

The Asian Harm Reduction Network

*Supporting Responses to HIV
and Injecting Drug Use in Asia*



Joint United Nations Programme on HIV/AIDS

UNAIDS

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The authors alone are responsible for the contents and views expressed in this document. The case study was commissioned by the UNAIDS Secretariat in collaboration with the Asian Harm Reduction Network (AHRN). The initial work and draft report were undertaken by Paul Deany, the first coordinator of the Asian Harm Reduction Network. He is now Senior Projects Officer at the Centre for Harm Reduction, Macfarlane Burnet Centre for Medical Research in Melbourne, Australia. The draft was circulated among various members of AHRN. The final version was prepared with substantial inputs from a team led by Ton Smits, the current Executive Director of AHRN. Olusoji Adeyi was the responsible staff member at the UNAIDS Secretariat in Geneva.

THE ASIAN HARM REDUCTION NETWORK

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Foreword by UNAIDS

With the onset of HIV/AIDS in the 1980s, the problem of drug use in Asia entered a new and more dangerous era. In addition to other means, the AIDS virus is transmitted through the sharing of contaminated needles, syringes, and other paraphernalia employed by drug users. Since many countries in Asia have a serious problem with drug use, and others are highly vulnerable, the prevention of HIV/AIDS among drug users is one of the priority areas for UNAIDS in this region.

Those working in the field of prevention of drug use and HIV/AIDS are very well aware that no simple interventions can solve the problem in a short period of time. Drug users are a highly vulnerable group; in many countries, the legal and political environment makes them hard to reach for preventive interventions. Many of them are very poor, a factor that contributes to their vulnerability. Health and social services often are not equipped to address their needs. Drug users' rights are frequently violated, and in several communities drug users are used as scapegoats for many social evils. Risk-reduction measures are successful if we encourage legal and political environments in which we can deliver interventions, if we provide the necessary health and rehabilitation facilities, if we address poverty, and if we work on the tremendous negative image that many people attribute to drug users. Over the past few years, UNAIDS, particularly the Asia-Pacific Intercountry Team, and the Asian Harm Reduction Network have focused on reducing drug users' vulnerability.

UNAIDS and the Asian Harm Reduction Network share a considerable part of their histories and philosophies: both organizations began their operations in 1996, both are using networking as one of their main tools, and both consider HIV/AIDS among drug users a priority area. We believe that effective responses have to be carried out in synergy: UNAIDS with its cosponsors and key partners; the Asian Harm Reduction Network with its members.

Over the past years, we have achieved some results in the prevention of HIV transmission among drug users, particularly in the area of advocacy; those achievements were possible only because we worked in tandem. But much remains to be done by both UNAIDS and the Asian Harm Reduction Network. We continue to see frighteningly high prevalence rates among drug users in many countries of Asia, and still there are no appropriate large-scale interventions. We know how to prevent HIV transmission among drug users and we have developed the tools to do it. Now the time has come for large-scale implementation of programmes, and this requires once again that we join forces.

This case study demonstrates that the Asian Harm Reduction Network has the potential to be again a decisive catalyst for action, to provide the skills-building capacities for large-scale interventions, and to assist all those in the communities to do what needs to be done. Looking back at our common history, I am convinced that the Intercountry Team together with its cosponsors and partners, and the Asian Harm Reduction Network with its many competent members, can contribute significantly. In cooperation we can reduce the incidence of HIV infection and other drug-related harm among drug users in Asia and provide care and support to those who need it.

*Dr Wiwat Rojanapithayakorn, Team Leader
UNAIDS Asia-Pacific Intercountry Team
Bangkok, December 2000*

Foreword by the Chair of the Asian Harm Reduction Network

In the past two decades, many countries in the Asian region have witnessed dramatic changes in drug-use patterns, with more individuals switching from smoking to injecting. These changes have resulted in the deterioration of the health status of drug users. Newer and more potent forms of drugs have flooded the Asian markets, and there has been a rapid increase in the numbers of drug users all across Asia. Legal and social impediments to needle and syringe availability have caused users to inject with inappropriate equipment in unhygienic circumstances. We have begun to see ugly wounds and abscesses among the injecting drug users (IDUs) and a rapid increase in the numbers of drug users infected with hepatitis B/C and HIV.

While the adverse consequences of injecting drug use have increased dramatically over the years, the prevention, treatment, and care services provided for drug users still remain far from adequate. Most of the existing services often provide only short-term detoxification or rehabilitation regimens, sometimes under inhuman and punitive conditions. Most services still do not take into account the fact that drug use is a chronically relapsing problem and needs long-term treatment and care. In some parts of Asia, hospitals still refuse to treat a sick person if the doctors find out that he or she is a drug user. In other parts of the region, authorities continue to jail drug users and even threaten with legal action those individuals and organizations that attempt to provide services to them.

Despite large-scale offensives in the various “wars on drugs” in Asia, the prevalence of drug use continues to rise. In some Asian countries injecting drug use has fuelled the HIV epidemic, and we see alarmingly high prevalence rates among IDUs. Yet, very little research exists to establish why drug users resort to sharing injecting equipment despite the knowledge of the inherent danger to health and welfare.

It is alarming to see that, despite the compelling evidence of high relapse rates and the failure of detoxification alone to address the serious public health issues of drug use, traditional methods striving for abstinence continue to be used across the region. Many of us who work in the field began in a similar manner but, on seeing the poor outcomes, have implemented innovative and appropriate treatment, rehabilitation, and care programmes that have proven to be more effective. Nonetheless, these programmes are few and far between, and there is an urgent need to scale them up to meet the challenges that HIV/AIDS poses to our communities. Members of the Asian Harm Reduction Network have more than 20 years of experience in working with drug users to protect them from the adverse consequences of drug use.

As this case study shows, programmes addressing drug-related harm in Asia often worked in isolation and lacked support, and their staff frequently suffered from severe stress and burn-out, having all too often been subjected to unreasonable criticism and harassment.

With the creation of the Asian Harm Reduction Network, an unprecedented mechanism was established to support these pioneering programmes and assist others in their efforts to

set up much-needed harm-reduction programmes. The network initiated processes to sensitize governments to the problems facing drug users and their families, and it continues to provide technical assistance and support to agencies in Asia.

I would like to take this opportunity to thank all our members for their trust and support and to urge them to continue to strive for humane and pragmatic approaches for reducing drug-related harm in their countries. I would also like to thank all the international organizations and their staff members, bilateral donors and agencies, and the many individuals for their continuing support to AHRN. I hope this case study will be a valuable source of information for all our colleagues and friends addressing drug use and HIV/AIDS, and that it contributes to a deeper understanding of the benefit of networks and, in the final analysis, helps those who need help most – the drug users, their families, and our communities.

Jimmy Dorabjee
Chair, Executive Committee, Asian Harm Reduction Network
New Delhi
December 2000

I. Executive summary

The drug-use situation in Asia is extremely complex. Asia has major drug-production areas that supply drugs worldwide, and there is significant spillover to local drug-consuming markets from both production areas and trafficking routes. In addition, drugs are diverted to local users from the region's large pharmaceutical industries. Although it is recognized that drug use is tied to the spread of HIV/AIDS, attempts to address this situation have been hampered by lack of cooperation among agencies and by inappropriate interventions. Despite such problems, and in the face of harassment and threats, some individuals and organizations have attempted to address drug use and HIV/AIDS in comprehensive programmes.

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 those institutions and individuals with experience and interest in the problem. The organization of such collective efforts faced a number of practical problems: geographical distance between existing programmes; cultural, linguistic, and political diversity; and large gaps in available resources. A mechanism was needed that would allow for the effective horizontal sharing of information and experience, the pooling of resources, the mutual support of programmes, and the development of a solid base for advocacy – all with limited administrative costs. The only way to meet these needs was to form a technical resource network. Starting with 46 managers and interested individuals, the Asian Harm Reduction Network (AHRN) was established in March 1996 in Hobart, Australia.

The Asian Harm Reduction Network was designed as a broad alliance to promote an expanded response to the issue of HIV/AIDS among drug users. For this reason, the founders of the network chose to establish an open network with the greatest possible participation from and interaction among its members. From the outset, AHRN's activities focused on supporting rather than implementing programmes. This meant strengthening existing initiatives and providing support for new ones in the areas of information dissemination, training, advocacy, and networking.

Through various means, the network has been instrumental in sharing and promoting regionally applicable examples of active programmes. Moreover, the Asian context requires that AHRN provide a great variety of capacity-building mechanisms. These included training in rapid situation assessment, formulating policies, planning appropriate programmes and projects, developing specific interventions, providing counselling and treatment, implementing information campaigns, and providing means to drug users to protect themselves from HIV transmission.

Most countries of the region are 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. The benefits of the network were demonstrated at the Fourth and Fifth International Congresses on AIDS in Asia and the Pacific, where AHRN initiated a number of activities to highlight the problem of HIV/AIDS among drug users in Asia and to bring harm-reduction workers together.

Applying UNAIDS' best practice criteria, AHRN should be judged as best practice. AHRN has significantly contributed to a more comprehensive understanding of patterns of drug use and associated harms, especially HIV infection, in Asia. Moreover, it has provided a forum that encourages communication and information exchange among its members. Member feedback indicates that the network has been influential in providing the information and skills needed to continue building capacity at the local level. The network is a valuable resource for developing and conducting national and multicountry training activities on HIV prevention and harm reduction.

One of AHRN's main achievements has been to put the issue of drug use and HIV/AIDS on the agenda of governments and international organizations. As a result of constant pressure from AHRN members, governments have begun to deal with drug use and HIV/AIDS and have asked intergovernmental organizations to provide assistance on policy and programme development. As an Asian network, AHRN is in an excellent position to address these issues in a culturally appropriate manner. AHRN members have a detailed knowledge of the political situation in their countries and know the stakeholders. They can thus provide valuable insights on the best strategies for policy development.

The example of AHRN shows that, thanks to the interactions of its members, the impact of an open network is stronger than the sum of its components.

II. Introduction

By early 2000, the number of people living with HIV was estimated to be 34.3 million worldwide, with injecting drug use proving to be a major accelerant of HIV infection in many countries. According to the World Health Organization (WHO), injecting drug use is facilitating the spread of HIV in 114 countries, many of them in less developed parts of Asia, Latin America, and Central and Eastern Europe.

Drug use and HIV/AIDS are complex problems having political, social, economic, and cultural determinants. Experience shows that no single agency is in a position to provide effective and comprehensive responses to all these issues; as a consequence, new forms of organizational structures had to be developed to initiate and implement comprehensive and large-scale approaches. Over the past few years, technical resource networks have been found to be successful in doing that.

The Asian Harm Reduction Network is such a technical resource network. Supported by UNAIDS and other agencies, it has become an important mechanism for promoting pragmatic approaches to the prevention of drug use and HIV/AIDS in Asia. The purpose of this case study is to examine those factors that made it necessary to establish this network – and why a network, not a traditional nongovernmental organization, was necessary. The study provides information on how the network was conceptualized and on its major activities during its first four years of operation. An assessment of the impact of its activities is provided, and future challenges are outlined. In the final sections, the benefits of harm-reduction networks are discussed in general terms, and the lessons learned in creating and maintaining the network are described.

III. Background

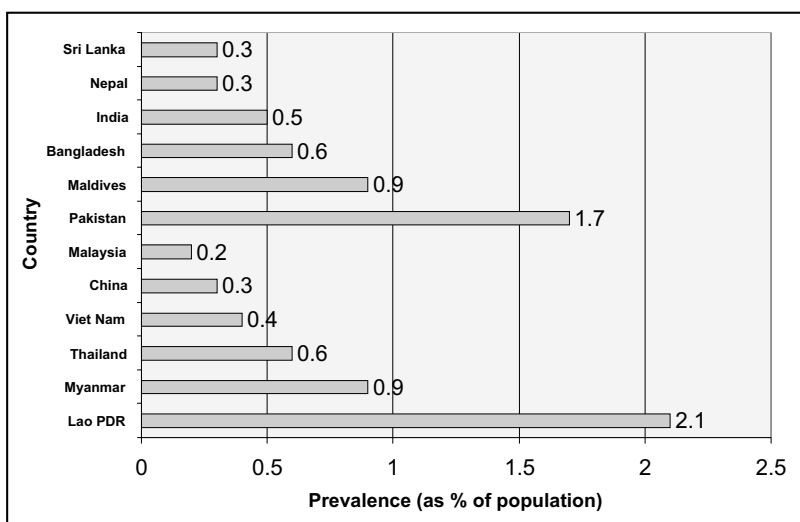
This section examines the factors that made it necessary to establish a technical resource network for addressing drug use and HIV/AIDS in Asia. Such factors include: the features of the drug-use problem in Asian countries; drug users' specific vulnerability to HIV/AIDS; available resources to reduce such vulnerabilities; and aspects of drug policies in Asian countries that either facilitate or impede the implementation of efforts to reduce drug users' risk behaviour and its underlying causes.

A. Epidemiology of drug use in Asia

For more than a century, Asia has experienced drug-use problems in the form of large-scale epidemics with devastating effects on its countries. Such epidemics caused social disintegration, civil unrest, and serious public health problems; exacerbated poverty and problems related to poverty; caused enormous direct and indirect economic costs; and impeded social and economic development. The drug trade, a multibillion dollar operation, has caused wars and abetted them financially; it continues to be a financial resource used by guerrilla armies for purchasing arms. Governments have undertaken strenuous measures to reduce drug-use problems; despite all efforts, however, drug use is not under control.

To date, the production of opiates has been reduced significantly in a number of areas. Trafficking and consumption, however, remain issues of serious concern. Over the past several years, an increasing trend from opium to heroin use has been observed in many countries. Codeine and other narcotic and psychotropic substances are also being used at a significant level, including buprenorphine products Tidigesic or Temgesic, Phensedyl, diazepam and nitrazepam. These substances are either produced in clandestine laboratories and distributed to the drug-user markets or produced legally by large pharmaceutical industries and diverted from there to illegal markets. Smoking or "chasing the dragon" continues to be the main route of heroin administration, though the use of injections is increasing all through the region. The trend towards injection seems to be related to the reduced availability and purity of heroin.

Figure 1: Prevalence of opiate use, selected countries



Source: Based on UNDP, *Global illicit drug trends 2000*, New York, 2000

Many countries in the region are currently experiencing an epidemic abuse of amphetamine-type stimulant (ATS), particularly of methamphetamine. Virtually all countries in South-East Asia are now affected to some extent. Data indicate that ATS use is generally higher among young adult males, although it is a continuing problem among special occupational groups such as truck drivers, fishermen, and construction workers. Commercial sex workers have also been identified as a high-risk group related to ATS. Because all these groups have a high degree of mobility, they are hard to reach through traditional prevention and treatment services.

In addition to the use of narcotics and psychotropic substances, endemic levels of inhalant use exist in many Asian countries. Such usage is particularly associated with street children living in impoverished, harsh conditions. Many countries have identified inhalant use as a significant drug issue in their cities. The use of cannabis in its various preparations also continues to be widespread in most countries of the region.

B. Drug users' vulnerability to HIV/AIDS

Drug use has serious social and health consequences. The majority of drug users in Asia are extraordinarily poor and often jobless or relegated to doing odd jobs. Homelessness is widespread. Many of them beg, borrow, or even steal. They are criminalized, stigmatized, and discriminated against. Such factors, combined with low self-esteem and little trust in authorities, make drug users a population to which traditional health and social services have little access.

Social consequences of drug use



Source: AHRN Clearing-house

The health status of drug users, particularly that of injecting drug users, is a matter of great concern: blood borne diseases such as hepatitis and HIV infection, abscesses and serious wounds from inadequate injecting equipment, and death from overdose are common. With the onset of the HIV/AIDS epidemic in the late 1980s, drug use in Asia entered an even more serious phase and became a major public health concern. Drug use has an intricate relationship with HIV/AIDS: HIV is transmitted through the sharing of contaminated needles and syringes and other equipment employed by drug users. In addition, alcohol and stimulant abuse often lower resistance to high-risk behaviour such as unprotected sexual intercourse.

Social consequences of drug use



Source: AHRN Clearing-house

Table 1. Drug use in selected countries of Asia (estimates)

Country	Drug users (000s)	Opiate users (000s)	% injectors	% drug users among HIV+	% HIV+ among drug users
Bangladesh	500–1,000	N/E	10–17	N/E	2.5
China	540	majority	66	69.4	40.5
India	2,250	500	25–90	N/E	1.3–68.4
Malaysia	300	200	50	77.0	10–27
Myanmar	300	majority	30	20–30	65.5–72.5
Nepal	30–50	majority	74.8	12.6	49.7
Pakistan	3,000	1,500	1.8–29	N/E	0.4–1.8
Sri Lanka	240	40	7.5	N/E	N/E
Thailand	1,270	219	60	5.25	30–40
Viet Nam	185	majority	no data	65.5	13.5–64.0

N/E = no estimates

Source: Regional Task Force on Drug Use and HIV Vulnerability, Drug Use and HIV Vulnerability Policy Research Study

Drug users in Asia are highly vulnerable to HIV transmission because of the legal, political, socioeconomic, health service, and cultural situations in which they live. These situations, however, vary considerably from country to country, even from community to community in the same country. In many countries of Asia, as elsewhere in the world, drug policies are highly politicized and are influenced by historical, social, religious, cultural, and economic factors. Strongly held beliefs about drugs and their adverse effects on the society, national experiences with drug use in the past, the extent and seriousness of past and present drug problems, and the interpretation of international conventions all have an impact on the development of policies and legal instruments directed at drug use.

In a number of countries, the law prescribes severe punishments for all drug-related offences including not only drug use but also possession of drugs and drug-use paraphernalia (e.g. needles and syringes). The level of penalties and the stringency with which they are applied locally affect the feasibility of preventive interventions for drug users. Indeed, these penalties may actually preclude providing drug users with information or with the means to protect themselves against HIV infection.

Drug-use practices contribute significantly to the vulnerability of drug users. Many drug users in the region use narcotics such as opium and heroin, and a significant percentage inject. In some countries injecting drug users go to secluded shooting galleries, but in other countries injecting takes place in more public locations: in a designated area users can get an injection from a dealer or person whose job it is to inject users. In most cases, dealers and public injectors have little or no information about HIV infection. The sharing of needles, syringes, and other drug-use equipment is common.

Social consequences of drug use



Source: AHRN Clearing-house

In addition to sharing needles and syringes, the sexual practices of drug users is another important area that contributes to their vulnerability to HIV infection. Drug users tend to be sexually active, and their condom use is often very low. In some countries, condoms are often used in sex with commercial sex workers but not with regular partners. Unprotected sex is often perceived to be less risky than sharing needles and syringes. A high prevalence of sexually transmitted infections among drug users reflects their unsafe sexual practices. They and their partners often act as a bridge to transmit HIV to other populations such as commercial sex workers, clients of commercial sex workers, and then to the general population.

The HIV/AIDS epidemic began to spread in Asia in the late 1980s. In a number of countries – China, Myanmar, Nepal, Thailand, and Viet Nam – drug users were the first to be infected; the epidemic then spread from drug-using populations to other groups, and from there to the general population.

Treatment and rehabilitation centres are often not readily available to drug users. In many countries, services provide detoxification only, or treatment is mandatory and carried out in a military style with a strong penal element to achieve total abstinence – strong reasons for drug users to avoid attending. In many regions of Asia, outpatient and substitution treatment as well as aftercare services are virtually absent. If services are available, they are often provided by non-specialists with limited knowledge about drug treatment and HIV/AIDS prevention.

C. Drug use and HIV/AIDS: What should be done?

A United Nations system-wide position paper, adopted in September 2000 by a subcommittee of the Administrative Committee on Coordination, spells out a comprehensive policy response to drug use and HIV/AIDS that reflects the thinking of many people working in that area over the past decades. Some of the principles of the policy response are:

- protection of human rights is critical for the successful prevention of HIV/AIDS;
- HIV prevention should start as early as possible;
- comprehensive coverage of the entire targeted population is essential;
- drug-abuse problems cannot be solved simply by criminal justice initiatives;
- the ability to halt the epidemic requires a three-part strategy – preventing drug abuse; facilitating entry into drug-abuse treatment; and establishing effective outreach to engage drug abusers in HIV-prevention strategies that protect them, and their partners and families, from exposure to HIV (i.e. encouraging the acceptance of substance abuse treatment and medical care).

D. Drug and HIV/AIDS policies in Asia

GOVERNMENT AGENCIES

For almost all Asian countries, at least two separate government agencies address issues concerning drug use and HIV/AIDS: while drug-use issues are under the purview of specialized

drug-control agencies, HIV/AIDS issues are usually addressed by the Ministry of Health or a subsidiary of that ministry. Prior to the establishment of AHRN – and, indeed, even up to the present in several countries – there was little communication and less cooperation between these government entities. Because of this, the process of developing and reviewing drug and HIV policies in Asian countries is difficult. In many countries, drug-control legislation was developed prior to the onset of the HIV/AIDS epidemics, and it is usually based on the United Nations Drug Control Conventions, which have been ratified by most countries of Asia. In general, drug policies are not supportive of effective HIV prevention among drug users. With the exception of law enforcement, drug problems are not generally accorded high funding priority. Consequently there are few government programmes in the region that directly address problems presented by the interface between drug use and HIV/AIDS.

If governments implement measures to prevent the spread of HIV among drug users and their sexual partners, they are often localized, short term, underfunded, and insufficient in scope. Adherence to traditional values is strong in many of the countries, making debate on HIV/AIDS prevention and sexual behaviour sensitive. Drug treatment almost invariably focuses on detoxification treatment. Drug users are afforded no choice of treatment, which is mostly compulsory, residential, and long term. Drug-treatment personnel are often non-specialists in the drug field, coming from the labour, public security, or nongovernmental sectors. Most treatments include a strong penal element.

NONGOVERNMENTAL ORGANIZATIONS

A great number of nongovernmental organizations (NGOs), probably numbering in the thousands, address issues related to drug use in Asia. The International Federation of Non-Governmental Organizations against Drug and Substance Abuse, established in 1981 and based in Kuala Lumpur, currently has 54 members, nearly all of them national umbrella organizations. Forum, another federation of nongovernmental organizations, currently has approximately 15 members. In the past, NGOs in the drug field have typically chosen to organize themselves in federation-type structures at the national and regional levels, the primary goals being to increase political influence and to solicit funding. Such federations are usually organized hierarchically, with information flowing vertically from the members of the federation to its secretariat and from there, after filtering, back to the base. Little interaction occurs horizontally – that is, among the members of the federation. As a consequence, those in the secretariat of the federation are usually better informed and in more powerful positions than the federation's members.

Another feature of Asian NGOs working in the field of drug use is that they rarely include drug users themselves. In many cases, these organizations work for drug users – or even against drug users – but not with drug users. Some organizations that are closely affiliated with law-enforcement agencies understand their mission as a “war against drugs,” with drug users viewed as criminals and, therefore, the enemy. Interventions developed by such organizations often embark on a fear approach, reinforcing stereotypes of drug users. They sometimes practise cruel and degrading treatment approaches such as “cold turkey,” a method of withdrawal without any supporting medication, or “haircuts,” which entails humiliating a drug user in public if he or she has not adhered to the rules of the treatment facility. All too often, human

rights of drug users are violated; such violations are not only tolerated by governments and the public, but also practised by government institutions themselves. Given such practices, these organizations naturally experience problems in reaching out to drug users, identifying their needs, and developing feasible low-threshold programmes – that is, programmes whose pragmatic admission criteria are designed to encourage drug users to seek help – that could address both drug use and HIV/AIDS.

In the field of HIV/AIDS, a great number of national and international organizations have evolved since the beginning of the epidemic, many of them addressing the needs of people living with HIV/AIDS and consequently involving them in the daily operations of the organization. In fact, since the launching of what is called the Greater Involvement of People Living with HIV/AIDS (GIPA) at the Paris AIDS Summit on 1 December 1994, it has become standard for nongovernmental organizations to include people with HIV/AIDS.

Interestingly, there is a similarity in policies between governmental and nongovernmental organizations when it comes to drug use and HIV/AIDS. NGOs working in the drug field state that HIV/AIDS is a health issue that should be dealt with by those institutions specializing in health issues. At the same time, NGOs working in the field of HIV/AIDS state that they do not work with drug users as there are already many institutions working in that field. As a consequence, few NGOs work with both drug use and HIV/AIDS. It should also be noted that drug NGOs have relatively little experience in working with HIV/AIDS, and HIV/AIDS NGOs generally lack adequate knowledge about drug issues. Those organizations addressing both drug use and HIV/AIDS face a number of difficulties; these include:

- isolation and marginalization;
- resource shortages;
- lack of institutional capacity and skills relating to programme design, implementation, and evaluation;
- little recognition that HIV epidemics among drug users are preventable;
- lack of information, such as documentation or research on effective models and interventions, and few suitable mechanisms for sharing information;
- slow or non-existent governmental responses, and little support for nongovernmental responses.

INTERNATIONAL ORGANIZATIONS

Until September 2000, United Nations organizations continued to send mixed messages regarding drug use and HIV/AIDS to governments in Asia. The United Nations International Drug Control Programme (UNDCP) together with the International Narcotics Control Board (INCB) advocated an abstinence-only policy to reduce drug use, believing this would lead to a reduction in the incidence of HIV infection among drug users. Both UNDCP and INCB insisted on adherence to international drug-control conventions, which exclude the use of narcotics for other than medical or scientific purposes. The main sponsor or partner organizations of UNDCP and INCB were usually powerful national drug-control agencies. The World Health Organization as well as UNAIDS, which began its operations in January 1996,

promoted various pragmatic risk-reduction strategies, including information campaigns, peer outreach, drug-substitution therapy, and needle- and syringe-exchange programmes. WHO and UNAIDS worked primarily with public health agencies, which are less influential than drug-control agencies with regard to matters pertaining to drug use. Slowly, a more pragmatic approach began to be accepted. In June 1998, the United Nations General Assembly adopted the Declaration on Demand Reduction, which called for addressing the adverse health consequences of drug use; and in April 1999, UNDCP became a cosponsor of UNAIDS.

A similar split can be observed in regional intergovernmental organizations such as the Association of South-East Asian Nations (ASEAN) and the South Asian Association of Regional Cooperation (SAARC). In both of these organizations, drug control was overseen by one entity, and HIV/AIDS by another, with each promoting contradictory policies. It was not until September 2000 that United Nations bodies and entities agreed on a common and system-wide position with regard to drug use and HIV/AIDS.

Prior to this agreement, a number of international organizations began to promote interventions to reduce drug-related harm, particularly the risk of HIV transmission among drug users. In 1996, the International Harm Reduction Association was established at the Sixth International Conference for the Reduction of Drug Related Harm in Hobart, Australia. The purpose of the association is to reduce the health, social, and economic harms associated with drug use. It works with local, national, regional, and international organizations to assist individuals and communities in the areas of public health advocacy.

E. The pioneers of a comprehensive approach

Starting in the early 1990s, some programmes began operating in different Asian countries to address both drug use and HIV/AIDS. One of the first of these was the Lifesaving and Lifegiving Society (LALS), an outreach needle-exchange programme in Kathmandu. According to Nepalese laws, that programme was not legal; but somehow the LALS staff managed, and the government tolerated their activities and carefully observed the effects on the growing epidemic of HIV/AIDS among drug users in this country. Around the same time, similar programmes began operating in other Asian countries; these included:

- Sharan, New Delhi, India
- Ikhlas, Kuala Lumpur, Malaysia
- the SHALOM Project, Manipur, India
- Save the Children Fund, Ho Chi Minh City, Viet Nam
- AIDS Surveillance and Education (ASEP), Cebu City, Philippines
- HIV/AIDS Prevention and Care Project for the Hilltribes of Northern Thailand (HAHP).

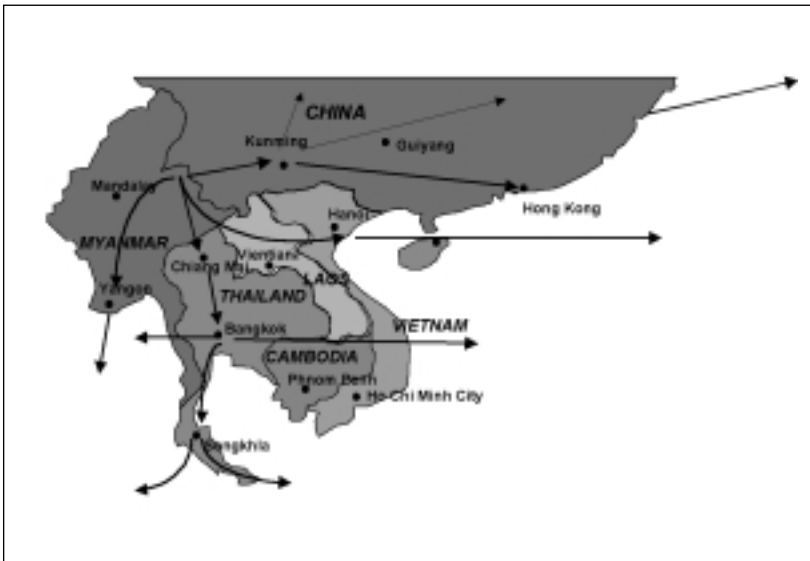
Funds and other resources were generated through fundraising activities in the local communities or were provided by foreign donors. Programmes whose prime focus was rehabilitation also began to expand their activities to include prevention of HIV infection through information, communication, and education campaigns, peer outreach, needle- and

syringe-exchange programmes, and drug-substitution programmes. With the support of the World Health Organization, the Australian Agency for International Development, and the United Nations Development Programme, among others, capacity-building and training workshops were held in a variety of Asian venues from 1991 through 1995. By 1996, the number of programmes addressing drug use and HIV/AIDS had slowly increased. Although these programmes were small, they were influential: by their very existence they demonstrated that it was possible to reduce the risk of HIV transmission among drug users.

IV. The birth of the Asian Harm Reduction Network

As has been described in the preceding sections, the drug-use situation in the countries of Asia is extraordinarily complex. Asia is home to main drug-production areas that supply drugs for trafficking all over the world. There is a significant spillover to local drug-consuming markets from production areas and trafficking routes. In addition, large pharmaceutical industries exist, from which drugs are diverted to drug users. The health and social consequences of drug use are severe and widespread. Current drug policies and programmes address drug use with an abstinence model, which is not in itself appropriate to respond to the growing HIV/AIDS epidemic. Moreover, little cooperation exists between policy makers and programme developers from drug-control and public health agencies. The nongovernmental response is inadequate, as it addresses either drug use or HIV/AIDS in isolation, not in combination. The few exceptions – individuals and organizations that addressed both drug use and HIV/AIDS in comprehensive programmes, often in a semi-legal environment – risked harassment or even imprisonment by law-enforcement officials.

Figure 2. Trafficking routes of South-East Asia



Source: UNDCP Regional Centre for East Asia and the Pacific

A. Establishing a technical resource network

Despite this background, a small but significant body of experience on the prevention of HIV transmission among drug users in Asia had been accumulated by the mid-1990s. Yet no regional meetings had been organized and no mechanisms had been established to share this experience. With small amounts of funding from WHO's Programme on Substance Abuse, the United Nations Development Programme (UNDP) and a range of other organizations, 46 programme managers and other interested parties from nine Asian countries were able to attend the 1996 International Conference on the Reduction of Drug Related Harm, which was held in Hobart, Australia. Following the conference, a two-day workshop was organized at nearby Coles Bay by the Melbourne-based Macfarlane Burnet Centre for Medical Research to exchange experience on the prevention of HIV transmission among drug users in Asia.

The primary aim of this workshop was to develop a harm-reduction manual for Asia. After reviewing the drug-use situation in Asia, participants at the meeting concluded that there was an urgent need to respond effectively and rapidly to the dual problems of drug use and HIV/AIDS through large-scale interventions. Participants recognized that governments faced too many impediments to develop such a response, and that programmes already operating lacked capacity and resources. There was documentation of programmes at the international level, but participants concluded that such programmes needed to be adapted to the specific political, social, economic, and cultural circumstances of Asian countries. That adaptation process, and the scaling-up of existing programmes, was too great a task for a single institution. The participants at the meeting therefore concluded that such an endeavour could be carried out only through the collective efforts of all those institutions and individuals with experience and interest in programmes addressing drug use and HIV/AIDS in Asia.

But how could that be done in practical terms? Those programmes with experience in drug use and HIV/AIDS were located in Australia, India, Nepal, the Philippines, and Viet Nam. Geographical distance alone constituted an enormous obstacle, as did cultural diversity, different languages, fundamentally different political systems, and large gaps in available resources. Options to overcome such barriers, including the establishment of an international nongovernmental organization or a federation of NGOs, were explored. The participants concluded that, because the flow of information in such traditional organizations is usually from the top down or the bottom up, as opposed to directly between members, none of these options would promote an effective response.

The only way out was to develop a new mechanism that would allow for the effective horizontal sharing of information and experience, the pooling of resources, the mutual support of programmes, and the development of a solid base for advocacy – and all that with a minimum of administrative overhead. Such a mechanism had to be able to give equal attention to programmes and projects working at the field level, drug user organizations, national and international organizations, research institutions, and interested individuals; thus, any hierarchical organizational structure would be inappropriate. The only way to meet such diverse needs and requirements was to form a technical resource network. The participants therefore agreed to form a regional coalition of institutions and persons working in the field

of drug use and HIV/AIDS. Starting with these 46 meeting participants, then, the Asian Harm Reduction Network (AHRN) was established in March 1996.

A mission statement was developed for the new network: "To reduce the harms associated with injecting drug use in Asia, especially HIV infection, through a process of networking, information sharing, advocacy, and programme and policy development." More specifically, six objectives were formulated:

- to establish a sustainable harm-reduction network based in Asia;
- to develop a more comprehensive understanding of patterns of injecting drug use and associated harms (especially HIV infection) in Asian countries;
- to provide a forum that will encourage communication and information exchange among individuals, organizations, and countries participating in the network;
- to provide training and support for individuals and organizations in Asia, sharing core skills and a coherent philosophy that can underpin their work;
- to facilitate policy and programme development at NGO, governmental, regional, and international levels;
- to promote national harm-reduction networks.

(The last objective was added in 1997.)

B. Developing and sustaining the network

With input from a 15-member provisional steering committee and a small grant from the Australian Agency for International Development (AusAID), a part-time coordinator was hired and work began on developing the network and securing continuing funding. The AHRN secretariat was established at the Macfarlane Burnet Centre for Medical Research in Melbourne until funding and structures could be established to maintain the network and set up a sustainable office in Asia.

The transition to an Asian base took place in early 1998, when AHRN moved its secretariat to a tiny, unused chemical-storage building in the grounds of the Office for Communicable Disease Control Region 10, in Chiangmai, Thailand. This move was supported by the following agencies:

- Office for Communicable Disease Control Region 10, Chiangmai, Thailand;
- Thailand Ministry of Public Health, Bangkok;
- Macfarlane Burnet Centre for Medical Research, Melbourne;
- UNAIDS Secretariat, Geneva, and UNAIDS Asia-Pacific Intercountry Team (APICT), Bangkok;
- the Drug Policy Foundation, United States.

In moving its secretariat from Australia to Thailand, AHRN lost considerable infrastructure support, including free office space, computers, administrative support, and communications services that had been provided by the Macfarlane Burnet Centre in Melbourne. Establishing the network's new Asian headquarters therefore involved many challenges: recruiting new staff;

establishing banking, computer, and communications services; securing further funding; registering AHRN as an NGO in Thailand; and supporting AHRN's growing membership, which numbered over 1,000 members in 48 countries. Carrying out these tasks while also maintaining the network was, and continues to be, a massive undertaking for AHRN's staff and management. Because there were no other specific models or networks to draw on, achieving each task took significant effort and often meant that the network had to expend considerable energy on ensuring its survival.

As it continued to grow in size and activities, it was clear that AHRN had an increasingly important role to play as a lead regional agency for harm-reduction programmes in Asia. To meet this growing demand, AHRN needed to focus outward, ensuring that the needs of running the network did not outweigh the needs of its members. From the beginning, AHRN was run by programmes for programmes. The network's management was always drawn from grass-roots harm-reduction programmes. This remained an important way of ensuring that the network's activities and focus reflected those of harm-reduction programmes in Asia. To maintain this focus and representation, the bimonthly *AHRN Newsletter* was developed and has been one of the network's main vehicles for communicating decisions and involving all members.

C. Adjusting the management structure

Since the network's formation, the AHRN management committee has seen several changes in structure and membership until a model could be found that was robust enough to steer the network through difficult decisions but flexible enough to avoid becoming a bureaucracy. Initially, AHRN was led by a 15-member provisional steering committee, chosen at the network's founding meeting in 1996. This committee provided direction and support to the AHRN coordinator, who at that time was the network's only paid staff member.

In 1997, the network held its first annual meeting, where a nine-member interim executive was chosen from the initial provisional steering committee and other invitees. This interim executive was refined in 1998–99 to the current seven-member executive committee (AHRNEX), which includes the AHRN Chair and AHRN Executive Director (formerly AHRN coordinator). AHRNEX holds elections every two years.

As the network grew, so did the need for secretariat staff. By 2000, AHRN staff included the following positions:

- executive director
- executive assistant
- clearing house coordinator / information technology expert
- clearing house assistant
- project coordinator
- office manager.

The staff members are aided by the services of computer-support personnel, publishing houses, AHRN executive committee members, external consultants, and volunteers. The network is also involved in collaborative projects, working with staff from partner-agencies. Since its establishment, AHRN has received financial support from:

- AusAID
- the Drug Policy Foundation
- UNAIDS Secretariat (Geneva) and UNAIDS-APICT (Bangkok)
- the Royal Dutch Government
- Family Health International – Asia Regional Office
- UNICEF
- United Nations International Drug Control Programme (UNDCP).

In 1999, AHRN was registered as a foundation in Thailand. The AHRN secretariat has an annual budget of approximately US\$100,000, which covers the daily running of the network, including the secretariat, but does not take into account specific activities such as workshops, which require separate funding. While AHRN has received broad funding support from a range of donor agencies, the network remains an independent organization, not owned or controlled by any single agency or donor. This independence has been an important factor in the network's success, because it has allowed the network to represent the needs and interests of its members first and foremost.

D. Membership

Membership is an important issue for all technical resource networks. There are closed and open networks, depending on their purpose. The Asian Harm Reduction Network was not designed as a forum for a few who want to discuss and take action on specific issues, but as a broad alliance to promote an expanded response to the issue of HIV/AIDS among drug users. The founders of AHRN therefore chose to establish an open network with the greatest possible participation and interaction among its members. Anyone can become a member of AHRN, and no membership fees apply. People from outside Asia are well represented, but AHRN's membership remains predominantly Asian. To join AHRN, interested persons simply need to provide the secretariat with their contact details and organizational profile so that they can receive the *AHRN Newsletter*, reports, and other information. By the year 2000, AHRN had more than 1,600 members, 82% from Asia, including people working in programmes and projects addressing drug use and HIV/AIDS, eminent researchers, officials of governments and nongovernmental organizations, staff members of international and intergovernmental organizations, and persons who are interested in the issue (see Figure 3).

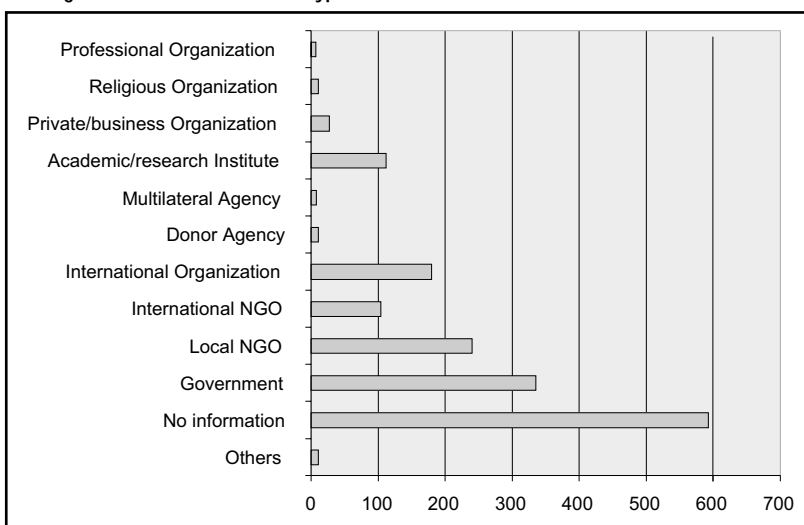
AHRN's membership has been built up in several simple ways:

- through word of mouth – people hearing about AHRN and then contacting the network;
- through AHRN executives and other long-time members recruiting members in their own countries;
- at regional and national meetings where the concept and benefits of AHRN are explained and people are encouraged to become members;

- through reports and products (including the *AHRN Newsletter*) that are regularly available only to network members.

The network operates mainly in English, although some materials and workshops developed by AHRN and its partners have been translated into Thai, Hindi, Mandarin, Bengali, and Vietnamese. Because many people in the Asian region do not speak English fluently – or do not speak it at all – language continues to be an important issue for AHRN as it seeks to make the network as inclusive and accessible as possible.

Figure 3. AHRN members of type



Another important issue for operating the network is the e-mail connectivity of the members – nearly 60% of all members from Asia do not have e-mail. This statistic underlines the importance of other means of communication, such as the *AHRN Newsletter*.

V. Major activities of AHRN

From the outset, AHRN's activities focused on supporting rather than implementing programmes. This meant strengthening existing ties and providing support for new responses in four main ways:

- information dissemination
- training
- advocacy
- networking.

A. Information dissemination

A key function of AHRN has been documenting, collecting, and disseminating examples of best practice on harm reduction in Asia. Through its newsletter, research reports, Web site, listserv, and other outputs, the network has been instrumental in sharing and promoting harm reduction strategies through regionally applicable examples of active programmes. The network has been circulating two powerful and important messages:

- Drug use is a serious part of the Asian HIV epidemic.
- HIV infection can be prevented among drug users, as demonstrated by harm-reduction programmes in Asia and around the world.

Published bimonthly, the *AHRN Newsletter* reaches over 1,500 people and programmes in over 56 countries through the network's growing mailing list. Featuring in-country updates, conference reports, and other articles on HIV prevention and injecting drug use in Asia, the newsletter, which is copied and circulated widely by its initial recipients, has become a catalyst and a voice for HIV/AIDS programmes across the region.

The dissemination of information was quickly recognized by other organizations such as UNAIDS and UNDCP as an important tool to improve the situation of drug users in terms of HIV/AIDS. These organizations therefore requested that AHRN provide its expertise in developing information, and distribute it widely, and they were willing to make financial contributions for these activities. With the creation of a Web site and the employment of a resource coordinator to run a clearing house, AHRN began in 1999 to ensure that valuable information was available in both printed and electronic formats to programmes and institutions across the region. AHRN also established a moderated electronic discussion group to provide rapid information to those with Internet access.

During late 1997, AHRN and the Macfarlane Burnet Centre were contracted by the UNAIDS Asia-Pacific Inter-country Team to carry out a detailed assessment of drug use and HIV vulnerability in 16 South-East and East Asian countries. Given AHRN's broad membership and extensive resource collection, it is doubtful that this intensive project could have been conducted easily without the network. Entitled *The Hidden Epidemic*, the 180-page research report confirmed that drug use is a central factor in the spread of HIV in many Asian countries. The report also indicated numerous gaps in information and national responses to

this problem, confirming the need for ongoing data collection and assessment. The report also provided strong arguments for more sustained governmental and nongovernmental responses towards drug use and HIV vulnerability. In this way, *The Hidden Epidemic* was an important advocacy tool for bridging the gap between rhetoric and action on HIV/AIDS among drug users in Asia. In 2000, the UNAIDS/UNDCP taskforce on drug use and HIV vulnerability endorsed the development of a second edition of *The Hidden Epidemic*.

Another key publication was developed in collaboration with the Centre for Harm Reduction (part of the Macfarlane Burnet Centre for Medical Research). Four years in the making, *The Manual for Reducing Drug Related Harm in Asia* was published in early 2000. It pools experience from harm-reduction programmes across Asia and provides practical steps for establishing and sustaining harm-reduction responses. Supported by Family Health International, the United States Agency for International Development (USAID), and WHO, this resource is already proving to be a valuable tool for training and programme design.

B. Capacity building

As described earlier, the HIV/AIDS epidemic among drug users requires a comprehensive and multi-pronged approach, including rapid situation assessment, formulating policies, planning appropriate programmes and projects, developing specific interventions such as outreach activities, providing counselling and treatment, implementing information campaigns, and providing means to drug users to protect themselves from HIV transmission. While in a number of countries the development of capacities would include skills building and technology transfer in concrete intervention strategies, other countries are not yet ready to implement programmes on the prevention of HIV/AIDS among drug users; at this stage, they require advocacy tools. Capacity building in the Asian regional context requires, therefore, that AHRN provide a great variety of capacity-building mechanisms.

Depending on the needs and circumstances of the target audience, AHRN has carried out capacity-building activities in a number of areas at workshops, international and regional conferences, and national and local meetings. For example, AHRN has provided significant inputs into the area of policy formulation at one national and three regional intercountry technical workshops and at a regional advocacy workshop for senior policy-makers. In addition, members of AHRN have developed a training module for field-level workers, which spells out in practical terms how to develop and implement interventions and how to deal with stakeholders; *The Manual for Reducing Drug Related Harm in Asia* describes methods of rapid assessment and response; and skills-building workshops were organized at the Fifth International Conference on AIDS in Asia and the Pacific, Kuala Lumpur, October 1999.

C. Advocacy

Prior to AHRN's formation, programmes addressing drug use and HIV/AIDS in Asia were isolated and had little opportunity to influence the policies of governments or donors. By linking and supporting these programmes, the network gave them a powerful collective voice, at both the national and international levels. Since its inception, the network has worked closely with

governments, donors, and the United Nations system, advocating for a more pragmatic approach to the problem of drug use and HIV/AIDS.

As described above, the main agencies concerned with this issue at the international level were the United Nations International Drug Control Programme and the World Health Organization. In January 1996, a new United Nations entity – the Joint United Nations Programme on HIV/AIDS (UNAIDS) – began operation. UNAIDS, with six cosponsoring organizations, represented a network in itself and was from the beginning a strong advocate of pragmatic approaches to reduce the risk of HIV transmission among drug users. Not surprisingly, close relations between AHRN and UNAIDS developed immediately; in fact, UNAIDS staff members assisted in the establishment of AHRN in 1996.

While UNAIDS assisted AHRN, the Asian network reciprocated, providing through its members valuable assistance to UNAIDS by continuously lobbying for prevention of HIV infection among drug users, even when UNAIDS could not state its position in public. At the same time, awareness among government officials of the devastating consequences of HIV/AIDS among drug users rose. Yet, legal factors and existing policies still made it dangerous, in some places even impossible, to voice such concerns in public. Through unofficial support for AHRN, sympathetic government officials encouraged a voice to express their concerns; the network assisted them in placing drug use and HIV/AIDS on the political agendas of their governments.

In 1997, UNAIDS established the Asia-Pacific Intercountry Team in Bangkok. Almost immediately, that team recognized that drug use and HIV/AIDS had to be a priority area of its work. In close collaboration and consultation with AHRN, the team established a Task Force on Drug Use and HIV Vulnerability, which brought together experts and stakeholders in the field of drug use and HIV/AIDS. From the beginning, AHRN was a member of that task force and the strongest advocate of pragmatic approaches to the prevention of HIV transmission among drug users. At the global international level, attempts at cooperation between UNAIDS, WHO, and UNDCP were often marked by friction resulting from the differing mandates of the respective organizations. But in Asia, UNDCP and WHO collaborated closely with the Asia-Pacific Intercountry Team and AHRN, assisting these organizations to get or keep drug use and HIV/AIDS on their agendas.

Although anecdotal information was available on the extent of HIV/AIDS in Asian countries, the Task Force on Drug Use and HIV Vulnerability quickly realized that the quality of that information was not sufficient to influence government policies. The task force therefore requested AHRN to compile all existing information related to drug use and HIV/AIDS in late 1997. The network proved to be an enormous advantage in working on that compilation, *The Hidden Epidemic*, because, through the members of the network, the information could be collected in a very short time. *The Hidden Epidemic* became an important advocacy tool for AHRN as well as for UNAIDS, UNDCP, and WHO.

In 1998, through the task force, the Asia-Pacific Intercountry Team began developing concepts for intercountry technical workshops on drug use and HIV/AIDS. The basic idea was to bring the middle management of drug-control and public health organizations together and to raise awareness on the dual problems of drug use and HIV/AIDS. The workshops – organized in April and May 1999 in collaboration with the Economic and Social Commission for Asia

and the Pacific (ESCAP), UNDCP, and WHO – had a strong training component, including the visiting of ongoing projects addressing drug use and HIV/AIDS. AHRN was essential not only in contributing to the concept of the workshops, but also in presenting case studies of ongoing projects in Asia and helping to organize field visits for the workshops. Through this collective effort, issues of drug use and HIV/AIDS became part of the agenda of drug-control and public health agencies.

In June 1999, AHRN organized a similar intercountry technical workshop in Nanning, China. This workshop brought together drug-control and public health officials from China and Viet Nam. It used a similar collective approach, with the following agencies partnering with AHRN:

- UNAIDS Asia-Pacific Intercountry Team, the Country Programme Advisers of China and Viet Nam;
- National Centre for AIDS Prevention and Control, People's Republic of China
- UNICEF, Beijing Office
- Fogarty International Programme at Johns Hopkins University, Baltimore, USA
- Australian Red Cross, Yunnan Province, People's Republic of China
- Commonwealth Department of Health, Australia
- Guangxi Centre for AIDS Prevention, Nanning, Guangxi Province, People's Republic of China.

All of these workshops developed a set of recommendations that could be used by the participating governments as a blueprint for policy and programme development. More importantly, however, interventions for the prevention of HIV transmission, even if they were viewed as controversial in the framework of traditional drug policies, became the subject of discussion and debate inside government agencies, and between the public health and drug-control sectors.

Already during the preparation for these workshops, AHRN members working at the field level identified significant gaps in national and international policies related to drug use and HIV/AIDS. That led to the development of a research design on policy factors facilitating and impeding effective interventions for the prevention of HIV transmission among drug users. By the end of 1998, the Asia-Pacific Intercountry Team recruited two international consultants, whose tasks included systematically examining drug and HIV/AIDS policies in seven Asian countries. Without the assistance of AHRN members in the study countries, the consultants would not have been able to carry out this task. The reports of the consultants were completed in May 1999, and was finally published in October 2000.

AHRN played a key role in two other workshops, the Thai National Policy Workshop on Drug Use and HIV/AIDS, and the Regional Advocacy Workshop on Drug Use and HIV Vulnerability, both held in Bangkok in October 2000. These two workshops contributed significantly to moving the policy agendas of the participating countries forward towards a more effective approach to drug use and HIV/AIDS among drug users.

The Asia-Pacific Intercountry Team had arranged for the participation of four key drug-control officials at the International Conference for the Reduction of Drug Related Harm in Geneva in April 1999. Members of AHRN, who were also participating at the conference,

used the opportunity to discuss with these officials the feasibility in the Asian context of policies and interventions presented at the conference. Similarly, in partnership with the UNDCP Regional Centre for East Asia and the Pacific, in Bangkok, AHRN arranged for the participation of five delegates at the Fifth International Congress on AIDS in Asia and the Pacific, held in Kuala Lumpur in October 1999. Participants were selected according to their profiles as senior drug-control officials and their capacity to influence national policy for the integration of HIV and drug-use prevention. At the conference, AHRN members provided these officials with detailed information on drug use and HIV/AIDS and discussed with them how to develop effective interventions in the political and legal environment of Asian countries.

D. Networking

The many activities described above were not carried out by a single member of the network or by the secretariat alone. They were collective efforts involving many members. For example, at a UNAIDS workshop held at Bangkok in April 1999, network members from Malaysia and Thailand participated as resource persons, while at a similar workshop in New Delhi in June of the same year, AHRN members from India and Nepal attended. Other examples include data collection for *The Hidden Epidemic*, which involved nearly all AHRN members, or development of *The Manual for Reducing Drug Related Harm*, which incorporated contributions and comments from a large number of AHRN members.

The benefits of the network could be demonstrated at the Fourth International Congress on AIDS in Asia and the Pacific, held in Manila in October 1997, and the Fifth Congress, held in Kuala Lumpur in October 1999. During both congresses, AHRN initiated a number of prominent activities to highlight the problem of HIV/AIDS among drug users in Asia and to bring harm-reduction workers together. These activities included:

- an information booth and promotional materials (newsletters, stickers, brochures, T-shirts);
- meetings for AHRN members;
- AHRN representation at the opening and closing ceremonies;
- skills-building workshops on the prevention of drug use and HIV/AIDS;
- a press conference on HIV and drug-use issues;
- coverage of drug-use and human rights issues in the local media;
- formal and informal meetings with international and local organizations.

Many people who had attended previous AIDS conferences commented at Manila and again at Kuala Lumpur on the stimulus and added value AHRN has given to harm-reduction programmes and drug-use issues in general.

VI. Assessing the impact of AHRN

Demonstrating AHRN's impact is difficult because the network is relatively new and has not yet been the subject of formal evaluation. Many of the network's activities are indirect – that is, they are aimed at *supporting* harm-reduction programmes rather than directly implementing them. However, if one applies UNAIDS' best practice criteria – ethical soundness, efficiency, relevance, effectiveness, and sustainability – AHRN should be judged as best practice. AHRN's activities are definitely ethically sound: AHRN advocates the human rights of drug users and people living with HIV/AIDS. AHRN's operations are also efficient: the network operates with a small budget to produce a significant effect. For the Asia region, AHRN's activities are clearly relevant, as drug use and HIV/AIDS are among the most serious problems in the region. Effectiveness requires the establishment of quantitative indicators and the comparison of such indicators after different time intervals. Strictly speaking, therefore, the criterion of effectiveness does not apply to AHRN, which supports programmes but does not implement interventions on its own. AHRN has, however, met its objectives, and could, therefore, be called effective. The final criterion is sustainability. In March 2001, AHRN celebrates its fifth anniversary, an indicator that AHRN is sustainable. A number of different organizations and institutions have expressed interest in collaborating with AHRN and supporting its network activities.

Looking at AHRN's core activities, early evidence suggests that the network has met the differing needs of its members in four interlinked ways:

- sharing and disseminating information;
- developing capacity;
- contributing to supportive environments for harm-reduction programmes;
- expanding responses to HIV and injecting drug use.

These four areas are generally accepted as necessary components for preventing HIV/AIDS at the national and subnational levels.

A. Sharing information

Two of AHRN's main objectives are:

- to develop a more comprehensive understanding of patterns of drug use and associated harms (especially HIV infection) in Asian countries;
- to provide a forum that will encourage communication and information exchange among individuals, organizations, and countries participating in the network.

The network has certainly achieved the objective of providing a forum for information sharing among network members. This has, in turn, assisted with the objective of developing a more comprehensive understanding of drug injecting and HIV in Asia. By creating a forum

for research, documentation of responses, rapid situation assessments, and information dissemination, AHRN is stimulating new dialogue and learning, thus filling the gaps in information on HIV and drug use in Asia.

AHRN has clearly created a platform for information and opinion sharing between individuals. This is occurring through its growing membership, its newsletter, and its e-mail listserv. Information sharing across the network occurs both formally and informally. In its first year of operation, the network received over 5,000 e-mails – and this at a time when use of the Internet was still limited in Asia. The increasing role played by information technology gives prominence to the question of how this technology can best be used to strengthen networks like AHRN.

Through its newsletter, Web site, presentations at meetings, research reports, and other documents, the network is demonstrating that harm reduction is both possible and worth pursuing in Asia. Probably the best example of documenting and sharing examples of best practice is *The Manual for Reducing Drug Related Harm in Asia*, which provides a clear rationale for harm reduction and includes numerous examples from programmes across Asia that are already practising harm reduction.

AHRN has been an effective mechanism for documenting and disseminating news, information on important issues, examples of outstanding harm-reduction responses, and other information on best practice in the area of HIV and drug use. As a network of researchers and workers on the front line of Asia's HIV and drug use epidemics, AHRN provides a ready-made research collection and dissemination web for sharing information on:

- recent trends in the spread of HIV among drug-injecting populations;
- current policies relating to HIV and drug use;
- existing and emerging responses;
- published and unpublished literature.

The network's access to up-to-date field information was demonstrated by the production of *The Hidden Epidemic*, which was written in only eight weeks in partnership with the Macfarlane Burnet Centre and with support from the UNAIDS Asia-Pacific Inter-country Team. AHRN is planning a revised and expanded version of this report, which has already been cited in many regions as an example of best practice in rapid situation assessments of drug use and HIV vulnerability. The fact that *The Hidden Epidemic* needed to be reprinted within 12 months of publication is further testimony to its popularity and relevance.

Creating and sustaining an Asia-based regional network on HIV and drug use has been one of AHRN's major achievements. AHRN has created a vehicle for the inclusion and networking of a growing number of people across the region. Having a network like AHRN has generated opportunities previously unavailable to programmes in Asia. These include:

- expanded participation and involvement
- new long-term alliances
- strengthened partnerships
- instant communication
- problem solving
- access to information.

B. Developing capacity

HIV/AIDS among drug users is a complex problem, and harm reduction is an even more complex concept. Many communities still lack the capacity to adequately understand and control the related epidemics of drug use and HIV/AIDS, as is evidenced by the growing number of countries across Asia experiencing uncontrolled HIV spread among drug users. HIV prevention among drug users has proven to be difficult in any circumstances; but when skills and local capacity are critically low, as is the case in many parts of Asia, translating perceived needs into effective programmes has proved near impossible. Core competencies that are lacking include:

- design and implementation of public health programmes targeted at drug users;
- policy options for reducing harms associated with drug use;
- skills in building community and political support for responses;
- development of responses targeting special risk groups such as women, prisoners, ethnic minorities, and youth;
- drug treatment and counselling;
- evaluation and documentation of responses;
- advocacy and fundraising to sustain responses.

Whether AHRN has significantly assisted capacity development in all these areas is difficult to ascertain at this relatively early stage. Yet, the member feedback to date indicates that the network has been influential in arming programmes with the information and skills needed to continue building capacity at the local level.

The network has proved to be a valuable resource and mechanism for developing and conducting national and multicountry training activities on HIV prevention and harm reduction. These activities have occurred throughout Asia and have targeted policy makers, health workers, law-enforcement officials, drug-treatment workers, government and non-government staff, and people interested in harm reduction.

Supporting new programmes is perhaps the greatest challenge for AHRN. In Asia, there are still only a handful of specific harm-reduction programmes. In the absence of policies, policy dialogue, and programmes specifically targeting drug users, HIV prevalence is increasing in many settings. Another major problem is programme coverage: much progress will be needed before programmes exist on a scale commensurate with the epidemic. The situation is best summed up by a delegate at the Fifth International Congress on AIDS in Asia and the Pacific in Kuala Lumpur who said, "harm reduction responses have definitely increased over the past few years, but the problem of HIV among drug users has grown even more, meaning that the gap between the epidemic and the response is larger than ever."

C. Advocacy

AHRN is an effective mechanism for facilitating policy dialogue and presenting policy makers with policy options from Asia and around the world to address drug use and HIV/AIDS.

The network has facilitated a number of workshops and meetings for government officials from the health, law-enforcement, and drug-control sectors, helping these sectors to work together more effectively at the national level. In addition, the network has been involved in advocacy for harm-reduction issues at the international level through conferences, media briefings, and ongoing work with the United Nations system.

Many observers of the drug-policy situation in Asia state that AHRN's main achievement has been to bring the issue of drug use and HIV/AIDS to the agendas of both national governments and international organizations. Over the past four years, as a result of the constant pressure of the secretariat and the members of the network, governments began to deal with drug use and HIV/AIDS and even requested intergovernmental organizations such as UNAIDS and UNDCP to provide assistance on policy and programme development. AHRN's strategy was to work first with those government sectors which were in favour of policies addressing both drug use and HIV/AIDS – usually this was the public health sector – and at a later stage involve those sectors that had difficulties with more pragmatic approaches. Being an Asian network, AHRN was in a much better position to address these issues in a culturally appropriate way than were many foreign staff members of intergovernmental organizations, who were often regarded as outsiders in the region. In addition, AHRN members usually have detailed knowledge of the political situation in their countries and know who the stakeholders are. They could, therefore, provide valuable insights on the best strategy for policy development.

The harm-reduction approach has been enhanced by a number of programmes and people participating in the network. This approach is gradually becoming accepted as an appropriate and effective response to HIV and drug use in Asia. This acceptance may partly be a reflection of the general growth of harm-reduction activities globally and the recognition that current approaches to illicit drugs in Asia are failing to prevent HIV. The role played by AHRN in legitimizing harm reduction must be acknowledged, as evidenced by the growing number of agencies and individuals in the network who are openly advocating for harm-reduction activities in their sphere of work.

AHRN has certainly made drug use a higher regional priority within the HIV/AIDS community. Other priorities the network has identified and begun advocating for include:

- improved mechanisms for the collection and exchange of information;
- distillation of useful principles and approaches from successful programmes;
- strengthened capacity and skills for better responses;
- determination of better ways to influence the policy-development process;
- identification and meeting of programme needs;
- establishment of more harm-reduction programmes.

D. Expanding responses to HIV and injecting drug use

The acceleration and linking of existing efforts to expand the response to the HIV/AIDS epidemic among drug users has been a major achievement of the Asian Harm Reduction Network. Although AHRN started many years after the epidemic began, it is important to note

that the support for harm-reduction responses certainly improved after the advent of the network, with many governments and communities now considering HIV and drug use to be serious national problems. It is difficult to gauge how much a network like AHRN has been able to influence this process, but the early evidence suggests that the network has played a pivotal role in paving the way for expanded responses to HIV and injecting drug use.

AHRN has been very successful in mobilizing and coordinating resources in a way that would be hard for smaller national agencies. The network has been able to coordinate multicountry research and training projects and to facilitate regional assessments and meetings. It has also provided an important regional collection of technical expertise in developing responses to HIV and drug use, thus reducing the region's reliance on outside assistance. For example, when a harm-reduction programme began in the Philippines in the late 1990s, it was able to send its staff to another programme in the network that had been running needle-exchange and other harm-reduction activities for many years. Now, when agencies need expertise to plan interventions or conduct training workshops, the network provides an easily accessible database of experienced consultants and documents. In these and other ways, AHRN has demonstrated and promoted the value of technical resource networks for pooling and utilizing technical expertise.

Individual agencies have made, and continue to make, substantial contributions in specific areas of HIV prevention and care. However, the need to act simultaneously and synergistically in a number of different areas – health services, communications, legal reform, education, rural development, and the status of women – requires that a range of strategic alliances be developed and maintained. It is increasingly evident that single agencies, whether government departments, United Nations agencies, nongovernmental organizations, or groups for people living with HIV/AIDS, do not have the capacity to deal with the multiple determinants of HIV and drug use.

At this stage, countries of the region have not mounted large and expanded responses to drug use and HIV/AIDS. Many countries, anxious not to violate existing drug legislation or international conventions, still think in terms of pilot projects. However, recent developments at the international level as well as in Asia – notably the adoption, in Bangkok in October 2000, of guidelines for effective responses to drug use and HIV/AIDS – indicate that large-scale programmes will be implemented sooner or later. But is Asia prepared for such programmes? Are there sufficient human resources to develop and implement interventions?

AHRN has repeatedly noted that it is not enough only to advocate for an expanded response; it is also important to initiate preparations to establish the necessary human resource base to implement such a response. At this stage, this is also an advocacy issue: cooperation needs to be fostered between different sectors of government; closer alliances must be forged among governments, communities, field programmes, and workers. AHRN has already been a highly effective catalyst for building and strengthening these types of strategic alliances and has shown the value and importance of networking between different types of agencies. AHRN will continue to work for establishing the necessary base for expanded responses to drug use and HIV/AIDS.

VII. Future directions

In its brief history, AHRN probably has had as many challenges as achievements. Some of the challenges to developing, sustaining, and managing the network have been noted earlier. It is not particularly difficult to anticipate a number of factors that will need to be addressed in the near future of AHRN. These factors include sustainability, representing and involving members of the network, accessing information, and network activities.

A. Sustainability

Sustaining AHRN, as it has grown from a small project to an internationally recognized regional organization, has been a continual challenge. On several occasions early in its existence, the network's survival was threatened by lack of funding, lack of a formal base, and lack of legal status; but, step by step, the network has surmounted each of these obstacles.

Because AHRN currently is supported by annual donor funding, the network's long-term sustainability is still not assured. AHRN is dealing with this issue by building a broad range of donor support. Other networks have dealt with this issue by charging membership fees or fees for their services. Such a strategy has been implemented mainly in developed regions, such as the United States, where member agencies can afford to pay these fees.

Although AHRN has made great progress, there are always new threats and challenges, especially as demands on the network continually outstrip capacity – for example, the network has already outgrown its small office in Chiangmai, less than two years after moving there. Responding to these constant challenges is part of the work of sustaining a network.

Key factors in building AHRN's sustainability include:

- having an appropriately staffed secretariat to carry out the network's daily activities;
- ensuring that the secretariat is supported by an active and involved management committee;
- having an agency or agencies willing to support the network as it grows;
- working hard to build donor support;
- continuing to demonstrate the effectiveness of the network.

Experience with the history of HIV/AIDS among drug users indicates that drug-use patterns and the political environment at the local, national, and international levels could change quickly. Only if the AHRN secretariat is able to meet the changing needs of its constituency – that is, the members of the network – will the network survive. At this stage, many governments of the region and donor agencies are still contemplating how best to develop policies and programmes to prevent the transmission of HIV among drug users. However, there are increasing calls to scale up existing programmes and to establish new programmes with large coverage. That will require extensive training activities and institutional capacity-building, a task that AHRN would have to carry out in collaboration with its partners. AHRN would need, therefore, to begin its preparations immediately to meet these future challenges.

B. Representing and involving members

In a large network with members spread across many countries, representing and involving members is a challenge. As mentioned above, a central tenet of AHRN's structure has been to ensure that field programmes from a broad range of Asian countries are represented through the network. Yet the reality is that the AHRN executive committee and the secretariat often do not receive substantial feedback and input from members, especially as meetings between network members are few.

Many attempts have been made to canvas members' views and needs through the *AHRN Newsletter* and the network's e-mail listserv. These processes are slowly involving more people in discussions about the network's needs and various issues facing harm-reduction programmes. Still, there is a continuing danger that the network will remain too centralized, placing large burdens on the AHRN secretariat and turning the network into an agency that represents it members rather than a network that involves them.

AHRN is well aware of this issue and has devised several ways to ensure that the network staff and management interface as much as possible with members. These strategies include:

- regular contact between members and AHRN staff through meetings, workshops, and conferences;
- surveys through the *AHRN Newsletter*;
- establishing a listserv where AHRN members can discuss their views;
- responding to e-mail, mail, and phone requests.

The AHRN secretariat is also involving members by working with them in joint activities such as training workshops, materials preparation, and research. The challenge of involving members in this way is that it adds to the work expected of the AHRN secretariat to coordinate activities. Another option is to decentralize the network so that it has national focal points or even national networks. This option has been considered several times by AHRN's management, but thus far AHRN has focused on running one regional network.

Using English as the language of the network leads to language disparity – a fundamental problem experienced in many international organizations. AHRN is fortunate to be in a region where English is widely used as a second or third language. By contrast, networks in Central and Eastern Europe have to produce documents in both Russian and English, and networks in Latin America have to use both Spanish and Portuguese.

Even in Asia, network communications are still skewed towards those fluent in English, including westerners working in Asia and those coming from countries, such as India and Malaysia, where English is widely spoken as a first language. This creates tensions between those fluent in English – who often have an advantage in speaking at meetings, participating in e-mail discussions, or preparing proposals – and those with little English fluency, whose views simply may not be adequately heard.

One possible solution is to develop services in several languages, but to date this has been an affordable option only through country-specific workshops and projects. Another option is to decentralize the network so that it has national focal points or even national networks,

as mentioned above; but again this option has not been actively taken up in Asia, due mainly to the vast resources that would be required.

Meeting members' wide-ranging needs is a constant challenge for a network operating in a region as large and diverse as Asia. Drug-use patterns, HIV trends, national policies, programme responses, and other parameters vary greatly from country to country.

Representing and responding to these differing situations in a single and unified way is often difficult. The network often deals with this issue by embracing regional diversity in the following ways:

- It ensures that AHRN's membership and management represents as much of Asia as possible.
- It features a broad range of articles and country-reports in its newsletters and other materials.
- It keeps membership open to all countries, especially those Asian countries not well represented in the network.

Basing the network's focus more on need than on political boundaries has created some difficulty for AHRN's work with donor and United Nations agencies, which are often restricted to specific geographical regions. Tensions were created in the network when activities – such as the UNAIDS-sponsored research report, *The Hidden Epidemic* – focused only on South-East Asia, despite the fact that substantial HIV spread among drug users was occurring in South Asian countries such as Bangladesh, India, and Nepal.

Such conflicts could have seen AHRN split into two separate networks (for South Asia and South-East Asia). However, AHRN felt that it was best to remain as one large regional network. This situation may change in the future, with subregional or issues-based networks forming on specific topics (e.g. harm-reduction networks focusing on Christian or Islamic communities).

C. Accessing information

Access to information is an issue facing many HIV networks, especially those where information sharing is a major activity. Because drug use and HIV infection often occur in remote regions, programmes and workers targeting these problems frequently have little access to research, resource materials, the Internet, and other information sources. In some regions, it may take 50 attempts to make an international phone call, a fax may take days to get through, and access to the Internet is still years away. As a consequence, programmes are unable to access the information and research that people in developed countries take for granted.

This limited access to information and research is partly because fewer harm-reduction programmes exist in Asia than in developed regions, but also because the programmes that do exist have extremely limited access to conferences, international journals, newsletters, e-mail, and other forms of information exchange. Redressing this imbalance is a constant challenge to AHRN. The rapid increase in Internet connections may mean that electronic communications become cost- and time-saving modes of sharing information across Asia. For now, AHRN still places great emphasis on its newsletter and other published information as well as on meetings where people can communicate face to face.

A potential problem with networks that have information sharing as part of their mandate is that they can overload participants with material via e-mail, reports, and other sources. Information overload has often been a concern for those working in the HIV/AIDS field, but has not yet been a problem in the area of harm reduction, given the overall paucity of pertinent information available in Asia.

D. Network activities

The temptation to try to do everything at once has been a problem for AHRN. With so much needing to be done on harm reduction in Asia, it is difficult to decide what should be the network's highest priorities. The challenge of prioritizing seems common to all types of technical resource networks working in the HIV field, but it is a particularly complex challenge for harm reduction, with its combined concerns of HIV and drug use. AHRN's management and secretariat have spent a significant amount of time drawing up detailed work-plans outlining the network's main activities.

Many of the difficulties in determining how the network is controlled have been discussed above in terms of AHRN's management and structure, membership base, independence, and work with network members. Extensive work in all these areas has helped AHRN to avoid serious internal or external conflict. Nevertheless, the issue of control is always a potentially difficult one. Actions by staff, management, and donors can threaten harmony within the network. Donor interests, for example, can exert pressure on the network to move in a particular direction. Alternatively, network interests can be dominated by particular countries or individuals. That AHRN has largely avoided these problems and continues to grow is testimony to the fact that the network has devoted considerable energies to ensuring that the network runs smoothly.

Overall, harm-reduction responses in Asia are still being attempted in a sporadic manner, if at all. Cooperation and networking between sectors and across country borders are often weak, and rapid responses to increasing HIV prevalence among drug users are rare. AHRN therefore needs to look for ways in which people and organizations in all sectors (governments, NGOs, the private sector, donors, health and development agencies, religious organizations, and others) can work cooperatively and can communicate with each other about problem definition as well as resolution. These processes should be directed towards consensus building and decision making around difficult issues, facilitating the creation of critical links between people and organizations within and between countries and enhancing the capacity of these people and groups to act.

Finally, we must not forget that what actually breaks the chain of HIV transmission among drug users is behaviour change by the people who are using drugs. Programmes to educate people and to encourage and facilitate this behaviour change are still the key element in any programmatic response to the HIV epidemic. Programmatic response thus provides a context for judging the usefulness of networks – do they support and encourage the functioning and growth of effective programmes?

VIII. Discussion:

The benefits of harm-reduction networks

The alpha and omega of a network is effective communication between its members. In Asia this is a serious problem because in many countries and areas appropriate means of communication have not yet been developed. As described above, many programmes, for technical or even political reasons, have no access to the Internet. As AHRN is demonstrating, other forms of communication need to be developed to keep the network alive.

A. Strengthening responses and reducing isolation

Open technical resource networks are particularly useful for issues where responses are new or weak, as is often the case with harm reduction. Such networks provide for rapid exchange of a wide variety of information and experience, and they lay the foundation for the pooling of resources. Certainly such networks are most appropriate on issues of drug use and HIV/AIDS in Asia.

As described earlier, isolated individuals and programmes were the first to recognize the need for effective approaches to HIV/AIDS among drug users, but these programmes had to struggle with repressive drug and restrictive political and funding environments. The establishment of AHRN provided them with some support, even if it was only the recognition that, somewhere on the continent, like-minded people faced the same difficulties.

The early evidence from the Asian Harm Reduction Network indicates that individual programmes can achieve much more by forming a technical resource network than they can on their own. Networks can link and strengthen existing programmes by providing additional technical resources and political support. They can build new alliances, strengthen strategic partnerships, and foster the development of new programmes in regions or countries where responses are absent.

Networks can be effective mechanisms for carrying out many of the activities identified by UNAIDS as critical elements for effective and broad-based responses to HIV/AIDS. These elements include:

- gathering and sharing technical expertise;
- documenting and understanding the spread of HIV among drug users;
- advocacy on behalf of local programmes and drug users;
- setting priorities and seizing opportunities;
- providing new policy options for governments;

- mobilizing individuals and resources;
- developing new responses;
- learning from experience;
- reducing isolation.

B. Setting norms

Being an active member of a network and contributing through sharing of information and views is a specific form of peer review that has a norm-setting character. This is particularly true if a network has developed a culture of debate. Getting feedback on programmes from fellow network members could provide a basis to correct mistakes in programmes or to enhance the effectiveness of interventions. Networks can also offer much-needed solidarity and peer support to individuals and member programmes, providing these people with a sounder philosophical and technical basis for their work.

Being part of a network can help groups and individuals influence government decisions and make a stronger defence against inappropriate demands by government bodies, funding organizations, and other stakeholders. Not to be understated, membership in a coalition or network can also provide the credibility and foundation needed to attract large-scale funding from governments and multilateral organizations. Donors are increasingly interested in regional responses to regional problems such as HIV/AIDS; networks, with their broad geographical coverage, often have the scope and coverage to take on large cross-border and regional projects.

C. Drawing expertise together

Regional networks can also help reduce a region's reliance on outside technical assistance when developing responses to HIV/AIDS. All networks in developing or transitional countries have initially been reliant on outside support, usually from western countries, as have many if not most of their member programmes. Although this has been expedient for a response to HIV/AIDS among drug users, it is often not sustainable, and in some cases interventions were not appropriate for the political, social, economic, and cultural environment in which they were carried out. Increasingly, programmes in these countries are looking to their fellow network members in the same region for technical support. This increase in self-reliance builds capacity, enhances the functioning of the network, and saves money.

At the workshop in 1996 at which AHRN was formed, a common experience reported by those representing programmes in Asia was that sanctions were applied against them or their programme if they became involved in political advocacy. By diffusing responsibility and building a constituency, harm-reduction networks can advocate with governments or agencies on behalf of their members without fear of reprisal against individuals or individual programmes. With the valued support of UNAIDS, harm-reduction networks have achieved a position of significant influence at high policy levels, especially within multilateral agencies.

Again with backing from UN agencies, this has led to the increased profile and influence of these networks in many of the countries in which their members work.

Even where harm-reduction programmes exist, especially in developing countries, there is an overwhelming need for demonstrations of their effectiveness. Networks are perhaps not best placed to carry out such evaluations, but they have an important role in stimulating and coordinating them and in setting and communicating standards for good practice.

IX. Conclusion

Although drug use had been widespread in many countries in Asia for a considerable time, and HIV/AIDS epidemics began to develop in the late 1980s, governments and many nongovernmental organizations did not respond adequately to these serious problems. Even the response from intergovernmental organizations, including United Nations bodies and entities, was hesitant. The main reasons for this inadequate response were historical, political, and cultural considerations related to drug use, and the absence of an effective mechanism to lobby for policy reform and effective interventions in that field. The establishment of AHRN in 1996 changed the political landscape significantly; it provided a voice for the few who did pioneering work in the field of drug use and HIV/AIDS.

The setting up of AHRN as an open technical resource network was most appropriate, allowing for the unification of all the diverse forces existing already in the area: field-level workers, researchers, politicians, officials from government agencies, nongovernmental and intergovernmental organizations, and last, but not least, drug users themselves. Forming AHRN as a network also provided the basis for pooling technical, human, and financial resources; for sharing information; for mutual support of network members; and for developing much-needed advocacy strategies.

What happened quickly after the formation of AHRN confirmed the need for its establishment: the number of network members soared from 46 at the beginning to more than 1,000 twelve months after its inception. AHRN had not yet established its office when requests for support from national and international organizations were received. AHRN was decisive in establishing a task force on drug use and HIV/AIDS 1997 in Bangkok; readjusting the work programmes of UNAIDS and UNDCP to put more emphasis, respectively, on drug use and HIV/AIDS; bringing drug use and HIV/AIDS to the agendas of governments; and lobbying relentlessly for pragmatic and humane prevention approaches.

It would not be right, of course, to say that no action had been taken in the area of HIV/AIDS and drug use until 1996. A number of organizations and individuals worked very hard to prevent HIV transmission among drug users. Some, due to ignorance, did the wrong things – rounding up drug users, chaining them for fear of HIV/AIDS, and putting them into prisons. In hindsight, it is amazing how strong a change occurred once the network was formed. The example of AHRN shows that the impact of an open network does not result simply from the combined impact of its components; the interactions between network members result in a much stronger force than the sum of its parts.

X. Lessons learned from AHRN

A. Creating and managing AHRN

- The concept of the AHRN grew from the observation that isolated harm-reduction programmes had few opportunities to share resources and information.
- An international founding meeting was a crucial first step in bringing people together to discuss and launch the network.
- AHRN benefited from being formed and governed by programmes in the field, rather than being initiated by donor agencies.
- A significant number of support agencies were required to help the network seek funding and locate an appropriate and diversified funding base.
- Having a funded secretariat, staffed by a full-time coordinator, was critical to developing the network, servicing its members, and securing funding for subsequent years.
- Developing AHRN's activities, establishing its secretariat, and securing funding required considerable professional expertise.
- Cross-cultural adaptation of harm-reduction strategies was critical to their acceptance.
- Support from local organizations and individuals has been critical to the network's recognition and success.

B. Impact of activities

- The Asian Harm Reduction Network is a good example of best practice in information dissemination and networking.
- Documents such as *the AHRN Newsletter*, *The Hidden Epidemic*, and *The Manual for Reducing Drug Related Harm in Asia* have been valuable resources for harm-reduction programmes in Asia.
- Early on, it was very important for AHRN to clarify and then promote its core functions: advocacy, information sharing, networking, and training.
- A network such as AHRN can play an important role in advocating for HIV prevention among drug users at the national and regional levels.
- AHRN has had a strong impact on United Nations agencies to build legitimacy for harm-reduction programmes.
- Networking between programmes is crucial for their recognition and to enhance their impact.
- AHRN has helped add professionalism to harm reduction in Asia.
- The dynamics of the AIDS epidemic demand the flexibility and pragmatism a network such as AHRN has been able to offer.
- Harm reduction and networking are adding value to HIV-prevention activities in Asia.

- HIV is spreading among drug users at increasing rates in Asia and other regions. This means that much more work is needed by networks, programmes, and governments in order to mobilize communities and responses more effectively in the coming years.

C. Network issues

- The network's efficacy needs to be demonstrated and sustained.
- Finding financial resources to support the network's ongoing activities is of crucial importance.
- Technical capacity needs to be built among harm-reduction programmes in Asia.
- The principles, processes, and elements of best practice for HIV prevention among drug users must be clearly identified.
- Additional rapid responses to the HIV epidemic among drug users need to be catalysed.
- Access to information and resources needs to be increased for people and programmes in less-developed countries.
- Technical barriers must be addressed, and AHRN must ensure that members are satisfied with the network's services.
- Communications must be improved across geographical and linguistic barriers.
- Access to the network needs to be increased for drug users, especially those living with HIV/AIDS.
- Network members need to have a clear understanding of where ownership of the network lies.
- A network culture needs to be developed through which members come to realize that their involvement is a central part of the network.
- A network needs a well-focused vision towards which all the stakeholders agree to strive. Having clear goals is an essential condition for a network's success.
- Networks need to be flexible. Members will put more effort into the network when it has the potential to meet their needs.
- An egalitarian relationship between members of a network must be maintained so that no one member or group dominates to the exclusion of others. A network's membership, whether individual or institutional, cannot depend solely on support from donors. Network members must be prepared to contribute financially, or otherwise, to help the network function efficiently and effectively.
- Lack of coordination might be the largest single reason for the failure of a network. Problems will arise if key stakeholders feel that they are excluded from the decision-making process.
- Good communication is essential to a network, particularly when distances between stakeholders are very great and access to communication infrastructure is uneven.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the leading advocate for global action on HIV/AIDS. It brings together seven UN agencies in a common effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations International Drug Control Programme (UNDCP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO) and the World Bank.

UNAIDS both mobilizes the responses to the epidemic of its seven cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV on all fronts: medical, public health, social, economic, cultural, political and human rights. UNAIDS works with a broad range of partners – governmental and NGO, business, scientific and lay – to share knowledge, skills and best practice across boundaries.



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