

**Report of the**  
**Donor Conference Harm Reduction**  
**Amsterdam, January 28 – 30, 2009**

*“...we are witnessing a revolution in practice – a revolution which brings together users and ex-users, human rights advocates, public health practitioners and of course those who have the financial resources to make a difference – to address a pressing problem for which there are straight-forward evidence-informed solutions”*

Michel Sidibé Executive Director, UNAIDS

## Introduction

In January 2009, representatives of donors, implementing governments, UN agencies, service providers, (ex) drug users, people living with HIV, activists and researchers convened in Amsterdam to work out proposals for scaling up harm reduction and accelerate progress towards universal access.

Although realistic in its ambitions, the Donor Conference on Harm Reduction was momentous in several respects. In the first place because participants endorsed a set of principles of engagement that are echoed in the words of Michel Sidibé that have been taken as the motto for this report. There was unanimity among the participants about the effectiveness of harm reduction and about the disastrous consequences of inaction.

In the second place because of the constructive atmosphere in which discussions between the different stakeholders were held. Both donors and recipients were frank about their limitations and about opportunities that they should exploit more fully.

The conference took place on the eve of a meeting where decisions will be taken about the future drug policy for the world. The gathering in Amsterdam helped to boost advocacy for humane approaches to drug use.

The contributions of many persons and organisations are acknowledged with great appreciation. Generous support for the conference has been received from the United Kingdom Department for International Development (DfID), Australian Agency for International Development (AusAID), Gesellschaft für Technische Zusammenarbeit (GTZ), Germany, Open Society Institute, AIDS Fonds and United Nations Office on Drugs and Crime. Thanks are also due to the members of the reference group who helped to design the conference programme.

This report summarizes the discussions and lists the proposals for concrete action, some of which are already taking shape. The energy and commitment among the participants of the conference have been most inspiring and make me confident that the momentum will not be lost.



Paul Bekkers

Ambassador – at large for HIV/AIDS

## List of abbreviations

AHRN	Asian Harm Reduction Network
ART	Anti-retroviral treatment
AusAID	Australian Agency for International Development
CND	Commission on Narcotic Drugs
EU	European Union
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
IAS	International AIDS Society
ICW	International Community of Women Living with HIV
IDU	Injecting drug use
IDUs	Injecting drug users
IHRA	International Harm Reduction Association
INPUD	International Network of People who Use Drugs
NSP	Needle and syringe programme
OSI	Open Society Institute
OST	Opioid substitution therapy
SRHR	Sexual and reproductive health and rights
UN	United Nations
Universal access	Universal access to HIV treatment, prevention, care and support
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
UNRTF	United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific

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## Summary

Injecting drug use and the related spread of HIV and other infectious diseases have reached alarming proportions in many countries. The world's response can be summarized as "too little, too late". On the initiative of the Netherlands, 120 representatives of donor and implementing governments, the United Nations, organisations of drug users and people living with HIV, service providers, policy makers and researchers went into the issues and formulated proposals to overcome the deadlock.

The Donor Conference on Harm Reduction had as its objectives:

- To increase SUPPORT for harm reduction and HIV prevention, both from a public health and a human rights perspective; and
- To increase COMMITMENT to the internationally agreed goal of Universal Access to HIV prevention, treatment, care and support for people who use drugs.

The opening speech by Michel Sidibé, Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS) reminded the meeting participants that the global commitments to universal access to HIV treatment, prevention, care and support must be made a reality for all – including the most marginalized and cast out by society, and reiterated that there is overwhelming evidence that harm reduction works and is very cost effective. He emphasized the low coverage of HIV services for IDUs which remains far short of universal access.

A major problem is the great lack of reliable data on injecting drug use and the related health hazards. Client organisations and service providers commented on the gaps in policy, the lack of financial and human resources, the unpredictability of funding streams and the persistent violations of the human rights of drug users. Women and young people are often left out of harm reduction activities. Advocacy and support in that area are much needed. Community-based responses are cost effective but grassroots initiatives have problems in accessing funds. Drug users and ex-users lead and guide harm reduction efforts and learn and empower themselves in the process. They need trust and support, both technically and financially.

The Accra Agenda for Action proved a useful guideline for the analysis of the roles and responsibilities of the different stakeholders and for the identification of possible improvements. Donor countries should coordinate their efforts better and implementing countries should exercise more leadership. Besides that, implementing country governments should be willing to assume responsibility for harm reduction programmes.

There is much intention and good will on the part of the donors currently engaged in harm reduction to continue and possibly scale up their efforts. However, existing granting mechanisms often impose a limit on the flexibility that bilateral donors can afford. It is difficult for donors to attend to numerous small requests from grass roots organizations. They appealed on civil society to build alliances, thus allowing for umbrella funding instead of small grants to a large number of small organisations. A mechanism like the Global Fund could possibly be more flexible and create a facility for small grants to NGOs. One remaining issue is how to engage donors who are currently not involved in funding harm reduction.

Georgia and Indonesia presented examples of how pragmatic approaches at country level can lead to demonstrable results and progress in harm reduction. A notable common denominator of success at country level is the close collaboration between government and civil society.

Across the conference, the following themes were highlighted:

- The appeal from IDUs and their representatives for a broad approach in harm reduction, i.e. one that is not narrowly focused on HIV prevention only, but encompasses interventions to reduce stigma and discrimination of IDUs; legal services for IDUs; food and shelter, advocacy towards policy makers; drug demand reduction; and capacity building activities for law enforcement agencies to create more constructive approach towards IDU and IDUs.
- Sustainability of funding: funding is too often ad hoc or not available where it can have the greatest impact. In addition, it is often unpredictable and interrupted while still needed. Governments need to show greater responsibility and step in as funders when external donors withdraw. Funding could be more effective if it was not just reactive, but also preventive in nature.
- The added value of a close collaboration between government, civil society and networks of drug users. “Nothing about us without us” remains a cornerstone and crucial principle of harm reduction. New ways of bringing this principle to life and making it work need to be found.

The conference agreed on a number of practical recommendations, among which the following stand out:

- Establishment of a Global Task Force which would work to harmonize definitions of harm reduction, promote critical and strategic thinking and map the needs, the gaps and potential resources. The Task Force should build on existing work and not “re-invent the wheel”.
- Institution of regular informal donor coordination meetings (working group on road map for scaling up).
- Inventory of existing monitoring tools in order to harmonize and reduce the reporting burden by countries (global monitor on harm reduction).

# Report

## 1. Opening

In his opening address, **Paul Bekkers, Ambassador – at large for HIV/AIDS of the Netherlands**, remarked that the conference should serve to move the international harm reduction agenda forward and achieve a more coordinated approach among the different stakeholders. He made reference to the responsibility of both implementing governments, donors, the United Nations and civil society. He thanked the reference group for its contributions and introduced Michel Sidibé Executive Director, UNAIDS.

**Michel Sidibé**, in his first speech abroad as **Executive Director of UNAIDS**, said that a revolution of practice is underway. A revolution which brings together IDUs and ex-users, human rights advocates, public health practitioners and of course those who have the financial resources to make a difference to address a pressing problem for which there are straightforward (one word) evidence-informed solutions. He commended the Netherlands for taking the initiative to convene the donor conference and for being a pioneer in proving that harm reduction can work.

He stressed that the global commitments to universal access must be made a reality for all – including those most marginalized and cast out by society. Drug users, often invisible to society, fall squarely into this category. According to Mr. Sidibé, the Netherlands has successfully demonstrated the power of universal access to harm reduction. By 2006, there were no more than six new HIV infections through IDU in the Netherlands. Similar successes have been recorded in other countries including, for instance, Australia, Switzerland, and more recently, Bangladesh and Malaysia. These achievements would not have been possible without legal reforms which also dealt effectively with stigma and discrimination.

He reiterated that there is overwhelming evidence that harm reduction works and is extremely cost effective. In Australia, for example, the return on investment of a decade of needle and syringe programmes (NSP) is estimated at one and a half billion dollars. In other words, harm reduction provides an excellent return on public investment.

However, the level of coverage of HIV services for IDUs remains far short of universal access. The 2008 UNAIDS Report on the Global AIDS Epidemic highlighted that only an estimated 47% of IDUs worldwide were reached by information on needle exchange services. In Eastern Europe, IDUs represent 83% of HIV cases but only 24% of those on treatment. Shocking human rights abuses of IDUs continue throughout the world. Police crackdowns on IDUs, for example, have massive negative health consequences:

- Overdose deaths rise because users are reluctant to call for medical assistance.
- IDUs who fear arrest are more likely to share needles; and
- There is a direct impact on access to harm reduction services.

In contrast, partnerships between law enforcement and public health officials are very successful, for example in Australia and the United Kingdom (UK).

In terms of what can be done about harm reduction. Mr. Sidibé proposed the following:

- Disseminate widely the evidence of what works.
- Stop the criminalization of IDUs.
- Focus on the most important gaps in HIV programmes for IDUs.
- Need for all international institutions to speak out loudly and clearly in favour of harm reduction.

He further underlined that addiction is an illness which needs treatment, not a crime in need of punishment and said that he would use his office to engage, country by country, as required, in proactive prevention diplomacy to ensure universal access for all to harm reduction services.

In concluding, he said that it was heartening to see that countries with huge populations, such as China and Indonesia, are seriously embracing the harm reduction challenge, and underlined four interlinked imperatives: universal access, human rights, a revitalized HIV prevention movement, and the full inclusion of IDUs in the HIV and AIDS response.

## 2. Setting the scene

In his introductory remarks, **Malcolm McNeil, Team Leader, AIDS and Reproductive Health Team, Policy and Research Division, DfID, United Kingdom**, stressed that the donor conference was a very rare and important occasion in that it brought together all major stakeholders in the field of harm reduction in one room. He emphasized the need for openness of all participants and not to be defensive even though it was clear that many stakeholders, including his own organization, had made mistakes and missed opportunities in harm reduction.

He noted that harm reduction is a much neglected issue but that the meeting had the potential to really drive the agenda forward. In light of potentially opposing views among the participants, he called on everybody to listen actively, share openly and be action-oriented in looking for solutions.

**“Let us not be defensive. Let us look for concrete solutions together”**

Mr. Malcolm McNeil, DfID, United Kingdom

In his presentation on IDUs and HIV prevalence, **Dr. Bradley Mathers, Senior Research Officer, University of New South Wales, Australia**, reported on the work of the Reference Group to the United Nations on HIV and Injecting Drug Use<sup>1</sup> and provided a panorama of the burden of HIV infection among IDUs.

He said that under the tenure of the current Reference Group secretariat the focus of work was on: review of the extent of IDU around the world and the prevalence of HIV among those who inject; review of the association between methamphetamine use and HIV; and review of pharmaceutical opioid injection and HIV. Mr. Mathers explained that there are reports of IDU from 148 countries meaning that IDU appears to be taking place throughout most of the world. Only a number of sub Saharan African countries form the exception along with Cuba, French Guiana, Guyana and North Korea where the Reference Group was unable to obtain any verifiable reports of IDU.

The prevalence of IDU, however, varies greatly from country to country. While 18 countries report an IDU prevalence of 0.00 - <0.25%, 22 countries report between 0.25% and 0.50%, 11 countries between 0.50 and 1%, and in 10 countries with the highest prevalence it was reported to be greater than 1% of the population. On the other hand, prevalence can also vary greatly within countries. In India, for example, the overall national IDU prevalence is estimated at 0.02% but some states have estimates of very high IDU prevalence, up to 3.98% in Manipur and 3.85% in Mizoram.

In terms of the total global number of IDUs, the current estimate is of 15.9 million, half of them in South Asia and Eastern Europe. It is worth noting that three countries – China, the Russian Federation and the United States - contain between them nearly 40% of the total estimated number of injectors in the world: China with 2.4 million, the United States with 1.9 million, and the Russian Federation with 1.8 million IDUs.

With regard to HIV prevalence among IDUs, the Reference Group reviewed reports from 127 countries. The prevalence of HIV among IDUs varies greatly across and within countries, from 0.0 – <7.5% in Australia and Germany, for instance, to 30% or greater in Argentina, Brazil and the Russian Federation. The number of IDUs who are living with HIV worldwide is estimated at currently 3.0 million.

He stressed, however, the significant level of uncertainty around the estimates regarding IDUs and HIV. For example, the range regarding the number of IDUs worldwide is from 11.0 to 21.2 million. With regard to the number of IDUs living with HIV, the range is from 0.7 to 6.6 million. However, what is clear from the available data is: HIV is prevalent among IDUs and their access to HIV prevention and care services is far short of the need.

As future challenges he highlighted the limited availability of data and the generally poor quality of data. Among the objectives of the Reference Group he mentioned the effort to generate better and updated data, especially from country level, and to centralize the

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<sup>1</sup> The Reference Group is an independent expert body providing technical advice and information on injecting drug use and HIV to the UN, for instance regarding the extent of IDU around the world and of HIV prevalence among IDUs, the level of coverage of HIV prevention and care services for IDUs, and other issues of concern regarding IDU and HIV.

information available. IDU data collection should be an integrated part of the response to HIV and AIDS. In addition, there is a need for a uniform set of definitions, data and indicators.

The presentation by **Annette Verster, Technical Officer, Focal Point on HIV, Injecting Drug use and Prisons, HIV Department, WHO**, focused on the importance of mainstreaming harm reduction as a public health response. She noted that countries with a public health approach to HIV prevention among IDUs have been most successful in preventing and controlling HIV epidemics associated with IDU, and in preventing the spread from IDUs to the wider population.

#### **WHO definition of harm reduction**

“A comprehensive package of evidence-based interventions that aims to reduce related harm

- with emphasis on public health and human rights; and
- with emphasis on public health indicators of harm and in particular HIV.”

Scientific evidence has demonstrated that comprehensive harm reduction programmes are effective and that epidemics can be prevented, slowed or reversed. The three UN organisations UNAIDS, UNODC and WHO have defined a comprehensive package of nine interventions for harm reduction.

#### **Comprehensive package of nine harm reduction interventions as defined by UNAIDS, UNODC and WHO**

1. Needle and syringe programmes (NSP)
2. Opioid Substitution Therapy (OST)
3. Voluntary Counselling and Testing (VCT)
4. Anti-retroviral treatment (ART)
5. STI prevention and treatment
6. Condom programming
7. Targeted Information, Education and Communication (IEC)
8. Vaccination, diagnosis and treatment of viral hepatitis
9. Diagnosis and treatment of TB

Ms. Verster explained that this package focuses on HIV-related interventions excluding broader interventions, such as overdose prevention. Which interventions countries needed to implement depends on a thorough assessment of the specific national situation and the most pressing needs of each country.

Further Ms. Verster presented the “Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users”, developed jointly by UNAIDS, UNODC and WHO and other partners. She said that the guide is an important step

towards harmonisation because it offers consistent methods of measuring and comparing countries' progress towards universal access and consensus as to which interventions should be included in a comprehensive package; provides guidance on defining and estimating denominator populations; proposes indicators to measure coverage; and includes indicative targets against which to measure progress towards universal access. She stressed the need for a uniform understanding and clear definition of all denominators and terminology involved. Before setting targets the environment needs to be fully understood and populations well defined, e.g. drug user versus injecting drug user or current user versus lifetime user.

**Future challenges in the area of harm reduction, according to Annette Verster, WHO:**

- Getting stakeholders beyond the UN, such as countries and donors, to adopt and use the UN methodology recommended in the UNAIDS, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users.
- Measuring the quality of harm reduction services, an area which is in need of much more attention.
- Introduction of harm reduction in prison settings; and
- Broadening the harm reduction agenda to non-opioid users.

Ms. Verster also briefly presented the work of the Middle East and North African Harm Reduction Network (MENAHRN) – an organization established in 2006 with support from the WHO and IHRA. Its aim is to develop harm reduction across the Middle East and Northern Africa through capacity building, training, advocacy, research and documentation, and networking.

With regard to the human rights perspective, **Rick Lines, Senior Policy Advisor, IHRA**, posed the following question: how can we use human rights as a tool to promote universal access? He underlined that scaling up of harm reduction is impossible without an enabling human rights environment. He presented six reasons why the human rights based approach should be used for harm reduction.

1. Human rights-based approaches are evidence-based approaches  
Human rights abuses undermine and negatively affect harm reduction activities. Human rights need to be respected for harm reduction to work.
2. Human rights are enshrined in international law  
According to the International Covenant on Economic, Social and Cultural Rights, Article 12, everyone has “the right... to the enjoyment of the highest attainable standard of physical and mental health.” “The steps to be taken ... to achieve the full realization of this right shall include those necessary for...The prevention, treatment and control of epidemic, endemic, occupational and other diseases”.

UN human rights monitors have identified access to harm reduction as necessary for States to be compliant with their legal obligations under Article 12.

3. Human rights law creates new ways to engage the UN system on harm reduction  
Advocacy in support of harm reduction can be used effectively within the UN architecture to influence the different bodies and agencies, such as, among others, the Commission on Narcotic Drugs (CND), the International Narcotics Control Board (INCB), UN Office on Drugs and Crime (UNODC) and the Human Rights Council.
4. Human rights create opportunities for collaborative advocacy with new partners  
An example includes the recent December 2008 supportive statement regarding harm reduction by the UN Special Rapporteur on the right to the highest attainable standard of health - which was the result of a coordinated advocacy process by, among others, IHRA and Human Rights Watch.
5. The human rights discourse empowers people who use drugs and people living which HIV (PLHIV) and validates their lived experience  
Principles such as “Nothing about us without us” are based in the human rights approach and are greatly empowering and encouraging to IDUs who are often not seen as worthy human beings.
6. The public health discourse alone has NEVER been sufficient to advocate for harm reduction  
Public health arguments alone do not work with every harm reduction stakeholder. The human rights discourse is an additional “weapon” for audiences not amenable to the public health discourse, such as, for example, politicians.

### 3. Client perspectives

In a panel on client perspectives, **moderated by Christoforos Mallouris, Director of Programmes, GNP+**, spokespersons of IDU constituencies, such as women, youth, IDUs and ex-users, exchanged their views, expectations and aspirations regarding harm reduction.

**Carmen Tarrades, International Community of Women Living with HIV (ICW), UK**, commented that women are often “invisible’ when it comes to harm reduction interventions, i.e. simply overlooked in terms of service provision and not consulted in the design and implementation of programmes. She emphasized the importance of advocacy, e.g. the one being conducted by ICW, to overcome gender issues and stigma with regard to IDU. She called on meeting participants to support the mainstreaming of gender and sexual and reproductive health and rights (SRHR) into harm reduction programmes.

According to **Prem Limbu, Recovering Nepal**, IDUs are the most hidden and hard to reach population for HIV prevention because of legal barriers, stigma and discrimination. He said that it is empowering and for IDUs to engage in networking and form alliances. Since IDUs are

so hard to reach with services, he stressed the importance of community-based, peer-led interventions. He emphasized that these interventions have proven to work and are cost effective. He appealed to donors to support IDU networking and service provision by and for IDUs.

With regard to young people and IDU, **Caitlin Padgett, Youth Rise, Canada**, stated that – quite similarly to women – young people and their needs are also almost invisible when it comes to harm reduction. She explained that her organisation propagates a broad approach to harm reduction, i.e. both going beyond HIV issues and including other drug use, not only injecting drug use. Ms. Padgett said it was high time to end the denial and recognise that young people use drugs and are affected by drugs, in some cases starting drug use as young as 12 years of age. Young people are denied their human rights when they are denied access to harm reduction services. She appealed to donors for technical support and guidance as well as core funding to support the work of her organisation.

**Vladimir Zhovtyak, All Ukrainian Network of PLHIV**, explained that IDUs and PLHIV started organising themselves in Ukraine in the late 1990s since nobody else would take on and tackle their issues. Nowadays, HIV and IDU are getting much more attention in Ukraine thanks mostly to the work of donors, in particular the GFATM, and the UN. The experience gained in Ukraine could probably be transferred to other countries, e.g. in Central Asia. He said that he strongly supports the integration of HIV and IDU services as opposed to stand alone programmes.

**Vito Georgievski, International Network of People who Use Drugs (INPUD), Former Yugoslav Republic of Macedonia**, representing current and ex-drug users, emphasized three key areas for IDUs: stepping up of international advocacy in support of IDUs and harm reduction; building of alliances with new partners, e.g. the International AIDS Society (IAS); and enhanced regional networking of IDU organisations. He also appealed to donors for core funding for his organisation.

In concluding, Christoforos Mallouris stated that the session demonstrated how diverse and complex the perspectives of IDUs are. Women and young people are often left out of harm reduction activities. Leadership and support in that area is much needed. Community based responses are cost effective but a remaining challenge is how to channel funding to these grassroots initiatives. The session showed that IDUs and ex-users lead and guide harm reduction efforts and that they learn and empower themselves in the process. They need trust and support, both technically and financially.

**“Young people are systematically denied access to harm reduction services because of age and other legal restrictions. The message they are getting is essentially: Wait until you are older and sicker, then we will serve you”**

Caitlin Padgett, Youth Rise, Canada

In a subsequent question and answer session, meeting participants stressed the resilience and resourcefulness of IDUs and their communities in dealing with IDU issues. It is clear that IDUs are experts when it comes to harm reduction. Community-based interventions are effective and deserving of support, especially in poor countries. Harm reduction could be

improved as a concept if it was not only reactive, i.e. responding to already existing IDU epidemics, but more comprehensive by focusing on prevention of drug use, in particular among young people.

#### 4. Service provider perspectives

In a panel on provider perspectives, **moderated by Ton Coenen, Director, AIDS Fonds, Netherlands**, representatives of organisations providing services to IDUs exchanged their views and perspectives. The panel consisted of **Tariq Zafar, Nai Zindagi, Pakistan; Willy de Maere, Asian Harm Reduction Network (AHRN), Burma; Sebastien Marot, Friends International, Cambodia; and Vitaly Djuma, Russian Harm Reduction Network, Russian Federation.**

The highlights of the discussion were as follows:

- Sustainability in harm reduction service provision

Often, harm reduction programmes are funded but the sustainability of funding is uncertain or unclear. This can lead to situations in which much needed service provision is suddenly interrupted. As an example, the panellist from the Russian Federation cited his country, where GFATM funding is currently available but uncertain if there will be further funding beyond the end of the grant in 2011. This uncertainty is compounded in countries where the government is not supportive of harm reduction. In those settings, the government often does not step in with own funding once donor grants are terminated. The panellist from Pakistan, however, gave the example that in his country the government did step in with its own funding after a DfID grant ended. This example, however, is a rare one. Donors should attempt to use their leverage to motivate governments to take ownership of harm reduction programmes wherever possible.

- A broad approach in harm reduction

Panellists emphasized that in many settings harm reduction only focuses on dealing with injecting drug use. This, however, leaves out a great number of users of other drugs, such as methamphetamines. In addition, harm reduction programmes often do not include socio-economic components. In Burma, for example, in the absence of any kind of social security schemes by the government to protect its citizens from poverty, harm reduction services – in order to be really effective - should be accompanied by measures such as provision of food, life skills education and income generation for (former) IDUs. Otherwise, the danger of relapse is very real in the face of severe economic hardship.

- Value added of involvement of civil society and IDUs

All panellists reiterated the real value added of civil society and IDU involvement in the planning, implementation and monitoring and evaluation of harm reduction programmes. In Burma, it was possible to make real strides in harm reduction – despite the extremely unfavourable human rights environment – due to a strong and broad coalition of stakeholders of non-governmental organisations (NGOs), of donors, the UN and IDUs.

**“It is important to realize that the term harm reduction is key as a bridge between human rights, public health, drug policy and HIV policies. It may also be a bridge between UNODC, CND, WHO, UNAIDS and UNHCR”**

Anne Skjelremud, NORAD, Norway

According to Ton Coenen, the following six points represent the service provider “wish list” to donors and governments:

#### **Service provider “wish list”**

1. Harm reduction should be based on a broad concept that includes not only injecting drug use but also other drug use and also focuses on accompanying supportive services, such as provision of food, life skills education, income generation, and legal services, for instance.
2. Harm reduction activities are severely underfunded. There is a need for increased funding, in particular to strengthen the management and administrative capacity of harm reduction service organisations.
3. Governments should be influenced to provide own funding and take ownership of harm reduction programmes once donor grants are terminated.
4. There is a need to step up advocacy in support of harm reduction both at national and international levels.
5. Young people need to be fully included in harm reduction services and involved in the planning, implementation, and monitoring and evaluation of harm reduction programmes.
6. The work of donors needs to be better coordinated and harmonized, and collaboration with civil society strengthened.

In a subsequent question and answer session, **Paul Bekkers, Netherlands Ambassador – at large for HIV/AIDS**, emphasized the need for governments and civil society to collaborate closely in the area of harm reduction in order to ensure results. He stated that the inclusion of young people is of paramount importance. For **Dfid, Malcolm McNeil** explained that donors are not able to handle a large amount of small-scale grants to a large amount of recipients. He appealed to IDU representatives to form strategic alliances and apply for umbrella funding to finance organisational capacity building and the provision of services to IDUs.

## **5. Accountability**

In his introductory remarks, **Ger Steenbergen, Senior Health Advisor, Ministry of Foreign Affairs of the Netherlands**, stated that accountability has become a leading theme in international development following the 2005 Paris Declaration and the 2008 Accra Agenda

for Action. Key to accountability as it is understood nowadays is country ownership. However, the numerous different conditionalities of donors and the lack of predictability of funding make accountability and country ownership difficult to achieve. Complicating the issue is the fact, according to Mr. Steenbergen, that harm reduction is a multi-sectoral and politically very sensitive “front line” issue. He concluded by saying that the human rights based approach is a very valuable tool in the area of harm reduction and that it is time to move on from lofty, unrealistic statements to concrete, verifiable action on the ground.

### **“Often commitments are made in the area of harm reduction but they come just six months or a year too late”**

Ger Steenbergen, Senior Health Advisor, Ministry of Foreign Affairs, the Netherlands

**Sandra Elisabeth Roelofs, First Lady of Georgia and Chair of the Georgian Country Coordinating Mechanism (CCM)**, provided an overview of Georgia’s efforts and progress in harm reduction. Ms. Roelofs explained that her country of 4.5 million is in the midst of comprehensive health sector reform. She stressed the importance of the GFATM CCM in Georgia which is seen as exemplary and has taken on responsibilities beyond its originally conceived role in the country. The CCM today in Georgia not only coordinates and finances the response to the three diseases AIDS, malaria and tuberculosis but is also in charge of health system strengthening and the programmes on all infectious diseases. She underlined that Georgia has already achieved universal access to HIV treatment which is important with regard to harm reduction with 59.9% of infections due to IDU. Georgia is set to achieve its target of reaching 800 individuals with OST – a great achievement for a small country, according to Ms. Roelofs.

Among the principal challenges for her country in the area of harm reduction she mentioned the need to scale up the work in penitentiary settings. While there are OST programmes, there are no NSPs yet in Georgian prisons.

In her presentation, **Ms. Nafsiah Mboi, Secretary, National AIDS Commission, Indonesia**, noted that only few donors (AusAID and DfID) support harm reduction activities in her country and that 45% of IDUs are sex workers and 52% young people. The HIV prevalence among IDUs in Indonesia is 52.4%.

Ms. Mboi explained that in her country a costed national action plan for HIV and AIDS for the period 2007-2010 is in place. The estimated unit costs for harm reduction are USD 50 per IDU per year for NSP and USD 132 per IDU per year for methadone maintenance treatment (MMT). The key targets of that action plan are:

- 80% of most at risk key populations reached by comprehensive prevention programmes.
- Behaviour change interventions in at least 60% of most at risk populations.
- All eligible PLHIV to receive anti-retroviral treatment (ART) and humane care, support and treatment services.
- Create an enabling environment: civil society participation; and prevent and fight stigma and discrimination.

Among the recent improvements, she noted that the number of NSPs in Indonesia increased from 17 in 2005 to 159 in June 2008; and the number of methadone clinics from 3 in 2005 to 30 in October 2008.

She highlighted the Indonesia Partnership Fund (IPF) as an example of real donor harmonization and country ownership. According to Ms. Mboi, what distinguishes the IPF from other initiatives is that it takes the Paris Declaration seriously in that: Indonesia is in control in the IPF; there is a high level of programmatic flexibility; there is appropriate oversight through a steering committee; and basket funding is open to funds from all kinds of donors.

Among IPF's major achievements is the creation of a viable management system that incorporates, for instance, a nationwide monitoring and evaluation system. She noted as beneficial that donor funds in Indonesia were not only given to NGOs but also to build the government's capacity to tackle harm reduction issues. In Indonesia, the close collaboration between the government and NGOs – supported by the IPF - was a “winning formula” in harm reduction. As a result, Indonesia will probably be able to reach its targets in terms of harm reduction coverage. However, there is a need to improve the quality of services.

**“This meeting has provided a first insight on the available funds dedicated to harm reduction, on the donors interested in funding harm reduction and on the huge gaps to be filled in the future”**

Annette Verster, WHO

**Alison Crocket, DfID**, reiterated her organisation's and the UK government's firm commitment to harm reduction. She said DfID has committed itself to producing concrete results in this area which will be measured with clearly defined indicators. The UK government supports harm reduction both directly through funding at country level (China, India, Indonesia and Burma, for example) and indirectly through its contributions to the GFATM. Among the comparative advantages of DfID she noted the provision of flexible funding directly to country-level activities and international networks, such as IHRA, and the support to international partnerships, such as UNODC, WHO and World Bank. In view of the upcoming 11-12 March 2009 High Level Segment of the CND and the fifty-second session of the CND also in March 2009 she reminded the meeting participants that the overall international support to harm reduction is still very low, mainly limited to Australia, European countries, and a few other countries, such as Afghanistan.

For **AusAID, Robyn Biti** explained that the cornerstone of her organisation's work in the area of HIV and AIDS is prevention and that her country is keen to continue its long national and international leadership in harm reduction. Being in full support of the Accra Agenda for Action, Australia believes in, among other things: moving away from stand-alone, donor-driven projects; country-owned activities with a focus on strengthening the usage and capacity of country systems; improving aid predictability by providing indicative estimates of rolling year programmes; and increasing credibility and accountability by producing a public annual review of the results of its aid programmes.

**Anne Skjelmerud, NORAD**, clarified that her organisation's activities in harm reduction are integrated in its HIV and AIDS portfolio. As a consequence, NORAD does not have a specific policy on harm reduction. She said that many aspects of harm reduction, however, are not HIV and AIDS related and that there is a need to work across sectors and to build bridges among different stakeholders and fields. With regard to requests for core funding, she said that it is difficult for a funder like NORAD to respond to very specific, small-scale funding requests as NORAD is under pressure to demonstrate large scale, structural results through its funding.

**Mick Matthews** stated that for the **GFATM** partnerships with civil society are of great importance in the area of harm reduction. He said that the GFATM viewed organizations representing or working with IDUs as equally legitimate as any other organization and is committed to working even more closely with such organizations.

Up to Round 7, the GFATM has funded approximately 60 grants in 40 countries for harm reduction with a funding volume of approximately USD 154 million – which probably makes the GFATM the biggest funder of harm reduction activities worldwide. He noted that two strengths of the GFATM are community system strengthening and the empowerment of NGOs by being appointed as Principal Recipients (PR) along a government PR, the so-called dual track financing. Both avenues can provide opportunities for strengthening and expanding grassroots harm reduction activities as well as raising the profile of harm reduction organisations.

Becoming a PR is not without its problems or challenges for NGOs, he said, but the GFATM is striving to improve its coordination with partners such as the Technical Support Facilities (TSFs), private foundations, and global and regional networks on preparing NGOs to undertake the PR role and in building their capacity to do so. Community system strengthening can be applied for in each proposal submitted to the GFATM and is an additional resource designed to strengthen the capacity of the community sector.

He said that currently is “the best time” for civil society to engage with the GFATM on harm reduction. His organisation is very open to scaling up its work in harm reduction and to developing a harm reduction strategy. Active civil society involvement in that is crucial. He said that the GFATM believes in more comprehensive and coherent support for harm reduction but that does not mean a “top down” donor approach.

In a subsequent question and answer session, meeting participants from Nepal, Pakistan and Vietnam all appealed for a broad approach to harm reduction which would mean going beyond providing services and interventions centred (only) on HIV prevention. Among the broader harm reduction activities participants highlighted: programmes to reduce stigma and discrimination of IDUs; legal services for IDUs; advocacy towards policy makers regarding the needs of IDUs; drug demand reduction; and capacity building activities for law enforcement agencies to create more constructive approach towards IDU and IDUs.

Mr. Matthews replied that the GFATM does fund stigma reduction activities and is ready to examine how legal services for IDUs can be strengthened through its grants.

## 6. The way forward

On behalf of the United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific (UNRTF), **Sam Beaver, Counsellor, AusAID, Bangkok**, presented preliminary findings of a study commissioned by the UNRTF with the purpose of tracking and analysing, by country and region, the financial resources available for harm reduction; estimating, by country and region, the funding required to implement a comprehensive package of HIV prevention, treatment and care interventions for injecting drug users; and providing information on the resource gap and recommendations for strategic allocation of resources. He described the context for harm reduction in the Asia and Pacific region as follows:

- Crucial role of IDUs in kick-starting major HIV and AIDS epidemic in several countries in Asia.
- Urgent need for information on resource needs and gaps for harm reduction for a scaled-up response.
- Low coverage (2-3%) of harm reduction interventions.
- Resource allocation does not match the drivers of the epidemic in this region: unsafe injecting drug behaviours.
- Lack of consistency on intervention standards and definitions of harm reduction service standards.

He stated that harm reduction has been identified as the prevention intervention with the lowest costs and highest impact in Asia and the Pacific. The current IDU resource need per year is estimated at USD 0.5 billion which represents less than 10% of the total resource need for all interventions estimated by the Independent Commission on AIDS in Asia. Of that, 69% (\$340.9m) are needed for NSP and OST; 17% or \$83.9m for ART provision and 14% or \$69.2m for other purposes. China alone accounts for more than 60% of resource need.

The annual cost per IDU for prevention is estimated at (only) USD 100. Nevertheless, the current resource gap for NSP & OST is approximately 90% of resource *need* in the region. The main message to donors and government is that prevention saves massive costs in the future. Even though the estimated IDU resource need of USD 0.5 billion per year in 2009 might seem high, this investment would certainly pay off in the future, for example through decreased demand for ARTs or other services. He said that the challenge for donors is how to leverage more resources internally with their governments and get further donors to get involved in harm reduction funding.

### **“It was a successful event with concrete action points to follow up”**

Christian Kroll, Global Coordinator for HIV/AIDS, UNODC

**Daniel Wolfe, OSI**, presented the findings of an exercise – based on a two page questionnaire – to examine the current resource flows in harm reduction. He said that 16 surveys had been completed, eleven by donors, one by a lender, three by re-granters and one by WHO. This represents, according to Mr. Wolfe, a valuable cursory diagnostic tool regarding the current resource flows.

Mr. Wolfe said the survey revealed many opportunities for enhanced donor collaboration and avoiding duplication in their work. To put things into perspective, out of the roughly USD 8 billion spent annually on HIV and AIDS globally, a staggering low USD 100 million is spent on harm reduction currently. This means less than 2 USD cents per day or USD 6 per IDU per year.

At country level, as for instance in Ukraine, the survey revealed much room for improvement. Donors could attempt, for example, to align their work more with each other and avoid duplication by commissioning joint country needs assessments instead of individual ones. The Russian Federation is an example of a country where funding is only secured at the moment but where it is unclear if the government will step in when current GFATM funding runs out in the near future. Estonia - as a European Union (EU) member state with a serious IDU issue – is a reminder that not only countries in the global South can face financial restrictions in financing an IDU response.

Among the donor challenges in harm reduction he cited: the need to agree on a common understanding of what harm reduction entails, including a definition of harm reduction within or beyond HIV prevention; the difficulty to track funding given an ever changing funding environment; and the lack of data on national government spending.

Despite the challenges and maybe justified pessimism, Mr. Wolfe said there is enormous utility in donors working together more closely and better coordinating their harm reduction activities. In doing so, they could avoid duplication; scale up harm reduction programming; achieve more sustainability; and diversify the range of donors in support of harm reduction. Ultimately, this would strengthen the political support for harm reduction at country and international levels.

**“I have been feeding back to the network and in our – fast approaching – International Strategic Plan will be looking at ways in which to develop some of the practical steps agreed by all”**

Carmen Tarrades, ICW, United Kingdom

In a subsequent question and answer session, **Michael Bartos, Team Leader, Prevention, Care and Support, UNAIDS**, underlined that there are quite a few systems already in place for estimating and tracking the spending on HIV and AIDS, among them the UNGASS on HIV and AIDS reporting mechanism. He said that these systems would be used in the future by UNAIDS, UNODC and WHO to estimate the costing needs and track the spending on the nine harm reduction interventions, as defined by these three organisations (see V.1.). Right now, 45 countries already provide disaggregated data regarding IDU in their national reporting systems. He said this number should increase in the future.

**Lanre Onigbogi, Vice-President, African Harm Reduction Network**, proposed a comprehensive needs assessment in the area of global harm reduction funding. He said that there is a great need to build the capacity of service providers and that

donors should make this a priority in their funding. In addition, he noted the necessity to support and fund advocacy for harm reduction, from the grassroots to the highest political levels.

Meeting participants also noted that need to include legal services in harm reduction interventions. Right now the costing exercises exclude these services which are of great importance to IDUs.

## 7. Recommendations

### 7.1 Resource tracking

In a working session a group of participants agreed that the discussion about resource tracking should be preceded by a discussion about fundamental questions such as:

- Definition: is harm reduction only NSPs or should it include food, shelter, legal counselling? How does one define the beneficiaries? Is it only about HIV? Hepatitis C and TB are equally important threats for IDUs.
- How will we collect information and how is it going to be used?
- At what level do we need data? There is a need to map resources *and* needs.
- Should there be a global entity for resource tracking and where should it be housed?
- Donor harmonization should not only occur within countries, but also across the globe. There are 72 countries without harm reduction programmes. There are donors who are not involved in the funding of harm reduction.
- Look into existing country reporting systems. Critical engagement from civil society is needed.

The working group underlined the importance of donors aligning their activities with the national strategies and priorities of implementing countries. By harmonizing, resources can be allocated where the need is greatest. Coordination at country level should include the views of the recipient government. Resource mapping should capture national resources too. Harm reduction should never be rigid but flexible and responsive to local needs and capacity.

A challenge is that donors increasingly put money through government systems. There is also a stronger focus on results which can overshadow efforts to find the right, most context-appropriate approaches and processes.

With regard to advocacy the group wondered who would pay for efforts to lobby governments to do their part in harm reduction. Who is willing to pay for advocacy? Continuity of funding was seen as another important aspect of donor responsibility. Donors should ensure that funding is not interrupted. Shutting down needle exchange programmes is a disaster. There should be an emergency fund for harm reduction.

The group suggested that there should be both a bottom-up and top-down approach as needed, at national, regional and global levels. A global effort should be made to agree on objectives and indicators, and recruit a sustainable expert reference group. More studies and analysis would have to be done at country level.

The working group called on stakeholders to build on existing work and not to “re-invent the wheel”. Developing new systems can take a lot of time. What is needed is a global needs assessment looking both at resources *and* needs. Data are to be used for advocacy and ultimately to try to increase resources and make targeting more precise.

Regarding definitions concerns were voiced as to what would happen to harm reduction when HIV and AIDS is no longer a priority. Should we focus on HIV or be broader? What about overdose prevention? There emerged a consensus, however, that the focus should be on HIV, broadly defined and development oriented.

The group agreed that ownership, accountability and harmonization should be the guiding principles for national engagement in harm reduction and came up with the suggestion to establish a Global Task Force which would undertake the following:

- Review and harmonize definitions of harm reduction.
- Promote critical and strategic thinking about the direction of HR interventions and epidemics.
- Map the needs, the gaps and potential donors.
- Bring together resource-tracking data and analysis (nationally and globally) which can be used for advocacy.

The group also recommended the creation of an emergency harm reduction fund which can respond rapidly to funding gaps and emerging epidemics.

## **7.2 Global monitor**

The working group stated that currently there are various mechanisms and instruments for monitoring harm reduction, among them:

1. UNGASS on HIV/AIDS global progress monitoring, which is done through government reporting and civil society shadow reporting. UNAIDS is the lead agency.
2. Global monitoring in relation to drugs, with UNODC being the leading agency.
3. Universal Access Monitoring Framework. WHO being the lead agency.
4. Monitoring by IHRA.

The different monitoring processes create a high administrative burden. In this context the working group proposed to create an inventory of main monitoring instruments and to reflect on their usefulness. Clarity is also needed on the purpose of monitoring: “what do we want to get out of it?” and “what should it lead up to?” Participants agreed on the need for simplified and practical reporting obligations.

Further the working group discussed the need for harmonization of instruments as well as of indicators. Indicators should include quantitative as well as qualitative data, including performance monitoring. Apart from access to NSP and OST services, access to legal services should also be monitored. At the moment there appears to be too much emphasis on

quantitative data, for example monitoring of coverage of services but not the quality of services. Furthermore there are other gaps in monitoring: the focus is now mainly on injecting of opioids and not on injecting of other substances like amphetamines or on non-injecting drug use such as crack. Participants agreed that the voice of IDUs should be included in the development and design of monitoring instruments. Furthermore regional differences and cultural backgrounds, e.g. sensitivity in some African countries regarding questions of blood, should be reflected in indicators and monitoring instruments. The working group suggested translating generic tools into country-specific indicators

Lastly participants mentioned the challenge of conveying the value of reporting. Many stakeholders do not recognize the importance of high quality data and monitoring. There is a need for capacity building in this area. Funding of data collection is sometimes perceived as a problem, while monitoring and evaluation are considered essential elements of funding proposals by the Global Fund.

The working group welcomed a mechanism to enable service providers, funders, beneficiaries and UN agencies to converge on the value and better use of data, also on a regional level.

### **7.3 Road map for scaling-up**

The discussants in this working group agreed that there are a few crucial issues in rolling out harm reduction interventions: political commitment and country ownership; capacity of service providers; and a good surveillance, monitoring and evaluation system. The quality of the services provided is key as well as the sustainability and predictability of funding and cooperation between civil society and government.

In order to enhance political commitment of international donor agencies as well as of implementing governments, more systematic advocacy campaigns and strategies are needed. IDUs and PLHIV should become more actively involved in advocacy. National and local NGOs should join forces, speak with one voice to their governments and ensure that the evidence of the effectiveness of harm reduction is available to decision makers.

## **“We think it was a very positive step in improving programming for IDU”**

Robyn Biti, AusAID, Australia

Large funding agencies and mechanisms such as the GFATM should develop specific strategies on harm reduction. In addition, the key role of civil society organisations in advocacy and service provision should be better acknowledged. Donor agencies and the GFATM should have specific budget lines for (core-) funding for NGOs. The European Union should also pay more attention to harm reduction in its communications as well as in the update of the EU Programme for Action on Aids, Tuberculosis and Malaria.

UNODC mentioned that in several countries road-maps for harm reduction already do exist but that implementation is lagging behind. In these countries priority setting is needed, possibly with the support of the World Bank which offers technical assistance to implementing governments. The Bank could assist countries in selecting the most (cost-) effective HIV prevention methods and linking national institutes with international expertise.

Several participants mentioned the need to link the international agreements and policies on HIV and AIDS with the international commitments on illicit drugs. This is becoming very urgent in view of the 11-12 March 2009 High Level Segment of the CND in Vienna and the commitments concerning universal access in 2010.

## 7.4 Practical actions

The recommendations of the working groups were summarized and translated into practicable actions as follows:

Recommendation	Time line	Who is responsible?
<b>Resource tracking</b>		
1. Establishment of a Global Task Force	3 – 6 months (preliminary plans to be presented at Harm Reduction Conference in Thailand, April 2009)	OSI / IHRA / UNAIDS / UN Reference Group on HIV and Injecting Drug Use.
2. Creation of an emergency harm reduction fund which can respond rapidly to funding gaps and emerging epidemics	To be determined	Netherlands Ministry of Foreign Affairs

<b>Global monitor</b>		
1. Inventory of existing monitoring tools in order to harmonize and reduce the reporting burden by countries		
2. Monitoring should include quality, effectiveness and access to legal services	To be determined	
3. Feedback mechanisms in order to understand value of data collection and to improve utilization of data at country level		
4. Voice of IDUs is included and respected at all levels “Nothing about us without us”		
5. Lead in coordination with all different stakeholders		

<b>Road map for scaling-up</b>		
1. Call upon the EU to ensure that scaling up of HR is addressed in the new communication about combating HIV/AIDS in the EU and neighbouring countries		EU Henning Mikkelsen / permanent representations
2. Call upon EU member states to better co-ordinate and strengthen action among themselves and other partners. One EU country should take the lead.	EU Presidency. Before June 2009	EU Henning Mikkelsen / Paul Bekkers / permanent representations
3. Request the GFATM to create a harm reduction strategy	12 months	GFATM Governing Board / Mick Matthews
4. Request the Global Fund to create a facility for small grants to NGOs	6 months	GFATM Governing Board / Mick Matthews
5. Request to facilitate regular informal donor coordination meetings	6 months	UK / UNODC / UNAIDS / WHO and others
6. Seek funding for the UN Reference Group	Immediately	Netherlands, UNODC, UNAIDS
7. "Nothing about us without us" advocacy		INPUD, UNAIDS, All
8. Scaling up should include services to address hepatitis Criminalization and overdosing prevention		All stakeholders
9. Disseminate tools for HIV and AIDS strategy action planning	2 weeks	World Bank <i>delivered on February 10</i>
10. Come up with a road map for advocacy which includes funding needs	3 months	Harm reduction networks

## 8. Closing remarks

In his closing remarks, **Bert Koenders, Minister for Development Cooperation of the Netherlands**, pointed out that harm reduction is an area in need of greater political attention. Working in harm reduction is all about breaking taboos and having the courage to put the issue on the agenda. He said that the Netherlands has taken a very pragmatic approach to harm reduction and drug use in general. For example, the policy is to prevent drug use by young people but also to deal with it when it occurs, and not to be in denial about it. He lauded the conference participants for having come up with practical recommendations for scaling up the response in harm reduction, including the identification of responsible parties. He said that donors could make their efforts more effective by combining resources and collaborating more closely with each other. On the other hand, it is important to respect the different country contexts when working in harm reduction. Different contexts warrant different approaches.

Harm reduction is an issue to be dealt with without naivety. He said that this kind of pragmatism saves lives. If policy makers could accept that drug addiction is an illness, not a life style, it would be easier to convince them to promote harm reduction.

### **“Pragmatism in harm reduction works. It saves lives”**

Bert Koenders, Minister for Development Cooperation of the Netherlands

He went on by saying that the Dutch pragmatism is based on the respect for the dignity of each human being and that the Netherlands hopes to be able to share and transfer some of the lessons it has learned – sometimes “the hard way” – to other countries. He ended by saying that the Netherlands would continue its international support to harm reduction, for example in the 11-12 March 2009 High Level Segment of the Commission on Narcotic Drugs (CND) and the fifty-second session of the CND also in March 2009.

## Annex I

### Donor Conference Harm Reduction (28 - 30 January 2009)

#### Objectives and proposed outcomes

##### Objectives

- To increase SUPPORT for harm reduction and HIV prevention, both from a public health and a human rights perspective.
- To increase COMMITMENT to the internationally agreed goal of Universal Access to HIV prevention, treatment, care and support for people who use drugs.

##### Proposed Outcomes

- A better understanding of resources and needs for harm reduction and of obstacles to scaling up harm reduction programmes.
- An overview of the main donors, implementing agencies, capacity building and advocacy groups in the field;
- A starting point for better co-ordination and harmonization among donors;

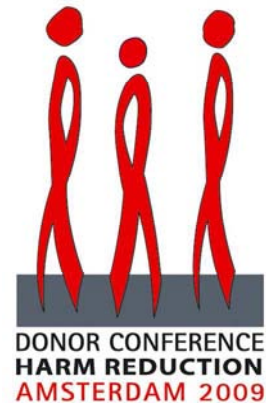
##### Proposed outputs

- Tools to prioritize harm reduction in policies of national governments, the UN and regional bodies:
  - proposals for a resource-tracking tool;
  - proposals for a road map for scaling-up harm reduction programmes and services to achieve Universal Access for IDUs;
  - proposals for a Global Monitor
- Conference report

##### Remarks

- The outcomes are based on the following principles: human rights, gender responsiveness, comprehensive approach, continuum of care, GIPA, inclusion of young people. *Nothing about us without us.*
- The conference in Amsterdam is a once-only event. Its proposed outputs will have to feed into existing national, regional and international policy processes. It is not a pledging conference. Thus the main aim of the conference is to boost commitment and support to harm reduction and Universal Access.

# PROGRAMME



## Wednesday 28 January 2009

19.00 hours: Welcome drinks

20.00 hours: Dinner

*Welcome by Paul Bekkers, AIDS Ambassador, The Netherlands  
Key note speech by Michel Sidibé, Executive Director UNAIDS*

## Thursday 29 January

09.00 – 13.00 *Chair: Paul Bekkers, AIDS Ambassador, The Netherlands*

14.00 – 17.00 *Chair: Sam Beever, AusAID*

### 09.00 – 10.20 **Setting the scene**

Introduction by Malcolm McNeil, DfID, United Kingdom  
- The Problem: IDUs & HIV prevalence, Bradley Mathers, Australia  
- The Public Health Approach, Annette Verster, WHO  
- The Human Rights Perspective, Rick Lines, IHRA

10.20 – 10.50 *Coffee break*

### 10.50 – 13.00 **Panel discussions**

Client perspectives. *Moderator: Christoforos Mallouris, GNP+*

Caitlin Padgett, Youth RISE, Canada  
Carmen Tarrades, ICW, United Kingdom  
Prem Limbu, Recovering Nepal, Nepal  
Vito Georgievski, INPUD, Macedonia  
Vladimir Zhovtyak, All Ukrainian Network of PLHIV, Ukraine

Service provider perspectives. *Moderator: Ton Coenen, Aids Fonds*

Tariq Zafar, Nai Zindagi, Pakistan  
Willy de Maere, AHRN, Myanmar  
Sebastien Marot, Friends International, Cambodia  
Vitaly Djuma, Russian Harm Reduction Network, Russia

13.00 – 14.00 *Lunch*

### 14.00 – 17.00 **Accountability**

Introduction:

- Mutual Accountability: The case for harm reduction, Ger Steenberg, The Netherlands

Implementing country perspectives:

- Indonesia, Nafsiah Mboi, Secretary National AIDS Commission  
- Georgia, Sandra Elisabeth Roelofs, Chair CCM  
- Other speakers to be confirmed...

15.30 – 15.50 *Tea break*

Donor country perspectives:

- United Kingdom, Alison Crocket  
- Australia, Robyn Biti  
- Norway, Anne Skjelmerud  
- Global Fund, Mick Matthews

## 17.15 – 21.00 Side programme

Regenboog	NSEP services
AMOC/DHV	NSEP/consumption room services
GGD Bijlmer	Comprehensive services (incl. heroine prescription)
Mainline	Historical tour – Amsterdam Centre

## 21.00 – 22.30 Dinner in town

Brasserie Harkema  
Nes 67  
1012 KD Amsterdam

When you exit the Krasnapolsky Hotel, turn left and walk straight ahead, this is the street called Nes. The Brasserie is on your left hand after about 200 meters.

## Friday 30 January

09.00 – 12.00 *Chair: Annemiek van Bolhuis, Ministry of Health, NL*

13.00 – 16.00 *Moderators: Annemiek van Bolhuis, Malcolm McNeil, Paul Bekkers*

## 09.00 – 12.00 The way forward

Overview ongoing initiatives in resource-tracking:

- UN Regional Task Force in Asia. Sam Beever, Australian Embassy to Thailand
- Preliminary update of donor resource flows. Daniel Wolfe, OSI

10.00 - 10.30 *Coffee break*

### Working Groups

- 1) Resource-tracking  
*Moderator Patricia Kramarz, GTZ*
- 2) Road map for scaling-up  
*Moderator: Christian Kroll, UNODC*
- 3) Global monitor  
*Moderator Michael Bartos, UNAIDS*

12.00 – 13.00 *Lunch*

## 13.00 – 16.00 Wrapping up

Feedback from working groups & plenary discussion

Address by Bert Koenders, Minister for Development Cooperation of the Netherlands

Closing remarks

Farewell drinks

## Annex III

### List of participants

Aditama, Tjandra Yoga	MoH	Indonesia
Ahmed, Iftikhar	Anti Narcotics Force	Pakistan
Ancion, Alain	MinBuZa	Netherlands
Anthony Flynn	IAS	Switzerland
Bains, Anurita	GFATM	Switzerland
Bakh, Uliana	GTZ	Ukraine
Bartos, Michael	UNAIDS	Switzerland
Bataringaya, Jacqueline	IAS	Switzerland
Beever, Sam	Australian Embassy in Bangkok	Australia
Beg, Monica	UNODC	Austria
Bekkers, Paul	MoFA	Netherlands
Belhirsch, Fatimazrah	MoFA	Netherlands
Bergh, Brenda van den	MoFA	Denmark
Bijl, Murdo	Health Connections International	Netherlands
Biti, Robyn	AusAID	Australia
Blans, Janhuib	consultant	Netherlands
Bolhuis, Annemiek van	MoH	Netherlands
Bounpone, Sirivong	Lao National Commission for Drug Control (LCDC)	Lao PDR
Broek, Ankie van den	Share-Net	Netherlands
Burrows, Dave	AIDS Project Management Group	Australia
Clear, Allan	Harm Reduction Coalition	USA
Cleeff, Maarten van	KNCV	Netherlands
Coenen, Ton	Aids Fonds	Netherlands
Crocket, Alison	DfID/FCO	UK
Cymerman, Pablo	Intercambios Asociación Civil	Argentina
Dam, Anke van	AFEW	Netherlands
Day, Marcus	CDARI	St. Lucia
Djuma, Vitaly	Russian Harm Reduction Network	Russia
Dolidze, Mikheil	CCM	Georgia
Donoghoe, Martin Christopher	WHO	Belgium
Dvoryak, Sergiy	Inst. on Public Health Policy	Ukraine
Everhardt, Victor	Response International	Netherlands
Ferrier, Kathleen	Multi-party Initiative on HIV/AIDS	Netherlands
Gade, Nils	PSI Europe	Netherlands
Georgievski, Vito	INPUD	Macedonia
Gerda van 't Hoff	MoJustice	Netherlands
Gill'ard, Chantal	Multi-party Initiative on HIV/AIDS	Netherlands
Giorgiobiani, Irakli	Ministry of Labour, Health and Social Affairs	Georgia
Grund, Jean-Paul	CVO-Addiction Research Center	Netherlands
Guarinieri, Mauro	GNP+	Vietnam
Guerma, Teguest	WHO	Switzerland
H.E. Ms. Maia Panjikidze	Embassy of Georgia in the Netherlands	Georgia
Ham, Allert van den	Hivos	Netherlands
Hoeven, Hein van der	MoFA, DFI	Netherlands
Hywel Jones	IAS	Switzerland
Iashvili, Eka	CCM	Georgia
Irrgang, Ewout	Multi-party Initiative on HIV/AIDS	Netherlands

Jensema Ernstien	TNI	Netherlands
Kamarulzaman, Adeeba	Malaysian AIDS Council	Malaysia
Keizer, Irene	Aids Fonds	Netherlands
Khan, Zafar	Deputy Minister of Counter Narcotics	Afghanistan
Khuat Thi Hai, Oanh,	Inst. for Social Development Studies	Vietnam
Khusrow, Shahzada Taimur	Ministry of Narcotics Control	Pakistan
Klinkert, Els	MoFA	Netherlands
Kort, Marcel de	MoH	Netherlands
Kramarz, Patricia	GTZ	Germany
Kroll, Christian	UNODC	Austria
Ladnaya, Natalia	Federal AIDS Center	Russia
Limbu, Prem	Recovering Nepal	Nepal
Lines, Rick	IHRA	UK
Maere, Willy de	Harm Reduction in Burma/Myanmar	Myanmar
Mai, Nguyen Thi Phuong	UNAIDS	Viet Nam
Malinowska-Sempruch, Kasia	OSI	Poland
Mallouris, Christoforos	GNP+	
Marot, Sebastien	Friends International Cambodia	Cambodia
Mathers, Bradley	Uni of New South Wales	Australia
Matthews, Mick	Global Fund to fight AIDS, TB & Malaria	Switzerland
Mboi, Nafsiah	National AIDS Commission	Indonesia
McClure, Craig	IAS	USA
McLean, Susie	Int. HIV/AIDS Alliance	UK
McNeil, Malcolm	DfID/FCO	UK
Meer, Joost van der	AFEW/HARP	Netherlands
Middelhoff, Monique	MoFA	Netherlands
Mikkelsen, Henning	DG DEV	Belgium
Mookerjee, Arindom	WHO	Switzerland
Munnik, Elly de	MoFA, DFI	Netherlands
Musch, Mirjam	Hivos	Netherlands
Nichols, Edwin	WAC	Netherlands
Onigbogi, Lanre	Sub-Saharan African Harm Reduction Network	Nigeria
Otiashvili, Dato	Georgian Harm Reduction Network	Georgia
Padgett, Caitlin	Youth RISE	Canada
Rai, Ganesh	Minstry of Home Affairs	Nepal
Roelofs, Sandra Elisabeth	CCM	Georgia
Rooijen, Peter van	ICCS	Netherlands
Rosenblum, Nicola	Dep. Of Foreign Affairs & Trade	Australia
Saifurehman,	MoPublic Health	Afghanistan
Schäffer, Dirk	DAH	Germany
Schleifer, Rebecca	Human Rights Watch	USA
Shorten, Tim	DfID	UK
Sidibe, Michel	UNAIDS	Switzerland
Skjelmerud, Anne	Norad	Norway
Smith, Jeff	Treat Asia	Thailand
Smits, Ton	AHRN	Thailand
Smyrnov, Pavlo	International HIV/AIDS Alliance	Ukraine
Soltani, Fariba	UNODC	Austria
Southwell, Matthew	INPUD	UK
Spreeuwenberg, Johanna	MoFA	Netherlands
Steenbergen, Ger	Ministry of Foreign Affairs	Netherlands
Stimson, Gerry	IHRA	UK

Stuikyte, Raminta	Eurasian Harm Reduction Network	Lithuania
Sulliman, Fayzal	Sub-Saharan African Harm Reduction Network	Mauritius
Tarrades, Carmen	ICW	UK
Thi Hien, Hoang	Department of Cult & Social Affairs	Vietnam
Thompson, Antony	WB	USA
Thomson, Kate	UNAIDS	Switzerland
Trace, Mike	IDPC	UK
Trautmann, Franz	Trimbos Instituut	Netherlands
Vale de Andrade, Paula	Institute on Drugs and Drug Addiction	Portugal
Verster, Annette	WHO	Switzerland
Westerhof, Gea	Mainline	Netherlands
Wildshut, Janine	Mainline	Netherlands
Wolf, Frank de	AFEW	Netherlands
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