence to ART care among PWID, screening and treatment of Hepatitis C as well as other co-infections, scaling-up OST, and inclusion of intimate partners and children into programs;

(c) multiply several-fold the existing capacities to deliver services, including the centrality of community capacities; and

(d) consider what additional longer-term milestones should be set to build on the current delivery of comprehensive HR package - as defined internationally and in countries - to be more inclusive, empowering and sustainable responses involving communities as well as the policy environment required to do this.

Based on recent surveillance data on continuing or emerging epidemics of HIV, Hepatitis and other co-infections, regular feedback on difficulties in the field and community-level assessments undertaken in these countries, it is likely that the

The current scope and depth of the HIV response to PWID is insufficient to have the required effectiveness and impact to reverse the course of the epidemic among PWID and their sexual partners.

Most countries in South Asia reported on the 2011 Medium Term Review (MTR) in 2013 that they are on track in 50% reduction in HIV infection among persons who inject drugs. In some cases, this assessment is more based on aspirations and plans to reach ambitious results more than anything else, including in ensuring and maintaining the scale-up of effective coverage at 60-80%.

Countries refer to specific positive indicators of progress and scale-up. While it remains difficult to associate effective programmatic responses and scale-up to declining HIV prevalence or infection, there is some correlation between specific indicators of increased coverage to reduced HIV prevalence and infection in Nepal and India. In India, for example, coverage of PWID has been reported at around 84% of the estimated total population of 177,000 PWID. By December 2013, there were 286 intervention sites across the country, inclusive of NSEP and other components of the generic package of services with the largest concentrations of sites in the NE states of Manipur (47), Nagaland (31), and Mizoram (22), followed by the states of Punjab (24) and the federal capital of Delhi (20). There were also 107 OST centres functioning by end of 2012 providing Buprenorphine, with a planned target to increase the number of OST centres and reach from the current 11,500 to 15,000 PWID through two service-provision modalities: either through accredited CSOs or public health facilities providing OST. Despite of the above progress, HIV infection continues to emerge in emerge in new localities among PWID in India, including in states and districts not previously prioritised.

However, if coverage is analysed more in term of the concept of **'effective coverage'** - looking at the critical interventions such as NSEP, OST, HTC and ART acting both separately and together - the existing evidence on the effectiveness of programs may be more mitigated.

Distribution of needles and syringes are estimated to be six times less than what is required in Nepal, with 35 needles or syringes being distributed per PWID per year as compared to a required minimum of 200. Coverage of testing is relatively low and varies between a low of 18% and a high of 79% among PWID in these countries: India (38%), Nepal (21%) and Pakistan (18%). Testing rates are the lowest among PWID as compared to other key populations.

Notwithstanding notable exceptions in ART coverage, access to ART among PWID remains generally low to very low across PWID sites. Until recently, it was estimated that only 2% of PWID are receiving ART in Pakistan. The potential impediments for PWID to increased access and adherence to ART includes addressing geographical distance [e.g. In Pakistan, which only has around 22 ART centres across the country and where, in Baluchistan, it is noted that travel of between 8 to 24 hours was needed to reach an ART centre; In Punjab and NE States in India access to ART centres is also difficult], transportation costs and, lastly, is actual or fear of stigma and discrimination.

In Pakistan, for example, if we try to calculate the 'effective coverage', we would note that currently NSEP is at 25%, HTC is at 18%, ART is at 2%, and OST is nearly non-existent for PWID.

Thus, while it can be said that countries are generally moving forward, it is unlikely that global and national targets will be reached.

The national average of HIV prevalence or incidence among PWID may conceal considerable diversity on the emergence of injecting drug use epidemics at **sub-national level** and the subsequent need to increase coverage of HR services despite limited human resources. Substantial on-the-ground challenges are reported by CSOs and health care service-providers, the beneficiaries of the services themselves and drug user forums providing feedback. These challenges relate to efforts to scale up coverage and implementation, including that

(a) There is a dual epidemic of HIV and Hepatitis C (HCV) among PWID;

(b) programs reaching out to sexual partners of PWID with services are very limited in scope of interventions and coverage;

(c) HTC and ART initiation and adherence are particularly low among drug users; and

(d) persistent policy, procurement, operational and human resource gaps limit the coverage and continuity of harm reduction services, in particular NSEP and OST.

In conclusion, evidence from countries indicate that the current investment in resources, capacities and programmatic response to HIV among PWID may still be insufficient for a comprehensive response that impacts on HIV infection as well as other health-related challenges.

To undertake solutions to the above challenges, will require considerable and continuous **evidence-based advocacy and lobbying** with government, decision-makers and other prominent societal actors on what are the stakes with regard to the potential positive impact of comprehensive programs for PWID and what would be the consequences of inaction, the benefits of countering social exclusion, and detailing the required investment of budgets to do this. Sustained advocacy has to be planned and done jointly by communities and civil society networks, in partnership with government. Given that no single government sector or department - health, drug control or home, social welfare - provides coordinated leadership on addressing the issue of health, well-being, and rights of PWID, it is also incumbent on the international partners - including The Global Fund, World Bank, UNAIDS, UNODC and WHO - to assist in addressing challenges in countries.

Inter-country initiative

There is urgency to further calibrate, prioritise and reinforce the HIV response among PWID in South Asia.

Given that the epidemic in relation to drug use knows no borders, it is essential to draw on the collective strengths of actors in countries in strategic advocacy, successful programmatic experiences, information-sharing, and capacity building in a pooled effort as part of a 'response beyond borders'.

There is currently no inter-country, sub-regional or regional platform for pooling of such information, knowledge, human resources, tools, efforts or convening role on the issue of PWID that is focussed on these countries.

Previous regional or sub-regional events or dialogues have been held through or with UN or multi-lateral support - namely through UNODC, UNAIDS, WHO, and the World Bank - in the sub-region or in the wider Asia-Pacific region on PWID, but these were largely one-time events that have largely been phased out as they were funded through time-bound projects.

For over ten years, the UN also had in place a Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and Pacific with the participation of multiple stakeholders until its last meeting in 2011.

Similarly, the Asian Harm Reduction Network (AHRN) and Asian Network of People who Use Drugs (ANPUD), on their own, both have limited resources and institutional strength at present to facilitate such inter-country dialogue, but they will remain key partners in all joint efforts.

The Response Beyond Borders (RBB) platform, involving leading CSOs in service-provision from both Pakistan and India - i.e. the two countries with the largest populations of PWID and currently the most wide-spread epidemic in the context of drug injecting - has held several regional and sub-regional events bringing together community, CSOs, governments, parliamentarians, policy-makers, and development partners under a similar focus on injecting drug use and HIV.

Dialogue on PWID between countries was previously undertaken through this framework with UN and multi-lateral (UNODC, UNAIDS, UNICEF and World Bank) support. The Secretariat of the RBB is Nai Zindagi (NZ) in Pakistan that has a close partnership with the CSO Sharan as well as the Indian Harm Reduction Network (IHRN) in India. These CSOs have field-level experience and have partnered with actors in Afghanistan, Bangladesh and Nepal on different occasions.

RBB, UNAIDS, UNODC and **WHO** agreed, therefore, as a first step to convene an **inter-country consultation** in a process to reinforce the HIV response among PWID in these countries through pooling knowledge, capacity and action in South Asia.

With regard to future inter-government interaction, it is to be noted that the sub-regional organisation, South Asian Association for Regional Cooperation (SAARC), has developed a Strategic Framework on HIV/AIDS 2013-2017 which also may be useful to coordinate future follow-up between the governments around this issue. This regional framework does include, in its specific operational plan, the convening of such thematic groups, including on HIV among persons who inject drugs.

Rationale

The highest HIV prevalence in South Asia is reported among PWID, and there is evidence that HIV infection continues to rise at an alarming rate in certain countries or in provinces-states within. HIV infection can also emerge rapidly among PWID in new localities.

There is urgent need to generally reinforce HIV responses among PWID in terms of coverage, inclusion of services, effectiveness, and quality at sub-national level and for specific sub-populations [i.e. intimate partners and children of PWID, women who inject drugs, young persons using drugs, and sex workers who inject drugs] to ensure countries reach the HLM target of 50% reduction in infection among PWID by 2015.

Communities and forums for persons who use drugs are increasingly requesting greater national and global commitment to implement comprehensive health and continuum of care approaches for PWID addressing, for example, Hepatitis, prevention and care of partners and children, etc.

Epidemiological, socio-cultural and institutional similarities in South Asia around PWID merit greater coordination among service-providers, civil society and community actors across countries, with the support of international partners. What is achieved or a breakthrough in practice in one country or locality can be of immediate benefit to efforts in other countries and localities through the exchange and transfer of information, knowledge and competence.

A sub-regional consultation is required to highlight the challenges currently faced by the countries as a whole and communities in particular, and to articulate potential solutions, including key policy and programmatic representatives of Government (health, drug prevention-control or law enforcement), CSOs providing harm reduction services, drug users' communities, and development partners.

Expected Outcomes

- An updated mapping and analysis is finalised of the HIV situation and response among PWID in the sub-region, including the current coverage of services, strategies in place and resource investment as of December 2013.
- Key recommendations made for evidence-based advocacy to be pursued with policy-makers, including on resource investment on PWID.
- Development of an initiative to reinforce community knowledge, engagement and competence to ensure appropriate tracking and feedback across countries.
- Outline of a proposal for strategic actions, including time bound operational plans detailing responsible stakeholders to be taken up.

Sub Regional Consultation

15th - 17th April 2014
Kathmandu, Nepal.

The objective of this consultation was to ensure consensus on evidence-informed HIV programmatic responses based on multi-stakeholder engagement. Supportive actions will be identified to accelerate efforts in reducing and addressing the consequences of HIV infection among PWID, their partners and children in Afghanistan, Bangladesh, India, Nepal and Pakistan.

Nepal was chosen as the host country and key PWID networks from Nepal organised the event under the leadership and guidance of UNAIDS, Nepal office. Funding was mobilized through UNAIDS, India office through its South-to-South Initiative.

Country teams comprised of participants from:

- Ministry of Health, National and State/ Provincial AIDS Programs
- Ministry in charge of drug prevention-treatment/home/law enforcement
- CSO service-providers
- Harm reduction networks and drug users' forum at national and sub-national level, where they exist
- Researchers, experts and policy-makers
- Selected parliamentarians and Government

The Regional and International participants who attended the consultation represented:

- ANPUD, The GFATM, UN Agencies, GiZ, Save the Children and Richmond Fellowship.

The three days of consultation were organised around: country evidence and response; gaps, needs and opportunities and way forward.

Approximately 90 delegates attended the sub-regional consultation and sessions were organised in presentations, question and answer sessions and group work.

A cocktail reception and a social event was hosted by RBB, National Harm Reduction Association (NHRA) Nepal, UNODC, WHO and the UNAIDS, Nepal Office for the delegates..

This report is divided into four sections:

- Pre-consultation activities
- And consultation activities, presentations and discussions on day one, two and three.

On behalf of RBB we would like to thank all delegates for their patience, tolerance and active participation during the sessions.

RBB recognises the guidance, leadership and un-matched commitment of Mr. Oussama Tawil towards the success of this consultation.

Day zero

Pre-consultation activities

A Concept Note for the sub-regional consultation was developed in close collaboration between RBB and the UN, and was finalised in the 1st week of March 2014. A preparatory mission to Kathmandu was organised in the 2nd week of March 2014 and a local organising committee was convened under the leadership of the UNAIDS Country Office (UCO) Nepal with members of CSOs and community representatives from Nepal.

A budget was finalised, including local budget in 3rd week of March 2014 by the UCOs of India, Nepal and Pakistan. The hotel package, including meeting rooms, full board and travel arrangements were also organised. A country Fact Sheet template which requested the following information was developed and sent out 3rd week of March 2014:

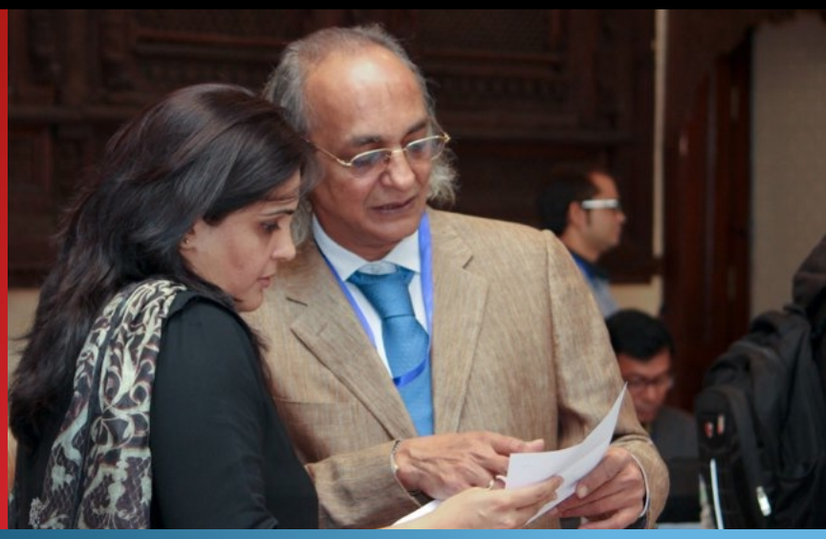
- Estimated size of PWID population (national, sub-national)
- Prevalence and Incidence of HIV among PWID, intimate partners
- Rates of Hepatitis and TB
- HR coverage, including NSEP, OST [number of sites, numbers covered]
- HTC, ART coverage, including HTC strategy
- Existing linkages to Hepatitis, TB programs
- Reach of intimate and casual partners, women injecting drugs, etc.
- Extent of funding resources available

Invitation letters were sent out to countries by 3rd week of March 2014 by RBB + the UNAIDS Regional Support Team (RST), and, where possible, in-country pre-consultation workshops to prepare sub-regional consultation were organised during the 4th week of March or - 1st week of April 2014 by the Country Task Teams. A Finalised Agenda and Logistic Note for the sub-regional consultation were sent out by 1st week of April 2014 by UCO India and Nepal. A Sub-regional review and power point (PPT) on HIV and drug use finalised by 1st week of April - RST + UNODC + UCO India.

The RBB secretariat had pre consultation meetings with the local organising committee prior to the consultation to support their efforts.

Day one

Country Evidence and Response



The inaugural session was chaired by HE Mr Arshad Saad Khosa, Ambassador of Pakistan to Nepal, with a panel of representatives from UNAIDS, the National Harm Reduction Association (NHRA), the Country Coordination Mechanism of The Global Fund and the Association of Women who use Drugs in Nepal.

The objectives and expected outcomes of the sub regional consultation were discussed. The panellists emphasised the fact that despite similar epidemiological contexts with regard to HIV infection among PWID in South Asia, there are also considerable differences. It is known that drug use and HIV knows no borders and a situation in one city in South Asia is likely to migrate to another in a very short time. What is achieved or a breakthrough in practice in one country or locality can be of immediate benefit to efforts in other countries and localities through the exchange and transfer of information, knowledge and competence.

A coordinated, efficient and immediate response beyond cities, states, provinces, countries and regional borders is vital to halt, prevent and reverse HIV among PWID in South Asia by multilevel stakeholders.

In a joint presentation by UNAIDS and UNODC, an overview of drug use related HIV in Asia highlighted the fact that globally 11.5% of an estimated 14 million PWID are HIV positive. The comprehensive package of 9 interventions was presented and discussed and the following was highlighted for Asia:

- Still low coverage of key interventions (NSP and OST)
- Low uptake of HIV testing among PWID
- Limited access to ART

The following intensified efforts by 2015 were emphasised to 'Reduce Transmission of HIV among people who inject drugs by 50% by 2015' as part of the 2011 HLM Political Declaration on HIV/AIDS:

- Geographical prioritisation at country level to reach larger numbers of PWID
- An urgent need to expand access to NSP and OST, and uptake of HIV testing and ART for PWID
- Improvement of quality of services.

The afternoon was organised into country panels to give an overview of the PWID related HIV situation, the response and question and answer sessions. The panel comprised of government, civil society and community representatives. The countries that presented were India, Nepal and Pakistan, with brief summaries also provided by civil society partners of the situations in Afghanistan and Bangladesh.

The key strengths specific to **India** are highlighted below, however the challenges, gaps and needs have been incorporated in the country group work on day two:

- India has considerably scaled up NSP and OST to reach 84% coverage of the estimated 177,000 PWID in HIV prevention programs.
- As a result of this scale up, HIV prevalence among PWID has declined and has been stable at 7.14% in 2007-2011
- Sixty three percent of the 2.7 billion US dollars for the national strategic plan, or the National AIDS Control Program (NACP IV), is funded by the government.
- NSP and OST have been rolled out to 286 and 147 sites, respectively, in close collaboration with CSOs and in Public-Private partnerships.
- Newer approaches in the Harm Reduction strategy have been introduced for delivering OST services, namely a CSO-OST model and a collaborative model in public health care settings.
- Accreditation of CSO-OST Centres through the National Accreditation Board for hospitals and health care has been revised.
- Representation and presence of community networks in the strategic planning for services and rights-based approaches for PWID.

The key strengths specific to **Nepal** are highlighted below, with the challenges, gaps and needs also incorporated in the country group work on day two:

- In the sub-region, Nepal is one of the earliest countries to start Harm Reduction services including OST.
- HIV prevalence among the 51,000 estimated PWID has drastically decreased in 2007-2012 overall, and to 6.3% in Kathmandu Valley.
- As a result of ongoing services safe injection practices are almost universal among PWID (95% in Kathmandu Valley).
- Proactive AIDS movement spearheaded by Nepalese PWID groups at a global, regional and national level, in particular of PWID living with HIV.
- Extensive formal and informal networks of PWID, women and young people who use drugs, service providers and drug treatment centres across Nepal.
- Nepal has a costed and detailed HIV investment plan (2014-2016) which endorses the immediate need for scaling up of quality services for PWID and their partners.
- New guidelines for the roll out and scale up of OST have been endorsed and approved by the government in 2014. As a result of this scale up HIV prevalence among PWID has declined and has been stable in 2007-2011.

Similarly, the key strengths specific to **Pakistan** are highlighted below with the challenges, gaps and needs incorporated in the country group work on day two:

- Forty percent of the estimated 90,000 PWID in the country have access to HIV prevention services including Needle Syringe Programs (NSP), but excluding OST.
- Response has been slow in comparison with the need hence an increase in HIV prevalence among PWID from 10% in 2005 to 37.8% in 2011.
- Comprehensive, accurate and updated data is available to plan and roll out strategic interventions for PWID based on a Management Information System (MIS) in real time.
- Community based (point of care) HTC and diagnostics (portable CD_4) have drastically improved access to ART for street based PWID.
- ART adherence unit is an effective intervention for street based PWID on ART and is essential and necessary to ensure optimum adherence.
- Services for wives, sexual partners and children of PWID have been incorporated and integrated with harm reduction services in Pakistan.
- Access to voluntary drug treatment for PWID in need of ART is an integral part of harm reduction services.
- District AIDS Councils have resulted in reduced violation of human rights, provided access to the general health care system and informed local administration and the general public of drug related HIV.

As the government delegation could not attend the sub regional consultation, key notes from Afghanistan were presented by a participant from DOH-International, who has worked extensively in the country over the last 3 decades. Colleagues from civil society in Bangladesh were invited as observers and also briefly highlighted some key points.

- Injecting drugs is on the rise in Afghanistan with an estimated 20,000 PWID. The highest prevalence of 15.7% is found among PWID in the city of Herat.
- Evidence related to PWID and HIV remains scarce, harm reduction services although expanding are still few, often sporadic and the quality of services is not always known.
- An OST pilot was initiated which has now been closed and future plans are not yet clear.
- Organisational management capacity of service providers in Afghanistan is basic and further guidance is needed.
- Networking among various stake holders: Government, international partners, CSOs and affected communities needs strengthening.
- Bangladesh has a large scale harm reduction program for PWID, however the sustainability of the program remains an issue.
- Prevention programs in prisons, capacity of service providers and access to ART for PWID are major areas that need attention in Bangladesh.

Day two

Gaps and Needs

The Package of 9 Interventions for PWID Assessment and Review

SHARAN-NAI ZINDAGI

SHARAN, India and Nai Zindagi, Pakistan jointly developed a methodology, tools and processes to review, assess and capture the quantity and quality of the UN-defined package of 9 interventions as available, accessible and acceptable to PWID in South Asia.

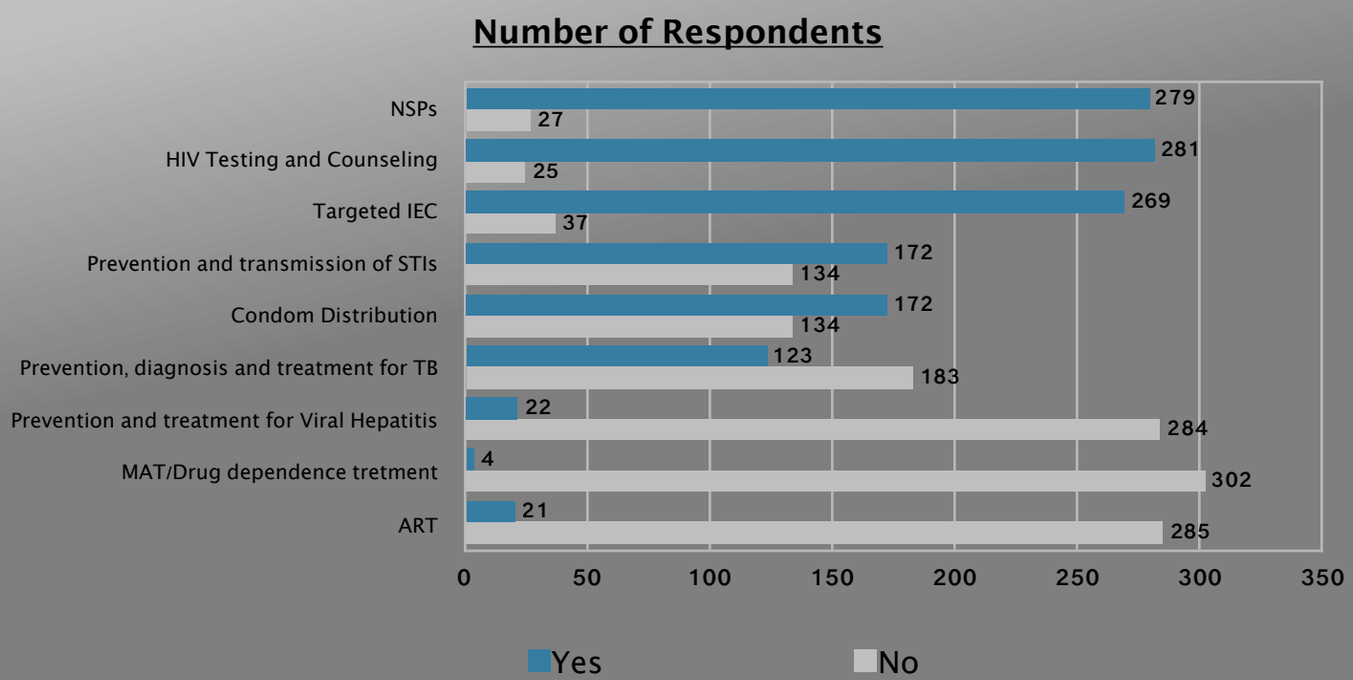
The participatory tools developed by SHARAN were tested in 5 national regions of India. Assessment instruments (questionnaire and focus group discussion guides) were translated into 5 different regional languages.

The main topics of the questionnaire were around the 9 interventions for PWID:

- Needle Syringe programs
- HIV testing and Counseling
- IEC for PWID and their partners
- Prevention and treatment of STIs
- Condom distribution for PWID and sexual partners
- Prevention, Diagnosis and Treatment of Tuberculosis
- Prevention, Diagnosis and Treatment of Viral Hepatitis
- Medically assisted treatment and other drug dependency treatment
- Anti retroviral therapy

Issues that were not part of the questionnaire but have equal importance in interventions for PWID - e.g. overdose, risk behaviour and quality of services - were captured in the focus group discussions. SHARAN and Nai Zindagi decided to review what is currently achievable and within community reach from the existing package of interventions and determine existing gaps experienced by the community in accessing service-delivery under the package being delivered across Pakistan as part of the Global Fund (GF) grant. Five cities of Punjab and Sind were selected and 306 current PWID accessing services for at least 6 months and willing to participate were part of this review and assessment.

The main findings are discussed below:



Assessment and Review
Key Findings

SHARAN-NAI ZINDAGI

NSP

- Almost all PWID access syringes in an outreach setting.
- Syringes acquisition was once a day among 92% of the respondents.
- Ninety five percent were satisfied with the syringe volume (cc), 83% were satisfied with the quantity of syringes being given to them while 78% were satisfied with needle gauge.
- Twenty one percent reported to have faced stigma and discrimination while accessing NSPs.
- Seventeen percent had accessed basic health care through referral.

HTC

- HIV testing and counselling services were accessed by 30% of the respondents from the Intervention sites while 54% received in outreach settings while 6% received from ART centres
- Satisfaction level with services in terms of:
  - Quality of individual testing and counselling (89%)
  - Couple/family counselling (13%)
  - Confidentiality (83%)

IEC

- Eighty eight percent had received information on HIV risks and safe injecting practices, 32% on TB and hepatitis and 5% had received information about human rights.
- Eighty nine percent have received this information in an outreach setting and 56% had received information once in a week.
- Satisfaction with IEC services in terms of:
  - Local language (85%)
  - Regularity of information (59%)
  - Relevant to situation (50%)
  - Easy to understand (89%)

Condoms

- Seventy seven percent of the respondents claimed that they use condoms and 94% had received condoms in outreach settings.
- Frequency of condom use:
  - Every time (7%)
  - Most of the time (30%)
  - Sometimes (44%)
  - Hardly ever (15%)
- Satisfaction of respondents in terms of:
  - Quantity (68%)
  - Quality (57%)
  - Distribution method (54%)

Key Findings of the Focus Group Discussions

- PWID witness overdose cases in their surroundings occasionally.
- Reasons vary from having excessive money to buy drugs, being forcefully abstinent from drugs for sometime, quality of drugs, injecting in femoral vein when it is hard to find vein otherwise.
- Mostly no support is available on the spots except help from other PWID who help in whatever way they may feel correct.
- In rare cases ORWs support clients with overdosage if it occurs in their presence.
- Police normally stays away in such cases, in case of death due to overdose police intervenes and that mostly causes harassment to other PWID.
- PWID were mostly satisfied with the availability of condoms, however, they do not feel comfortable carrying condoms with them all the time due to fear of police.
- HIV positive clients reported to use condoms while having sex with their wives in order to avoid HIV transmission.
- Use of condom is often not a priority among PWID while having sex as they rarely get an opportunity and they do not feel pleasure while having sex with condom.
- Majority of the PWIDs admitted sharing syringes and needles in the past when NSP services were not available to them but they claimed that they no more share syringes after receiving information about HIV transmission from ORWs.
- PWIDs were mostly satisfied with their accessibility to clean syringes, however, at times they admitted to re-use their own syringes in case it was difficult for them to access clean syringes after washing those with water.
- In very few instances sharing of ampoules - Avil (antihistamine) - was reported which is very commonly used in Pakistan.

HIV and HCV Co-infection

WHO - UNITAID-UNAIDS

Preliminary estimates suggest that approximately 5.5 million people may be co-infected with HCV and HIV, of whom approximately 2.5 million live in low and lower-middle income countries. ART has increased the life expectancy of HIV-positive individuals and, as a result, HCV infection can now reach advanced stages in HIV-positive individuals, and end-stage liver disease (ESLD) has become a leading cause of death for co-infected populations. The current HIV/HCV diagnostic and treatment paradigm is inappropriate for resource-limited settings due to unaffordable products that are complex to use.

Screening & Care

WHO recommends that HCV serology testing be performed on individuals who are part of a population with high HCV seroprevalence or who have a history of HCV risk exposure and/or behaviour, rather than at the time of presentation with symptomatic disease.

- Targeted HCV screening of PWID.
- Repeated screening is required in individuals at ongoing risk.
- Screening for HBV and HIV.
- Requires integration of services, as other health-care needs are often also present.
- HBV rapid vaccination regimen.

Treatment Guidelines

The WHO 2013 Consolidated HIV Guidelines recommend that the initiation of ART among people co-infected with HIV and HCV follows the same principles as for people with HIV mono-infection. While HCV emerges as major cause of death in ART Era it is not part of Zero AIDS Strategy and early treatment of PWID

- In ART era Hepatitis C remains the main opportunistic infection causing death .
- Zero death cannot be achieved without Hepatitis C treatment
- Hepatitis C treatment is available - needs to be made affordable and accessible with PWID as priority vulnerable group in Asia.

WHO recommended treatment

HCV infection can be cured with anti-viral drugs. The primary goal of treatment for chronic HCV infection is the elimination of viral infection, and a secondary goal is the prevention of progression to liver disease. Treatment success is measured by the absence of HCV, defined as the patient being HCV RNA negative 12 to 24 weeks after the end of treatment.

- WHO recommends that all adults and children with chronic HCV infection, including people who inject drugs, should be assessed for antiviral treatment.
- Pegylated interferon in combination with Ribavirin is recommended for the treatment of chronic HCV infection rather than standard non-Pegylated interferon with Ribavirin.
- Treatment with Telaprevir or Boceprevir is suggested for genotype 1 HCV infection.
- Sofosbuvir, given in combination with Ribavirin with or without Pegylated interferon (depending on the HCV genotype), is recommended in genotypes 1-4 HCV infection.
- Simeprevir is recommended for persons with genotype 1b HCV infection and for persons with genotype 1a HCV infection without the Q80K polymorphism.

Potential opportunities for treatment interventions

- Increase the affordability of medicines, notably the new DAAs, and/or diagnostics in resource-limited settings, through approaches such as aggregating demand, price negotiations, voluntary licensing or tiered pricing.
- Facilitate the uptake of new medicines and/or diagnostics, through approaches such as demand forecasting or support for the development of country roll-out plans, including updating national guidelines and programmatic integration.
- Accelerate/streamline the approval process for new medicines and/or diagnostics in low- and middle income countries.
- Develop new diagnostic and/or treatment approaches tailored for resource-limited settings and demonstrate HIV/HCV co-infection rates tend to be correlated with countries' overall overlapping risk factors for HIV and HCV. Countries where the main risk factors for HIV acquisition are the same as for HCV, for example, injecting drug use or men who have sex with men, will tend to have high rates of co-infection. Nevertheless, even in countries with low average co-infection rates, vulnerable groups such as injecting drug users, prisoners and men who have sex with men can be dramatically affected.

For details: Guidelines for the screening, care and treatment of persons with hepatitis C infection (www.who.int), Hepatitis C Medicines and Diagnostics in the context of HIV/HCV co-infection: a scoping report (www.unitaid.org)

HIV and HCV Co-infection

WHO - UNITAID-UNAIDS

While HCV emerges as a major cause of death in ART Era it is not part of Zero AIDS Strategy and early treatment of PWID particularly in resource constrained countries.

Policy Environment

New Oral Based Treatment (Direct Acting Antivirals) are expected in 2014: cost of production is lower than Interferon can work on all genotypes with shorter duration.

New point of care test would eliminate genotyping and liver scans.

Funding State of the Art Treatment

Zero death can not be achieved without Hepatitis C treatment.

Hepatitis C treatment is available - needs to be made affordable and accessible with PWID as the priority vulnerable group in Asia.

Summary

Potential game changers

- ZERO DEATH POLICY TO INCLUDE HEP C and GF CRITERIA
- AIDS SYNERGY RESOURCES TO PRIORITISE FUNDING FOR HEP C AND TO BE MONITORED FOR INTEGRATION
- SOUTH TO SOUTH INTERGOVERNMENTAL MECHANISM FOR PRE QUALIFICATION ; LICENSING ; PRICE SHARING AND REGISTRATION
- NEW FUNDING MODEL FOR CSOs

Global,Regional and National Actions

- Strategy: Zero Death Strategy of UN, PEPFAR GF include Hep C and early treatment of ART
- Policy: UN, GF and PEPFAR to include Hep C in co infection and criteria for application
- Evidence: Data on Hep C in Key Population (IDU and MSM, Pregnant women priority)
- Logistics: Inter governmental mechanism for Pre Qualification, registration and sharing of prices
- Resources: 'Synergy' AIDS resources to reprogram for GF eligible countries, mix other methods of resource pooling and price reduction, New funding model for CSOs
- Monitoring: Make Hep C monitoring part of GARP, IDU MSM sentinel sites

Challenges common to countries

Afghanistan - Bangladesh
India - Nepal - Pakistan

Based on presentations and discussions from day one and country specific group work the following gaps and challenges were identified which are common to all countries:

Stigma and Discrimination – 'from Drug Control to Public Health'.

Poorly informed Policies and Drug Control Acts often fuel the HIV epidemic among PWID. Rights and evidence-based science should inform policy and guided by the meaningful engagement of key stakeholders and, in particular, affected communities.

Availability, accessibility and acceptability of harm reduction services.

There is sufficient need for increasing and reaching out to more people with harm reduction services, particularly in recent evidence of newly emerging pockets of injecting drug use and related HIV.

Availability, accessibility and acceptability of HTC and diagnostics services.

The uptake of HTC and diagnostics services in the communities, when integrated into harm reduction services for PWID, increases many fold. These services are cost effective and efficient. Point of care technologies that are now available in the market are reliable and accurate, and their utilisation reduces the burden on the generic health care testing facilities and community-based testing is preferred by PWID.

HIV prevention services for non-injectors.

A majority of opiate users are smoking/chasing or sniffing heroin. Non injectors co-exist with injectors in street based drug sub-cultures and every year there is a significant number of non-injectors who shift to injecting. HIV prevention interventions for potential injectors need to be explored, tested and expanded to prevent and halt this shift.

HIV prevention services required in prison settings.

A high proportion (25%-45%) of PWID has been to jail and sharing of used syringes has been reported. In some instances, the HIV epidemic among PWID was initiated from prison settings. Currently, none of the countries reported any significant coverage of harm reduction initiatives in prison settings.

Challenges common to countries

Afghanistan - Bangladesh
India - Nepal - Pakistan

Capacity in service delivery.

The capacity of CSOs and service delivery organisations in the sub-region varies, which in turn impacts on the quality of services delivered and the eventual outcome. In particular, there is an immense capacity gap in availability and expertise of front line staff, e.g. outreach workers, field supervisors and site/program managers.

Addressing needs of specific populations.

Within the PWID communities, the needs, responses and the nature of interventions for women using drugs and young people using drugs vary in comparison to services for male adult street based PWID. To include these populations, programs need to be revisited and adjusted to expressed needs of these communities. In addition wives, sexual partners and children of PWID should be part of interventions.

Cross-border issues.

There is sufficient evidence that, within the sub-region, a significant migration between people who use drugs is present. Persons from one country seek services from another and this, at times, can result in additional burden on countries catering to PWID populations. The increase in HIV prevalence is also noted among PWID in cities linked across borders due to mobility and migration.

Management Information Systems in real time and at scale.

Service delivery data, including epidemiological data, is collected at various levels in the countries with a large variation in the sophistication of the data collected, relevance to programming needs and accuracy in terms of quality and efficiency (real time). There is sufficient room to improve and simplify methodology to collect and procedures to interpret and inform programming for an improved and efficient response.

Incorporating additional interventions in services for PWID.

Based purely on expressed needs of PWID, and to ensure programs respond effectively to the prevention of HIV among PWID and address needs of PWID living with HIV, there is need to think beyond the classic harm reduction interventions and incorporate additional components like residential drug treatment, nutrition, ART adherence interventions, etc. Access to services for co-infections, such as TB and HCV, as well as general health care, need to be strengthened in close collaboration with national programs and wider health systems.

Increased involvement of networks and affected communities.

PWID networks need to be encouraged to continue advocacy for rights-based approaches. However, the networks should also play a key role in program development, planning and eventually monitoring and informing on the quality of services.

Country specific needs

India - Nepal - Pakistan

- Advocacy with concerned Ministries facilitated by NACO.
- Primary prevention through School Health/ARSH program(MoHFW), Juvenile drug treatment/rehabilitation centres (MoSJE).

- Syringes distributed per PWID per year are quite low (36). This should be increased at least 4 - 6 times.
- Drop out of PWID from the OST programs is as high as 65%. Retention of clients in OST and scaling up of OST are both required.

- Stronger - high level advocacy for OST is needed.
- Accreditation of service delivery organisations to ensure a level of quality of service provision.

Potential opportunities for collaboration

- Afghanistan, Bangladesh, Nepal and Pakistan can benefit from the experience of India in scaling up OST and engaging the Indian government in serious investment in harm reduction programs. The accreditation process adopted by India could be adapted to country needs.
- The real time MIS developed in Pakistan under the Global Fund grant could provide a strong basis for a National expansion in Pakistan and adaptation by other countries.
- Nepal and India offer a rich experience of how community based networks have strongly advocated for rights of communities in country and Globally. Lessons learnt could benefit Afghanistan, Bangladesh and Pakistan.
- Point of care technologies (RDTs, portable CD_4 machines) have been deployed by various programs in some countries and could be expanded across the region.
- Pakistan has had extensive experience of working with wives, sexual partners and children of PWID and more recently establishing an ART adherence unit for PWID living with HIV and on ART. The experience gained and lessons learnt could fast track these interventions in other countries.

Day three

Opportunities and way forward

Investment Plan

Nepal

"The Nepal HIV Investment Plan calls for an HIV response of a scope, scale, intensity, quality, innovation and speed that will save the maximum number of lives, to keep people healthy, and to avert as many HIV infections as possible."

Dr. Praveen Mishra
Health Secretary,
Government of Nepal.
http://unaids-ap.org/2014/03/10/the-nepal-hiv-investment-plan/

The Investment Approach

1 Understand	2 Design	3 Deliver	4 Sustain
Understand the HIV epidemic	**Design the optimal package of interventions**	**Execute and scale up services**	**Sustain for impact**
What are the treatment priority & prevention needs?	Is the package of services optimised relative to need?	Is execution efficient and effective?	What resources are needed available in the long term?

Key Elements

- Main Priority areas are: female sex workers who inject drugs regularly; other people who inject drugs; street based female sex workers; transgender sex workers and male sex workers.
- Other Priority areas are: Migrant and mobile populations and their families; partners of people who inject drugs and gay men and men who have sex with men.
- Seventy three percent of the investment directly goes to program activities and services.
- Critical enablers where Nepal will invest are: reaching and maintaining HTC coverage; expansion of HIV prevention programmes; establishing public-private partnerships through out the continuum of care; implement test, treat and retain (TTR) programs; implementing effective ART adherence programmes and rolling out community test and treat competence (CTC).

The New Funding Model

The Global Fund

What is new in the NEW FUNDING MODEL?

- The Country Allocation ("Envelope").
- The (relatively) flexible application dates.
- An enhanced role of the FPM and the Country Team in shaping the proposals.
- A greater focus on Civil Society, e.g.
  - Rotation of CCM chairmanship.
  - Representation of KAP in the CCM.
  - Human Rights analysis.
- An online application process.

Aspects of NFM with relevance to PWID and HIV.

- Representation in the CCM of key populations and people representing and living with HIV and required documentation of inclusive Concept Note development.
- Participation in "Country Dialogue".
- Participation in "Disease Split" discussions.
- Involvement in NSP development incl. budgeting.
- Engaging in "Health Diplomacy":
  - Building Alliances (with bilaterals, multilaterals, influential individuals).
  - Engaging in early and substantial dialogue with your Country Team/FPM, convince, argue.
- Explore "incentive funding" opportunities.
- Earmarked Unfunded Quality Demand (not available everywhere).
- Time required for new funding model stages depends on the country context and can be: accelerated (7 months); average (11 months) and long (17 months) from pre-concept note to disbursement.

What is incentive funding?

- A separate reserve of funding designed to reward high impact, well-performing programs and encourage ambitious requests.
- It is made available, on a competitive basis (per component) to applicants within their own Country Bands.
- Awarding of incentive funding is based on the TRP recommendation. The GAC decides on incentive funding, which will be included in the upper-ceiling of the grant.
- The Boards criteria is: ambition; strategic focus; sustainability and co-financing.

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This report is available at: www.naizindagi.org


Program persons


Activists


Specialists in public health


Political will and leadership


Volunteers and media


Consultation organisers


Service providers


Representation of UN agencies


Representation of people living with HIV


International networks and experts


Provincial and states AIDS control programs


Informal networks