



ADVOCACY GUIDE: HIV/AIDS PREVENTION AMONG INJECTING DRUG USERS



WORLD HEALTH ORGANIZATION



Joint United Nations Programme on HIV/AIDS
UNAIDS
UNICEF • WFP • UNDP • UNFPA • UNODC
ILO • UNESCO • WHO • WORLD BANK



UNITED NATIONS
Office on Drugs and Crime

WHO Library Cataloguing-in-Publication Data

World Health Organization.

Advocacy guide: HIV/AIDS prevention among injecting users: workshop manual / World Health Organization, UNAIDS.

1. HIV infections - prevention and control 2. Acquired immunodeficiency syndrome - prevention and control 3. Substance abuse, Intravenous
4. Health promotion - methods 5. Manuals I.UNAIDS II.Title.

ISBN 92 4 159182 X

(NLM classification: WC 503.6)

© World Health Organization 2004

All rights reserved. Publications of the World Health Organization can be obtained from Marketing and Dissemination, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel: +41 22 791 2476; fax: +41 22 791 4857; email: bookorders@who.int). Requests for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – should be addressed to Publications, at the above address (fax: +41 22 791 4806; email: permissions@who.int).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

The World Health Organization does not warrant that the information contained in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use.

Printed in Switzerland

ADVOCACY GUIDE: HIV/AIDS PREVENTION AMONG INJECTING DRUG USERS



World Health Organization



Joint United Nations Programme on HIV/AIDS
UNAIDS
UNICEF • WFP • UNDP • UNFPA • UNODC
ILO • UNESCO • WHO • WORLD BANK



UNITED NATIONS
Office on Drugs and Crime

CONTENTS

Acknowledgements	
Introduction	1
Part 1. Principles of advocacy	11
1. Advocacy: overview and principles	11
Part 2. The advocacy process	23
2. Starting up	23
3. Analysis	32
4. Developing a strategy	37
5. Action and reaction	49
6. Evaluation	57
Part 3. Methods of advocacy	59
7. Use of research and evidence	61
8. Developing policy	73
9. Community-based approaches	89
10. Working with mass media	95
Part 4. Arguments and resources	97
11. Core arguments	99
12. Beliefs and attitudes opposing interventions	101
13. Resources	105

ACKNOWLEDGEMENTS

This manual was prepared by the International Harm Reduction Association (IHRA) and written by Dave Burrows, Consultant on HIV/AIDS and injecting drug use issues, Sydney, Australia. The following people edited the document: Andrew Ball, Monica Beg, Gundo Weiler, Richard Steen and Isabelle de Zoysa, Department of HIV/AIDS, WHO; Karl-Lorenz Dehne and Christian Kroll, Vienna Office, UNAIDS; and Moruf Adelekan and Chris van der Burgh, UNODC.

A Technical Reference Group was established to assist in preparing this guide by commenting on various drafts and providing information, case studies and exercises. WHO, UNAIDS and UNODC acknowledge the contributions from and thank the members of this group: Larisa Badrieva, Anindya Chatterjee, Miguel de Andres, Karl Dehne, Martin Donoghoe, Jimmy Dorabjee, Chris Fitch, Tatiana Hicarova, Silvia Inchaurreaga, Konstantin Ledezhetev, Annie Madden, Peter Markelov, Victor Marti, Palani Narayanan, Bill O'Loughlin, Sujata Rana, Gennady Roshchupkin, Timothy Ross, Sebastian Schmidt-Kaehler, Mukta Sharma, Komdon Singh and Emilis Subata.

WHO acknowledges the generous contribution of the Australian Agency for International Development (AusAID) to the development of this guide.

INTRODUCTION

WHY THIS GUIDE?

The World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Office on Drugs and Crime (UNODC) developed this guide jointly based on a wealth of experiences by individuals, institutions and nongovernmental and international organizations on the role of advocacy in establishing HIV/AIDS prevention and care programmes for injecting drug users (IDUs). It builds on several publications on general advocacy and specific advocacy programmes for HIV/AIDS, which are referred to Chapter 13.

HIV/AIDS among IDUs remains a neglected issue. Although policy-makers, programme planners at the community and national levels and international donors have paid increasing attention to HIV/AIDS in recent years, the specific epidemics of HIV/AIDS among IDUs and the response needed have attracted much less attention and funding. Efforts have been made within the United Nations to harmonize policies on global drug control and HIV/AIDS prevention and to build interagency collaborative mechanisms; however, country-level capacity to address HIV/AIDS among IDUs remains low. Prevention services remain extremely limited in most places. Care and support services frequently remain unavailable for IDUs and are not tailored to their specific needs, even where programming and funding for HIV/AIDS prevention has considerably expanded otherwise. A review of country responses in 2002 noted that IDUs tend to be excluded from highly active antiretroviral therapy, and often even from basic primary care, almost everywhere. An extra effort is therefore necessary to promote equal HIV/AIDS prevention and care among IDUs.

The purpose of this guide is to provide a wide audience with a systematic approach to such advocacy, which could be replicated and adapted to various cultural, economic and political circumstances. Part 1 outlines the general principles of advocacy for HIV/AIDS prevention and care for IDUs. This is followed by Part 2, a step-by-step process of establishing advocacy groups with specific goals; situation analysis; strategy development, including analysis of stakeholder and advocacy audiences; and implementation of action.

Part 3 contains descriptions of a wide range of tools and methods for achieving advocacy goals. It provides examples of their use in various country settings. Part 4 provides the most frequently used arguments related to HIV/AIDS prevention among IDUs and useful resources.

Not all advocacy methods work similarly in every social and political context; these methods should be adapted to the specific social, cultural and political circumstances in which they will be used. Most methods described here could be used, after such an adaptation, at the community, district and national levels, and even in the inter-country context, such as at the regional and global levels. They should be used at these various levels in parallel. Advocacy at the various levels interacts: for example, work at the national level affects the community level and vice versa, and policy changes at the global or regional level are often followed by national revisions in policies and practices.

A multi-level approach requires a combination of methods to be most effective. For example, the best assessment is useless if the results are not properly packaged and made available to the various target audiences. All methods presented here and how best to combine these methods should therefore be considered to achieve each specific advocacy objective.

Many advocacy success stories related to HIV/AIDS prevention among IDUs have not used the systematic approach outlined here. If a group of people is well versed in advocacy on other issues and has access to influential individuals and groups, they will often not need to follow every single step in this guide but will be concerned with maintaining what has already been achieved. Other advocates may be less experienced or operating in societal contexts where advocacy is unusual or where there is little knowledge of, or interest in, issues around HIV/AIDS and injecting drug use. They may find that closely following the steps outlined in this guide can lead to some early success, which can then lead to greater confidence and further advocacy work.

The guide is, therefore, designed for individuals, groups, institutions and organizations throughout the world concerned about HIV/AIDS among IDUs that want to establish and maintain an environment in which HIV/AIDS prevention among IDUs can be implemented effectively. Depending on the local situation, these may include health professionals, lawyers, judges, politicians, public servants, prison officials, drug users and their families, former drug users, journalists and other people in the mass media, national and international nongovernmental and intergovernmental organizations and funding organizations. This guide is for use by any member of these groups or anyone else interested in ensuring that HIV/AIDS among IDUs is successfully addressed.

THE NATURE OF THE HIV/AIDS EPIDEMICS AMONG INJECTING DRUG USERS

HIV/AIDS epidemics among IDUs tend to manifest themselves very differently from epidemics in which sexual transmission is the main risk factor. Although sexually transmitted HIV may remain virtually invisible for several years until the burden of disease slowly increases, sharing of injection equipment is a much more efficient mode of transmission, and drug-related epidemics therefore spread more rapidly. Once the virus is introduced into a community of IDUs, tens of thousands of HIV infections may occur. Infection levels among IDUs may rise from zero to 50–60% within 1–2 years, as demonstrated in cities as different as St Petersburg (Russian Federation), Imphal (Manipur, India) or Ruili (Yunnan Province, China).

The size of the drug-related HIV/AIDS epidemics that result largely depends on the number of people in a given location that regularly or occasionally inject (illicit) drugs and their risk behaviour. The size of the drug-injecting problem in turn usually depends on several factors, including the supplies of injectable drugs, such as heroin, amphetamines and cocaine; drug demand; and the patterns and norms of use among young people, such as whether drugs tend to be injected versus smoked or inhaled. Drug-related HIV/AIDS epidemics have followed the spread of cocaine injecting in Latin America and of heroin injecting in Asia in the 1980s and the massive spread of the injecting of heroin and other opiates in eastern Europe in the 1990s.

Injecting drug use has now been documented in 129 countries, 79 of which also report HIV transmission through contaminated needles, syringes and other injecting equipment. About 13 million people worldwide inject drugs, and about 10% of all new HIV infections globally result from the use of contaminated injecting equipment by IDUs. In many countries in Europe, Asia, the Middle East and the Southern Cone of Latin America, the use of non-sterile injecting equipment by IDUs has remained the most important mode of HIV transmission, accounting for between 30% and 80% of all reported infections (Fig. 1). The potential for HIV to spread from IDUs to their non-injecting sexual partners and the wider population differs from country to country and depends on the sexual behaviour of IDUs, their partners and the community at large and on sexual mixing patterns.

As the number of HIV-infected IDUs grows in many developing and transitional countries, not only programmes for HIV/AIDS prevention and drug dependence treatment but also AIDS care and support services are facing new and increasing challenges. In many countries and regions, the twin epidemics of injecting drug use and HIV infection linked to sharing of injection equipment have already profoundly affected health, and social and economic well-being.

Figure 1. Regions in which needle and syringe sharing is the major mode of HIV transmission



■ IDU is Major Mode of Transmission, 30-90 % of infections

Although injecting drug use is predominantly a city phenomenon, it is increasing in non-urban or semi-urban areas, along drug trafficking routes, in economically depressed communities and among marginalized ethnic minorities. The age at which people begin to inject drugs varies considerably and depends on factors such as social cohesion, norms and drug availability. In the Commonwealth of Independent States, injecting is especially frequent among young people, with initiation starting as early as 12 years of age. Between 65% and 90% of IDUs in developing and transitional countries are men 15–35 years old. However, the proportion of IDUs who are women and girls is reported to be increasing in some countries. Although all IDUs using potentially contaminated injecting equipment are at high risk of HIV infection, specific populations are especially susceptible to infection. These include young IDUs, because of inexperience in obtaining clean injecting equipment; female IDUs, because of sexual risk and injecting practices over which they may have less control and because of exclusion from services; and the increasing number of drug-injecting sex workers, both male and female. Similarly, inmates of prisons and other correctional institutions are at an increased risk of HIV infection because they lack access to preventive services.

All these particularities of HIV/AIDS epidemics among IDUs, including their linkage to illicit drug use patterns, their potentially explosive spread within communities of IDUs, the risk of further spread via sexual intercourse to the wider community and the specific vulnerability and risks of particular groups of IDUs need to be considered when advocating for services and programmes.

COMPREHENSIVE HIV/AIDS PREVENTION AMONG INJECTING DRUG USERS

Explosive epidemics have been occurring among IDUs in many different locations, but evidence shows that HIV/AIDS epidemics among IDUs can be prevented, slowed, stopped and even reversed.¹ In principle, the risk of HIV spread through the sharing of infected injection equipment can be reduced if:

- ▶ fewer people use drugs and especially those that are injected;
- ▶ those continuing to inject drugs do so less frequently and more safely: without sharing injection equipment.

Numerous programme and service options aim to facilitate a continuum of behavioural changes among IDUs. Young people at risk of using drugs are assisted in avoiding drug use in the first place and in initiating drug injecting in particular. Those experimenting with injecting drugs are encouraged to stop, to revert to other means of consumption such as smoking and ingesting or at least to inject less frequently. Those regularly injecting and dependent on drugs are offered drug dependence treatment including, where appropriate, substitution with oral drugs such as methadone. Those not willing to enter or not having access to drug dependence treatment and not in contact with health institutions are offered services through outreach and are provided risk reduction information and clean injection equipment, as well as condoms, and referral to treatment, as available.

Experience has shown that halting the epidemic requires: (i) preventing drug abuse, (ii) facilitating entry into drug treatment and (iii) establishing effective outreach to engage IDUs in HIV/AIDS prevention strategies that protect them and their partners and families from exposure to HIV and encourage the uptake of drug dependence treatment and health care. This three-part strategy is often referred to as the comprehensive package of interventions for HIV/AIDS prevention among IDUs. It may include, as individual service elements, drug abuse prevention, AIDS education, life skills training, condom distribution, voluntary and confidential counselling and HIV testing, access to clean needles and syringes, bleach materials and referral to a variety of treatment options.²

¹ For example, all Australian cities, London (United Kingdom) and Dhaka (Bangladesh) have maintained HIV prevalence among IDUs at less than 5%; the epidemic among IDUs in Nepal appears to have been delayed for several years; and HIV prevalence among IDUs in New York City, Edinburgh and Brazilian cities has fallen.

² Preventing the transmission of HIV among drug abusers: a position paper of the United Nations System. Annex to the Report of the 8th Session of the Administrative Committee on Coordination Subcommittee on Drug Control, 28–29 September 2000. Geneva, United Nations, 2000 (<http://www.unaids.org/publications/documents/specific/injecting/Hraids.doc>).

Unfortunately, certain effective but controversial elements are neglected in many countries. This imbalance must be redressed to reach many people at the highest risk and halt HIV epidemics. Important service elements that tend to be neglected include drug dependence treatment, outreach activities and needle and syringe programmes.

Drug dependence treatment, especially drug substitution treatment such as methadone maintenance, therapeutic communities and outpatient drug-free programmes, assists IDUs in significantly reducing their drug consumption and the frequency of injecting or in ceasing illicit drug use altogether. Voluntary treatment tends to be much more successful than mandatory treatment. Drug dependence treatment facilities in many developing and transitional countries have low capacity and sometimes low quality and lack serious funding support.

Outreach activities motivate and support IDUs who are not in treatment to reduce their risk behaviour, both sharing of injection equipment and sexual transmission. Research indicates that outreach activities taking place outside the conventional health and social care environments can reach out-of-treatment IDUs and increase the rate of drug treatment referrals. In many countries, outreach to IDUs is not part of recognized service packages.

Needle and syringe programmes are usually part of outreach activities and reduce the risk of HIV transmission through the sharing of drug use paraphernalia among those not in treatment. They serve as points of contact between IDUs and service providers, including from drug treatment programmes. The benefits of such programmes are considerable and increase further if they go beyond needle and syringe distribution to include AIDS education, counselling and referral to a variety of treatment options. Nevertheless, resistance to needle and syringe programmes remains considerable. They are sometimes believed to incite non-injectors to use drugs even though there is no evidence that such programmes increase the rate of injecting drug use or other public health dangers in the communities where they are implemented.

Further, HIV/AIDS prevention usually needs to be strengthened within the criminal justice system. HIV/AIDS prevention in penal institutions may include two distinct strategies, both of which tend to be lacking, even in severely affected countries.

Firstly, where there is increased risks of HIV transmission in penal institutions, the number of drug-dependent IDUs incarcerated should be reduced if possible. There may, for instance, be scope to replace mandatory prison sentences for those possessing small amounts of drugs by alternatives, including community service, and offers of drug dependence treatment.

Secondly, HIV prevention and drug treatment programmes within penal institutions are important components of a comprehensive response to prevent the transmission of HIV, as injecting and dependence tend to continue in detention.

Both strategies are too rarely implemented. Programmes to prevent HIV/AIDS in prisons are often hampered by governments denying the existence of injecting drug use and sexual intercourse in institutions of criminal justice. In reality, drug use in general and injecting drug use in particular (as well as sexual intercourse between men) are frequent in such institutions in many, if not most, countries. Available data indicate that the rates of HIV infection among inmates are significantly higher than in the general population in some countries, reflecting at least in part continued exposure to HIV among inmates.

In addition, the trafficking, injecting (and consumption in general) of substances such as heroin, other opiates, cocaine and amphetamines are illegal in most countries worldwide. HIV/AIDS prevention and drug control policies often need to be harmonized further, for example, to avoid that punishment renders IDUs more vulnerable to HIV. A balance must be struck between public health and public order.

Another programme area that is often neglected is the lack of appropriate HIV prevention services for young IDUs. Most services concentrate on adults or those who have already injected for some time and are addicted and perhaps already infected. Especially in some regions, such as eastern Europe, many young people experiment with drugs, using drugs on weekends, irregularly and recreationally – making standard interventions that only target marginalized addicted drug users, the stereotypical “junkie in the street”, inappropriate. Similarly, female IDUs are frequently underserved.

In conclusion, drawing on policies expressed in the United Nations drug control conventions and the Declaration on the Guiding Principles of Drug Demand Reduction, United Nations human rights documents and United Nations documents on health promotion policy, the following principles and strategic approaches should be used for addressing HIV/AIDS among IDUs.

- ▶ Protecting human rights is critical to success in preventing HIV/AIDS. People are more vulnerable to infection when their economic, health, social or cultural rights are not respected. Responding effectively to the epidemic is difficult if civil rights are not respected.
- ▶ HIV prevention should start as early as possible. Once HIV has been introduced into a local community of IDUs, it may spread extremely rapidly.
- ▶ Interventions should be based on regular assessment of the nature and magnitude of drug use as well as trends and patterns of HIV infection.
- ▶ Comprehensive coverage of the entire population is essential. As many individuals in the at-risk populations as possible must be reached for prevention measures to be effective in changing the course of the epidemic in a country.

- ▶ The reduction of drug demand and HIV prevention programmes should be integrated into broader social welfare and health promotion policies and preventive education programmes. A supportive environment in which healthy lifestyles are attractive and achievable, including poverty reduction and opportunities for education and employment, should sustain specific interventions for reducing demand for drugs and preventing HIV transmission.
- ▶ Drug problems cannot be solved by criminal justice initiatives alone. A punitive approach may drive the people who most need prevention and care services underground.
- ▶ Treatment services need to be readily available and flexible. Treatment systems need to offer a range of treatment alternatives, including substitution treatment, to respond to the different needs of groups of IDUs.
- ▶ Developing effective responses to the problem of HIV among IDUs is facilitated by assuring the active participation of the target group in all phases of developing and implementing the programme.
- ▶ Drug treatment programmes should provide assessment for HIV/AIDS and other infectious diseases and counselling to help IDUs change behaviour that places them or others at risk of infection.
- ▶ HIV/AIDS prevention programmes should also focus on sexual risk behaviour among people who inject drugs or use other substances.
- ▶ Outreach work and peer education outside normal service settings, and normal working hours are needed to extend services to groups that are not effectively reached by existing traditional health services. Specific services may be needed for young IDUs, women and sex workers. Adequate resources are required to respond to the increase in client load that is likely to result from outreach work.
- ▶ Care and support, involving community participation, must be provided to IDUs living with HIV/AIDS and to their families, including access to affordable clinical and home-based care, effective HIV prevention interventions, essential legal and social services, psychosocial support and counselling services.

THE RESPONSE TO DATE

Despite the support from international agencies and signatures on international agreements, effective programmes related to HIV/AIDS and injecting drug use comprising at least some of the key interventions mentioned here have been implemented in only about 55 countries worldwide. Even in countries that have implemented one or more effective programmes, such activities are often provided at a very small scale or on a pilot basis and not as part of a national policy.

The introduction and maintenance of such effective programmes has been vigorously opposed in many countries. This opposition has taken many forms, including:

- concern, unsupported by any evidence, that some HIV/AIDS prevention activities, especially needle and syringe programmes, increase illicit drug use;
- concern that methadone maintenance and other programmes are not appropriate forms of drug treatment because ending illicit drug use is not their immediate goal;
- criticism that some measures are too liberal and should be replaced by punishment of drug users;
- mass-media descriptions contrasting “generous” programmes for allegedly incorrigible drug users with “innocent” patients who are not drug users and are unable to obtain proper health care;
- opposition from city administration and neighbourhood groups to the establishment of sites for programmes on the grounds that these services attract IDUs, diminishing the attractiveness of the neighbourhood;
- perception by some health care personnel that health care treatment for IDUs wastes scarce resources on “worthless” drug users or replaces one addiction with another;
- concern that emphasizing HIV/AIDS prevention programmes for IDUs compromises primary prevention within drug and abstinence-oriented drug treatment programmes;
- concern that HIV/AIDS prevention among IDUs could divert resources otherwise available for preventing the sexual transmission of HIV among the general population; and
- criticism, often based on limited or no knowledge of prevention programmes, that such programmes are in contradiction to the culture of a country or the tenets of a prevailing religion.

The reasons for this opposition vary according to the culture of each country, but some common themes include:

- ▶ lack of or late recognition by officials and politicians that injecting drug use exists in a country or is of serious concern, often coupled with lack of experience in dealing with drug issues and related problems such as substance dependence (especially in transitional and some developing countries, where such problems may have been rare previously);
- ▶ lack of knowledge among decision-makers regarding how quickly HIV infection can spread among and from IDUs and the evidence for the effectiveness and cost-effectiveness of prevention approaches outlined here;
- ▶ traditional reliance in many countries on law enforcement mechanisms and an abstinence-only approach to “solving” drug issues (including HIV transmission related to drug use);
- ▶ lack of experience or training in drug and HIV/AIDS prevention approaches among health professionals and the staff of nongovernmental organizations (NGOs);
- ▶ lack of community awareness of the effectiveness of these approaches and the benefits of controlling and reducing HIV epidemics among IDUs; and
- ▶ lack of experience or training in advocacy and lobbying among health professionals, staff of NGOs, policy-makers and others to start, manage or promote HIV/AIDS prevention among IDUs.

This guide provides various methods to overcome these and other obstacles.

1. ADVOCACY: OVERVIEW AND PRINCIPLES

1.1 WHAT IS ADVOCACY?

Advocacy has several different definitions, all of which state that advocacy aims at influencing decision-making with the goals of developing, establishing or changing policies and of establishing and sustaining programmes and services. For the purposes of this guide, advocacy is defined as in Box 1.

Box 1. Definition of advocacy

Advocacy for HIV/AIDS prevention among IDUs is the combined effort of a group of individuals or organizations to persuade influential individuals and groups and organizations through various activities to adopt an effective approach to HIV/AIDS among IDUs as quickly as possible. Advocacy also aims at starting, maintaining or increasing specific activities to a scale where they will effectively prevent HIV transmission among IDUs and assist in the treatment, care and support of IDUs living with HIV/AIDS.

Policy is another critical term. Policy can be defined as how societies and their institutions deal with any issue. Policies may be written (such as laws) or unwritten (for example, etiquette or social mores). Policy can be formal (a national AIDS strategy) or informal (the fact that some workplaces do not want to employ people living with HIV/AIDS). Informal policies are often referred to as (policy) practices. Public policy tends to be formal and written and includes statements, policy papers or prevailing norms and practices established by those in authority to guide or control institutional, community and sometimes individual behaviour.

Advocacy has no exact equivalent in some languages. Translators and interpreters in each language need to decide which word (or words) most closely approximates advocacy in English.

1.2 PRINCIPLES

The principles of advocacy work on HIV/AIDS among IDUs are as follows.

ADVOCACY ACTIVITIES SHOULD AVOID INCREASING HARM

When change is sought to an existing system, those advocating change may not be able to control all of the results. Advocates for HIV/AIDS prevention among IDUs must therefore avoid increasing harm to IDUs. For example, local police may allow a specific activity such as outreach on the condition that police are able to observe and, if they like, arrest clients of the programme, or the programme has to provide a list of IDUs in that locality with their names and addresses. Such a system would

not only destroy the programme's credibility with drug users but would increase harm to the clients of the programme because drug users' exposure to HIV may increase through arrest and incarceration. Measures would therefore have to be taken to reach an agreement with the police to avoid such an outcome.

Another common problem is harm caused to an individual advocate. For example, to gain mass-media focus on issues related to HIV/AIDS and drug use, an individual IDU could be enticed to speak publicly on television, including stating that he or she is an IDU. This could lead to serious consequences, including prosecution, which the advocacy organizers should foresee and prevent. A drug user should clearly consent to being presented in this way and understand all possible consequences of the decision before appearing in public.

ADVOCACY ACTIVITIES SHOULD AIM TO PROTECT THE RIGHTS OF IDUS AND PEOPLE LIVING WITH HIV/AIDS

IDUs are often denied basic human and legal rights. Advocates should carefully examine and research these issues and collect evidence to make an appropriate case. Human rights issues can often be an important entry point to discussing specific issues such as access to care and treatment, information and resources.

ADVOCACY ACTIVITIES SHOULD BALANCE SHORT-TERM PRAGMATIC GOALS WITH LONG-TERM DEVELOPMENTAL GOALS

This point is central to many of the arguments that advocates make about HIV/AIDS prevention among IDUs. Many people in every society want a complete and lasting solution to the use of illicit drugs, usually meaning that no young people will begin to use illicit drugs and all current drug users will stop using. Achieving this goal would take many years or even decades, and some people believe it will never be achieved. Achieving this may also require the massive reduction of many other social problems such as unemployment, poverty and sexual, social, gender and racial discrimination.

However, protecting IDUs from HIV transmission requires putting programmes and policies in place in the short term. It is therefore necessary to accept that there are IDUs in a society who will not immediately stop injecting and that some young people will probably start injecting each year. The emphasis of advocacy efforts must therefore be on short-term pragmatic goals, such as keeping current IDUs uninfected and alive, without losing sight of the longer-term goals such as demand reduction or a drugs free society.

THE OBJECTIVES OF ADVOCACY MUST RELATE TO APPROACHES AND ACTIVITIES SHOWN BY RESEARCH TO BE EFFECTIVE IN ADDRESSING HIV/AIDS AMONG IDUS

It may seem obvious, but all advocacy activities must work towards implementing programmes that research has shown to be effective. There have been widespread advocacy campaigns in some countries for approaches that have not been shown to be effective in preventing HIV transmission among IDUs. Advocates need to be

aware of the research basis of approaches and to keep up to date with new research and new ideas related to preventing HIV/AIDS, as outlined in the introduction.

ADVOCACY ACTIVITIES SHOULD CONCENTRATE ON BOTH HIV/AIDS PREVENTION AMONG IDUS AND ON TREATMENT, CARE AND SUPPORT

Prevention and care approaches to HIV/AIDS are mutually reinforcing in several ways. Comprehensive, high-quality care services, which imply the availability of medicines, create a receptive audience for prevention messages, and effective prevention ultimately reduces the demand for care services. Such a comprehensive approach helps to build trust and reduces the stigmatization of IDUs. IDUs should have the same access to HIV/AIDS care as all other people living with HIV/AIDS.

SPECIFIC AND TARGETED ADVOCACY ACTIVITIES SHOULD FIT THE SOCIAL, CULTURAL, POLITICAL AND LEGAL CONTEXT OF THE SOCIETY

In many ways, the advocacy approach used and the key targets of the approach depend on the overall societal context. Activities that are highly successful in one country may be difficult to implement and even counterproductive in another. Countries differ substantially in history and current levels of participation by citizens, trust of institutions (such as law enforcement, criminal justice and narcotics control), health services and access to information by citizens. In addition, many countries are in transition, not just economically but also from one political philosophy to another. Strict social norms may govern the appropriate behaviour of men and women, and this may affect advocacy activities.

Throughout this guide, advice is based on the experience from a wide range of countries from many traditions and political systems at many different stages of development or transition. Advocates should know the history, society, and cultural and political systems in the country in which they are working and adapt their activities to suit that context.

ADVOCACY ACTIVITIES SHOULD TARGET DIFFERENT SECTORS OF SOCIETY AND KEY INDIVIDUALS, USING MULTIPLE ADVOCACY TECHNIQUES AT THE SAME TIME IF POSSIBLE

Successful advocates use multiple complementary strategies to achieve their goals. Many influential individuals and groups need to be targeted at the same time to achieve widespread implementation of and a supportive environment for HIV/AIDS prevention among IDUs.

Advocacy should also be seen as a process involving activities at various levels from the local neighbourhood or village, to the district, city or prefecture, the state or province, the country, the subregion, the region and the world. Although some specific advocacy activities and methods may be emphasized at a specific level – for example, the exchange of experience between provinces – a wide range is usually needed at any given level for sustainable, successful advocacy.

ADVOCACY SHOULD AIM AT QUICKLY ESTABLISHING SUPPORTIVE POLICIES AND LARGE ENOUGH PROGRAMMES WITHIN THE SOCIAL, POLITICAL AND FUNDING CONTEXT OF THE COUNTRY

Because HIV can spread rapidly among IDUs, time is a critical factor in advocacy efforts and in starting programmes that effectively address HIV/AIDS among IDUs. Service reach or coverage is also important, as effective approaches only prevent or stabilize and reduce an epidemic when they are carried out at a large enough scale. The exact scale depends on many local factors such as the specific numbers and the injecting and sexual risk behaviour of IDUs. This means, for example, that pilot programmes should be seen as a means to an end. The pilot should show the effectiveness of an activity in the specific context, and the results of the pilot should be provided to target groups, leading to policy change and introduction of the activity at an effective scale.

ADVOCACY SHOULD BOTH LEAD TO ESTABLISHING NEW POLICIES AND PROGRAMMES AND REACT TO HOW INSTITUTIONS, THE MASS MEDIA AND OTHERS DEAL WITH HIV/AIDS AMONG IDUS

The advocacy process should be considered not only in terms of working towards the goals set by the advocacy group but also in reaction to unfolding events. At each level where advocacy is carried out, events may occur that lead to new opportunities for advocacy. For example, a politician may find out that his son or daughter is using drugs or a newspaper survey may find that many citizens are concerned about increasing drug use among young people. Advocates need to monitor current events to look for these opportunities and have the resources available to take advantage of opportunities.

Opposition to HIV/AIDS prevention among IDUs is often expressed. Advocates need to be ready with evidence and appropriate channels of communication to ensure that opposition is quickly responded to and should respond in a strategic manner.

ADVOCACY ACTIVITIES SHOULD INVOLVE, TO THE EXTENT POSSIBLE, IDUS AND PEOPLE LIVING WITH HIV/AIDS IN PLANNING, IMPLEMENTING AND EVALUATING PROGRAMMES

In a context where IDUs and people living with HIV/AIDS may be able to be involved in discussions with authorities without increased personal risk, they must play a leading role in designing, implementing and evaluating advocacy activities and programmes. This involvement increases the speed with which programmes can assist IDUs and people living with HIV/AIDS and leads to higher programme quality.

In accordance with the first principle of avoiding increasing harm, however, IDUs and people living with HIV/AIDS should not be involved if this will most likely lead to identification, arrest or compulsory treatment or violence. If conditions

for IDUs and people living with HIV/AIDS make attending meetings and working on advocacy or programme planning dangerous for them, outreach workers should seek their views through other lower-profile methods.

ADVOCACY ACTIVITIES SHOULD CONSIDER DIFFERENCES BETWEEN GROUPS OF IDUS ACCORDING TO GENDER AND ETHNIC BACKGROUND AND TO VULNERABILITY TO HIV/AIDS AND PROMOTE EQUITY IN TREATMENT, CARE AND SUPPORT

In many countries, gender and ethnic differences among IDUs are not well understood and assumptions are made that most or all IDUs are male and that there is little difference between IDUs. Drug use, especially drug injecting, by women and girls may be more hidden than male drug use because of cultural factors and a lack of female-specific services that might attract female drug users. Also, depending on cultural rules, the significance of injecting drug use may differ in different ethnic groups. Advocacy activities should seek to expand the knowledge base of drug use by male and female IDUs and ensure that both advocacy and the implementation of services take into account gender and ethnic differences.

1.3 ADVOCACY STEPS

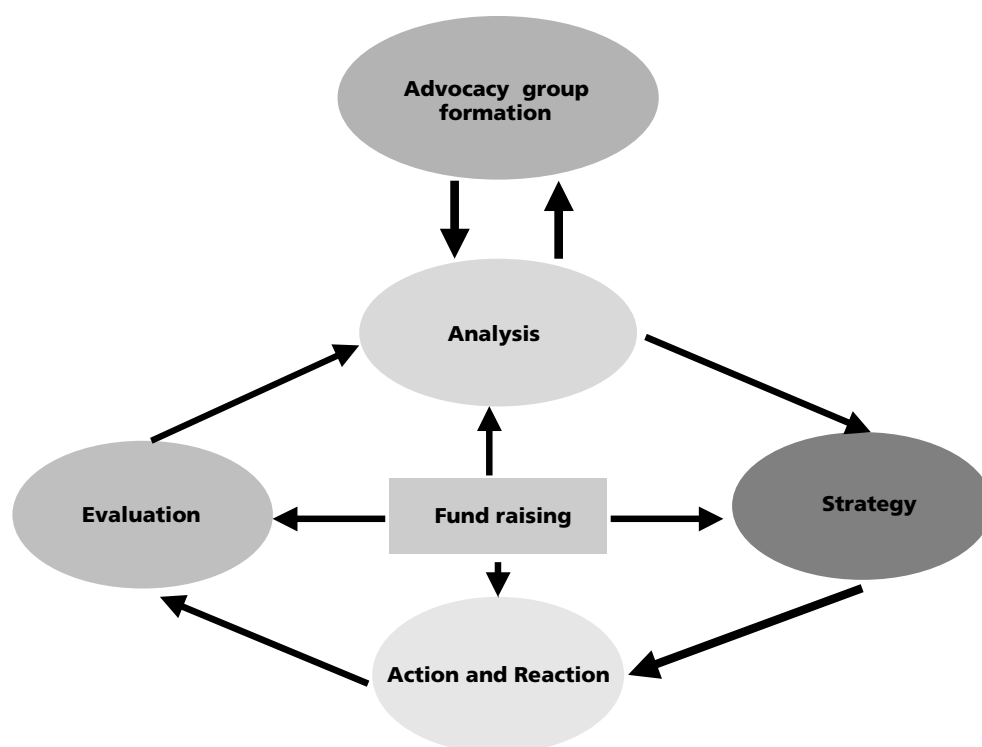
Advocacy usually starts when a group of concerned people perceives an issue as being so problematic that they decide that it should be put on the public agenda with the aim of addressing the problem. Advocacy includes developing possible proposals to solve the problem and building support for acting on the solution. This process consists of a set of steps, carried out for different aspects of an issue at many levels of society simultaneously in varying order. These steps may include starting up, analysis, strategy, action and reaction and evaluation.

- **Starting up.** A formal or informal advocacy group or coalition is formed. Specific funding for advocacy, which is usually needed, should be sought at this stage or at any of the next three steps.
- **Analysis.** The group analyses the identified problem more systematically, including key stakeholders, existing norms and policies, the implementation or non-implementation of these policies, the organizations involved in putting those policies into practice and the channels of access to influential people and decision-makers. The more familiar with the situation the advocates become, the more persuasive the future advocacy can be.
- **Strategy.** Every advocacy effort needs a strategy; in this step, potential solutions to a problem are formulated and the process of arriving at these solutions is envisaged. The strategy phase builds on the analysis to direct, plan and focus on specific goals and to position the advocacy effort with a clear path to achieve these goals and objectives.

- › **Action and reaction.** An advocacy action plan is formulated, and support is built for changes to policies and practices. Implementation of the campaign may arouse various reactions by decision-makers and influential groups. Reacting to critics of the advocacy goals helps to keep attention and concern on the issue.
- › **Evaluation.** Since advocacy often provides partial results, a team needs to review regularly what has been accomplished and what more remains to be done. Process evaluation, such as assessing whether progress has been made in identifying advocacy allies, may be more important (and more difficult) than evaluating the impact on actual decisions. Evaluation should be used as the first step in reanalysis, leading to an ongoing cycle of advocacy work and evaluation.

The advocacy process is shown in Fig. 2.

Figure 2. The advocacy process



Advocacy is therefore a dynamic process involving changing actors, ideas, agendas and policies. The stages of the advocacy process must be viewed as fluid because they may occur simultaneously or progressively or the process may stall or reverse itself. Three case vignettes (Boxes 2–4) illustrate that successful advocacy needs to reach the many individuals and groups in a society who can influence HIV/AIDS and drug policies and should carefully monitor political shifts to quickly and effectively address groups with growing influence.

Box 2. The advocacy process: Jakarta and Bali in Indonesia

In Indonesia, evidence began to emerge in the late 1990s that injecting drug use was increasing rapidly and that HIV was spreading among IDUs. Activities by the Government of Indonesia and NGOs appeared to have little chance of preventing a massive epidemic of HIV among IDUs, because neither was familiar with HIV/AIDS prevention among IDUs. Further, those working on HIV/AIDS expressed their concern that the Indonesian community and government officials would oppose some specific approaches such as needle and syringe programmes or substitution treatment, because of legal reasons and lack of awareness of the effectiveness of such methods.

In 1999, a coalition of NGOs and donors decided to form an advocacy group to lobby for acceptance of these approaches in Indonesia. In early 2000, the group supported a training course on rapid assessment and response methods, which led to assessments of injecting drug use and of the dissemination of HIV infection in eight cities. The assessments were used to provide information for further advocacy work as well as data to help in planning interventions.

Initial results from these rapid assessments were presented to key government officials and NGOs in each province assessed. Final results were presented at provincial and national seminars, leading to increased interest in issues related to HIV/AIDS among IDUs.

Specific advocacy groups were formed in Jakarta (national) and Denpasar (for Bali Province), and these teams identified potential allies and opponents of advocacy with regard to new approaches and developed objectives for their work. The core teams used the rapid assessment results to persuade influential individuals and groups that HIV/AIDS among IDUs was a serious and growing problem in their area and in Indonesia as a whole and to encourage the implementation of preventive activities. Other studies backed these results by showing worrying trends in HIV transmission among IDUs and prisoners, which received wide mass-media coverage. Workshops were organized to concentrate political and community attention on the issue. Key politicians were contacted many times to build support for changes in government policy and the introduction or expansion of pilot outreach, methadone and needle and syringe programmes.

In 2001, a study tour to Sydney, Australia was organized for senior government and NGO officials to visit a wide range of programmes related to drugs and HIV/AIDS and to consult with senior police, politicians, a High Court judge and representatives of the Department of Health in that country. During this study tour, the participants decided to form a Harm Reduction Steering Committee for Indonesia (mostly comprising government representatives) and the Indonesian Harm Reduction Network (chaired by an NGO in Bali).

By mid-2002, several further advocacy activities for HIV/AIDS prevention were underway in Indonesia.

- ▶ The Harm Reduction Steering Committee members met regularly and assisted in building relationships between health sector staff and police and other important community members.
- ▶ The Indonesian Harm Reduction Network received funding to begin capacity-building and networking activities.

- ▶ Six programmes (in four cities) were started to provide, through outreach, HIV/AIDS prevention, education and information materials to IDUs.
- ▶ Pilot programmes for needle and syringe provision were prepared for three sites in Jakarta and for both Denpasar and the rest of the island in Bali. The Indonesian government agreed to consider such programmes an integral part of its national HIV and drugs policy, subject to the successful evaluation of the pilot programmes.
- ▶ Two pilot methadone programmes, also approved by national and provincial governments, were planned.
- ▶ A larger advocacy campaign for HIV/AIDS prevention among IDUs began through national meetings aimed at specific target audiences such as police, criminal justice staff (including judges, lawyers and prison officials), religious leaders and the mass media.

At the end of this process, several prevention programmes using new approaches had been initiated, although a degree of scepticism remained among staff of certain sectors of the government.

Sources: Ruddick A et al. Advocacy for harm reduction and 100% condom use in Indonesia. *6th International Conference on AIDS in Asia and the Pacific, 6–11 October 2001, Melbourne, Australia*; and personal communication, Ruth Birgin, Advocacy Programme Co-ordinator, Centre for Harm Reduction, Jakarta, Indonesia.

Box 3. The advocacy process: countries in central and eastern Europe and the Commonwealth of Independent States

When HIV started spreading rapidly among IDUs in an ever-increasing number of cities in Belarus, Kazakhstan, the Russian Federation, Ukraine and other countries in the eastern part of the European Region during the mid-1990s, governments were ill prepared to face this new threat. The number of young people injecting illicit drugs, especially opiates and amphetamines, had been rising rapidly, and HIV infection had entered many communities of IDUs. Drug dependence treatment services were limited in capacity and not designed to care for the large number of opiate users. Partly because of their experiences under communism, IDUs mistrusted authorities, including government health institutions, and most therefore even kept away from health services. In this situation, International Harm Reduction Development Programme (IHRD), was one of the first international agencies to offer support. Funds were offered to local authorities and health services, both government and NGOs, on a competitive basis, to establish outreach, information and needle and syringe exchange services. Many cities accepted these offers and submitted proposals, even though there often was no national guidance as to whether such new approaches should or should not be embraced. Several local authorities issued statements opening the way or explicitly supporting this new type of service for IDUs. At the same time, the police continued to harass many IDUs, even those attending the newly created “trust points” or needle and syringe and information outlets for health reasons.

Later during the 1990s, the number of methadone pilot projects IHRD funded also increased throughout this region. A group of IHRD technical consultants was also involved in training courses, and there were exchange visits for staff of drug dependence treatment centres interested in starting in such projects.

In 2001, concerned that national governments in the region were not sufficiently scaling up the more than 150 small IHRD programmes, IHRD established a regional Policy Initiative. The Policy Initiative promotes the harm reduction philosophy, public health values and respect for human rights and advocates for policy shifts towards less repressive and more supportive approaches towards HIV/AIDS prevention among IDUs throughout the region. It is an integral part of IHRD's overall three-part strategy of direct support for services; training and capacity-building; and public policy and advocacy. Policy Initiative activities are closely linked with all three components.

The Policy Initiative builds on the efforts of those engaged in harm reduction and HIV prevention among IDUs and makes new and strong alliances with human rights activists and civil society. Through these efforts, IHRD hopes to bring harm reduction into the mainstream of drug policies so that it is no longer seen as controversial and marginal.

There are now some good examples of government support for effective harm reduction in this region, at least partly resulting from the advocacy efforts of IHRD as well as assistance provided by the United Nations, bilateral donors and other NGOs, including Médecins Sans Frontières–Holland, the AIDS Foundation East-West and Médecins du Monde (Doctors of the World). In Poland, the national government pays for outreach workers at most needle and syringe programmes throughout the country. In Bulgaria, the Bulgarian national AIDS programme recently included harm reduction principles. In Ukraine, the national AIDS policy states that all IDUs should have access to clean needles and syringes, and several provinces and oblasts are investing in outreach to IDUs and information and needle and syringe exchange themselves. In Estonia, Kyrgyzstan, Latvia, Lithuania and Poland, methadone has been registered, and in most other countries in this region (except for the Russian Federation), the process of introducing substitution treatment and registering the medicine (either methadone or buprenorphine) is underway.

Current IHRD Policy Initiative activities include supporting the establishment of self-help groups for drug users and people living with HIV/AIDS; supporting the participation of influential individuals in international events dedicated to drug policy; study tours for police and criminal justice officials; police training; support for harm reduction networks; advocating for methadone substitution; research on legal and other impediments to harm reduction; publishing and distributing harm reduction materials; and active cooperation and partnering with other Open Society Institute programmes and national foundations, United Nations agencies, governments, NGOs and others.

Source: IHRD Policy Initiative Presentation to OSI Public Health Sub-Board, November 2001, unpublished.

Box 4. The advocacy process: failure of advocacy

Advocacy processes are not always successful. As no country wishes to be distinguished by its lack of action to prevent a HIV/AIDS epidemic, this case study will refer to Country X.

In Country X, the fact that HIV was spreading rapidly among IDUs became evident. Nongovernmental organizations persuaded the Health Ministry to allow them to provide funding for training on HIV/AIDS prevention and to set up pilot programmes. For more than a year, health professionals were trained and, after discussions with local officials, many pilot programmes were established. The Health Ministry approved the prevention projects and made them part of its AIDS strategy.

Four years passed and the epidemic among IDUs continued to grow. Few government resources were provided for prevention activities, and public statements of support by the Health Ministry became fewer. Increasingly, public statements by the Ministry of Police became more critical towards HIV/AIDS prevention among IDUs, saying that IDUs disturb public order and engage in illicit activities. A powerful religious organization then added its voice to the criticism: and the mass media, which had been generally supportive, increasingly reported only criticism. All of the previous training and pilot programme work was threatened with collapse, despite clear evidence that the programmes would have had an impact on the epidemic if only the government had provided funds to implement them at a large enough scale. However, the government chose to spend its AIDS budgets on other matters, including general HIV/AIDS awareness-raising and surveillance, neglecting practical HIV/AIDS prevention work among IDUs. The most senior levels of government rarely mentioned HIV/AIDS related to drug use and only spoke of drugs as a scourge that must be cleansed from the country. At the end, approvals for the pilot projects were not renewed, and many closed down.

What went wrong in Country X? Five factors appear to have been most important. First, no broad coalition was built to advocate for HIV/AIDS prevention and no systematic campaign was undertaken. Although the NGOs recognized early in their work that advocacy would be needed, the tasks of training and starting pilot programmes were so overwhelming that little time was left for advocacy. Potential coalition partners were unconvinced that HIV/AIDS prevention among IDUs could be successfully implemented in Country X, due to its history of opposing such ideas. Only after several years of evidence of their effectiveness did the coalition partners become interested in expanding these activities. By this time, the backlash had begun and potential partners feared that their involvement in effective activities could threaten their other HIV/AIDS programmes and activities.

Second, there was little history of organizations working together on issues that crossed provincial borders, boundaries between scientific disciplines – for example, substance dependence and HIV epidemiology – and sectors of the government, such as law enforcement, health, criminal justice and social welfare. Organizations that could have become partners often had no access to computers, the Internet or fax machines, and there were few existing networks that could be used to foster cooperation.

Third, the police were rarely involved in the training and initial advocacy process, except at the local level, where pilot programmes were established. The importance of police collaboration to the long-term sustainability of programmes related to illicit behaviour such

as drug use was understood, but resources to train and educate them were not available. Health professionals and the Health Ministry are of lower political importance in Country X than the Ministry of Police. The police, therefore, should have been included in education and advocacy efforts from the beginning, as they could shut down programmes started by health officials or NGOs at any time.

Fourth, the religious organization mentioned above was not involved in discussions about HIV/AIDS among IDUs. An assessment early in the training project found that the religious organization had little power or influence in the country. However, during the five years described here, the organization grew much stronger, especially through its links to the main political parties. When the religious organization decided to express criticism of the advocated approaches to HIV/AIDS prevention among IDUs, it had many channels by which it could ensure that its messages reached the highest political levels. Because of a mistake in the initial assessment and a lack of monitoring and regular reassessment, the religious organization was not approached until after it had widely published its concern. Publication of the criticism now became an entrenched position for the organization and, despite some advocacy attempts at this late stage, the organization was unwilling to change its position.

Finally, and related to the other factors, there was a failure to reach those at the highest levels of government. The experience of many countries has shown that political will by the head of state can have an enormous impact on a country's response to a HIV/AIDS epidemic. Without a clear statement from the highest levels, law enforcement officials and the religious organization believed that they were allowed or even supposed to oppose and criticize those providing outreach services to IDUs. After this negative press coverage, the head of state was even less likely to publicly approve or widely implement appropriate activities. Again, the need to gain support from the highest level of government was understood, but no effective method was ever found of reaching these people.

2. STARTING UP

To illustrate these various steps and show them in real life, the example of the fictitious City Z has been developed.

City Z is a residential district of 100 000 people with many IDUs. The district is poor, and IDUs have few formal employment opportunities except for occasional casual work. The district has one hospital, a community health centre and several NGOs working on HIV/AIDS and drugs, including one promoting general community awareness of HIV/AIDS to all district residents and one providing drug treatment in a therapeutic community. In addition, the district has 80 police staff, local politicians, informal community leaders and some small businesses. Drug injecting is new to the district; most residents can remember a time about a decade ago when hardly anyone injected drugs. Now, drug trafficking seem to be a main source of income for some people, and there are IDUs in many families. Residents of the district are angry that these drug users congregate at various places such as an abandoned warehouse, under a bridge and at some of their homes. Politicians and residents encourage the police to get rid of the drug problem in the district, and the police have responded by arresting alleged drug traffickers and users wherever possible or encouraging them to leave the district, but they have not yet been able to catch the main dealers. Health professionals at the hospital and community health centre and workers of the NGO believe that drug addiction is a problem but have found no reason why HIV/AIDS among IDUs should be considered very important. Like other members of the community, they want drug users to simply stop using drugs or move away.

2.1 ADVOCACY GROUP

Advocacy efforts usually start when people become concerned about the threat HIV/AIDS poses to IDUs, their families and their communities. That could be at the beginning of a potential epidemic or at a stage when the epidemic is already well established. Most often, such people are working in the fields of HIV/AIDS or drug use and already have some access to information on injecting drug use and HIV/AIDS. For example, staff of hospitals or health care centres may observe a growth in the number of people with symptoms related to HIV/AIDS or infections related to needle-sharing such as hepatitis C. Outreach workers may notice a change in drug consumption behaviour from inhaling or smoking a drug to injecting. Parents or friends of drug-dependent young people may have heard about a new type of infection affecting drug users. In many cases, government officials or staff of international organizations come across some epidemiological data, such as sentinel surveillance reports, and think that something needs to be done.

Usually such concerned people begin advocacy work by raising the issues, pointing out the dangers of an HIV/AIDS epidemic among IDUs, searching for more information and suggesting some new interventions. However, such informal advocacy does not go very far, because it does not implement a systematic campaign and reach the audiences that can change policies and develop appropriate programmes.

The first step towards more formal and systematic advocacy is usually to establish an advocacy group. This can be a group of only two or three people or it may include 10 or more. Interaction is generally easier if the group remains fairly small. The purpose of this group is usually to plan and oversee advocacy tasks, carry out analysis and specific advocacy activities and act as spokespeople for the mass media in case they and others want to contact the group.

The role and activities of the advocacy group depend on the level – community, provincial or national – at which the group is operating and the emphasis they place on advocacy. In the example in Indonesia (Box 2), nongovernmental and funding organizations involved in HIV/AIDS programmes formed an advocacy group. This group broadly aimed to advocate for greater emphasis on injecting drug use in HIV/AIDS programmes and to sensitize policy-makers about effective HIV/AIDS prevention among IDUs and about what has worked in other countries. This type of national-level group often has many tasks, of which advocacy for HIV/AIDS prevention among IDUs is just one. They also address issues related to sex work, men who have sex with men and more general issues related to developing national strategy. By contrast, the groups at the provincial levels (in Jakarta and Denpasar) were formed specifically to work on advocacy for HIV/AIDS prevention among IDUs. These groups had narrower objectives related to the situation in each province and sought to persuade relevant officials to implement effective programmes and to ensure that all sectors of government, together with NGOs, collaborated to facilitate this implementation.

Similarly, where advocacy groups establish themselves at the local level, they usually aim to gain support for very specific activities to be carried out by local organizations. The aims here are narrower still, such as trying to gain political and community support to allow a project or programme to open and ensuring that outreach workers who provide IDUs with HIV/AIDS information materials and clean injecting equipment are not arrested by police.

Advocacy is often required at several levels simultaneously. Advocating for a local programme is difficult when the national government has passed a law prohibiting specific activities. Working towards a national change in laws or policies is also of little immediate use if this will not be reflected in increased programming at the local level. Advocacy at one level influences advocacy at other levels, and the cooperation of different people at different levels increases the leverage to implement or maintain effective policies and programmes.

The best way to ensure an effective advocacy group depends on the social, cultural and political context in the country, the specific activities the group plans to undertake and at what level the group plans to work. The group should start small and grow larger by seeking people with the specific skills needed for advocacy tasks. These skills are normally identified during the analysis phase.

Generalizing about the qualities to be sought in members of the advocacy group is difficult. However, at least some members should:

- ▶ be able to understand and interpret scientific literature;
- ▶ be and be considered leaders;
- ▶ have experience with drug use and HIV/AIDS;
- ▶ understand how policies develop within the cultural, social and political context within which the group is working;
- ▶ be aware of and understand cultural norms that relate to gender, ethnicity and sexual orientation of IDUs and people living with HIV/AIDS and how attitudes and cultural sensitivities may affect programmes and activities;
- ▶ be able to raise and account for funds, if needed; and
- ▶ be available and “appropriate” to address the public, including through mass media.

Leadership is an important issue to consider. Some advocates may be people who are only interested in HIV/AIDS and injecting drug use and in helping IDUs – such as parents of IDUs or their partners – but lack formal qualifications such as academic degrees or positions of authority. Such a group may have difficulty in gaining access to the mass media, politicians, policy-makers and others and in being accepted by target audiences.

At least one member of the advocacy coordination group should be a community leader of some type. This person might be a professor of public health, epidemiology, psychiatry or some related discipline; a political leader or someone well known in political circles; a retired policy-maker; a prominent businessperson; the son or daughter of prominent people; or a celebrity whose opinions are valued in the community, city, region or country (Box 5).

Box 5. Membership in a national advocacy group

In one Asian country, an NGO was able to establish a drop-in centre for IDUs despite political resistance because a member of the organization was the daughter of a health minister and granddaughter of a chief minister. Through her links with politicians, the daughter of the president also became an advocate for HIV/AIDS prevention among IDUs.

Likely members of an initial advocacy group at the local or national levels could include:

- ▶ physicians, other health workers and lawyers;
- ▶ parents and partners of IDUs;
- ▶ IDUs, including those living with HIV/AIDS and former IDUs;
- ▶ drug treatment centre staff, outreach workers, social workers and other staff of organizations working with disadvantaged groups; and

- ▮ representatives of other civil society organizations, academics and/or the mass media.

In addition, representatives may be sought, if feasible, from police, narcotics control, public security, the business sector, religious groups, women's groups and international organizations. Potential members of the advocacy group sometimes need to be informed and sensitized about HIV/AIDS prevention among IDUs. Many people have little or no knowledge of this field, so the information in section 1.3 may be useful in persuading colleagues to become members of the group.

Establishing an advocacy group in City Z. In the district of City Z, two people have become increasingly worried about the rapid spread of HIV among IDUs: A.C., a woman physician working at the community health centre and E.B., the director of the NGO carrying out general HIV/AIDS awareness-raising in the district. Knowing that there are IDUs in their district, A.C. and E.B. have decided that they should form an advocacy group to make the municipality focus on HIV/AIDS prevention, treatment, care and support.

They organize a small meeting with colleagues who work in various agencies around the district at which they discuss the situation of IDUs and their risk of contracting HIV/AIDS. A.C. presents some international research findings about how HIV spreads among IDUs, the urgent need to stop this spread and details of approaches to HIV/AIDS prevention that have been effective elsewhere. E.B. explains that a joint effort by an advocacy group is needed to overcome the many obstacles to introducing such prevention approaches in City Z.

The group discusses these ideas, and some group members think that focusing on IDUs is wrong, as the district has so many other problems. A.C. and E.B. argue that experience has shown that HIV/AIDS epidemics could overwhelm health systems with AIDS 5–10 years after the initial epidemic has occurred. Unless HIV/AIDS is brought under control, a massive wave of AIDS cases can occur that will dwarf all the country's other health problems. Eventually, two other district residents, a woman whose son is an IDU and a journalist from the city's main newspaper, choose to join the advocacy group.

This small group works at first just to inform other concerned people and organizations in the district about the group and the need to work on HIV/AIDS among IDUs; in this way, over time, a coalition begins to emerge. The advocacy group asks A.C. to be the group's spokesperson and to chair meetings of the group to formulate a strategy to address the issue.

The two examples above describe advocacy groups at the city and national levels. Box 6 illustrates the establishment of the Asian Harm Reduction Network, which has as one of its main objectives advocacy campaigns in various countries in Asia.³

³ Asian Harm Reduction Network. Supporting responses to HIV and injecting drug use in Asia. Geneva, UNAIDS, 2001 (<http://www.unaids.org>)

Box 6. Advocacy at the inter-country level: the Asian Harm Reduction Network

By 1996, it had become clear that addressing the increasing problem of drug use and HIV/AIDS in Asia would require the collective efforts of all the institutions and individuals with experience and interest in that area. The organization of such collective efforts faced several practical problems: geographical distance between the few existing programmes; cultural, linguistic and political diversity; and large gaps in available resources. A mechanism was needed that would allow the effective horizontal sharing of information and experience within the region, the pooling of resources, the mutual support of programmes and the development of a solid base for advocacy – all with limited administrative costs.

Starting with 46 project managers and interested individuals, the Asian Harm Reduction Network (AHRN) was established in March 1996 in Hobart, Australia, designed as a broad alliance to promote an expanded response to the issue of HIV/AIDS among drug users. Most governments in the region were not yet ready to implement programmes for the prevention of HIV/AIDS among drug users; rather, at this stage, these countries require advocacy tools. Consequently, AHRN's main activities include advocacy and assistance in policy development. AHRN organized and participated in numerous meetings and workshops with the goal of establishing a suitable environment for effective policies and programmes for the prevention of HIV/AIDS among drug users. AHRN assisted in drafting policy guidelines and recommendations and worked closely with various intergovernmental organizations. AHRN's activities were collective efforts involving many of its members.

2.2 SETTING GOALS

During the establishment process, the group usually discusses what it wants to do. At this stage, usually only a broad vision or goal exists, which should ideally be informed by existing research and information about the HIV/AIDS epidemic and the drug situation in the specific locality, by existing programmes and by documents and publications on what works in preventing HIV/AIDS among IDUs.

The group may then spend some time in formulating its goals, because the public should understand what the group wants. The goal should therefore be easy to understand, short and simple. A well-formulated goal or mission statement can attract the support of many people; help build alliances with other sectors, NGOs and influential people to form a coalition; and assist the group in raising money or other resources to support its work.

Goal setting in City Z. The advocacy group in the district has adopted the following goals. Concerned about the rapidly expanding HIV/AIDS epidemic among IDUs, the group aims:

- to expand prevention activities in the district of City Z;

- ▶ to prevent HIV transmission among IDUs to the extent possible; and
- ▶ to improve the quality of life of the IDUs living with HIV/AIDS and their families.

To determine which specific measures are most needed in City Z, the group has decided to further assess drug use and HIV/AIDS in the district in more detail. Following the assessment, objectives can be developed.

2.3 BUILDING COALITIONS

Coalitions and networks are an important foundation of advocacy work. The stronger the coalition and the more people with influence are included, the more likely that advocacy will succeed. Coalitions take time and energy to build and maintain because a complex set of factors influences the interactions between individuals and organizations. Most organizations that could be potential allies will have to check whether the objectives of the advocacy group are in line with their own and whether working in the advocacy group will influence already established relationships with their constituency, funding organizations and other partners. Similarly, individuals will check whether work in the advocacy group will affect career prospects and whether it is compatible with the work they are currently doing. The initial advocacy group should therefore start building wider coalitions early in the process.

In addition, coalitions sometimes develop their own dynamics, consisting of leadership issues, the need for recognition, personal and organizational agendas (often hidden) and many other factors. There are many examples of coalitions starting out optimistically and full of enthusiasm only to recognize at a later stage that working together for HIV/AIDS prevention among IDUs was more difficult and required more energy than expected. This has led, in some cases, to the entire group collapsing.

Tips for building coalitions include the following.

- ▶ Try to contact and, if possible, include diverse groups as coalition members to increase the coalition's impact on policy. These include NGOs, government agencies, international organizations, professionals, people already working on issues related to drugs, abstinence-oriented groups such as Narcotics Anonymous, people living with HIV/AIDS and IDUs, including their families.
- ▶ Propose relatively easy objectives at first; an early success will build confidence and cement the coalition together.
- ▶ If you are the leader, keep in touch with coalition members personally; get to know other members and their views, which may differ considerably.

- ▶ Strive for consensus on coalition decisions to generate ownership of goals, objectives and activities.
- ▶ Build service links and networks for regular sharing of information, shared training and advocacy activities.
- ▶ Establish a means to keep all coalition members informed of activities and results and provide positive feedback to coalition members.
- ▶ Involve powerful coalition members in all decisions; if they are left out, they can cause significant problems and time will be wasted on coalition members fighting among themselves instead of working together for advocacy.
- ▶ Use the coalition to discover and share information about potential funding sources, available resources, information and education sources, relevant research and possibilities for participation in training.

Special care needs to be exercised when including people living with HIV/AIDS and IDUs in coalitions. First, a principle of this type of advocacy is to avoid increasing harm to drug users and people with HIV/AIDS. This means that they must understand the risks of speaking publicly, even in meetings with coalition members, about their drug use or HIV status.

2.4 NETWORKING

Beyond building a coalition or as part of building broader coalitions is the task of networking individuals and organizations interested in HIV/AIDS prevention among IDUs. Advocacy groups and coalitions often grow out of networks, or networks take up advocacy activities.

Networks such as drug treatment networks or harm reduction networks normally have a broader focus than solely advocacy, including technical assistance, training and information dissemination; nevertheless, advocacy is usually a core part of their work. Networks allow organizations, advocacy groups and interested individuals to swap ideas, experiences and information within and between cities and countries. Networks such as the FORUM network of drug treatment agencies in southern Asia and the regional harm reduction networks (see section 14.2) have played an important role in starting HIV/AIDS prevention programmes for IDUs and assisting organizations in learning from one another.

National or regional networks can be very useful when starting an advocacy group or initiative, as they can provide contacts with groups in other parts of the country or in the wider region, which may already be operating. This allows newcomers to advocacy to learn from others with more experience on a similar issue. As advocacy groups start and gain experience, networks are also useful

in sharing stories of success and failure. Section 14.2 provides the addresses of networks.⁴

2.5 FUNDRAISING

Although many advocacy activities can be carried out with little or no funding and some activities have usually already been carried out before a formal group is started – for example, by concerned health practitioners or relatives of drug users – the reality of most people's lives is that they need to be paid for at least some of their (additional) work. Advocacy is likely to proceed much more quickly and effectively if some activities can be funded, including preparing documents, attending public meetings, making telephone calls and using the Internet to search for relevant information. Research activities, holding conferences and starting pilot programmes involve greater costs. If funding is not found for these activities, individuals may have to pay or organizations have to divert funds meant for other purposes to pay for these activities.

For example, if no one in the advocacy coordination group is paid, the group members will need to fit the advocacy work in with all their other work. In some cases this is possible but, in most countries where advocacy activities have been successful and sustainable, either trained people have been employed as members of the advocacy group or some payment has been provided to at least one member of the group.

From the perspective of a funding organization, there are two types of funding: one for the core costs of the group, such as the salary of a coordinator, office costs, etc., and the other for specific activities, such as preparing documents, campaigns and training courses. Getting funding for specific activities is usually easier, and advocacy groups are well advised to find ways to include personnel and overhead costs in their funding proposals.

Depending on the level at which the group is working, possible funding sources include local, district and national governments, the private sector, national and international nongovernmental and intergovernmental organizations and bilateral and multilateral funding organizations. Government commitment and funding is desirable, as strengthening HIV/AIDS prevention services is in the public interest. However, government funding may not be forthcoming at this stage of the advocacy process, as it is at the core of the aims the advocates want to achieve. Wherever possible, the advocacy group should try to get funding from more than one source, to ensure that it can advocate on all the issues, including controversial ones, related to HIV/AIDS and drug use. For example, some funding organizations may not want the group to address support of needle and syringe programmes; funding from a range of sources is therefore often necessary.

⁴ Networking for policy change: an advocacy training manual. Washington, DC, POLICY Project, 1999 (<http://www.policyproject.com/pubs/AdvocacyManual.cfm>).

As with fundraising for other programmes, knowing which funding organizations are present and interested in HIV/AIDS or drug use programmes is important as well as any limits to their funding – such as types of organizations or groups, the size of grants and specific activities that are excluded. The group should set up a funding application template so that it can respond quickly to news of any available funding. The advocacy group should also develop relationships with key individuals in funding bodies so that arguments can be provided personally and informally as well as by a funding application.

Fundraising in City Z. The advocacy coordination group in the district of City Z raises US\$ 1000 through a range of fundraising activities to carry out its initial work (such as writing letters and developing a pamphlet including the group's mission statement), and the members of the group donate their time in attending meetings of the group and starting the activities outlined in the following chapters. Then the group begins to talk with a major organization that funds HIV/AIDS programmes about whether a larger advocacy pilot project could be supported in the district.

3. ANALYSIS

One of the earlier steps of the advocacy process is to determine more in detail the parameters of the problem to be addressed and to develop specific goals and objectives of advocacy work. This is often done in parallel with the actions described in the previous section, depending on the availability of expertise and resources.

3.1 ASSESSMENT

To figure out more clearly how the situation of IDUs could be improved and the risk and rate of HIV transmission reduced, the situation of IDUs should be assessed in more detail and the political context may be reviewed. Members of the advocacy group could carry out this systematic assessment depending on their experience, expertise and knowledge of the situation regarding HIV/AIDS and injecting drug use in the country, region or locality. In most cases, however, experts may be asked to carry out such assessments, especially if the group works at the national level.

The assessment needs to address both the situation regarding HIV/AIDS and injecting drug use in the location, the response to the problem so far and the social, economic, cultural and political context in which drug use happens. The following data are essential in profiling the drug use and HIV/AIDS situation:

- ▮ characteristics of IDUs, such as number, age, gender, income, education, ethnic background, patterns of drug use, types of drug used and prevalence of HIV infection and hepatitis;
- ▮ risk behaviour, especially through sharing of injecting equipment and the living conditions of IDUs; and
- ▮ gender differences in drug use and sexual behaviour of IDUs.

The response analysis would map the availability of services for IDUs such as treatment, outreach and primary prevention. The response analysis should also include opportunities for voluntary testing and counselling and the treatment of sexually transmitted infections. Important factors are issues of confidentiality, acceptance of services provided, and whether the services are provided voluntarily or mandatorily. Where serious gaps in knowledge exist, research might need to be initiated, especially in the areas that may influence the effectiveness of programmes.

The following information is essential in examining the social, economic, cultural and political context:

- ▮ **Legal and law enforcement context.** What laws are relevant to starting or expanding HIV/AIDS prevention among IDUs? What are the attitudes of police, narcotics control, lawyers and judges towards IDUs and HIV/AIDS?

- **Social and cultural context.** What are the attitudes of the government, nongovernmental and community-based organizations, community and religious leaders and families of IDUs on starting or expanding programmes?
- **Gender analysis.** What barriers may advocates face in reaching both male and female IDUs? How do various agencies treat pregnant IDUs?
- **Health and welfare context.** What are the attitudes of health professionals and social workers?
- **Funding sources.** Who might be interested in funding effective programmes?

This assessment should provide a picture of the HIV/AIDS and injecting drug use situation and opportunities to improve this at the national, regional or local levels. The results may be published as a report in various formats. One version could contain a summary of all information collected under themes such as “prevalence of HIV infection and hepatitis”, “HIV/AIDS risk behaviour”, “living conditions of IDUs and their families” and others. This report should usually be provided to all members of the advocacy group and the coalition and disseminated to important people as part of the advocacy effort.

A second version could be made that highlights the most important points related to the environmental factors helping or hindering effective programmes. The factors may be presented in order of their importance. This report should be used for the process of developing more specific advocacy objectives.

Assessment in City Z. The advocacy group has asked researchers from a nearby university to work with staff of several NGOs on a systematic rapid assessment of the situation related to HIV/AIDS and injecting drug use in the district. Because the group has no funding for this, the process takes several months as the university and workers of the NGO fit the assessment work in with their other duties. With funding, the process could have been completed more quickly.

The assessment found that the district has about 1000 IDUs, most using opiates and living on the streets and 60% male. About 80% of both male and female IDUs share needles and syringes with their friends regularly. Twenty per cent have shared injecting equipment with strangers in the past week. No scientific studies exist, but at least 20% are believed to be HIV infected. Fewer than 10% of the male and 30% of the female IDUs use condoms regularly during sex, with many of the male IDUs having non-injecting partners. Ten per cent of the male IDUs and 40% of the female IDUs were involved in sex work in the past year.

Drug users can buy their needles and syringes from two pharmacies in the district. Drug treatment, without substitution drugs, is available from an NGO and the hospital. Drug treatment for six months in a therapeutic community costs three months' wages but is free for 12 days of detoxification at the hospital. Four beds are available at the hospital and 20 at the NGO.

Most IDUs say in interviews that they want to stop using drugs, but only 2% know about all the modes of HIV transmission. They rarely buy new needles and syringes because, as they say, they need to use their money to buy drugs; in addition, male IDUs have a tradition of sharing needles and syringes among close friends as a sign of “brotherhood” as do spouses and lovers of IDUs. Most IDUs are also afraid of buying injecting equipment at local pharmacies, as the police stand nearby and arrest them when they leave, and IDUs rarely or never attend hospitals and community health centres because they are afraid staff may find out they use drugs. IDUs understand that the community wants them to stop using drugs or leave the district but they feel unable to stop their drug use and the district is their home; they feel they have nowhere else to go.

Developing specific problem and issue statements based on the assessment is helpful. A problem statement simply outlines the general parameters of a problem.

Problem statement from City Z. The following is the problem statement.

- ▶ The problem of injecting drug use has been increasing considerably in the district over the last couple of years, with heroin being the main drug consumed.
- ▶ IDUs often share needles and syringes, leading to increased risk of HIV transmission among them.
- ▶ For several reasons, IDUs rarely use condoms when having sex, implying an increased risk of HIV transmission among them and to their sexual partners.
- ▶ Drug treatment is not accessible for most of them, so they have difficulty in reducing or stopping their drug injecting and drug use.
- ▶ They are either not informed that they may acquire HIV or not concerned, as they struggle to cope with meeting their daily needs, so they are unlikely to reduce their risk behaviour for acquiring and transmitting HIV if no specific measures are taken and services offered.
- ▶ Politicians, the community, law enforcement staff and most health workers know little about drug use, injecting drug use, drug dependence and how HIV can spread among drug users, so these groups are less likely to ensure that appropriate HIV/AIDS prevention is carried out.

Issue statements focus on the causes of the problems and suggest directions in which to seek solutions.

Issue statement from City Z. The following is the issue statement.

IDUs often share needles and syringes because they:

- ▶ fear arrest and fear buying new injecting equipment from the pharmacy;
- ▶ are not sufficiently educated about HIV/AIDS and how infection can be transmitted and prevented;
- ▶ cannot access drug dependence treatment; and

- ▶ cannot access appropriate other services that might address their health and other needs, as these services are not provided in the district.

Such statements are needed for developing specific advocacy objectives the group may want to achieve. They are only examples to explain possible reasons for risky behaviour. There may be many other reasons, and there may also be factors behind these reasons, factors explaining why drug use and injecting have increased, why services are not yet adequately developed and why relevant staff are not familiar with most of the issues.

3.2 DEVELOPMENT OF OBJECTIVES

The differences between goals, objectives and activities are often confused. A goal is a general description of what a group would like to see happen at the end of the advocacy process. It is a vision that may be difficult to attain but that assists all people working on the project in remaining focused and working together with a single overall aim.

Objectives are the more specific points to which advocacy work is aimed: objectives should be the result of the group's work and should be specific, measurable, achievable, relevant and time constrained (SMART). It should be possible to measure whether an objective has been reached at the end of the process. Without the SMART attributes, an objective is simply another goal.

Activities are the work done to achieve each objective. Activities should also be as specific as possible to assist group members to know that they are moving closer to achieving the objective.

After the steps that are needed are considered, SMART objectives are developed.

Specific. The objective should state clearly what the programme is trying to achieve.

Measurable. The objective should be able to be measured without massive resources devoted to research and evaluation.

Achievable. The objective should be able to be achieved within the available resources (financial, human and other). The objective should not be too ambitious. For example, it may not be realistic for a small district to advocate for a decision by the local council to introduce substitution treatment if the national government strongly opposes this.

Relevant. The objective must be useful to the overall process of working towards the goal.

Time-constrained. The objective must contain a limit to the time it will take to be achieved; otherwise it is impossible to measure.

Objectives arising from the assessment in the district of City Z. Within 12 months, IDUs should have the opportunity to and will be encouraged to reduce

their HIV risk behaviour. This should be achieved by achieving the following subobjectives.

- ▶ **Fifty per cent of the IDUs expressing interest** in treatment will have accessed (affordable) drug treatment services. This will include increased access by IDUs to an increased range of treatment options, including detoxification and a therapeutic community as well as substitution therapy.
- ▶ **Knowledge on HIV transmission among IDUs will have increased by 50%.** IDUs need to be contacted by someone they trust and informed about HIV transmission and prevention. Health professionals need to know more about drug use and HIV/AIDS, and other groups in the district, such as police, politicians and community leaders, need to learn more about HIV/AIDS prevention in the district. Prevention messages need to be tailored to the needs and interests of different groups, taking gender, age, background and other factors into consideration.
- ▶ **Sharing of injecting equipment with friends and regular partners reduced by 40%.** Increased access by IDUs to clean injecting equipment through increasing access to pharmacy supplies and through a new needle and syringe programme should result in such a decrease.

The objective and subobjectives can be measured because an assessment, including baseline information on these parameters, was carried out first. A second assessment, for instance after 12 months, can measure whether the changes sought by the objectives have taken place.

For advocacy, SMART objectives can be more difficult to achieve than others because it is often difficult to predict how long they will take to achieve, who will exactly be influenced and persuaded by when, and the measurement of their achievement may not be able to take into account such important information about the advocacy process. However, the SMART system may be used as a guide in developing advocacy objectives.

The advocacy group should also carefully consider which objectives are achievable.

- ▶ Is the selected issue so sensitive that policy-makers cannot be approached directly about it, and processes will therefore have to be indirect and take more time?
- ▶ Are there past examples of people or coalitions trying to advocate on this issue that may have failed? What lessons can be learned from their experience? Are there better channels and methods to achieve the same objectives?
- ▶ Is the information available sufficient to persuade policy-makers? If not, a specific objective should perhaps be changed to include collecting of further information.

The advocacy group may develop a draft set of objectives, and priorities should be set among them.

4. DEVELOPING A STRATEGY

The advocacy group may by now have a clear picture of the problems it wants to address and some preliminary objectives for advocacy. The question now is how these objectives can be achieved.

4.1 THE POLICY-MAKING PROCESS

It is important to understand how policies are made in the various sectors of society that advocacy activities are attempting to influence. There may be procedures regarding how regulations are formed and amended, directives are developed and legislation is put together. Advocates need to understand all these in case the formal avenues can be used or become available during the advocacy process, especially if they work at the national level and want to change national policies. In contrast, local regulations, practices and traditions may influence local HIV/AIDS prevention rather than well-formulated policies, which require different strategies for change. Especially at the beginning, seeking out the informal channels by which issues are raised and initial decisions are taken is usually necessary, and many things can be done by trial and error.

The process of introducing new policies can be roughly divided into five stages, independent of whether the process is formal or informal, and advocacy activities should follow these stages.

- ▮ **Stage 1.** Identify problems or issues within an organization, which might be government or nongovernmental. At this stage, an issue is placed on the organization's agenda.
- ▮ **Stage 2.** Introduce an idea or proposal to solve the identified problem. The problem together with a proposed solution is provided to policy-makers and decision-makers.
- ▮ **Stage 3.** The problem and the proposed solutions as well as other options are discussed in, for example, a board meeting or at the city council, the advantages and disadvantages considered and the political feasibility assessed. The proposed solution is often altered to accommodate the wishes and needs of influential individuals, organizations or parts of the constituency.
- ▮ **Stage 4.** A decision is reached. Normally the proposal is either approved or rejected (either the original or an amended version), but sometimes further information is sought or the proposal is approved subject to certain conditions.
- ▮ **Stage 5.** Move to the next stage: if the proposal is rejected, it may be reworked and the process may begin again. If further information is needed or conditions set, these may be provided and the proposal may return to stage 4; if the proposal is approved, it may go on to the next level of decision-making or implementation can begin.

Policy development in City Z. In City Z, both health services and the police are accountable to the city council, composed of elected politicians. The city administration bureau, composed of civil servants, serves this council: the chief of police as well as the chief of health services must answer to the head of the city administration bureau.

- ▶ **Stage 1.** The advocacy group has identified the following problem: the presence of police outside pharmacies is a major reason why IDUs do not buy new needles and syringes. The group has informed the city chief of police, but the chief says he is following the orders of the city administration bureau to check potential IDUs for breaches of drug laws and to ensure calm and order in public places.
- ▶ **Stage 2.** The advocacy group makes a proposal to the city council that police be asked to suspend their practice of waiting outside pharmacies for a six-month trial period while a pilot programme works to increase the access of IDUs to new needles and syringes.
- ▶ **Stage 3.** The council considers the proposal, listens to arguments from the police, from the city health chief and from A.C. of the advocacy group.
- ▶ **Stage 4.** The council decides it should not order the police to suspend their practice but accepts that some method must be found to protect drug-dependent people from being infected with HIV and therefore allows the pilot project to proceed.
- ▶ **Stage 5.** The council asks the city administration bureau to hold a meeting between A.C. and her colleagues and the police to discuss how the pilot project can proceed without causing any problems for the police. The bureau is asked to provide a report (including recommendation) for the next council meeting (at which time the process begins again at stage 2).

Even in the very formal setting of this example, many factors affect a decision. If the police already know of the proposal and accept that it is necessary, they may support it at the first council meeting. If the city administration argues strongly in favour of the proposal, the council may decide to adopt it, despite opposition from one of the sectors. If the council is mostly composed of people that are uninterested in health issues, the council may not even allow the proposal to be discussed but reject it immediately. If the chief medical officer or chief of police of the city has a friend whose daughter is an HIV-infected IDU, they may be more sympathetic than in other cases.

An enormous number of factors and variables can be involved in this single decision. In addition, the advocacy needed to achieve an advocacy objective may include many separate decision-making processes. For this reason, advocacy groups try to break down this complex process into simpler parts.

4.2 AUDIENCES: PRIMARY AND SECONDARY

Policy maps are used to determine who are the most influential people and groups related to any decision. This process considers the audiences for advocacy as follows.

- ▶ A primary audience includes decision-makers with the authority to directly affect whether and how an objective is achieved.
- ▶ Secondary audiences are individuals and groups that can influence the decision-makers (primary audience). These may include allies (people who support the advocacy objective), neutrals (those who neither support nor oppose) and opponents. Some secondary audiences may also be part of the primary audience or may be an extension of the primary audience.

The key to effective advocacy is to determine which groups and individuals are likely to have the most influence over any decision and to try to persuade them to support the advocacy objectives.

Advocacy audiences in City Z. The advocacy group has examined the following objective:

- (1) Fifty per cent of the IDUs interested in drug treatment will access affordable drug treatment services, either detoxification and a therapeutic community or substitution therapy, within the next two to three years.

In talks with its wider coalition, the group has decided this may be brought about by achieving three subobjectives:

- (1.1) increasing the funding from the city health department to the two existing drug treatment services and reducing the fees charged for participating in the therapeutic community to allow them to treat more IDUs;
- (1.2) introducing a pilot substitution treatment programme based at the community health centre that will treat IDUs on an outpatient basis following exploration of the feasibility of regulatory issues, local production or importation of substitution drugs, funding, capacity-building, sustainability issues etc.; and
- (1.3) conducting outreach education to IDUs about the increases in drug treatment options and the reduction in their costs, encouraging them to seek treatment.

City health department officials, drug dependence treatment specialists and NGOs will all have to be influenced to support the achievements of these subobjectives. The group now carries out a more detailed policy mapping exercise for these subobjectives (Tables 1 and 2).

Table 1. Advocacy audiences in City Z, subobjective 1

Primary audience	Secondary audience
Subobjective 1: Increase funding to the two current drug treatment services	
Head of the Health Department of the City Administration Bureau	Staff of the City Health Department. Most departments have experts to whom the department head may turn for advice. Researchers at the faculty of public health of the nearby university. Professional peers can be very strong influences. National Ministry of Health. The City Health Department will not usually (and sometimes cannot) make a decision that contradicts national health policy; therefore, the City Health Department could be influenced through the national Ministry of Health.
Director, local NGO	Staff of the NGO. The staff of the organization has to cope with the enlargement of the programme; are they ready to do so? Board of directors of the NGO. The board of directors would need to approve enlargement of the programme; are their views taken into account sufficiently? Staff of the funding organizations supporting the NGO. In addition to receiving government funding, the organization receives also support from a donor; is an increase in government funding in the interest of the donor institution?
City Council	Staff of City Council. City councillors often ask their staff for their opinions. Mass media. Councillors want to know how the mass media will treat the decision to increase funding: favourable or unfavourable? Informal community leaders. Councillors are humans who interact with their families and with shopkeepers, employers and employees throughout the district. How will these people react to the decision? Will it make people more or less likely to vote for the councillors at the next election? Religious leaders. Do religious leaders oppose or support this type of drug treatment? International funding organizations of HIV/AIDS or drug programmes. Because City Z is poor, will international funding organizations pay for the funding increase at least for the first three years (so that the councillors do not have to take money away from some other project)?

Table 2. Advocacy audiences in City Z, subobjective 2

Primary audience	Secondary audience
Subobjective 2: Introduction of a pilot substitution therapy programme based at the community health centre	
IDUs	Peers, family and friends, health professionals and mass media. All of them influence IDUs to accept and use the new service.
Director, local NGO	Staff of the NGO. Do they agree with the concept of substitution treatment? Are they willing to network with the programme?
Community health centre director	Staff, clients and neighbouring residents of community health centre Professional colleagues at universities, other community health centres and the City Health Department National Minister for Health City Council and the mass media
Head of the Health Department of the City Administration Bureau	Staff of the City Health Department Researchers at the faculty of public health of the nearby university National Ministry of Health
City Police Chief	National Minister for the Interior City councillors Drug control police officers and the mass media
City Council	Staff of city councillors and the mass media Informal community leaders Religious leaders International organizations that fund HIV/AIDS or drug programmes
National Minister for the Interior	Prime Minister Police experts on drug crimes International police colleagues and the mass media
National Minister for Health	Prime Minister National Minister for Police and other national parliamentarians National and international experts on HIV/AIDS and drug use Religious leaders and the mass media International funding organizations of HIV/AIDS or drug programmes

These tables show that a small number of people may make a decision, but a very wide circle from professionals to religious leaders and informal community leaders whose opinions are sought on any new ideas can influence this group of decision-makers. They also show that introducing some changes, such as increasing funding for existing services, could be much simpler and occur much faster than others, such as starting a substitution therapy programme.

City Z. However, the advocacy group in City Z realizes that both these actions need to occur, along with outreach education and activities, to achieve the other objectives mentioned in the previous chapter, to effectively address HIV/AIDS among IDUs in the city. They also feel that effective mechanisms of referral would need to be developed.

Another important point is the pervasive effect of some influential groups such as the mass media, at least in some countries. The mass media are not primary audiences for either subobjective, but they are likely to influence almost all the primary audiences if they get involved. Similarly, in some countries, some groups of government officials, such as the Ministry of Planning, or other civil society groups, such as associations of physicians or lawyers, have great influence. These groups would therefore be included in the secondary audiences for most decisions as well.

IDUs are included as a primary audience for the substitution programme (and in principle for the expansion of other treatment) because they are vital to the success of the programme. If they refuse to attend the programme, then it will have no effect on preventing HIV/AIDS and reducing crime. By expressing their need for such services, IDUs in some countries have assisted in introducing prevention activities. In addition, people living with HIV/AIDS are often crucial to decision-making on these topics. If they have a spokesperson who is able to appear regularly on mass media and in committees addressing influential politicians, they can have a very powerful effect on what services are started or expanded to deal with HIV/AIDS.

City Z. Through meetings with various IDUs and people living with HIV/AIDS and their families, the advocacy group has managed to attract three more members, two of whom are HIV-positive and two of whom are IDUs. The new members work on various educational materials and are interested in providing speeches at conferences and committee meetings. They are effective in conveying the message that many drug-dependent people would like to seek treatment but that there are few opportunities. They also convey the message that drug-dependent people are humans too and that their views should be listened to and their experience in such areas as care-seeking should be taken seriously.

4.3 AUDIENCE CHARACTERISTICS

Once the primary and secondary audiences are identified for each objective, as much as possible needs to be found out about these groups and individuals. What are their opinions about HIV/AIDS and injecting drug use? What are their interests in these issues? What motivates them? How do they generally learn about new issues: by personal contact or by reading a newspaper or using other mass media? This information can be gained in several ways.

- ▶ Many officials and influential people state their opinions on various topics in interviews, speeches and other publicly available documents. Reading these closely can sometimes provide either direct quotes about their views about drugs and HIV/AIDS or their views on some similar topic. Care needs to be taken with this technique, as many politicians in particular believe they need to be considered “tough on drugs”, regardless of their private opinion. For this reason, getting to know people close to politicians can sometimes give a more realistic picture of their views.
- ▶ Official policies are usually written down in laws, regulations, directives, orders, plans, strategies, protocols and so on. For all primary and secondary audiences, all these documents related to HIV/AIDS and injecting drug use should be collected and examined.
- ▶ Surveys or polls are sometimes carried out on drug use or attitudes to drug use, drug users and people with HIV/AIDS. These can be especially useful in gauging the opinion of the community.
- ▶ Mass-media analysis can assist in predicting specific mass-media viewpoints and community opinions on some topics. This analysis can be as simple as counting the number of articles about drugs in a newspaper over a specific period, such as six months. The general themes of the stories are noted: for example, that drug users are evil, drug users should be expelled from their families, drug users are sick, some drug users have stopped taking drugs or some drug users play useful roles in society. It may also be useful to assess whether the journalist has tried to be sensationalist or well balanced and to note the names of the journalists who seem interested in balance and greater depth of information.
- ▶ Focus groups can be used to gain an understanding of how audiences think about specific topics: these can either comprise members of the general community or specific audiences such as health professionals, lawyers and police.

Analysis of this information should focus on whether the organization or individual already supports (or is likely to support) or opposes (or is likely to oppose) the advocacy objective. Some secondary audiences in particular are hard to investigate and their support is difficult to predict. These groups should continue to be assessed while messages are developed and delivered to the other audiences.

The second phase of policy mapping is to chart what audiences know, feel and believe about specific issues related to advocacy objectives. This information is often useful for framing persuasive messages. If an advocacy objective can be linked to an issue about which the audience cares deeply, the audience is much more likely to listen.

Special care should be taken to examine what the audiences know about drugs, drug use and its health effects, dependence and trafficking. In many countries, knowledge about illicit drugs, drug use and the nature of dependence is often limited to a small group of specialists. Advocates should consistently educate their audiences about these topics to ensure that debates are not based on false assumptions, such as that drug-dependent people should “just say no”.

Audience knowledge and attitudes in City Z. The advocacy group continues its policy mapping exercise for the second subobjective (Table 3).

Table 3. Audience knowledge and attitudes in City Z (examples)

Subobjective 2: Introduction of a pilot substitution therapy programme at the community health centre

Audience	Knowledge about subobjective	Beliefs and attitudes about subobjective	Issues about which the audience cares
Community health centre director	Knows little about substitution treatment and its management	Can see that this activity is important. Concerned about how the programme affects other (non-IDU) community health centre clients and should also be concerned about logistics, such as the safe storage of controlled substitution drugs	Overall health of district residents Not being criticized Not being dismissed Good professional practice

Table 3. Audience knowledge and attitudes in City Z (examples) cont'd

Audience	Knowledge about subobjective	Beliefs and attitudes about subobjective	Issues about which the audience cares
Community health centre staff	Some attend advocacy group meetings and have read widely about substitution therapy; others know little	Range of attitudes from fully supportive to unsupportive; most support the programme idea	Each staff member is concerned about a specialist area of health; fear of getting into trouble Not being dismissed Good professional practice Working time, potential salary increase
Neighbours to community health centre	Never heard of substitution treatment	No specific attitudes yet. Will have no problem with the programme as long as clients do not disturb them	Amenity: the state of the district as a place to live and work Peace and quiet
University researchers	Have read international research	Mostly supportive; some believe that a method that replaces one dependence with another is not worthwhile	Scientific curiosity Academic advancement Publication
City Council	Knows virtually nothing about the subject	Mixed reaction: City Council feels responsible for stopping AIDS in the district but is worried about voters being hostile to the programme because it may be seen as encouraging drug use	Overall welfare of community throughout the city Re-election and reappointment Good professional practice Cost and financing
Head, City Health Department	Has heard of it but knows little of research or how substitution therapy works	Supports the programme very strongly and believes it will save many lives	Overall health of community throughout the city Not being dismissed Good professional practice

Table 3. Audience knowledge and attitudes in City Z (examples) cont'd

Audience	Knowledge about subobjective	Beliefs and attitudes about subobjective	Issues about which the audience cares
Mass media	Know virtually nothing about the subject	Likely to be interested in issue to provide coverage; focus on controversy and conflict	New ideas and events Conflict, especially over new ideas Providing information Selling the medium and advertising
Religious leaders	Know virtually nothing about the subject	Not known	Consistently speak out against drug use and helping drug users; state that drug use is a sin
City police chief	Knows virtually nothing about the subject	Could be hostile. Believes the only way to deal with IDUs is to punish them. Does not know that substitution treatment could reduce illicit drug use and dealing	Preventing crime Maintaining public order Not being dismissed Good professional practice
IDUs	Have heard of substitution therapy but do not know much	Supportive; believe that the programme will help them to stop injecting drugs	Survival and friendship Poor experience with inpatient treatment, which they considered to be more like incarceration

Table 3. Audience knowledge and attitudes in City Z (examples) cont'd

Audience	Knowledge about subobjective	Beliefs and attitudes about subobjective	Issues about which the audience cares
Friends and families of IDUs	Most have little knowledge	Most who know about substitution therapy are very supportive. Some (especially parents) are opposed to substitution and believe that any available money should be used for programmes that stop young people from using any type of drugs	Welfare of IDUs Freedom from drug use for IDUs if possible
International funding organizations	Have carried out international research and have high degree of knowledge	Supportive, willing to fund pilot programme if enough community support can be demonstrated; promoting service models from other countries	Reducing poverty Preventing HIV/AIDS globally Political influence and visibility
National drug policy experts	Most have a high degree of knowledge	Some are very supportive, have seen substitution programmes in other countries and will help start programmes. Some are completely opposed to substitution	Professional reputation as experts Relationships with powerful institutions and individuals Ability to influence national policy

Table 3. Audience knowledge and attitudes in City Z (examples) cont'd

Audience	Knowledge about subobjective	Beliefs and attitudes about subobjective	Issues about which the audience cares
National Minister for Health	Has heard of it but knows little technical detail	Concerned about AIDS, especially in City Z, but unsure whether substitution is the best national policy	Overall health of communities throughout the country; fate of individual IDUs at the local level less important Re-election and reappointment
Staff of National Minister for Health	Some have read international research	Support a trial in City Z based on which national policy can be set	Specific areas of health care across the country Good professional practice
National Minister for Police	Unknown; research needed	Research needed	Maintaining public order Re-election and reappointment
Prime Minister	Knows virtually nothing about the subject	Likely to be hostile; open to other views	Elected on a platform that included "tough on drugs" measures; regularly promises to rid society of drugs; possible approach "be tough on drugs and dealers; be supportive to those who are vulnerable"

Table 3 demonstrates the wide range of knowledge, attitudes and beliefs among the audiences in City Z and at the national level. This is often the case, because the issues raised by various activities are complex and often controversial and seem to contradict other common measures related to drug use.

After completing policy maps for objectives and subobjectives, the advocacy group has a picture of what groups or individuals know and believe and how they could influence decisions on matters related to the objectives. The group may also have learned more about the situation of drug users and HIV/AIDS among drug users. A set of activities can now be devised to address these audiences with specific messages.

5. ACTION AND REACTION

5.1 ACTION PLANNING

After collecting and analysing substantial information about primary and secondary audiences and their mutual relations, the advocacy group can start developing an action plan describing the situation, advocacy objectives, intended audiences, key activities, timelines and indicators of success to evaluate each activity. As coalitions develop, all partners should be encouraged to participate in achieving the objectives. In the action plans, the audiences with highest priority should be addressed first and for maximum impact with minimal effort. Based on the objectives and policy maps, the action plan should list every activity needed to address each audience and the messages to be delivered.

Action plans in City Z. The advocacy group has become very excited that it has completed its objectives and policy maps. It now has not only a clearer picture of the nature and extent of the problem but also of the different groups to which it needs to talk and some hints about what is needed.

The subobjective on establishing a substitution programme at the district community health centre (Table 3) shows that two major categories of activity are needed: information and education and persuasion.

Information and education. The audiences who know little or nothing about the issues raised need to be informed about HIV/AIDS prevention among IDUs, the effectiveness of substitution therapy for HIV/AIDS prevention, its compatibility with national and international laws, benefits of the therapy for IDUs and the community and the specific need to start a pilot substitution programme at the community health centre.

Persuasion. Those known or likely to be hostile to the substitution programme may be persuaded by arguments or by other means, including observing substitution programmes in other countries, visits from international experts and public debates about the risks and benefits of substitution therapy.

In addition, different (but related) messages need to be provided depending on the audience. For example, the community health centre's neighbouring residents are likely to be most concerned about how the community health centre will deal with security issues. These include ensuring that the substitution drug is not stolen or given to non-drug users and whether the new programme will lead to many drug users "hanging around" the community health centre. The Prime Minister is likely to be more concerned about the costs of interventions and the economic effects of an HIV/AIDS epidemic on the country. The city police chief is likely to be most interested in whether starting a substitution programme will reduce or increase crime.

Other general tips on planning and action include the following.

- ▶ For each advocacy objective and each audience, deliver consistent messages through a variety of communication channels and from a variety of sources over an extended period of time. Messages are not always immediately heard, absorbed or understood; repeating core messages, with some variation, is therefore vital. Consistency is important to avoid confusion, and variety helps to ensure that the audience is not bored.
- ▶ Plan events incorporating credible spokespeople from coalition partner organizations.
- ▶ If you are the speaker or leader, delegate responsibilities clearly to coalition members to implement and monitor specific events and activities.
- ▶ Organize training and practice in advocacy.
- ▶ Identify, verify and incorporate key facts and data to support advocacy objectives.
- ▶ Present information in a brief and memorable fashion. Do not fear controversy and try to turn it to your own advantage.
- ▶ Incorporate human interest and anecdotes into messages. Make these diverse to represent different groups of IDUs and people living with HIV/AIDS.
- ▶ Clearly specify desired actions and outcomes such as policy changes.
- ▶ Emphasize the urgency of the recommended action.
- ▶ Plan for and organize mass-media coverage to publicize appropriate events and present new data.
- ▶ Monitor and respond rapidly to other views and opposition moves. Be flexible.
- ▶ Work with all levels, from local to national and international, through appropriate networks.
- ▶ Keep a record of successes and failures.
- ▶ Avoid getting carried away, becoming too emotionally involved and overstating your case.

This guide describes specific advocacy methods in greater detail later.

Action plan of City Z. The advocacy coordination group is now carrying out a wide range of activities according to an action plan agreed with its various coalition partners (Table 4).

Table 4. Sample action plan from City Z

Activity	Audiences	Who is responsible?	Complete by?	Status
Objective A: Within 12 months, to increase access of IDUs to clean injecting equipment through (a) pharmacies and (b) starting a needle and syringe programme				
Convince pharmacists to provide needles and syringes to IDUs, describe costs and other implications	Pharmacists	A.C.; assisted by pharmacy association	Four weeks	Pharmacy association has agreed to host meeting; invitations issued to pharmacists; training materials being prepared
Meet city police chief to discuss role of police near pharmacies and needle and syringe programme sites	City police chief and five senior staff	A.C. plus one other group member	Four weeks	Made appointment with head of city drug squad; will ask for help to arrange meeting with city police chief
Prepare leaflet for politicians with arguments for needle and syringe programme	City councillors and their staff and national politicians	A journalist who is a member of the advocacy group	Six weeks	Received international research data in English; translated to local language; will begin writing next week
Lobby City Council on the needle and syringe programme by personally meeting each councillor and providing with information on needle and syringe programme	City councillors (12) and their staff (20)	All members of advocacy group working in pairs (each pair to meet at least three councillors and staff)	12 weeks	Not started; waiting for leaflet for politicians to be completed

Table 4. Sample action plan from City Z cont'd

Activity	Audiences	Who is responsible?	Complete by?	Status
Objective B: Within 12 months, to increase access of IDUs to affordable drug treatment (both detoxification and therapeutic community) and an increased range of treatments (including substitution therapy)				
Investigate legal status of substitution drugs for proposed programme at community health centre	All city audiences, national Minister for Health and Minister for Police	Legal student helping advocacy group	Completed	Methadone and buprenorphine are registered and may be used; legal restrictions and costs provided in report
Write formal letter requesting approval to start substitution therapy at community health centre	City Council	A.C.	One week	All data now found; community health centre director has agreed to seek approval after letter is written
Seek approval for starting substitution treatment	City Council	Community health centre director	Five weeks	Three city councillors agree to support proposal and four are opposed; will meet with these four plus remaining five councillors to lobby for programme before vote in six weeks

Table 4. Sample action plan from City Z cont'd

Activity	Audiences	Who is responsible?	Complete by?	Status
Brief mass media on substitution programme	All city audiences	A journalist who is a member of the advocacy group	Two weeks	Identified two key journalists (one newspaper, one television) Produced two-page summary of research evidence for substitution therapy and community health centre proposal Will provide exclusive interviews with community health centre director

Table 4 presents a selection of activities undertaken by the advocacy group and its coalition partners in City Z. The main purpose of this string of actions is to persuade pharmacists that they can provide needles and syringes without economic losses or breaching the law. Introducing substitution treatment usually entails a legal process, which could take some time. Other important steps in the process include obtaining import licences, training and accreditation, licensing those who prescribe, establishing distribution systems and decisions on responsibility for safe storage.

Because the workload is increasing, funding is being sought from international funding organizations for a part-time advocacy coordinator and for the costs of some advocacy activities (especially the booklet for the general community and the police training workshops). A.C. can no longer carry out all the coordination tasks while continuing her job at the community health centre. The advocacy group is also working with groups of people living with HIV/AIDS in City Z to provide a mass-media awareness-raising workshop about stigma and discrimination among people living with HIV/AIDS.

IDUs and HIV-positive members of the advocacy group now feel confident enough to speak at conferences and meetings about their living conditions and the need for preventing HIV/AIDS. The advocacy group is consulting with local journalists to determine whether there is one who is likely to tell a well-balanced story and to help to achieve the group's advocacy aims through an interview with IDUs and people with HIV/AIDS. This is an important but also dangerous step, but both groups want to educate the public and many influential groups about the reality of living with HIV/AIDS and living as an IDU, so they are keen to give the interviews.

5.2 ADVOCACY MESSAGES

After defining target audiences for advocacy, specific messages need to be developed. Different messages often need to be developed for different audiences. Whenever possible, advocacy messages should be short and persuasive statements about each advocacy objective: what should be done, why and how? The underlying reasons, arguments and rationales can be provided when necessary. The purpose of the message is to produce action, so the message should clearly specify what action should be taken and by whom.

The following is an example of a message.

An HIV/AIDS epidemic among drug users is looming. The prescription of methadone (or buprenorphine) by trained health personnel is an important component of an effective programme to reduce the risk of spread of HIV among drug users. The Health Ministry needs to register methadone (or buprenorphine) so that these programmes can begin.

Sometimes messages are condensed to such slogans as: "Methadone works: for the community, for drug users and for HIV/AIDS prevention. Register methadone now."

Language is extremely important, including the words used in the message, metaphors and links to other issues important to the target audience. Some words or phrases should be used and others will prevent some audiences from hearing the message or getting them to reject it immediately. Successful messages often contain words or phrases that have positive connotations or particular significance for an audience, such as "family", "children", "community", "national security" and "economic benefit". Advocates should avoid jargon and technical language (except for specialist audiences). Other important elements of messages and the mass media include the following.

- ▶ **Arguments and data used to persuade the audience to act on the message.** These should not only be accurate but also suit the audience. If charts or diagrams are used, these should be kept simple and easy to understand.
- ▶ **Credibility of the source.** Whom will the audience believe?
- ▶ **Time and place.** Is there a venue, such as an AIDS conference or a specific day, such as World AIDS Day or the United Nations International Day against Drug Abuse and Illicit Trafficking, on which the message is likely to attract more attention?

The format of the message depends on the channel through which it is delivered. For example, a message delivered in personal consultations with a member of parliament will have a different format than a message delivered at a press conference with journalists of the national news media. There is a whole

range of channels of message delivery, including personal discussions, scientific publications, sending letters, making statements at meetings and conferences, distributing leaflets and pamphlets, posters, billboards and using the news media such as newspapers, radio and television stations.

5.3 REACTION, CONTINUITY AND NEW INITIATIVES

After the initial phase, much of an advocacy group's work will be concerned with reaction to circumstances and current events. As each advocacy activity is undertaken, some target audience individuals and organizations will react to these activities. For example, some newspapers constantly seek sensational stories. Instead of writing that drug treatment options are being expanded to improve health services and prevent an HIV epidemic, they may write "Health Department soft on drug users". Prominent radio hosts may describe an emphasis on health services to IDUs as "a disgrace: what about the elderly in our society who do not have enough to eat?". Religious or political figures may attack changes they see as damaging to "traditional values" but may also show compassion to the specific plight of drug users. Because of press reports or the experience of key stakeholders, community members may become concerned that HIV/AIDS prevention activities could disturb the peace in their neighbourhoods, and shopowners and other small businesses may express their apprehension that they may lose customers.

Each of these events will influence advocacy activities. Such events should be carefully monitored for ongoing analysis and evaluation. Why has the religious figure spoken out? Has enough advocacy work been done with religious organizations? Does the radio host represent a large or small section of the community? Are these views just a way of increasing the popularity of the radio show?

The advocacy group must consider how and when, and sometimes whether, to respond to such opposition. If relations with the mass media are generally good, responding quickly with a press release and a press conference is often useful. If a politician has made an opposing statement, perhaps another politician can be encouraged to make a public statement of support. Nevertheless, in some cases, having supporters visit the opposing politician and discuss the issues away from the mass media may be useful to try to persuade the opposing politician to become a supporter. Remember that most opposition to measures that will prevent HIV/AIDS occurs in an environment of incomplete information or misunderstanding. Meeting with an opponent and explaining the full reasons for the advocacy objectives can sometimes transform the opposition into support or at least neutrality and tolerance.

On other occasions, concrete undesirable effects of a new policy or a new service will have to be dealt with if they have not been anticipated. Events should be examined for further advocacy opportunities. The advocacy group should stay alert to any reports being commissioned, committees that are meeting, medical and legal conferences, politicians going on fact-finding missions to other countries, all of which are opportunities for advocacy. Perhaps the politician can be persuaded to visit effective HIV/AIDS programmes for IDUs in other countries. The medical or legal conference can be asked to emphasize the specific problems of HIV transmission among IDUs and how best to deal with these problems. The advocates can contribute to committee hearings or reports.

The advocacy group should also create its own opportunities and anticipate likely changes. An example of creating opportunities is using United Nations resolutions and declarations on HIV/AIDS, drugs and human rights: where a national government has signed a declaration stating that it will implement and expand HIV/AIDS prevention among IDUs, the advocacy group can provide a report card showing which promised actions have been achieved and which have not. Such an undertaking may be risky and should be done only with a powerful coalition, for example of HIV/AIDS NGOs and government allies.

Anticipation is clearly illustrated by parliaments in which the ruling party changes from time to time. If all advocacy work has been carried out with the ruling party only and none with the opposition, then major problems can occur when the majority changes, because, for example, decisions could be delayed and current activities may not be expanded. The advocacy group should anticipate these problems by ensuring that it delivers its messages to all politicians.

6. EVALUATION

Evaluation should be formalized in an annual or more frequent event in which the advocacy group analyses its successes and failures to date and decides on new objectives, subobjectives and activities for the following 12 months. This is often done together with some or all of its coalition members, supporters and interested parties. The analysis at these events should be rigorous. Achievements should be celebrated, but failures and backlashes should also be analysed to see what lessons the group can learn. After this analysis (or at any time in the advocacy process), advice can be sought from advocacy groups elsewhere about how to overcome specific problems or arguments, which may prove effective when previous arguments have failed. Evaluation should aid this process.

Evaluation can assist an advocacy group in determining whether activities have been successful and in which directions changes should be made to objectives, strategies, activities and messages. The effects of advocacy may also be measured as a research activity or to persuade funding organizations to provide support for further advocacy activities.

Evaluation can be divided into process and outcome evaluation. Process evaluation aims to monitor the implementation of the advocacy process as planned. Outcome evaluation aims to assess the impact and outcomes of the advocacy activities on services for IDUs and stakeholders' attitudes. Process evaluation describes and monitors how activities have been carried out. This is necessary to examine which strategies and methods have been most successful and should be expanded and which have been least successful and should be curtailed or adapted.

Outcome evaluation has two main aims. It assesses the impact of the programme and the extent to which objectives have been achieved. Second, it seeks to demonstrate that any observed change in the target populations can be attributed to the advocacy process, which is often difficult.

Outcome evaluation of advocacy can be carried out by tracking the changing perceptions over time of key individuals, such as senior police officers, health ministry officials, community leaders, editors and reporters; analysing mass-media reports and commentary to map changes in the public discussion of relevant issues; and preparing critically reflective accounts of the advocacy process written by the advocates themselves.

Another method of evaluating outcome is to repeat the systematic situation assessment described in Chapter 3. If assessments are carried out at regular intervals, changes can be described in the risk behaviour of IDUs and in the many processes that affect this behaviour. A major problem with such an evaluation is to show clearly which and how much of these changes advocacy activities caused.

Most advocacy groups use evaluation to check the progress and direction of their work. This should be done regularly. Evaluation can be performed informally at meetings of the advocacy group or more formally, using research methods such as structured questionnaire surveys and focus groups. For example, at set times,

perhaps every six months, the group can devote a few hours to thinking about and discussing its objectives and strategies.

- Are the objectives still appropriate? Are some redundant? Are new objectives or subobjectives needed? For example, a needle and syringe programme has been introduced but reaches only 30 IDUs. The current programmes therefore need to be expanded. Or, although the needle and syringe programme is running, the evaluation indicated that the quality of services is inadequate.
- Should the priority of activities be changed? Should some activities be stopped because they are ineffective or because they are too costly in time or resources? Should new activities be added? Have the target audiences changed?
- Are resources sufficient to carry out all the activities? Is sufficient funding available now and for the remainder of the advocacy period? Is more fundraising needed?
- Have audiences changed? Does the group know more about audiences? Can policy maps be updated with new audiences and new knowledge about audiences and their attitudes and beliefs? Are there new audiences that can be anticipated?
- Are messages reaching their target audiences? Which messages did the audience accept best? Which media and methods have worked best for which audiences?
- Are different messages and advocacy techniques needed for male and female IDUs across age groups? What are the major barriers? How can they be overcome? Have messages reached male and female IDUs, and if not, how could they be improved?
- Were data presented convincingly? Were they easy to understand? Are there ways that presentation could be improved?
- What is the state of the advocacy coalition? Do coalition members feel involved in the advocacy process? Do they feel at least partly responsible for successes and failures? Are there any ways to increase participation by coalition members in advocacy activities?
- Can the current advocacy group carry out all the listed activities? Are new members needed? Are new skills needed?
- What opportunities are there for advocacy that have not yet been discussed? Is the group responding quickly and appropriately to advocacy opportunities and to opposition?
- Are other advocacy activities underway, unconnected with HIV/AIDS and injecting drug use, from which the group could learn? Have these other advocacy activities been successful? What could be learned from their successes or failures?

Advocacy activities or advocacy campaigns aim at specific outcomes: for example, that IDUs receive essential services to reduce the transmission rate of HIV among them or that IDUs with HIV/AIDS and their families receive care and support. To arrive at such results, activities are carried out using specific methods, some of which are described more in detail in the following chapters.

7. USE OF RESEARCH AND EVIDENCE

One important principle is that advocacy needs to be based on scientific evidence. This evidence must be used to convince policy-makers and programme planners to do the right things at a large enough scale to stop and reverse the HIV/AIDS epidemics among IDUs.

Scientific evidence can be used:

- ▶ to identify specific issues for policy action;
- ▶ to assess what policy changes would be necessary;
- ▶ to choose advocacy goal and objectives;
- ▶ to directly influence policy-makers and programme planners;
- ▶ to inform the mass media, the community and other important people about the situation among IDUs and to use them to lobby for change;
- ▶ to counter positions or arguments opposing specific methods of preventing HIV/AIDS among IDUs;
- ▶ to change the attitudes of the public towards IDUs to establish an environment in which HIV/AIDS prevention among IDUs could be implemented;
- ▶ to challenge myths and assumptions about what works in HIV/AIDS prevention among IDUs and to generate debate on strategies or policies that have been shown to be ineffective; and
- ▶ to confirm that HIV/AIDS prevention among IDUs indeed works in a specific country or locality (Box 7).

Box 7. "We are different ..."

A frequent argument against some methods of HIV/AIDS prevention among IDUs is that they are "unsuitable" in that particular country. This is especially true for countries that have a prevailing view of themselves as different to all other countries. In such cases, local research must be carried out to persuade policy-makers and programme planners that HIV/AIDS prevention can indeed reduce prevalence and incidence. This is often done with carefully evaluated pilot projects.

Arriving at scientifically sound data is often difficult for drug use and HIV/AIDS because drug users are hard-to-reach populations. Essential information about the number of people using illicit drugs, the numbers of people with HIV/AIDS and their specific risk behaviour is often not easily available. In addition, information on the effectiveness of specific prevention methods such as outreach, needle and syringe programmes and substitution treatment is often not available for a specific locality. Such lack of information creates difficulty in convincing policy-makers and programme planners to take appropriate action. This chapter outlines how to gather such information and how to use it in an advocacy campaign.

7.1 RAPID ASSESSMENT AND RESPONSE

If information is lacking for advocacy campaigns, rapid assessment and response methods can quickly provide information on the drug use and HIV/AIDS situation and the context in which drug use is happening. Such methods have been developed for a variety of groups, including IDUs and sex workers.⁵ These methods are used to examine:

- ▶ the nature of drug problems and the factors influencing them at various levels;
- ▶ the adverse health consequences of drug use, including the transmission of HIV and hepatitis C virus;
- ▶ specific drug use behaviour such as the sharing of needles, syringes and other drug use paraphernalia and the sexual behaviour of drug users, including condom use;
- ▶ the resources that are or might be available to respond to drug and HIV/AIDS problems; and
- ▶ interventions that are socially, culturally, religiously, politically and economically appropriate and acceptable.

The key advantages of rapid assessment methods are that they:

- ▶ are fast, pragmatic and cost-effective;
- ▶ use multiple indicators, existing data sources and rapid methods to collect any new data that is needed;
- ▶ establish a quick understanding that is refined based on further evidence;
- ▶ use the knowledge and opinions of a wide range of people; and
- ▶ provide relevant results for programming and policy development.

Rapid assessment can be completed fairly quickly, usually within two to four months, and sometimes even faster, using a variety of qualitative and quantitative methods.

For advocacy purposes, the results are analysed to produce reports for specific target audiences, highlighting the most significant and relevant findings. These reports should not only describe findings but also how the findings were obtained and how they were checked through cross-referencing information or triangulation. Reports on rapid assessment include options for a rapid response, specifying what needs to be done. The completed report – and especially the

⁵ Stimson G, Fitch C, Rhodes T, eds. The rapid assessment and response guide on injecting drug use (IDU-RAR). Version 5. Geneva, World Health Organization, 1998 (http://www.who.int/substance_abuse/publications/epidemiology/en).

executive summary – can be used for a variety of purposes, including persuading important advocacy audiences, such as policy-makers and programme planners and funding organizations, to support the recommendations and undertake the necessary action.

Not only the report on the results of an assessment provides advocacy opportunities. An example from the Russian Federation (Box 8) shows how the process of assessment is used to establish programmes and obtain funding.

Box 8. Rapid assessment for advocacy in the Russian Federation

In 1997, Médecins Sans Frontières–Holland began an extensive training programme in the Russian Federation to ensure that people working on HIV/AIDS prevention among IDUs had the skills to conduct rapid situation assessment to determine the extent of drug use and related HIV risk and infection in their city or province and to plan HIV/AIDS prevention programmes targeting drug users. The training encouraged participants to provide similar training to others in their city or province. The training programme concluded in February 2000.

The training cycle took place over a period of four months. It began with an initial 11-day training course in Moscow followed by 12 weeks of work by participants in their cities assembling a team and attempting to carry out a rapid situation assessment with technical support and city visits from Médecins Sans Frontières–Holland staff and consultants. It concluded with a five-day return training course in Moscow to discuss the processes and results of each city's rapid situation assessment and to use these results for initial programme planning and writing funding proposals.

Between January 1998 and February 2000, 199 participants from 61 cities attended the training course. Of the 61 cities, rapid situation assessment was completed or almost completed in all cities in the 12 weeks between the initial and return training courses. An important result of the training programme was that participants in most of the cities used the rapid situation assessment results to begin negotiating with city or regional officials about HIV prevention programmes. In some cases, this negotiation began before the rapid situation assessment. In evaluations of the training courses, participants from all cities indicated a willingness to develop HIV prevention programmes among drug users.

To the training organizers, the greatest benefit of carrying out rapid situation assessment was this political process of raising the issue of HIV prevention among IDUs, both with decision-makers and the general community, and gaining support for interventions. The rapid situation assessment is a practical step that the participants felt capable of undertaking with training and city visits. It was also a noncommittal step: by undertaking rapid situation assessment, the participants were seeking information on a topic for which they had some responsibility in their cities rather than starting to talk about interventions from the very beginning. While support was being sought for the rapid situation assessment, and during city visits by training staff, any contentious issues were raised for discussion in the context of data from rapid situation assessment, which showed rapid rises in drug injecting and high levels of risky behaviour for HIV transmission. Also, by seeking support and information from various agencies in the city, an education process occurred in which important decision-makers from several sectors were shown the dimensions of the problems and were introduced to strategies that could be used to combat these problems. Finally, when

the rapid situation assessment results were used to design programmes, all the important decision-makers were at least aware of the rationale for the proposed programmes.

By mid-2000, of the 61 cities, 40 sought funding for a HIV prevention programme among IDUs from a special grant scheme run by the Open Society Institute – Russia. The Open Society Institute – Russia had funded 35 new harm reduction programmes in the Russian Federation by July 2000. The new programmes included a mix of fixed and mobile needle exchange programmes, outreach and group education of IDUs, preparation and distribution of specific educational materials, referral and provision of other services. As there were only four HIV prevention programmes for IDUs in the Russian Federation at the beginning of 1998, this amounts to a 900% increase in HIV prevention programmes in 30 months.

Source: Burrows D et al. Processes and outcomes of training on rapid assessment and response methods on injecting drug use and related HIV infection in the Russian Federation. *International Journal of Drug Policy*, 2000, 11(1–2):151–167.

7.2 SCIENTIFIC AND PROFESSIONAL PUBLICATIONS

Most research related to HIV/AIDS prevention among IDUs is published in English in a wide range of professional and scientific journals. This makes it difficult for non-English-speaking professional audiences to learn the evidence for these approaches. A similar issue arises for practitioners of prevention programmes: most guides, training guidelines and other materials are produced in English.

The publication of reviews and summaries of international evidence, best practice reviews of effective approaches, guidelines and other materials in local languages is vital for educating professionals and researchers and for convincing policy-makers and programme planners. At an early stage in advocacy campaigns, the translation of international evidence-based key documents into local languages can greatly facilitate lobbying. The WHO Evidence for Action on HIV/AIDS Prevention among IDUs Series summarizes the evidence for a wide range of effective programme activities up to early 2002. This series should be translated into local languages, and publication should be sought of key papers (or summaries of the most relevant papers) in local scientific journals. Many countries have almost no locally produced professional and academic journals. In this situation, such a publication may be founded or a newsletter produced that translates and summarizes major new research for the local audience.

Many other materials that may be useful in educating professionals are available in English and increasingly in such languages as Spanish and Russian. These should be reviewed and selectively translated, with priority placed on the publications most relevant to the advocacy objectives. The web sites of international organizations working in HIV/AIDS prevention (including UNAIDS, WHO, UNODC, the United Nations Children's Fund (UNICEF) and the United Nations Educational, Scientific

and Cultural Organization (UNESCO)) should be accessed regularly to check which publications are available in relevant languages.

In some contexts, translating materials developed in industrialized countries so that they remain relevant and useful is difficult. There may be differences in legislation, societal context, the speed and direction of HIV epidemics, services available and others. There may also be cultural taboos against certain types of information being publicly discussed. Materials must therefore sometimes be adapted to ensure that not only the words but also the concepts are understood locally.

An example from Indonesia (Box 9) shows how such an adaptation process could be organized and that the adaptation in itself was used for advocacy purposes.

Box 9. Adaptation of materials in Indonesia

As part of a set of advocacy activities in Indonesia, it was decided to produce a local version of a key guide to starting and maintaining harm reduction programmes, the **Manual for reducing drug related harm in Asia**⁶ produced by the Centre for Harm Reduction in Melbourne, Australia. Chris Green coordinated the process of adapting the manual and described the process as follows.

Having been involved in the response to AIDS since the early 1990s and having started to work to stimulate responses to a perceived IDU threat in 1998, I warmly welcomed the arrival of the **Manual for reducing drug related harm in Asia** when it appeared in early 2000. And as I got deeper into it, it became clear to me that this was a priceless resource not only for people working in the field of harm reduction but also for organizations responding more generally to AIDS. But it was also clear that the English version would be of little value in Indonesia, where few would feel competent enough in the language to attempt to read a 360-page manual. A version in Indonesian was therefore essential.

It was decided that the process of translation and adaptation should follow a team approach, using workshops where appropriate to engage and encourage discussion and exchange of ideas. With very little actual harm reduction activity going on and very limited experience among all concerned, those invited to join the team were mainly drawn from two sources: those involved with the response to AIDS and interested in expanding into harm reduction; and those in the drug-treatment community, including users in recovery.

The book was produced in two versions: a small book explaining the rationale of harm reduction, to be used as an advocacy tool; and the complete manual, in format similar to the original, for distribution to organizations actively responding to the HIV/AIDS epidemic among IDUs. Funding to print the small book came from the Australian Agency for International Development, while the United States Agency for International Development (through Family Health International) took responsibility for printing and distributing the complete manual.

⁶ Costigan G, Crofts N, Reid G. Manual for reducing drug related harm in Asia. 2nd ed. Melbourne, Centre for Harm Reduction, Macfarlane Burnet Institute for Medical Research & Public Health, Asian Harm Reduction Network, 2003 (<http://www.ahrn.net/manual.html>).

The Coordinating Minister for People's Welfare launched the manual nationally in Jakarta with the Minister for Health present, who had written the foreword. Initial response to the Indonesian manual has been very positive, with considerable demand for both books. It has also been used as a model for country-specific versions elsewhere in Asia.

Source: adapted from: Green C. Translation/adaptation of the Manual for reducing drug related harm in Asia into Indonesian. Unpublished, 2001.

7.3 PILOT PROJECTS AND PROGRAMME EVALUATION

In many situations, arguments about HIV/AIDS prevention among IDUs remain largely theoretical and ideological. Thus, various individuals argue about what would happen if, for example, a needle and syringe programme or methadone treatment begins or drug users gain access to a broader range of treatment options or if HIV-positive IDUs gain access to treatment, care and support services. One way to settle these arguments is to start such a programme and study its effects. This can be done formally or informally.

A formal method of starting a pilot programme often involves a university or independent researcher working with the developers of a HIV/AIDS programme. The team of practitioners and researchers normally conducts a baseline study to show what the situation is prior to starting the programme, often including some surveys of IDUs about their injecting and sexual risk behaviour. This can sometimes be done using rapid assessment methods or as part of the rapid situation assessment described above. The programme begins and evaluation is carried out at some point to examine what changes have occurred as a result of the programme.

Such formal programmes must follow certain rules to be useful for advocacy. First, the programme needs to be resourced to a sufficient degree to be able to produce a significant effect. This means that the programme needs to receive sufficient funding, trained staff, materials, such as information brochures, needles and syringes, methadone and condoms as appropriate. Further, support or at least non-interference from government structures and the community is needed to ensure that the programme can carry out an effective set of activities.

Second, the programme needs to be in place for sufficient time to produce an effect. In many cases, because of the amount of work needed to build trust among IDUs, such programmes can take well over a year to reach a stage where a clear effect can be detected. Pilot programmes should therefore usually be at least two years in duration or three years if all the research tasks are added, as the baseline study often takes several months prior to the programme being set up and the reporting of results often takes several months after the pilot has been concluded.

Pilot programmes are only a means to an end. The pilot should show the effectiveness of an activity in the local context through evaluation. The results of the pilot should be provided to influential individuals and groups, leading to policy changes and introduction of the activity at an effective scale. For this purpose, interim evaluation at the end of the first year of the programme is useful to avoid shutting down the programme at the end of the pilot phase.

A pilot project must be well planned and sufficiently resourced with staff and materials. Only if these preconditions are met should the project start. A pilot project that fails is a very serious setback for advocacy work, because those in opposition will use the failure of the project as a strong argument against HIV/AIDS prevention among IDUs.

An example from the Islamic Republic of Iran (Box 10) shows how a pilot project can be expanded to a larger programme.

Box 10. Advocacy through pilot programmes in the Islamic Republic of Iran

The Ministry of Health of the Islamic Republic of Iran started HIV prevention programmes targeting IDUs in 2000 as a pilot project in two provincial capitals (Kermanshah and Shiraz) and the national capital (Teheran). The programmes, based in outpatient clinics, provided needle and syringe distribution, methadone treatment, counselling and treatment of sexually transmitted infections and services for people living with HIV/AIDS, including counselling, clinical management and social support.

The pilot programmes reached many IDUs and others who had previously not sought prevention and treatment services. For example, in Kermanshah, the clinic was serving 700 clients per month by mid-2001, mostly people living with HIV/AIDS and their families, with 150 clients attending the methadone programme and 50 attending the needle and syringe programme.

The Ministry of Health evaluated the programme. The results of the pilot programme were presented to the Cabinet and President in mid-2001. Continuation of the programme was approved, and plans were accepted for expansion of the programme to 15 more clinics in 2002.

Source: The status and trends of HIV/AIDS/STI epidemics in Asia and the Pacific. Geneva, UNAIDS, 2001 (<http://www.unaids.org>).

Informal establishment of pilot programmes has been common, especially in the early years of the HIV/AIDS epidemics. If this is illegal, this guide does not recommend this method. In this process, an individual or group began a controversial programme, often in the knowledge that the police or other officials would force the programme to close. The resulting publicity, sometimes including court cases, raised the issue of HIV among IDUs and increased the likelihood that the mass media would mention some of the evidence for the approach taken. Many needle and syringe programmes in the United States and some in Brazil (Box 11) were started by this method.

Box 11. Needle and syringe programmes in Brazil

Specific interventions addressing HIV/AIDS among drug users in Brazil began already in 1989 in Santos. A harm reduction project was launched there in 1993, in which outreach workers attempted to organize a needle and syringe programme. The outreach workers were apprehended by the police and the project was stopped. In 1995 the first tolerated needle and syringe programme was implemented in Bahia State in Salvador. In 1998, Bahia State legalized needle and syringe programmes, followed quickly by other states. In 2001, a federal law was introduced legalizing needle and syringe programmes. The law was approved in 2002 and entered into force very recently.

After a pilot project has been converted into a large-scale programme with sufficient coverage, advocacy activities must aim at maintaining the programme. There are many examples of programmes with insufficient ongoing advocacy attention that resulted in, for example, budget and staff cuts and ended in failure. An important method of preventing programmes from failing is ongoing data collection, monitoring and evaluation. The results of such efforts can warn programme implementers if something is going wrong and enable them to fine-tune programme activities. Ongoing monitoring and evaluation can also provide information on changes in drug-using behaviour, new drugs injected by drug users and emerging user groups, which might require different programme implementation strategies.

7.4 COST-EFFECTIVENESS STUDIES

One of the most important advocacy methods, especially for politicians, is analysing the effects of a HIV/AIDS epidemic on the economy and demography of a country, the costs of such an epidemic to a country, province or locality and how much can be saved through prevention efforts. These cost-effectiveness, cost-benefit and other economic studies usually require specialist researchers and substantial time to be carried out. However, there are now good models for such studies. A group of researchers in the United Kingdom, for example, has developed a model to assess the cost-effectiveness of some types of HIV programmes targeting IDUs,⁷ and the socioeconomic study described in Box 12 is an excellent example of a wide-ranging report on the likely effects of a HIV/AIDS epidemic on demography, employment, health, life expectancy and productive capacity.

As economic studies are often rather complex, people from a university or research institute need to be persuaded to carry out such studies. Advocacy groups can contact organizations with an interest and expertise in such studies, such as the World Bank (<http://www.worldbank.org/aids-econ>, accessed 17

⁷ London School of Hygiene and Tropical Medicine, HIV Tools Research Group. Costing guidelines, cost-effectiveness studies and mathematical simulation models. Web site: <http://www.hivtools.lshtm.ac.uk>.

March 2004) or the International Labour Organization (www.ilo.org/public/english/protection/trav/aids, accessed 17 March 2004), to get advice on who might be the most appropriate researchers and perhaps funding support.

Box 12. Socioeconomic impact of HIV/AIDS in Ukraine

Based on data of the Ministry of Health, a research group attempted to project the situation of the spread of HIV/AIDS in Ukraine to determine the potential effects of the epidemic. Two scenarios were used: an optimistic one and a pessimistic one.

According to the optimistic scenario, the number of HIV-positive people will be 582 000 by 2010, the number of new AIDS cases will reach 44 360 and the number of deaths 43 400. The situation will require more investment in the response strategies, more hospital beds will be needed, the demand for health care services will increase, etc. By 2010, the population will be 45 480 000, including those living with HIV/AIDS.

According to the pessimistic scenario, the number of HIV cases will reach 1 440 000 by 2010, the number of new AIDS cases will be twice as high as in the optimistic scenario (95 210 people), and the disease will kill 89 200 people. The total population will decline to 44 890 000.

As the epidemic cannot be stopped “instantly”, its economic, demographic and social effects will develop over time and affect future generations. A specific aspect of this disease is that, even with effective prevention slowing the pace of the epidemic, the number of illnesses and deaths will increase throughout the next several years. This means that the epidemic will affect individuals, families, working teams, regions, specific sectors of the economy, the labour market, the health care system, the social infrastructure, the system of social protection and the administrative system. It will affect the level of social tension in society, demographic policy and national security.

At the level of enterprises, vulnerability will manifest itself depending on the quality of the workers who become infected. Training of managers and qualified workers requires time, skills and experience. This means that the cost of recruitment, training and social insurance (including health care) of the labour force will increase. Effects are also defined for the health care system, income, life expectancy, care of orphans and social problems.

To organize an effective response to the epidemic, the society should implement a comprehensive strategy as a priority. Such a strategy will include: effective solutions for HIV/AIDS diagnosis and treatment; effective prevention strategies at the national level; and political solutions in the fields related to the epidemic. This will require appropriate steps to be undertaken by the whole society. This problem is complex and thus requires a complex solution based on an intersectoral approach. This will require joint action from the state, private sector and civil society.

Source: Balakireva O et al. The social and economic impact of HIV and AIDS in Ukraine: a re-study. Kiev, British Council/Ukrainian Institute for Social Research, 2001.

7.5 MOBILIZE RESEARCHERS

Establishing the evidence base of HIV/AIDS prevention among IDUs requires some degree of expertise in methods of social science and public health and often computer facilities, which are often not available in an advocacy group. For example, carrying out rapid assessment requires at least prior training, and specific research questions arise afterwards that need to be looked into in detail. Similarly, soundly evaluating a pilot project requires expertise in statistics.

Most countries have people who can assist in carrying out research. Some of these people may be at universities or private research institutions, but many are not interested in working with IDUs because of prejudice against drug users and lack of funding and other incentives. How can the research community be mobilized into preventing HIV/AIDS among IDUs?

In many countries, advocacy activities have targeted the research community itself. Activities to motivate researchers and institutions can include providing international scientific materials, information about and scholarships for conferences, information about research grants and inviting them to meetings at which issues related to HIV/AIDS prevention among IDUs are being discussed. International and funding organizations can provide some assistance in motivating researchers by inviting them to international conferences or offering consultancies for specific tasks. For those working in advocacy, establishing contacts with both the research community and international and funding organizations and linking these groups are important.

Once a research institute has begun to work in HIV/AIDS prevention among IDUs, the impact can be extraordinary beneficial, because activities are often not restricted to pure assessment work but also include research related to action. The Centre for Studies and Therapy of Drug Abuse at a university in Brazil (Box 13) illustrates that a research institute can carry out many important interventions for the prevention of HIV transmission among IDUs within the framework of its teaching and research obligations and, through its reputation, move the policy agenda ahead significantly.

Box 13. Action research in Brazil

The Centre for Studies and Therapy of Drug Abuse (Centro de Estudos e Terapia do Abuso da Drogas, CETAD) of the Federal University of Bahia, Salvador, is a free public health service that provides therapeutic and prevention support for drug users, their families and the general population in Salvador. CETAD was established in 1985 and received support from the Ministries of Health, Justice, Education and Social Affairs. It was one of the first reference centres to receive support from the joint projects between the government and UNDCP (now UNODC), and it received additional support from the United States Agency for International Development and SENAD (Brazil National Antidrug Secretariat).

As an institute in a university, CETAD carries out teaching and research tasks and delivers services to communities. Students of law, social sciences, public health and nursing can enrol in courses that include both theoretical instruction and practical work. They have the opportunity to write their term papers and theses on projects of CETAD. The current coordinator of CETAD wrote his doctoral dissertation on the community outreach work of CETAD.

The work of CETAD is therefore well grounded in scientific evidence, and all projects have a strong component of data collection and analysis. The projects of CETAD are usually well documented through various media, including the general press, scientific and peer reviewed journals, conference papers and posters and video and DVD. Currently, 19 outreach workers and 8 supervisors are working in CETAD, all students or staff members.

In March 1995, CETAD implemented the first state-sanctioned needle and syringe programme, which was successful for about one year until the target community was swept by a major crack epidemic. As crack users were extremely violent, outreach activities had to be reduced. CETAD staff observed, however, that crack users were not well accepted by communities and that crack use slowly declined and was replaced again by cocaine injection, which resulted in the resumption of needle and syringe programmes and other outreach activities such as education on sexually transmitted infections and referral to clinics.

CETAD has set up the following projects.

Fix points. These are permanent outposts in communities where drug users and interested people can obtain clean needles, syringes, condoms and counselling on sexually transmitted infections and other issues.

Mobile unit. A minibus with outreach workers tours various communities and delivers services similar to those of the fix points.

Pharmacy project. Staff of pharmacies are trained to deliver HIV/AIDS counselling services and convinced to distribute condoms and clean needles and syringes free of charge.

Prison project. Harm reduction activities are being carried out in a prison, and prison staff are being trained to address issues related to HIV/AIDS appropriately.

A special project addresses various issues related to street children.

Source: Secretaria da Justica e Direitos Humanos, CETAD, 2002 (http://www.bahia.ba.gov.br/sjdh/conen_pcetad.htm).

8. DEVELOPING POLICY

Establishing the evidence base is only a means to an end – to change policies and establish a favourable environment in which HIV/AIDS prevention among IDUs can be carried out, in which large-enough programmes can be developed and implemented to halt and reverse the epidemics and in which existing programmes can be maintained at a level at which they produce results with sufficient impact. It is a fallacy that evidence alone produces such effects and that policy-makers automatically change their views and attitudes when they are provided with some data, publications and the right information. Factors other than scientific evidence influence political decisions. These can include mandates from constituencies; influence from powerful groups such as workers', employers', business and religious organizations; macroeconomic considerations and priorities; or pressure from neighbouring or major donor countries. This section outlines methods of influencing policy and programme development in favour of HIV/AIDS prevention among IDUs.

8.1 LOBBYING FOR POLICY REVIEW AND CHANGE

The process of policy development changes significantly from country to country, but a single person rarely decides a policy. Decision-makers (Box 14) usually rely heavily on the advice and views of a number of institutions, groups and individuals, including people with specialist knowledge, for example, related to health, economics or law enforcement, and people with vested interests in various government policies. Policy-makers try to anticipate the reactions of various influential groups and the general public and take into account these anticipated reactions before they make policy decisions. If a policy-maker expects, for example, the opposition of the entire business sector, large trade unions or influential religious groups, he or she will think twice before adopting a controversial policy and undertake some effort to find a compromise and establish a consensus with such stakeholders (see also section 5.3).

Box 14. Who are the policy-makers and decision-makers?

For local advocacy, policy-makers and decision-makers include the head of the city administration, the head of the health department, the city police chief, the heads of the social services, education and finance departments and staff of the city administration. In addition, members of the community council and various commissions and committees have a say in decision-making. At the provincial and national levels, there are usually similar structures with responsibility for health, law enforcement, social services, education and justice, etc. The national level often has drug control and HIV/AIDS commissions, with membership from various government sectors and participation of civil society. Members of the parliament and parliamentary institutions often play an important role in developing and blocking policies. International and funding organizations usually establish various groups and committees, such as a thematic group on HIV/AIDS, special working groups for injecting drug use and national and regional task forces, which have some influence and leverage on national policy development. Such regional groupings as the Commonwealth

of Independent States, Association of Southeast Asian Nations and South Asian Association for Regional Cooperation address HIV/AIDS and develop policy guidelines. At the global level, policy guidance is developed in the United Nations System, such as the General Assembly, the Economic and Social Council, the Commission on Narcotic Drugs, the World Health Assembly and in governing boards of various agencies and programmes such as UNICEF, the United Nations Development Programme (UNDP), UNESCO and UNAIDS.

Lobbying as a method of advocacy requires the advocacy group to establish direct and indirect contacts with the people developing and adopting decisions and those who influence policy-developers and decision-makers. Most often this is done through participating in various meetings of groups, commission and committees, often initially as an observer, and later as full participants. Such participation in meetings allows advocacy group members to identify important people and to ascertain their views on issues related to HIV/AIDS prevention among IDUs. It also provides opportunities for consultations, often beginning with informal talks, and lobbying inside an institution by requesting some participants of the meeting to raise the issue in their organizations.

Working from inside an organization tends to be effective because key people, their decision-making ability and their beliefs and attitudes may already be known. These insiders can sometimes become members of the advocacy group but often cannot. In either case, they should be kept informed of advocacy activities and objectives and asked about important target audiences and people and which arguments may be most suitable for them. HIV/AIDS prevention often comes onto the agenda of an organization through this process, and policy changes are initiated in a tacit way (Box 15).⁸

Box 15. Changing health policy in Bogotá, Colombia

Health policy does not always have to be changed in documents and public announcements for effective approaches to be started. An approach in Colombia has used small, incremental steps to incorporate effective approaches into health practice on the streets, slowly moving upward to create de facto policy.

For example, cancer pain control was the only legal use for methadone in Colombia until 2000. In late 1999 and early 2000, after reports were published of confirmed cases of HIV acquired through shared injecting equipment, lobbying began for methadone to be made available to heroin users to prevent HIV infection. Senior Health Ministry officials were discreetly lobbied by a small alliance of mid-level staff, an outreach worker and a handful of heroin users. The most useful argument, they found, was simply that the health of the general public was at risk from a HIV epidemic that spread among IDUs and from them to sex partners and children and on to the general public. In a short time, methadone was

⁸ More detailed information is available in several of the guides mentioned in section 13.1. In particular: Sharma RR. An introduction to advocacy: training guide. Washington, DC, Support for Analysis and Research in Africa, AID Africa Bureau Office of Sustainable Development, United States Agency for International Development, 1997 (http://sara.aed.org/sara_pubs_list_sara_5.htm). International HIV/AIDS Alliance. Advocacy in action: a toolkit to support NGOs and CBOs responding to HIV/AIDS. Brighton, International HIV/AIDS Alliance, 2001 (<http://www.aidsmap.com/web/pb4/eng/4782D096-C740-41A5-AF06-D67C14B46DB8.htm>).

authorized as a substitution treatment for heroin users. Without any publicity that could have provoked negative reactions, it has become an accepted option. Advocacy for access by drug users to health services seems to work best and is hardest to resist when it is part of broader arguments for public health gains.

Source: Ross T. Notes from South America. *International Journal of Drug Policy*, 2001, 12:27–30.

Government agencies are usually interested in collaborating with civil society organizations. This is part of good governance and is promoted by many intergovernmental organizations, such as UNDP, the World Bank and UNICEF. Government agencies also hope that NGOs can do part of their work and contribute human and financial resources and expertise. Being invited to various meetings of commissions and committees is therefore often not very difficult. In many cases NGOs are already participating, and the advocacy group can contact these representatives and request them to address HIV/AIDS prevention among IDUs. In such cases, these organizations become target audiences of advocacy activities. Once a group has invited and can participate in such meetings, further invitations follow nearly automatically.

Many NGOs are requested to contribute to the preparation of or to participate in intergovernmental meetings as part of the country delegation (Box 16). Examples include United Nations General Assembly special sessions on HIV/AIDS and on drugs, sessions of the Commission on Narcotic Drugs and the Programme Coordinating Board of UNAIDS.

Box 16. Contributing to the United Nations General Assembly Special Session on HIV/AIDS from Asia

Strategic networking has been one of the key strategies of the Asian Harm Reduction Network (AHRN). United Nations agencies, international organizations and government and community-based organizations are key target groups for AHRN's networking activities.

Because of this networking, AHRN was well positioned when the debate on the Declaration of Commitment on HIV/AIDS of the United Nations General Assembly Special Session on HIV/AIDS started. As an active member of the Coalition of Asia Pacific Regional Networks on HIV/AIDS, AHRN ensured that harm reduction for drug users has been well represented in the Coalition's recommendations on cross-cutting issues to the United Nations General Assembly Special Session on HIV/AIDS and to the meeting of the Association of Southeast Asian Nations in November 2001.

Prior to the United Nations General Assembly Special Session on HIV/AIDS, AHRN had been lobbying intensively to include harm reduction recommendations in the final Declaration of Commitment on HIV/AIDS with ambassadors from Asian countries and from governments known to be sympathetic to the issue. In addition, AHRN also attended actual meetings at the United Nations General Assembly in New York in June 2001 and, in partnership with key partners from other regions such as Latin America, central and eastern Europe, central Asia and Africa, AHRN lobbied extensively during these days to include harm reduction for drug users in the final Declaration.

This resulted in a joint press conference at the United Nations, television interviews and wide mass-media coverage on the need for pragmatic policies for preventing HIV/AIDS among drug users. After the United Nations General Assembly Special Session on HIV/AIDS, AHRN has been advocating for wide application of the recommendations, in particular for paragraphs 23, 52, 62 and 64 (Box 24). AHRN has disseminated these recommendations widely through its web site and on CD-ROMs. Implementation of the United Nations General Assembly Special Session on HIV/AIDS has been mentioned in one breath with AHRN recommendations for implementing the United Nations System position paper on preventing HIV/AIDS among drug users.⁹

Source: personal communication, Ton Smits, Asian Harm Reduction Network, 2002.

Another way of lobbying is to invite policy developers and decision-makers to participate in the meetings of the advocacy group or even to become members of the group. This could be initiated, for example, by inviting an official of a drug control agency to give a lecture on drug laws in the country and to convince him or her to continue contributing to the work of the group. The example from Slovakia (Box 17) shows that such a strategy can have beneficial effects.

Box 17. Advocacy with policy-makers in Slovakia

Slovakia has 5.5 million inhabitants and just 160 officially registered people living with HIV/AIDS (as of June 2002), two of whom are HIV-positive IDUs. No epidemic of HIV/AIDS has been declared. However, injecting drug use is on the increase and field data about the actual situation are limited. The Open Society Foundation Slovakia established a Harm Reduction Advocacy Group to prevent a HIV/AIDS epidemic among IDUs by assisting in establishing a network of effective programmes throughout the country. The Group also promotes the idea of harm reduction among policy-makers and makes it an integral part of health and drug policy, attempts to influence the legislative framework of drug policy and works with stakeholders, such as police, to change their attitudes towards drug users and to promote equal access to services by IDUs.

One objective of the Group has been to make effective approaches to HIV/AIDS prevention among IDUs an integral part of national drug policy through the participation by the Open Society Foundation in preparing a National Declaration on HIV, Young People and Drug Use. This Declaration was an initiative by WHO and UNAIDS involving both the government and nongovernmental sectors. The Declaration (which should soon be followed by an action plan) specifically mentioned harm reduction (the first official government document to do so).

The group has also worked with policy-makers in the police force. First, the group identified key representatives from the police. In cooperation with the government body for drug control, an offer was made to the police department to examine effective and new ways of dealing with drug use and using the expertise and potential from the region. Supportive materials were presented to the police representatives. A study tour was organized to a site

⁹ Preventing the transmission of HIV among drug abusers: a position paper of the United Nations System. Annex to the Report of the 8th Session of the Administrative Committee on Coordination Subcommittee on Drug Control, 28–29 September 2000. Geneva, United Nations, 2000 (<http://www.unaids.org/publications/documents/specific/injecting/Hraids.doc>).

where there is well-developed cooperation between police, NGOs and the city. After the study tour, the group has assisted in providing further education to the police representatives and making them trainers on harm reduction for the police.

As a basis for these and other activities, the advocacy group has developed country-specific advocacy materials in Slovak. Manuals developed for the region on HIV/AIDS prevention in general are adjusted to country needs and translated into the local language. These are useful in approaching any stakeholders, policy-makers and potential service providers for harm reduction.

Source: personal communication, Tatiana Hicarova, Open Society Institute Slovakia, 2002.

The example from Slovakia shows that the advocacy group or other NGOs are invited to participate and contribute to policy development in the course of the lobbying process. In this process, the opportunity usually develops for the group to meet a senior government official, such as the health minister or the chair of the drug control or HIV/AIDS commission. For such an occasion, the advocacy group should prepare a short written description of the issue to be discussed with the official, including one or more recommendations for action. Each recommendation should be carefully considered to ensure that it can be accomplished. For example, for a national health minister, the recommendation might be “to double the level of funding available for drug treatment in the country in response to the HIV/AIDS crisis among IDUs” or “to make needle and syringe exchange a key HIV/AIDS prevention activity, directing each provincial health department to ensure that needle exchange programmes are started within the next few months”. For a village head or the head of the city administration, it may be “to request that the health department and police work together to ensure that an outreach programme can reach IDUs with education and disinfectant without police interference”.

In some cases, members of parliament take up HIV/AIDS prevention among IDUs and use their channels for policy development, which are usually high-level and very influential committees. Here it is important to provide parliamentarians with all kinds of information, from assessment of the country situation to international evidence. As a result of their work, parliamentarians are often in a position to draft laws that legalize HIV/AIDS prevention among IDUs. An example from Brazil (Box 18) shows how complex the process of policy development and legal changes can be and that it can take quite some time until laws are changed.

Box 18. Harm reduction laws in Brazil

Paulo Teixeira relates how needle and syringe programmes became legal and expanded in Brazil.

I am the author of the first Harm Reduction Law in Brazil. The first Harm Reduction Programme was begun in 1989 in Santos in São Paulo State, where almost 60% of the drug users were at that time HIV-positive. When the Municipality of Santos introduced a needle and syringe programme as part of the Harm Reduction Programme's activities, a judge prosecuted the public health officials because the Programme was regarded as a stimulus to drug use.

Because of the interdiction of this Programme and the legal action against those responsible for it, I presented to the São Paulo State Parliament legislation to authorize this programme, based on three aspects.

- ▶ **Legal.** The programme was not designed to promote drug use but instead to help in changing the risk behaviour of drug users.
- ▶ **Financial.** It was important to prove that the cost of the prevention programme was extremely low compared with the cost of treatment for AIDS and hepatitis. This was an important argument for the government and helped to promote a strategy for prevention.
- ▶ **Political.** The programme is an effective mechanism for the government to prevent HIV/AIDS spreading among and from IDUs.

In 1998, the law was approved, three years after being submitted to the São Paulo State Parliament. This process was aided by the following institutions.

- ▶ **Social movements.** They led many struggles – for example, to provide universal access to antiretroviral therapy medication to all people with AIDS in São Paulo State as well as guaranteeing attention to AIDS cases in the health insurance system so that the costs of AIDS to the São Paulo State could be weighed against the costs of prevention.
- ▶ **Mass media.** With the constant publication of the increasing number of reported AIDS cases, the spread of HIV and hepatitis could be associated with the unsafe use of illicit drug injection. Further, the positive results achieved by countries that had implemented harm reduction strategies were published.
- ▶ **Harm Reduction Programme.** The needle and syringe programme continued, so the São Paulo State Parliament saw that it was necessary to formalize it.

The São Paulo law was also introduced and passed soon afterwards in three other states: Rio Grande do Sul, Rio de Janeiro and Santa Catarina, and in January 2002, a new Federal Law on Drugs legalized needle and syringe programmes throughout Brazil. By March 2002, there were more than 100 such programmes in the country, and harm reduction programmes have started in prisons.

Source: Teixeira P. The role of politicians in promoting policy changes. 13th International Conference on the Reduction of Drug Related Harm, Ljubljana, Slovenia, 3–7 March 2002.

8.2 ANALYSIS OF LAWS AND PRACTICES

In many countries, drug laws and regulations were adopted before the onset of HIV/AIDS epidemics and do not take into account the requirements of HIV/AIDS prevention among IDUs. This pertains especially to laws and regulations relating to treatment, specifically substitution treatment and imprisonment; paraphernalia laws, particularly the legality of selling needles and syringes in pharmacies and distributing clean needles and syringes to IDUs; and issues related to outreach. Such laws and regulations are usually, but not always, built on the various United Nations conventions, and more often than not policy-makers and programme designers of both the health and drug control sectors are not clear about the implications of current legislation for HIV/AIDS. An important method of advocacy is, therefore, to analyse the various laws and regulations related to injecting drug use, what they stipulate and whether the various methods of HIV/AIDS prevention among IDUs can be implemented under the current laws and regulations. The analysis also needs to provide guidance on which HIV/AIDS prevention interventions are possible under the current legal system, and, if necessary, how the legal system pertaining to drug control and health needs to be harmonized.

Questions addressed in this analysis include the following.

- ▶ Do the current laws and regulations allow for the full package of HIV/AIDS prevention among IDUs, including substitution therapy and needle and syringe programmes?
- ▶ Can outreach be done using drug users as outreach workers?
- ▶ Is the possession of needles and syringes used as evidence of unlawful behaviour?

Another set of legal questions addresses the issue of treatment instead of imprisonment. Is it possible that drug users, instead of going to prison, undergo therapy? And finally, the analysis must include laws for the protection of human rights, the rights of drug users and of people living with HIV/AIDS, addressing also such issues as mandatory testing for HIV, confidentiality and benefits from the social security system, if applicable.

Such an analysis in itself is not an advocacy method unless it is used to convince policy-makers and programme planners at various levels to implement appropriate HIV/AIDS prevention interventions at a large enough scale. That means that a report needs to be prepared and provided to the policy-makers and programme planners working on issues related to injecting drug use. In practice, such a report usually stimulates a debate inside the relevant government departments and sets in motion a process of legal review and amendment of the current legislation pertaining to injecting drug use. Officials of the public health sector often but not always support HIV/AIDS prevention efforts. They are grateful to see such a legal analysis and often use it to lobby for their

interests. But there are also many cases in which an advocacy group, through a legal analysis, discovers that a number of interventions can be carried out even under the current law if only there is political will. Box 19 provides an example at the global level in which a legal analysis resulted in a reinterpretation of international drug conventions.

Box 19. Drug control conventions

In 2002, the Commission on Narcotics Drugs (CND) called for harmonization of national drug control and HIV prevention policies, and endorsed the implementation of measures that reduce or eliminate the need to share non-sterile injecting equipment.

The International Narcotics Control Board (INCB), in its Annual report of 2003, explicitly stated that

- “Governments need to adopt measures that may decrease the sharing of hypodermic needles among injecting drug abusers in order to limit the spread of HIV/AIDS.”
- “Drug substitution treatment does not constitute any breach of treaty provisions, whatever substance may be used for such treatment in line with established national sound medical practice.”

To analyse laws and regulations, an advocacy group usually requires the help of the legal profession: lawyers, especially those who specialize in work on human rights, and judges. Usually they are interested in issues related to HIV/AIDS and injecting drug use and most willing to review such laws. They themselves can be powerful advocates and can provide useful legal advice to advocacy groups. Human rights advocates often receive a sympathetic hearing in the mass media and, in some countries, in the government and courts (Box 20).

Box 20. Coalition-building with human rights activists in Hungary

Faced with difficulties in starting and expanding harm reduction programmes in Hungary in the late 1990s, a group of advocates enlisted the support of the Hungarian Civil Liberties Union. This organization was founded in 1994 as an independent body to promote the fundamental rights and principles laid down by the Hungarian Constitution and by international conventions. The Hungarian Civil Liberties Union made harm reduction drug policy a focus of its work, together with policy work related to patients' rights, freedom of expression, disability rights, freedom of information, abortion, euthanasia and the death penalty.

The Hungarian Civil Liberties Union reviewed the literature related to harm reduction and determined that a policy based on this approach was the best way to prevent HIV epidemics among IDUs as well as protecting the rights of drug users as members of Hungarian society. In February 2002, the Hungarian Civil Liberties Union released a report criticizing the government's approach to drug use and calling for, among other actions:

- ▶ greater publicity for the methods and advantages of harm reduction activities to reduce misconceptions and prejudice;
- ▶ substantial increases in the proportion of funds directed towards providing treatment and rehabilitation of drug users;
- ▶ increase in the access of opioid users to methadone maintenance treatment; and
- ▶ governments actively supporting needle exchange programmes instead of tolerating them.

The report concluded: "Hungary should recognize the achievement of countries which have integrated harm reduction into their drug policy and have shown that drug policy has serious chances of success in the long run if it sets realistic targets, focuses on the genuine interests of public health, relies on well-established scientific results and pays respect to the principles of human rights."

Source: HCLU on harm reduction drug policy. Budapest, Hungarian Civil Liberties Union, 2002.

For virtually every advocacy campaign addressing legal issues, there is a difference between what is stipulated in laws and regulations and what is enforced. There are many degrees of discretion in law enforcement, which can lead to a practice enabling the implementation of HIV/AIDS prevention among IDUs, at least for a certain time until laws and regulations are amended with the explicit purpose of accommodating HIV/AIDS prevention.

For example, police at the national level can decide that the highest priority in drug policing is to apprehend drug traffickers rather than drug users. This can be transmitted down the chain of command so that resources at the local level are weighted towards investigating and preventing large-scale drug manufacture and movements and away from constant attention towards individual drug users. In addition, courts can decide not to hear certain cases that judges or magistrates believe are a waste of time. Prosecutors may decide not to prosecute certain crimes in some countries.

How can such enforcement practice for IDUs that are more compatible with HIV/AIDS prevention be achieved? Addressing HIV/AIDS among IDUs means that both health professionals and law enforcement, including prison authorities, need to work together. The advocacy method of choice is to lobby for the establishment of a joint working group or committee in which these two sectors and possibly other sectors, including NGOs, start to communicate and develop strategies for HIV/AIDS prevention. To do this, an advocacy group needs to find an institution or senior people – a senior health or police official, or an NGO, for example – to take the initiative to organize and invite participants to the first meeting. Experience shows that all participating groups usually benefit from such meetings and acknowledge these benefits (Box 21).

Box 21. Collaboration with law enforcement personnel in St Petersburg

Some programmes have managed to assist law enforcement staff in learning more about HIV/AIDS and its relationship to drug use. In St Petersburg, Russian Federation, for example, active advocacy by the Médecins du Monde needle and syringe programme with local police was carried out to alert police to the risks of HIV infection and to inform police about harm reduction methods. Close contact was formed with the Psychological Service of the Department of Internal Affairs, which led to further contacts with militia (police) units. At the request of the Department, staff of the needle and syringe programme developed a leaflet on HIV transmission and prevention for militia, printed from the militia budget and then widely distributed to law enforcement in the city.

Depending on how such meetings proceed, several other steps can be taken. Experts can be invited to brief the meeting on various prevention methods. Personnel from funding organizations can be asked to join to increase incentives to work in the group. Staff of international organizations can be asked to participate and to provide input by sharing best practices and lessons learned from other countries. Members of the group or committee can be provided with a whole range of materials available for HIV/AIDS prevention among IDUs such as case studies, programming guides, manuals and policy papers (Box 22).

Box 22. Working with public security and justice personnel in China

The role of the national Ministry of Public Security and provincial departments of public security is very broad in China. As well as providing police, public security also manages and staffs drug rehabilitation centres. Public security staff come into regular contact with drug users, especially IDUs in recent years, as do staff of the Ministry of Justice and departments of justice, which manage the labour re-education and rehabilitation centres of the judicial system.

The China-UK HIV/AIDS Prevention and Care Project worked with Chinese experts on HIV/AIDS and drug use to develop an information and training package for staff of these two sectors. The package, with a foreword by the Deputy Secretary General of the National Narcotics Control Commission and Director of the Department of Narcotics Control of the Ministry of Public Security, provides staff with a wide range of useful information and training exercises specifically developed for their work areas.

The project of producing the manual and implementing it in two provinces, Sichuan and Yunnan, has assisted in closer collaboration between staff of the health sector and the departments of public security and justice. The China-UK HIV/AIDS Prevention and Care Project found in implementing the training that these officers had a great desire for knowledge on HIV/AIDS, partly because they were very poorly informed and were worried about their own risk of occupational exposure. The Project staff hoped that improving their knowledge of HIV/AIDS and drug use would reduce their fear and the stigmatization of people living with HIV/AIDS.

Source: China-UK HIV/AIDS Prevention and Care Project. [STD/HIV/AIDS prevention and harm reduction: a training manual for public security and justice personnel.] Beijing, Department of Diseases Control, Ministry of Health; China National Narcotic Control Commission & Ministry of Public Security; Bureau of Re-education-through-Labour Administration, Ministry of Justice; China-UK HIV/AIDS Prevention and Care Project, 2002.

One method of working on law enforcement practices at the national and provincial levels is using study tours and participation at conferences where law enforcement and criminal justice staff can discuss issues of HIV/AIDS and drug use with their counterparts from other countries (Box 23).

It is helpful for the process if members of both the health and enforcement sectors participate together in such events, especially if their relationship at home is not well developed.

Box 23. Participation in international conferences as an advocacy tool

In October 1998, the UNAIDS Asia-Pacific Intercountry Team began consultations with the UNAIDS co-sponsors and key partners on selecting key people from drug control agencies to participate in international conferences on HIV/AIDS among drug users. The purpose of the participation was to increase the awareness of drug control organizations on matters pertaining to HIV/AIDS among drug users.

After a long consultation and negotiation process, the Team was able to select officials of the China National Narcotics Control Commission, the Malaysia National Narcotics Agency and the Thailand Office of the Narcotics Control Board to participate in the 10th International Conference on the Reduction of Drug Related Harm in Geneva, Switzerland in March 1999. After the Conference, the participants firmly believed that rapid action should be implemented to prevent HIV/AIDS in their countries, but there was considerable controversy on how to intervene. The appropriateness of methods such as substitution treatment, needle and syringe programmes and safe injecting rooms were especially questioned. The participants were of the view that their institutions would need to explore first the legal feasibility of specific interventions.

Similarly, a number of officials from drug control agencies from Bangladesh, China, India, Indonesia, Malaysia, Pakistan, Thailand and Viet Nam participated in the 5th International Conference on AIDS in Asia and the Pacific in Kuala Lumpur in October 1999. At this Conference, the participants had the opportunity to discuss with their colleagues from other countries in the region and with officials of public health agencies as well as NGOs the issue of HIV/AIDS among drug users.

8.3 LOBBYING FOR ACTION

Laws, policies and international declarations remain useless paper unless they are followed by actions on the ground providing concrete services to IDUs. This means that policy and legal changes and declarations need to be followed up and translated into action. This requires determining which policies and international agreements the country has adopted, which is not always easy because some government agencies are not transparent. In addition, the text of these instruments needs to be used to argue for concrete HIV/AIDS prevention programmes for IDUs. Box 24 provides the text relevant to injecting drug use from the Declaration of Commitment on HIV/AIDS of the United Nations General Assembly Special Session on HIV/AIDS, and Box 25 shows that a regional grouping took up the Declaration and translated it into action points. Nevertheless, there is a long way to go until IDUs are provided with essential services.

Box 24. Excerpts relevant to injecting drug use from the Declaration of Commitment on HIV/AIDS of the United Nations General Assembly Special Session on HIV/AIDS

...

23. ... effective prevention, care and treatment strategies will require behavioural changes and increased availability of and non-discriminatory access to, inter alia, vaccines, condoms, microbicides, lubricants, sterile injecting equipment, drugs including anti-retroviral therapy, diagnostics and related technologies as well as increased research and development;

...

52. By 2005, ensure: that a wide range of prevention programmes which take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections;

...

62. By 2003, in order to complement prevention programmes that address activities which place individuals at risk of HIV infection, such as risky and unsafe sexual behaviour and injecting drug use, have in place in all countries strategies, policies and programmes that identify and begin to address those factors that make individuals particularly vulnerable to HIV infection, including underdevelopment, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection, all types of sexual exploitation of women, girls and boys, including for commercial reasons; such strategies, policies and programmes should address the gender dimension of the epidemic, specify the action that will be taken to address vulnerability and set targets for achievement;

...

64. By 2003, develop and/or strengthen national strategies, policies and programmes, supported

by regional and international initiatives, as appropriate, through a participatory approach, to promote and protect the health of those identifiable groups which currently have high or increasing rates of HIV infection or which public health information indicates are at greatest risk of and most vulnerable to new infection as indicated by such factors as the local history of the epidemic, poverty, sexual practices, drug using behaviour, livelihood, institutional location, disrupted social structures and population movements forced or otherwise;

...

Source: United Nations. Declaration of Commitment on HIV/AIDS. (http://www.unaids.org/en/events/un+special+session+on+hiv_aids/declaration+of+commitment+on+hiv_aids.asp, accessed 17 March 2004).

Various organizations have released guidelines on how to do this.¹⁰ Policies and international agreements need to be brought to the attention of relevant government agencies and the general public. Government agencies need to be encouraged to develop action plans and to implement such plans. In this phase of lobbying, government agencies responsible for HIV/AIDS prevention among IDUs need to be especially emphasized. Such agencies include the health, social and justice sectors.

The lack of technical capacity and financial resources are common problems that may need to be addressed.

Box 25. Use of the Declaration of Commitment on HIV/AIDS of the United Nations General Assembly Special Session on HIV/AIDS in the Commonwealth of Independent States

In eastern Europe and central Asia, UNAIDS has followed up on the Declaration of Commitment on HIV/AIDS by assisting the Council of Heads of Governments of the Commonwealth of Independent States to develop a Resolution on the Programme of Urgent Response of Member States of the Commonwealth of Independent States to the HIV/AIDS Epidemic. In this Resolution, the governments of 12 countries in the Commonwealth of Independent States commit themselves to carrying out 26 tasks contained in the Declaration of Commitment on HIV/AIDS. Among the tasks are, by 2005:

- ▶ to create a legislative basis for cooperation between government, public and private sectors, ensuring full involvement of all parties concerned, including the most vulnerable groups and people living with HIV/AIDS, in the implementation of strategies to respond to the epidemic; and
- ▶ to develop and adopt the relevant legislation and regulations ensuring the implementation of HIV/AIDS prevention programmes among the most vulnerable population groups: IDUs, commercial sex workers, migrants, including displaced people and refugees, as well as other groups at risk.

¹⁰ The International Council of AIDS Service Organizations) has released guidelines on how to use several documents: International Council of AIDS Service Organizations. Advocacy guide to the Declaration of Commitment on HIV/AIDS. Toronto, ICASO, 2001 (<http://www.icaso.org/icaso/ungass/advguidedectncomit.htm>). Also available in French and Spanish. International Council of AIDS Service Organizations. An advocate's guide to the International Guidelines on HIV/AIDS and Human Rights. Toronto, ICASO, 1999. Also available in French and Spanish.

Source: Resolution on the Programme of Urgent Response of Member-States of the Commonwealth of Independent States to HIV/AIDS Epidemic. Moscow, Council of Heads of Governments of the Commonwealth of Independent States, 30 May 2002.

An excellent way to address capacity issues is to initially encourage attendance of officials at specific conferences and meetings and to organize study tours where they can gain first-hand experience of HIV/AIDS prevention among IDUs or of countries using these approaches. Meetings may be regional or global events concentrating on HIV/AIDS among IDUs. Conferences may be specifically on this topic – such as the International Conferences on the Reduction of Drug-Related Harm (<http://www.ihra.net>, accessed 17 March 2004) – or may be on broader topics such as the international and regional AIDS conferences and regular conferences on drug use: these broader conferences often have sessions on drug use and HIV/AIDS. Study tours can include a brief visit to one or two programmes in the city where a conference is being held or a more structured event in which several different types of organizations are visited and discussions are encouraged with a wide range of officials and implementers of programmes (Box 26). International and funding organizations of HIV/AIDS programmes often provide support for participation at these events.

Important principles of using this method of advocacy include the following.

- ▶ Selection of participants is vital. People with no interest in the issue or no power to influence change to policies and programme development will provide little or no benefit in return for the costs of accommodation, transport and conference fees.
- ▶ Participants must be committed to taking the event seriously. All countries (industrialized, developing and transitional) have individuals who enjoy travel and shopping but pretend to be interested in an issue to gain access to foreign cities. Participants should be encouraged to see the event as important and worthy of their time and concentration.
- ▶ The event needs to cater for the language and cultural needs of participants. Effective HIV/AIDS prevention among IDUs can be complex to discuss, so interpreters that allow discussion in participants' first (or other strong) language should be used wherever possible to aid communication.
- ▶ Sites visited on study tours need to reflect good practice.
- ▶ Wherever possible, participants at the event should be allowed time to discuss issues with other participants in similar occupations from other countries. As Box 26 shows, a police officer is likely to learn much more from another police officer or a politician from a politician than from a physician or a worker in a nongovernmental organization.

Box 26. Report after a study tour to the Netherlands

Alexander Zelitchenko, a Colonel of Internal Affairs in Osh, Kyrgyzstan, attended a study tour in the Netherlands with several colleagues from central Asia in 1999. He reports the following.

On the way back (to Kyrgyzstan), a Dutch police officer picked up a manual published in the Netherlands (including the following): 10 golden rules for mostly safe drug-abusing; how to make a solution; how to take a portion of drug; how to use a syringe for injection; and the schematic picture of human blood vessels with marked points for heroin injections.

Shocking reading? I wish you could see the faces of my colleagues – police officers – browsing this booklet. They were dumbfounded and demanded its destruction. Meanwhile, this manual has been issued by a special request from UNAIDS and is intended for wide circulation.

How could it happen that, at the same time our society is penalizing abusers, blacklisting their names in special police registers, forcing school pupils to listen to lectures about “fatal addiction” ... an enlightened Europe is establishing a philosophical and practical approach to “harm reduction” and is publishing free booklets of this kind?

In fact it is because they realized, much earlier than we did, that a non-repressive, human rights-defending, scientifically proven approach is considerably more promising and fruitful than segregation and the forced treatment of abusers This approach, conditionally called “harm reduction”, involves a wide range of measures aimed at a progressive lasting improvement in social conditions and the health of drug abusers. Every positive step in this direction, even a very small one, is worthwhile. Complete recovery remains the first aim of the programme, but (let’s be realistic) this is not the only possible positive result. I would like to repeat: the programme is first aimed at the maximum reduction in the harmful consequences for abusers and for society as a whole as well, especially in view of the HIV danger.

The only agencies trying to help the drug abuser now (in Kyrgyzstan) are anti-AIDS organizations. I would like them to keep on trying! The leader of the Republican Anti-AIDS Centre team recently visited the southern region and made a conclusion that became the headline of an article: “Your addicts are covered and hidden so much, as if they are wrapped up in bitumen!” Our domestic addicts are so scared of a police uniform and doctor’s whites [uniform] ... that they do everything possible to remain unknown.

It was difficult for me ... to do away with stereotypes fixed for years in my mind. I am a life-long police officer, and it is much easier for me to understand (to understand but not to obey and adopt) the desire to protect society and segregate abusers All these innovations, as with everything new and fresh, cannot be easily achieved. The existing legislation should be changed and public opinion as well. At the same time, all law enforcement agencies should strengthen and consolidate their activity against drug dealers, traffickers and organized criminal groups to decrease the black-market supply.

Source: adapted from Zelitchenko A. Wrapped up in bitumen. CEE-HRN Newsletter (Central and Eastern European Harm Reduction Network), 1999, Issue 3.

9. COMMUNITY-BASED APPROACHES

Communities can be defined in two different ways: as a group of people sharing the same geographical location, such as a village, an area in a city or in a district, or as a group of people sharing the same characteristics independent of the location where they live. The latter definition includes the community of people living with HIV/AIDS or the community of IDUs. Both types of communities can become both the subject of advocacy and advocates themselves.

9.1. COMMUNITY MOBILIZATION

Especially at the local and district levels, HIV/AIDS prevention can be implemented by mobilizing community members to either implement activities themselves or to pressure relevant authorities at the community level to do so, such as health care or drug rehabilitation centres. Mobilizing the local community increases the likelihood of developing and implementing culturally appropriate HIV/AIDS prevention strategies that the community accepts and that can effectively reach drug users and their sexual partners in their natural environments. Community members also often have a direct influence on leaders, as they are their constituency. In terms of advocacy, community members are often first the target and, at a later stage, become advocates themselves.

There are many guides and manuals on community-based approaches for drug abuse and HIV/AIDS prevention.¹¹ The common features include community organization and empowerment, gender equality, establishment of self-help and support groups and low-threshold, user-friendly services such as drop-in centres and outreach activities. Whether it is used for directly providing services or to pressure authorities to become active, the process of community mobilization often follows a specific sequence consisting of raising awareness, carrying out assessment, planning and implementing activities, providing training and evaluating the implementation of activities.

Box 27 provides an example of a community implementing HIV/AIDS prevention by themselves. Interesting in this example is the fact that the community operated the programme although it was against the law.

¹¹ Prevention of HIV transmission among drug users. A training module for field-level activities. UNAIDS Asia-Pacific Intercountry Team, Bangkok, December 1999.
Burrows D et al. Training on HIV/AIDS prevention strategies among injecting drug users in the Russian Federation. Moscow, Médecins Sans Frontières–Holland, 1999.
Costigan G, Crofts N, Reid G. Manual for reducing drug related harm in Asia. 2nd ed. Melbourne, Centre for Harm Reduction, Macfarlane Burnet Institute for Medical Research & Public Health, Asian Harm Reduction Network, 2003 (<http://www.ahrn.net/manual.html>).
Community-based drug demand reduction and HIV/AIDS prevention. A manual for planners, practitioners, trainers and evaluators. Bangkok, United Nations Economic and Social Commission for Asia and the Pacific, 1995.
Approaches to community-based HIV/AIDS prevention in the ESCAP region. New York, United Nations, 1998.
Strategies for community-based drug demand reduction in the ESCAP region. New York, United Nations, 1999.
Manual on community-based responses to critical social issues: poverty, drug abuse and HIV/AIDS. New York, United Nations, 1999.

Box 27. Mobilizing a community for HIV/AIDS prevention in Thailand

The rapid spread of HIV in Thailand and the endemic use of opiates, including heroin injection among Hill tribe villages in northern Thailand, led to the implementation of needle and syringe exchange programmes in several villages. The programmes were developed through community consultation. The villagers themselves ultimately decided to operate a needle and syringe programme in the villages following discussions on the various methods available to prevent HIV transmission.

Once the programme was established, the villagers operated it on a strict exchange basis with a high return rate. A registry was established, and only IDUs from the nominated villages were allowed to use the programme to avoid the villages becoming inundated with IDUs from neighbouring areas.

Evaluation of the programme has demonstrated a number of important points. Firstly, it has shown that introducing the programme did not result in an increase in the number of IDUs. The numbers of IDUs in six of the eight villages with a programme remained static. Secondly, in a small cohort of 22 IDUs, only two known seroconversions and a possible third occurred between 1993 and 1996. HIV seroprevalence remained low at 19% among IDUs in the villages with the needle and syringe programme versus 45% among IDUs attending the local hospital.

Finally, the programme operated in violation of Thai law, resulting in shortages in the supply of needles and syringes and concomitant needle and syringe sharing. In addition, there were some initial problems with new or young IDUs not being able to access the service and resentment towards the IDUs, who often demanded services day and night. Nevertheless, the programme is an example of successful intervention for a specific ethnic group developed with community consultation.

Source: Christian Kroll, consultant, 2002.

Box 28 presents another example of community mobilization. Here the group lobbied successfully for prevention activities but did not implement by themselves.

Box 28. Mothers against drugs

In the Russian Federation, a group called Mothers against Drugs was established in many cities in the mid-1990s. This group was mostly concerned with increasing law enforcement efforts aimed at catching drug dealers and was generally composed of mothers of drug users. However, in cities such as Volgograd, the head of Mothers against Drugs participated in training courses on HIV/AIDS and drug use and became the major impetus behind the comprehensive approach taken in that city, which includes drug prevention for school and out-of-school youth, drug treatment, needle and syringe exchange, outreach and care of HIV-positive IDUs.

A frequent issue related to community mobilization is sustaining ongoing programmes. Drug use, HIV/AIDS and prevention interventions often cause considerable fear in communities, which often leads to stigmatization and discrimination and to excessive reactions from the community. In such cases, the community becomes the subject of advocacy. Providing accurate information about drug use and HIV/AIDS, and other hands-on assistance helps change attitudes, as the example in Box 29 shows.

Box 29. Community advocacy in Bangladesh

Dhaka had an estimated 7650 IDUs and at least 11 000 heroin smokers. For IDUs, the drug of choice was injectable buprenorphine as well as other prescription drugs such as diazepam, promethazine and pheniramine. More than 90% of IDUs had previously smoked heroin, so that the 11 000 heroin smokers could be viewed as potential IDUs. More than 80% of IDUs had shared needles and syringes, and 90% had shared other injecting paraphernalia.

The first drop-in centre was set up in May 1998. Direct drug-selling and -buying spots were avoided. Project staff held formal and informal meetings with local government, community leaders, police and youth clubs. Finally, the ward commissioner provided space in his own office building free of charge. By June 1998, peer outreach workers, who were all active IDUs, had reached 150 IDUs and given out 1753 syringes.

Within three months, the ward commissioner came under pressure from various community groups, the local elite, religious leaders, youth groups and police to shut the project down. The project was accused of promoting drug use and not treating and rehabilitating drug users. The ward commissioner began to react to this pressure, worried that he had made a mistake in assisting the project. In August 1998, the biggest flood in history hit Bangladesh, and almost the whole of Dhaka was under water. As the IDUs had no work, they turned to petty crime to get money for drugs.

Community people got furious towards the IDUs and eventually towards the programme. One day when we went to the field to do our normal outreach activities, the local leaders and the ward commissioner demanded that we do something for the flood victims if we really want to help the community people in their distress. About 5000 people in that and nearby areas took shelter at that community centre and in another nearby government school.

We had one medical doctor and one qualified nurse in our intervention staff. Those two with the help of other field staff and peer outreach workers formed an emergency medical team. As we had no funds for medication for the flood victims, we started just giving medical advice and health education regarding food, drinking-water, sanitation, hygiene practices and communicable diseases. In about a week, we were able to dispense free medicine for the flood victims, which was donated by pharmaceutical companies.

Eventually, in about two weeks, the team convinced other agencies to fund this work and they continued to provide services for flood victims for one month until the flood was over. That timely response to the community need helped us a lot to regain their trust and acceptability. Since then, the ward commissioner himself and other community people have become strong advocates of our programme.

Source: adapted from Beg M. Injecting drug user intervention, SHAKTI Project, CARE Bangladesh. Activity report March 1998 to June 1999. Dhaka, CARE Bangladesh, 1999.

9.2 PEOPLE LIVING WITH HIV/AIDS AND INJECTING DRUG USERS

In several countries, people living with HIV/AIDS and IDUs have organized their own networks or organizations to lobby for their interests such as HIV/AIDS prevention and access to services, especially costly antiretroviral therapy. Such groups also have a strong agenda for protecting human rights and address discrimination and stigmatization. Although organizations of people with HIV/AIDS exist nearly everywhere where there is HIV/AIDS, organizing drug users has generally been less common.

Such groups have the great advantage that they can speak for themselves and lobby for their own interests. Advocacy groups are well advised to support them and to include them in their activities. IDUs know much better than anyone else what their problems are and how to address these effectively. Similarly, people with HIV/AIDS have first-hand knowledge of HIV/AIDS and what kind of support they need.

Groups and networks of IDUs and people living with HIV/AIDS can provide direct assistance to their members in terms of care and support or they can lobby for their interests and provide advice for policy and programme development, as the example in Box 30 shows.

Box 30. Advocacy by drug user groups in Germany

Under the pressure of increasing mortality rates and the spread of HIV/AIDS among IDUs, the Government of Germany started to implement methadone programmes in the mid-1980s. This treatment released many IDUs from the need for daily heroin injections and thus greatly influenced their everyday life. Suddenly they had time and the opportunity to act for their own interests. They could appear before the public and did not have to hide from the police because the methadone was prescribed legally. In this context, a large NGO providing HIV/AIDS education, care and support throughout Germany started to organize seminars for IDUs and methadone clients. In 1989, the participants of such a seminar founded JES (Junkies, Ex-users, Substituted users), a self-help organization for drug users.

The organization continued to support JES by financing the employment of a coordinator who was a drug user himself. The organization also provided the logistical and organizational structure necessary for JES to be able to operate throughout Germany. JES developed into a self-help network for drug users at a national level that represents their political interests, allows them to define their own objectives for an effective approach among IDUs and promotes harm reduction programmes.

Although many politicians and decision-makers had the perception that IDUs are irresponsible or even insane, JES met more and more favourable responses during the 1990s. The work of JES showed that drug users have the ability to represent their interests and to make

their own decisions. Further, the existence of JES was a very important factor in actually involving IDUs in HIV/AIDS prevention programmes. JES serves as a primary contact for public authorities and as a go-between for the Federal Ministry of Health and groups of IDUs.

Today, JES is involved in various projects that are financed by a department of the Federal Ministry of Health or other authorities. JES autonomously designs courses and seminars for drug users and puts them into practice. In the past year it published a booklet on the safer use of drugs that received international acclaim. Finally, it maintains its own drop-in centres in various parts of the country. These facilities are exclusively run by active or former drug users.

Source: personal communication, Sebastian Schmidt-Kaehler, Deutsche AIDS-Hilfe e.V., 2002.

10. WORKING WITH MASS MEDIA

An important advocacy method is using electronic and print mass media (Table 5) to raise awareness on HIV/AIDS prevention among IDUs, and, in some cases, to lobby or even push for change in policies and programmes. Supportive treatment by the mass media can greatly help in making the public and specific target audiences aware of advocacy messages. Negative treatment by the mass media, however, can lead to major problems and even shut down a programme. This guide does not provide detailed information on how to work with the mass media. Several manuals and guides have already been developed, and readers are strongly advised to consult these before including the mass media in an advocacy campaign.¹²

Advocates need to carefully consider whether running high-profile mass-media campaigns is useful and ultimately helpful. In some cases, for example, when a government has adopted new policies or when a regional meeting has made recommendations pertaining to HIV/AIDS prevention among IDUs, it might be useful to get mass-media coverage. Also, the results of a rapid assessment or other important research could be sent to some specific journals or newspapers. But there are other cases in which working quietly in the background is better. These can include the opening of a drop-in centre, the establishment of a needle and syringe programme or some outreach activities. Too much attention can disturb programme implementation and jeopardize the confidentiality of activities.

Table 5. Who are the mass media?

What are the mass media?	Personnel of the mass media
Radio	Journalists, reporters and correspondents
Television	Columnists and feature writers
Film and video	Script writers and editorialists
News agencies	Commentators, freelance writers and producers
E-mail and Internet	Broadcasters and news page subeditors
Print media include:	Editors-in-chief and producers
Newspapers	Station managers and programme managers
Magazines and journals	Media managers and media house owners
Publications such as comics and brochures	Journalists' associations

Decisions on whether to attack or be critical of government officials or institutions through the mass media need to be considered carefully. This often "hardens" the fronts, and most government agencies are much more powerful than an advocacy group with regard to mass media and usually much more skilled in handling mass media.

¹² International HIV/AIDS Alliance. Advocacy in action: a toolkit to support NGOs and CBOs responding to HIV/AIDS. Brighton, International HIV/AIDS Alliance, 2001 (<http://www.aidsmap.com/web/pb4/eng/4782D096-C740-41A5-AF06-D67C14B46DB8.htm>). AIDSCAP Project. Partnership with the media. Arlington, VA, Family Health International, 1998 (<http://www.fhi.org/en/HIVAIDS/Publications/manualsguidebooks/BCC+Handbooks/BCC+Handbook+Partnership+with+Media.htm>).

Should an advocacy group, after careful consideration, decide to include media work in its activities, the group must obtain extensive knowledge of the various media. Advocates should determine which audiences are most likely to pay attention to which mass media and what the prevailing types and tone of articles and programmes are. Some newspapers, journals and radio or television stations are really interested in facts and report objectively, but increasing the number of subscribers drives others and they tend towards sensationalism and exaggeration. Personal contacts should be established with media personnel who work in health or similar areas, including journalists, editors, commentators, columnists and feature writers, and they should be provided regular information and explained what HIV/AIDS prevention is all about. Before mass-media coverage can be used as an advocacy method, mass-media personnel often become an audience of advocacy, as the example in Box 31 shows.

Box 31. Working with mass-media personnel in Uruguay

In Uruguay, a project was established to encourage journalists to report on drug issues without sensationalism and to provide wider coverage of HIV/AIDS prevention among IDUs. The National Drug Agency and the local NGO El Abrojo organized a seminar in September 2001 that advocated for HIV/AIDS prevention among IDUs. The seminar brought 60 journalists from more than 40 newspapers, radio and television stations across the country's 18 provinces. The journalists discussed a wide range of drug issues with national authorities and several foreign speakers including Eusebio Fernandez Mejias, President of the Foundation against Drug Addiction (FAD) in Spain, and Silvia Inchaurrea, Executive Secretary of the Latin American Harm Reduction Network.

Some of the more sensitive issues discussed at the seminar were the criminal aspects of drug use (as possession of drugs is not illegal in Uruguay) and distribution of needles and syringes for IDUs (not available in Uruguay but increasingly used in neighbouring Argentina). The seminar concluded that drug issues need to be considered primarily as health and social issues.

Evaluation by the organizers showed that, after the seminar, mass-media reports on drug-related issues were better informed, and, consequently, the seminar led to greater impact for the Abrojo Harm Reduction Programme by raising community visibility.

Sources: Seminario "Virtual – Drogas" de capacitación para comunicadores sociales. Montevideo, El Abrojo, 2001; and personal communication, Agustín Lapetina, El Abrojo, 2002.

Advocacy involves the use of political power to achieve its goals. Although the specific activities of advocacy may not appear political on the surface, successful advocacy efforts are always based on sound knowledge of political processes and “players” (influential individuals and groups) and an understanding of the motivations of each player.

Although the advocacy process has many activities, the most important underlying feature of each activity is that it seeks to persuade someone towards a specific viewpoint and, usually, towards specific action. Argument is often the basis of persuasion: this can be done either formally (such as through scientific papers) or informally (in a chat with an influential community member), in a group (such as a speech to parliament or to the mass media) or between individuals. In each case, the advocate marshals some information and ideas together and presents a case. This “case” should be very specifically designed for the target audience. For example, providing detailed theoretical papers to politicians who are busy and who are dealing with many important problems is often not useful. The argument should be based on the specific concerns of the audience; use language the audience will understand and try to pre-empt the audience’s questions and concerns.

An opponent or group of opponents will often argue against the advocate from a different viewpoint, either in the same forum or through separate channels (such as other scientific papers or their own mass-media conferences). The advocate must be ready and able to deal with opposing viewpoints, and this is done most easily if the advocate knows in advance the most likely arguments of the opponents. By trying to think of such arguments in advance, the advocate can sometimes address opponents’ concerns early or can be ready to argue back against any opposing viewpoints.

This argument process requires, above all, that the advocate try to think from the viewpoint of both the target audience and the opponent. This is the single most important technique in advocacy. Doing this successfully requires very close and careful listening. When an opponent is talking, starting to argue back immediately is often the immediate reaction. If however, the advocate listens carefully, opponents or advocacy targets will usually reveal their deepest concerns about effective approaches to HIV/AIDS among IDUs. By listening to these, the advocate can build up a picture of what motivates the opponents, what interests them and what arguments may sway them.

A second important point is that peer education has been shown to be successful in many areas of education on HIV/AIDS and other topics. This holds true for all areas of life, so that the best way to persuade police is often to use other police; for politicians, to use other politicians. The peer educator is more likely to know the target audience well, to know their concerns and to be able to couch arguments in the most effective way to influence the audience.

The final general point concerns the use of emotion and evidence. One of the greatest problems for advocates of effective approaches to HIV/AIDS and injecting drug use is that the evidence for these approaches is overwhelming,

yet this evidence does not automatically lead to the implementation of effective approaches. The reasons for this gap between evidence and action are complex and remain the subject of much debate, but one reason is that evidence means more to some people than to others.

The use of drugs, especially by young people, is often viewed as a moral issue, and any discussion related to drug use can lead to strong emotions being expressed. Many senior politicians and policy-makers actively dislike or hate drug use and drug users, and the thought of assisting them in anyway is abhorrent. Advocates trying to describe the dangers of HIV/AIDS epidemics among IDUs often receive the reply: “we are hoping that the AIDS problem will fix the drug problem” (that all the drug users will die of AIDS, thus “fixing” the drug problem).

For people who are passionate about the need for effective approaches to HIV/AIDS and injecting drug use, such emotional statements from a target audience or opponent can lead in turn to emotional responses, to anger, heated words, yelling and the like. This rarely does any good. When used properly, emotion (linked with evidence) can be a powerful tool for winning arguments (“hearts and minds”). However, emotions can also cloud reason, preventing the advocate from examining an argument clearly and preparing for and responding to the arguments being presented. Emotion is a tool that needs to be used carefully and with a cool head.

11. CORE ARGUMENTS

EVIDENCE BASE

There is overwhelming evidence for the effectiveness of the approaches being advocated. They should therefore become standard parts of the country's response to HIV/AIDS and should be implemented at an appropriate scale throughout the country. If no or insufficient local data are available, then adequately resourced pilot programmes should be launched and then properly evaluated. National health policy should be based on the outcomes of these pilot programmes and evaluations.

EVIDENCE BASE (SPECIFICALLY FOR POLICE)

In many countries, drug use, including injecting drug use, is a growing problem. There is evidence that problems related to drug use need to be tackled by a societal approach in which police play an important part but so do other agencies related to health and welfare, for example. Drug use can be prevented and the number of people injecting can be reduced over time – for example, through drug dependence treatment – but at present people are injecting drugs in this country who are at risk of serious diseases. Changing health policy will not prevent HIV/AIDS epidemics among IDUs unless the police allow programmes to operate.

Sharing responsibilities makes police work easier. Police in many countries are under-resourced and yet are expected to do many different types of work. In reality, many crimes cannot be addressed because police are working on other issues. By working collaboratively with health authorities on HIV/AIDS prevention among IDUs, the workload of the police can be reduced as staff of the health sectors and of NGOs take responsibility for various activities.

PUBLIC HEALTH

HIV spreads quickly in communities of IDUs, with 50% or more of them in some cities and provinces acquiring HIV within one year. Mobility and the sexual behaviour of drug users can lead to wide geographical spread and to many sectors of the community being affected very quickly. Many IDUs have sex partners who are sex workers, and many sex workers are IDUs. From IDUs and sex workers, HIV can pass to many other people. HIV/AIDS prevention among IDUs not only protects IDUs but can prevent a massive epidemic that reaches people who have never been involved with injecting drug use or sex work. HIV/AIDS prevention among IDUs is only a sensible way to protect the public.

PUBLIC ORDER

This builds on the public health argument. A massive HIV/AIDS epidemic can lead to problems of public order and national security, especially if HIV is increasingly found among military and police staff. HIV/AIDS prevention among IDUs not only protects IDUs but can prevent a massive epidemic that reaches people who have never been involved with injecting drug use or sex work.

THE TIDAL WAVE

Given the rapid spread of HIV among IDUs, the number of people seeking attention from health professionals for conditions related to HIV/AIDS will increase massively within 5–10 years after the epidemic among IDUs begins. This group has been so large in some countries that a substantial proportion of health spending has been diverted from other health issues into HIV/AIDS treatment and care. A HIV/AIDS epidemic among IDUs is an important issue for all health and welfare professionals, as it may profoundly affect the future workload. Ministries or departments of health need to be concerned about the massive impact on financial and health service resources such an epidemic would have.

COST-EFFECTIVENESS

Many studies have demonstrated the cost-effectiveness of the advocated approaches. However low the prices eventually fall for drugs for HIV/AIDS treatment, the need for increased health care intervention, HIV/AIDS treatment and management of opportunistic infections will continue to mean that each person with HIV will cost the health service dearly.

HUMAN RIGHTS

Health is a human right, and each individual's human has the right to access to the information and means to protect health.

FUTURE OF THE COUNTRY

Children are the future of the country. Many IDUs are young, sexually active and have children. AIDS will devastate this generation of youth. Effective approaches to HIV/AIDS and injecting drug use can save these young people's lives. AIDS will lead to great demographic changes, as young people will die in far greater numbers than expected, leading to population loss and many social problems.

EFFECTS ON ECONOMIC DEVELOPMENT

A large AIDS epidemic can devastate economies, including reductions in the tax base, labour force and economic development. Economic development has been set back in all countries with large AIDS epidemics, some by the equivalent of 50 years. An AIDS epidemic must be prevented.

12. BELIEFS AND ATTITUDES OPPOSING INTERVENTION

THERE IS NO PROBLEM

This is a common argument in countries with few recorded cases of HIV infection among IDUs.

REPLY:

Few recorded cases does not mean a small number of cases. Every country with injecting drug use is at risk of an epidemic of HIV/AIDS among IDUs. Prevention that starts early is much less expensive and much more effective in saving lives than prevention efforts after an epidemic is established. Rapid assessment should be done immediately to determine the extent of injecting drug use and related risk behaviour. If these types of behaviour exist, then action should be taken immediately at a scale large enough to prevent a HIV/AIDS epidemic among IDUs or to bring an existing epidemic under control.

DRUG USERS DO NOT MATTER

Some people believe that drug users are “bad” or “evil” and therefore should not be provided with health services.

REPLY:

The use of drugs is an activity that may change across a person’s lifetime. Many drug users are young people experimenting with drugs. In any case, no one deserves to die of AIDS. Drug users are members of society, and the signatories to the health for all policy have stated that the health of all people in a society is important and must be protected.

THERE ARE MORE IMPORTANT HEALTH PROBLEMS

This is a very common argument, especially in developing and transitional countries. It is also often true, at least in the short term.

REPLY:

The truth about HIV/AIDS epidemics is that they overwhelm health systems with AIDS 5–10 years after the initial epidemic has occurred. Unless HIV/AIDS is brought under control, a massive wave of AIDS cases can occur that will dwarf all of the country’s other health problems. The only way to prevent this from happening is to prevent HIV transmission now, even though malaria, tuberculosis or other diseases may look like a much greater problem at present.

NEEDLE AND SYRINGE PROGRAMMES AND SUBSTITUTION TREATMENT ENCOURAGE DRUG USE AND DRUG INJECTING

This attitude is especially common among those who only look at some of the proposed activities and do not read background papers about evidence.

REPLY:

This is not true. Harm reduction activities have been studied extensively to determine specifically whether they lead to any negative consequences such as increased drug use or increased injecting. In no research has this been shown to occur. In fact, the effect is often the opposite, with drug users attracted to outreach or needle and syringe programmes voluntarily seeking help to stop using drugs. This comes about as a result of the trust established by such programmes with IDUs.

HIV/AIDS AMONG IDUS IS NOT MY PROBLEM

This is a very common response.

REPLY:

HIV/AIDS is not just a disease. It has social and economic effects throughout every sector of the society. Evidence shows that every sector of the society needs to play a part in addressing HIV/AIDS.

THE AIDS EPIDEMIC WILL FIX THE DRUG PROBLEM

This is quite a common response, usually said with a laugh but meant at least partly seriously.

REPLY:

This is not the case. In no country where HIV has spread among IDUs has there been a massive reduction in drug use. HIV/AIDS affects men, women and children: not just drug users and their families, but many other people in society as well.

POLICE MUST ENFORCE THE LAW AND SHOULD THEREFORE APPREHEND DRUG USERS

This is a very common argument.

REPLY:

Although this is true, it is also common practice to enforce the law with some discretion in many areas. Police may determine whether to enforce laws more or less vigorously, in which areas to focus their resources and on what crimes they will concentrate. Evidence shows that fear of arrest by the police is often stronger than fear of acquiring HIV/AIDS, so that drug users are likely to take greater risks in injecting drugs when they fear arrest. They will also not come forward for education in an atmosphere of trust unless they are sure they will not be arrested. Health workers need to be able to provide this education and build up this trust so that education is successful.

NEEDLE SYRINGE PROGRAMMES AND SUBSTITUTION TREATMENT SEND THE WRONG MESSAGE

This is extremely common, especially from politicians, in almost every country. It means that the government is committed to “fighting drugs” and that the politician or policy-maker believes that the advocated activities contradict this policy.

REPLY:

This is not true. Implementing the advocated activities does not imply “weakness” or being “soft on drugs”. All countries that have implemented these activities also continue to have strong policies on reducing the supply of and the demand for drugs. A balanced approach is needed that allows a government to maintain control over drug use by its citizens and to prevent a HIV/AIDS epidemic among drug users.

THE LAWS ARE FIXED, AND I CANNOT CHANGE THEM

This is especially common among departmental (bureaucratic) policy-makers.

REPLY:

In this circumstance the law may not need to be changed. There may be regulations that can be amended while legal review or change is pending. There may be policy statements that can be changed, which can put pressure on legislators to change laws.

DRUG USERS SHOULD NOT RECEIVE SPECIAL ASSISTANCE

REPLY:

The advocated activities do not mean that drug users receive special assistance. It means that a society gives priority to HIV/AIDS prevention in this group to protect the health of all members of society, to ensure that health insurance premiums do not have to rise and to ensure that hospital beds are available for frail and elderly people instead of all of society’s resources being needed to care for people living with and dying from AIDS.

IDEAS FROM WESTERN (OR INDUSTRIALIZED) COUNTRIES ARE UNSUITABLE IN THIS COUNTRY

This is a common argument even from health professionals, lawyers and especially police and politicians in some countries.

REPLY:

These approaches may not be effective in this country. For this reason, pilot programmes may be needed to begin with. If the programmes are shown to be effective in this country and they will reduce or stop an HIV/AIDS epidemic, then they are suitable for this country.

13. RESOURCES

13.1 PUBLICATIONS AND WEB SITES

Advocacy guide to the Asia-Pacific Ministerial Statement on HIV/AIDS. Sydney, Australian Federation of AIDS Organizations/National Association of People Living with HIV/AIDS in Australia, 2002 (<http://www.ahrn.net/AdvocacyGuideMinisterial.pdf>, accessed 17 March 2004).

AIDSCAP Project. *Policy and advocacy in HIV/AIDS prevention.* Arlington, VA, Family Health International, 1998 (<http://www.fhi.org/en/HIVAIDS/Publications/manualsguidebooks/BCC+Handbooks/Policy+and+Advocacy+in+HIV-AIDS+Prevention.htm>, accessed 17 March 2004).

AIDSCAP Project. Policy development and HIV/AIDS prevention: creating a supportive environment for behaviour change. In: *Making prevention work: global lessons learned from the AIDS Control and Prevention (AIDSCAP) Project 1991–1997.* Arlington, VA, Family Health International, 1998 (http://www.fhi.org/en/HIVAIDS/Publications/Archive/aidscapeports/makingpreventionwork/Mak_Prev_Work_AIDSCAP_91-97_Part_Acro.htm, accessed 17 March 2004).

Ball A. Policies and interventions to stem HIV-1 epidemics associated with injecting drug use. In: Stimson GV et al., eds. *Drug injecting and HIV infection: global dimensions and local responses.* London, UCL Press, 1998.

Ball A, Crofts N. HIV risk reduction in injecting drug users. In: Lampthey PR, Gayle H, eds. *HIV/AIDS prevention and care in resource-constrained settings.* Arlington, VA, Family Health International, 2002.

Burrows D. *Starting and managing needle and syringe programmes: a guide for central and eastern Europe and the newly independent states of the former Soviet Union.* New York, Open Society Institute, International Harm Reduction Development Program, 2000 (http://www.soros.org/initiatives/ihrd/articles_publications/publications/starting_20000101, accessed 17 March 2004). Published in English, Russian and Slovakian.

Burrows D, Alexander G. *Walking on two legs: a developmental and emergency response to HIV/AIDS among young drug users in the CEE/CIS/Baltics and central Asia region: a review paper.* Geneva, UNICEF, 2000.

Burrows D, Dorabjee J, Wodak A. Advocacy for harm reduction: objectives, strategies and activities. In: *Proceedings of Global Research Network on HIV/AIDS and Drug Use Durban Meeting July 2000.* Washington, DC, National Institute on Drug Abuse, 2001. Published in Spanish as: Burrows D, Dorabjee J, Wodak A. Herramientas para abogar por los derechos de los usuarios de drogas en relacion con la epidemia de VIH/SIDA. *Ensayos y Experiencias*, 2001, No. 39 (July/August).

Canadian HIV/AIDS Legal Network. Wide range of publications including on HIV/AIDS and IDUs, stigma and discrimination, criminal law, prisons, commercial sex work, gays and lesbians, occupational issues for health workers. Web site: <http://www.aidslaw.ca/Maincontent/infosheets.htm> (accessed 17 March 2004).

Chapman S. Advocacy in public health: roles and challenges. *International Journal of Epidemiology*, 2001, 30:1226–1232.

Costigan G, Crofts N, Reid G. *Manual for reducing drug related harm in Asia*. 2nd ed. Melbourne, Centre for Harm Reduction, Macfarlane Burnet Institute for Medical Research & Public Health, Asian Harm Reduction Network, 2003 (<http://www.ahrn.net/manual.html>, accessed 17 March 2004). Also available in Bahasa Indonesia, Mandarin, Thai and Vietnamese, with new editions soon in other Asian languages.

Derricot J, Preston A, Hunt N. *The safer injecting briefing*. Liverpool, HIT, 1999 (<http://www.drugtext.org/library/books/needle/top.htm>, accessed 17 March 2004).

Global Network of People Living with HIV/AIDS. Networks of people living with HIV/AIDS and resources related to involvement of people living with HIV/AIDS in advocacy and programmes. Web site: <http://www.gnpplus.net> (accessed 17 March 2004).

Information & Knowledge for Optimal Health (INFO) Project. "A" frame for advocacy. Set of nine web pages providing short descriptions of steps in advocacy for public health. Baltimore, Johns Hopkins University, Bloomberg School of Public Health, Center for Communications Programs. Index and introduction: <http://www.infoforhealth.org/pr/advocacy/index.shtml> (accessed 17 March 2004).

International AIDS Economics Network. Focuses on the economics of HIV/AIDS prevention and treatment, providing data, tools, and analysis for researchers and policy-makers. Web site: <http://www.iaen.org> (accessed 17 March 2004).

International Council of AIDS Service Organizations. *Advocacy guide to the Declaration of Commitment on HIV/AIDS*. Toronto, ICASO, 2001 (<http://www.icaso.org/icaso/ungass/advguidedectncomit.htm>, accessed 17 March 2004). Also available in French and Spanish.

International Council of AIDS Service Organizations. *An advocate's guide to the International Guidelines on HIV/AIDS and Human Rights*. Toronto, ICASO, 1999. Also available in French and Spanish.

International HIV/AIDS Alliance. *Advocacy in action: a toolkit to support NGOs and CBOs responding to HIV/AIDS*. Brighton, International HIV/AIDS Alliance, 2001 (<http://www.aidsmap.com/web/pb4/eng/4782D096-C740-41A5-AF06-D67C14B46DB8.htm>, accessed 17 March 2004).

KIT (Royal Tropical Institute) Health. *KIT Health approach to AIDS*. Amsterdam, Royal Tropical Institute, 2004 (http://www.kit.nl/health/html/aids_.asp, accessed 17 March 2004).

London School of Hygiene and Tropical Medicine, HIV Tools Research Group. Costing guidelines, cost-effectiveness studies and mathematical simulation models. Web site: <http://www.hivtools.lshtm.ac.uk> (accessed 17 March 2004).

Pact. *Survival is the first freedom: applying democracy and governance approaches to HIV/AIDS work*. Washington, DC, USAID, 2001 (http://www.dec.org/pdf_docs/PNACL456.pdf, accessed 17 March 2004).

POLICY Project. *Assessing the HIV/AIDS policy environment in Kenya*. Washington, DC, POLICY Project, 2000 (<http://www.policyproject.com/byTopic.cfm?topic=HIV>, accessed 17 March 2004).

POLICY Project. *HIV/AIDS toolkit: building political commitment for effective HIV/AIDS policies and programs*. Washington, DC, POLICY Project, 2000 (<http://www.policyproject.com/byTopic.cfm?topic=HIV>, accessed 17 March 2004).

POLICY Project. *Networking for policy change: an advocacy training manual*. Washington, DC, POLICY Project, 1999 (<http://www.policyproject.com/pubs/AdvocacyManual.cfm>, accessed 17 March 2004).

Preston A. *Methadone briefing*. Liverpool, HIT, 1997 (<http://www.drugtext.org/library/books/methadone/default.htm>, accessed 17 March 2004).

Sharma RR. *An introduction to advocacy: training guide*. Washington, DC, Support for Analysis and Research in Africa, AID Africa Bureau Office of Sustainable Development, United States Agency for International Development, 1997 (http://sara.aed.org/sara_pubs_list_sara_5.htm, accessed 17 March 2004). Also available in French.

Stimson G, Fitch C, Rhodes T, eds. *The rapid assessment and response guide on injecting drug use (IDU-RAR)*. Version 5. Geneva, World Health Organization, 1998 (http://www.who.int/substance_abuse/publications/epidemiology/en, accessed 17 March 2004). Also available in Portuguese, Russian and Spanish.

UNAIDS. *Drug use and HIV/AIDS. UNAIDS statement presented at the United Nations General Assembly Special Session on Drugs, June 1998, Geneva, Switzerland*. Geneva, UNAIDS, 1998 (<http://www.unaids.org/publications/documents/specific/injecting/una99e1.pdf>, accessed 17 March 2004). Also available in French, Russian and Spanish.

UNAIDS. *Drug use and HIV/AIDS: UNAIDS statement presented at the United Nations General Assembly Special Session on Drugs, Committee of the Whole, New York, Tuesday, 9 June 1998*. Geneva, UNAIDS, 1999 (http://www.unaids.org/html/pub/publications/irc-pub02/jc-summbok1-1_en_pdf.pdf, accessed 17 March 2004).

UNAIDS/UNDCP. *Drug use and HIV vulnerability: policies in seven Asian countries*. Bangkok, UNAIDS, 2001 (<http://www.unaids.org/publications/documents/health/access/Drug.pdf>, accessed 17 March 2004).

UNAIDS/UNODC. *Drug abuse and HIV/AIDS: lessons learned. Case studies booklet: central and eastern Europe and the central Asian states*. Geneva, UNAIDS, 2001 (<http://www.unaids.org/publications/documents/specific/injecting/JC673-DrugAbuse-E.pdf>, accessed 17 March 2004).

United Nations. *Declaration of Commitment on HIV/AIDS*. (http://www.unaids.org/en/events/un+special+session+on+hiv_aids/declaration+of+commitment+on+hiv_aids.asp, accessed 17 March 2004). Also available in Arabic, French, Portuguese, Russian and Spanish.

United Nations. *Preventing the transmission of HIV among drug abusers: a position paper of the United Nations System*. Annex to the Report of the 8th Session of the Administrative Committee on Coordination Subcommittee on Drug Control, 28–29 September 2000. Geneva, United Nations, 2000 (<http://www.unaids.org/publications/documents/specific/injecting/Hraids.doc>, accessed 17 March 2004).

United Nations Administrative Committee on Coordination. *ACC guidance note for United Nations System activities to counter the world drug problem*. Geneva, United Nations, 2001 (<http://www.ahrn.net/Final-Guidance-Note-layed-out2.pdf>).

United Nations Commission on Narcotic Drugs. *Resolution on HIV/AIDS and Drug Abuse*. 45th Session, 11–15 March 2002, Vienna, Austria. Web site (includes links to the Resolution and associated speeches): <http://ahrn.net/drugcontrol.html>, accessed 17 March 2004).

United Nations Development Programme. *HIV/AIDS: implications for poverty reduction*. Background paper prepared for UNDP for the United Nations General Assembly Special Session on HIV/AIDS, 25–27 June 2001. New York, UNDP, 2001 (<http://www.undp.org/dpa/frontpagearchive/2001/june/22june01/hiv-aids.pdf>, accessed 17 March 2004).

United Nations Fund for Population Activities. Advocacy Booklet Series. Includes: *Preventing HIV infection, promoting reproductive health; UNFPA response 2002*. New York, UNFPA (http://www.unfpa.org/publications/index.cfm?filterPub_Type=4, accessed 17 March 2004).

United Nations Office on Drugs and Crime. Web site: <http://www.unodc.org> (accessed 17 March 2004).

World Health Organization. *Ottawa Charter on Health Promotion*. Geneva, WHO, 1986 (http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf, accessed 17 March 2004).

World Health Organization. *Working with street children: a training package on substance use, sexual and reproductive health including HIV/AIDS and STDs*. Geneva, World Health Organization, 2000 (WHO/MSD/MDP/00.14).

World Health Organization. Evidence for Action on HIV/AIDS Prevention among IDUs Series.

World Health Organization. *What do people think they know about substance dependence?* Geneva, WHO, 2001 (http://www.who.int/substance_abuse/about/en/dependence_myths&facts.pdf, accessed 17 March 2004).

13.2 HARM REDUCTION NETWORKS

International Harm Reduction Association. Global network, includes links to regional harm reduction networks and the International Conferences on the Reduction of Drug Related Harm. Web site: <http://www.ihra.net>.

Asian Harm Reduction Network. Web site: <http://www.ahrn.net>.

Canadian Harm Reduction Network. Web site: <http://www.canadianharmreduction.com> (accessed 17 March 2004).

Central and Eastern European Harm Reduction Network. Web site (in English and Russian): <http://www.voxpopuli.lt/ceehrn.org> (accessed 17 March 2004).

Harm Reduction Coalition (USA). Web site: <http://www.harmreduction.org> (accessed 17 March 2004).

Latin American Harm Reduction Network. Web site (English, Portuguese and Spanish): <http://www.relard.net> (accessed 17 March 2004).

Oceania Harm Reduction Coalition (Australasia/Pacific). Web site: <http://www.chr.asn.au> (accessed 17 March 2004).

For further information, please contact:
World Health Organization
Department of HIV/AIDS
CH-1211 Geneva 27, Switzerland
Fax: +41 22 791 4834; email: hiv-aids@who.int

ISBN 92 4 159182 X



9 789241 591829