Drug abuse and AIDS

stemming the epidemic

- The state of emergency in Eastern Europe and Asia
- What education for drug users?
- Redefining prevention in terms of harm reduction
- Reaching out to the fringes of society
- Cocaine injection in Europe: a new challenge

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In addition to marginalisation, social exclusion and drug abuse, the end of the 20th Century has witnessed the disastrous AIDS pandemic*. By now, this dreadful disease has been in existence for 20 years. In several parts of the world, it has developed on such a scale that it is actually threatening to undermine the social and economic fabric of the countries involved. Although AIDS mainly affects socially vulnerable populations, the epidemic is also hitting some of the most literate, highly trained and educated adults participating in all the processes on which their country’s development depends.

The AIDS epidemic is synonymous with socio-economic regression, since it is sapping vital forces, reducing production capacities, enlarging the enormous gap between rich and poor and striking down populations already suffering from discrimination. M. r. K. Matsuura, the Director General of UNESCO, has therefore decided to place the war on AIDS at the top of the agenda.

At the World Education Forum, which was held in Dakar in 2000 to promote Education for All, it was stressed how AIDS makes for further inequalities, since it prevents members of already indigent populations from having access to education: AIDS is decimating the members of the teaching profession, adults in the prime of life and the youth on which the country’s development depends.

Health education and AIDS preventive education also feature among the main challenges to be met. UNESCO, which is responsible for the follow-up of this conference, immediately focused its activities on meeting this vital challenge.

To achieve the goals it has been set, UNESCO is working in collaboration with other organisations on the following strategic lines, as recommended in the report on HIV/AIDS Preventive Education, in which the initiatives to be launched as the result of the Dakar conference were announced: promoting the creation of information networks and facilitating exchanges between the various educational fields (health education, teaching self-reliance, fighting discrimination, furthering the cause of Education for All, etc.), mobilising its forces and those of the Member States, contributing to the training of educators and other professionals committed to the cause, and encouraging preventive practices.

In keeping with these objectives, the PEDDRO project has led to the publication of the present special issue, which provides a useful overview of the situation on all fronts: it presents the latest findings, reports on current debates and describes the policies and practices which have proved to be the most effective means of preventing the further spread of the drug-related AIDS epidemic.

The PEDDRO project was launched by UNESCO and the European Commission in 1993: it is a network focusing on drug prevention via education, whose members include health professionals, NGOs, schools, institutions and members of the teaching profession. This project was launched in response to the increasing need for training and information which had arisen among the actors in this field, who were also in need of a meeting-point where they could exchange their ideas. When drug abuse is linked to the AIDS epidemic, it should not be allowed to become a doubly taboo subject: people working in health education and preventive circles must strive to put the problem into words, encourage people to discuss it openly and make communities aware of their responsibilities so that new strengths and tools can be forged.

In line with preventive education, the present issue of PEDDRO, which has benefited from the special support of UNAIDS and that of the European Commission, aims “to promote health and prevent disease by dispensing knowledge, teaching people the right attitudes, giving them the requisite skills and the means of encouraging and subscribing to harm reduction, promoting safety and decreasing the impact of the disease”. Based on these principles, this special issue can be said to be at the very forefront of the battle. Preventive education involves two-way communications, and this means listening as well as speaking: in this way, not only will individuals and the community to which they belong be sure to be treated with due respect, but also concrete results will be achieved.

And results, when it comes to dealing with AIDS, are a matter of life and death. Drug abuse may become a death row if public health policy-makers do nothing about it, and if there is no collective move in which all those concerned (drug abusers and those most highly exposed to AIDS and drug abuse, such as young people and women) decide to join forces and tackle the problem. It is the duty of the international community to mobilise its forces at all levels: the States naturally carry a large share of the responsibility, but civil society and the private sector must also play their part. In this battle, care should be taken not to dissociate preventive education and other anti-AIDS efforts from national health policies and the socio-economic context in general.

The world has been responding to HIV/AIDS for twenty years, and some universal lessons have been learned during that period. One is that effective AIDS responses have to start with the world as it is, not as we would like it to be. A second lesson is that blaming or castigating people at risk of HIV infection simply adds to the stigma, drives risky behaviour underground and fails to stop the spread of the epidemic. And a third lesson is that no matter how well-hidden it may be, HIV transmission via injecting drug use has been at least partly responsible for the epidemic nearly everywhere.

Up to now, 114 countries have reported the occurrence of HIV infection among their drug injecting communities. Injecting drug use is either the main mode of transmission of HIV infection or one of the main modes in many countries in Asia, Latin America, Europe, and North America. Even in the epidemic in sub-Saharan Africa, although the great bulk of HIV transmission is attributable to sex, injecting drug use is also a source of risk. Since sharing injecting equipment causes a great deal of contamination, this practice can be responsible for the unpredictable mushrooming of the epidemic. But the spread of HIV as the result of injecting drug use is never confined to the injecting drug users alone: injecting drug users also have sexual partners, and may also be mothers needing to protect their infants from HIV, and in many places the sex trade and drug abuse are closely associated. HIV transmission via injecting drug use therefore has the potential to kick-start much wider epidemics, such as that which occurred at the end of the 1980s in Thailand.

Halting the HIV epidemic wherever it is being driven by injecting drug use requires a three-fold strategy. First, drug abuse* itself needs to be prevented. Young people in particular need to be given priority in the prevention of drug abuse.

Secondly, access to drug abuse treatment should be facilitated, both because treatment helps to improve the quality of life of those with a history of drug abuse, and because health services provide an opportunity to pass on the message about HIV prevention and care.

Thirdly, effective outreach strategies should be implemented to engage drug users in HIV prevention strategies protecting them and their partners and families from exposure to HIV, and encouraging the uptake of substitutive treatment and medical care.

One of the main problems involved in responding to an epidemic fuelled by illicit behaviour is that of social exclusion. Not only does social exclusion make people more susceptible to HIV infection, but it also makes them harder to reach.

Finding effective responses to the problem of HIV among drug users means understanding the views of drug users, their cultural habits and those of the communities they live in and encouraging them to participate in designing solutions that work for them. Programmes need to be based on solid reality and they must be meaningful to the people they are designed to reach.

Street-based and other innovative outreach activities make it possible to reach untreated drug injectors, increase the number of people undergoing drug treatment, and possibly reduce illicit drug-related risk behaviour and sexual risk behaviour as well as the incidence of HIV infection.

Several studies on the effectiveness of syringe and needle exchange programmes have shown that they do reduce both needle risk behaviour and the rate of HIV transmission, and no evidence has been found that they may encourage injecting drug use or increase any other public health risks in the communities served. These programmes also provide points of contact between drug users and service providers. Syringe exchange strategies multiply their benefits if they also include AIDS education, counselling and referral for medical treatment.

HIV prevention programmes focusing on injecting users should not neglect sexual risk behaviour among people who inject drugs or use other substances. The epidemiological evidence shows that HIV transmission via the sexual pathway is increasing among injecting drug users as well as among crack-cocaine* users.

Sexual risks arise in the context of other risks and dangers, such as the risks associated with overdose or needle sharing. These other risks may be more immediately perceived, and as a result, the sexual transmission of HIV among drug users tends to be overlooked.

Efforts to respond to the HIV epidemic have always shown that prevention and care are mutually reinforcing strategies. The care and support provided to drug users living with HIV/AIDS and to their families needs to include access to affordable clinical and day care, essential legal and social services, psycho-social support and counselling, as well as effective HIV prevention interventions.

Responding to the HIV/AIDS epidemic is a complex task. There are no magic recipes and no single short-cut solutions. But there are solutions. One of the keys consists of finding pragmatic, effective responses to the epidemic by working along with the injecting drug users, making sure that they actually participate in finding the solutions.
Three objectives for Europe

at the European Commission

by Francesco de Angelis
Director of Horizontal Operations and Innovation of the Eurocooperation Office of the European Commission

The European Commission’s role and activities in the three-fold drugs - AIDS/HIV - education issue (education being one of the solutions to the HIV/AIDS public health problem caused by drugs) are stated in the EU Action Plan to combat drugs for 2000-2004 and the EC Programme for Action on communicable diseases for 2001-2006.

As regards HIV/AIDS in particular, the Commission presented the Programme for Action on communicable diseases in February 2001, targeting HIV/AIDS, malaria and tuberculosis. The aim here is to reduce poverty and to constitute a broad, coherent, collective and simultaneous Community response in addition to the Community support from which national health programmes in various countries already benefit. The European Community’s policy focuses on actions designed to increase the impact of existing interventions, improve the geographical accessibility and the affordability of medicines, and to carry out research and development on specific public goods on the global scale. These fields of action are inter-active and synergetic.

As far as drugs are concerned, the EU Action Plan is in line with the principles adopted by the UN General Assembly: these are based in particular on shared responsibility and on the principles set out in the UN Charter and international law, especially those relating to the sovereignty and territorial integrity of States.

In this EU Action Plan on Drugs, the priorities are preventing drug abuse, reducing the demand and reducing the adverse consequences of drug use. The main targets of the Strategy are as follows: reducing illicit drug use and drug-related health damage, increasing the number of successfully treated addicts, and reducing the drug supply and drug-related crime. The Action Plan was also designed to promote co-ordination at both national and Union levels, as well as international co-operation. This Action Plan provides guidelines and sets priorities for the activities of the European Union for the period 2000-2004, and places the emphasis on co-ordination, information and evaluation, demand reduction, preventive programmes, reducing the supply, and promoting international co-operation. It provides a clearly defined basis for assessing the EU Drugs Strategy: for the Commission will have to assess the extent to which the actions carried out in the framework of the Action Plan meet the objectives of the Drugs Strategy.

The Commission is preparing to publish further information about the implementation of the Action Plan.

As regards the Commission’s external activities in non-member countries, drug-related programmes have been launched in 100 countries at a total cost of more than 100 million. These projects cover a wide range of activities, including prevention, treatment, the social and occupational re-integration of drug users, epidemiological studies, alternative strategy development, testing chemical precursors, customs and police co-operation, institutional support for the development of national policies, combating money laundering, and drafting new legislation.

In the fields of prevention and treatment, various three-fold drugs - AIDS/HIV - education programmes have been set up on the following lines: reducing drug demand by carrying out prevention, treatment and rehabilitation programmes, reducing harm by setting up awareness programmes on the health risks associated with drug consumption and particularly the use of unsafe needles, and reducing the rate of AIDS/HIV contamination, especially that occurring due to unprotected sexual intercourse. In 1998, a specific 3-year programme was launched, for instance, in India focusing on comprehensive HIV/AIDS and STD treatment and care for intravenous drug users (IDUs) and their sexual partners.
A policy to be consolidated

by Bernard Kouchner
Minister of Health for France

The urgent need to fight the HIV epidemic has led most of the industrialised countries, especially the European ones, to set up strategies for reducing the risks of contamination to which drug abusers are particularly exposed. These policies have proved to be highly effective, since they have rapidly decreased the rate of HIV infection among this population: these efforts need to be sustained, however, as well as being adapted to fight the hepatitis C epidemic, another urgent issue, and extended to cover all the problems facing drug abusers, which have serious implications in terms of public health and damage to society.

In France, it was estimated that the HIV epidemic affected 40% of all the drug abusers in 1987, and the Ministry of Health therefore decided in 1989 to authorise the prescription-free sale of syringes to adults at chemists’ shops. In 1993, a voluntarist overall policy came into force, in which provision was made for the following:

- more extensive health care coverage for drug users in the framework of the general health care system (hospital care, city hospital and general practitioners’ networks),
- Harm reduction initiatives,
- and setting up structures providing substitutive treatment.

As in most countries where policies of this kind have been adopted, a set of action principles was defined and applied, as follows:

acje Finding responses to the underlying public health and social problems

Taking steps to prevent contamination by the AIDS and hepatitis viruses as well as to avoid the complications resulting from drug addiction and abuse: those due, for example, to injecting products under unsuitable conditions, or to the social problems caused by isolation, nomadism and the various emotional, family and occupational rifts with which the history of drug addicts is beset. Taking steps to accompany drug users who have not yet decided to give up taking drugs. Reaching out inclusively in this way means paving the way to help even the most socially excluded drug abusers.

- Providing drug abusers with the means of preventing contamination:
  - authorising the prescription-free sale of syringes (in single units) and preventive kits (“Steriboxes” and other kits) at chemists’ shops,
  - installing 270 vending machines and/or kit vending and/or exchange machines in 60 communes,
  - setting up 100 syringe replacement schemes (mobile units, fixed points, street workers) with the help of associations and the participation of former addicts; drug prevention workers, educators and nurses providing sterile equipment, information and advice and giving drug users a hearing.
  - access to substitutive maintenance programmes (using methadone and Subutex®*)

- Opening special meeting places

The first meeting places for active drug users were opened in June 1993 in Marseilles and Paris. By the end of the year 2000, 42 “drug boutiques” had been created. These pioneering points of contact involved a whole range of different projects, practices, beneficiaries and field workers, but they were all based on similar outreach and care provision strategies.

Syringe exchanges were basic to all these points of contact. Thanks to the spirit of warm, open hospitality in which these places are run, they serve several functions: they restore the body by providing simple medical aid, access to showers, washing equipment and food supplements; they create or restore social links by giving people an opportunity of chatting over a cup of coffee and exchanging syringes; they are educational establishments where there is a set of rules which have to be either obeyed or discussed: within this solid framework, drug abusers can re-discover what it means to respect and be respected by other people; and they are a place of guidance, since the workers act as mediators and facilitate the users’ access to the health care and social services to which they are entitled.

These places are not intended to deal with drug addiction itself. The broader networks to which these groups of workers belong therefore play a vital role: drug users can be accompanied to hospital outpatient consultations, medical centres and social services by people who will help them to open the doors. These meeting places are the first step towards a system capable of helping those excluded from all existing social spheres. Some of the people targeted at these centres will obviously either not be willing to join the health care system, or will not yet be able to do so. These “last resort” places of refuge must be non-intrusive, otherwise the drug abusers might reject them and go back on the streets. By accepting and respecting people as they are with no questions asked, it is hoped to possibly help them to communicate and then to start moving in the right direction.

- Developing outreach initiatives

Most drug abusers have benefited from none of these schemes so far, of course: those living on the farthest fringes of society under highly precarious conditions and the youngest members of these communities, who are also the most vulnerable, can be reached only by associative initiatives where the workers go out to meet them in their squats or on the streets, where self-support is a decisive factor. These associations have to fit in with local policies. Developing peer education and self-support systems with the help of former drug addicts is central to all these schemes, but it is necessary to recognise the role of the peers who participate and to give them a proper status.

These policies are having concrete, measurable effects everywhere. In France, fewer new cases of contamination by the HIV virus are now occurring among drug abusers (who accounted for 14% of all the new cases in 2000, as compared with 22% in 1994). Although the prevalence has been reduced (by 20%, according to the 2000 survey on syringe exchange programmes), drug abusers are still the group in which the rate of HIV infection is the highest. These efforts must therefore be sustained, especially as the prevalence of hepatitis C in this population has been reported to be as high as 70%.

Harm reduction policies of this kind have often been rather shaky, especially in France, because public opinion ignores and fails to recognise them. They therefore need to be consolidated and extended by political and public health decision-makers, who should make strong commitments on these lines as well as promoting concerted co-operative efforts between countries.
In several parts of the world, the AIDS epidemic is mainly hitting the drug injectors, and it is alarming to note how closely the spreading pattern of contamination follows the shifting routes taken by the narcotic traffickers, especially in Asia. The epidemic has mushroomed in some places, especially in Russia, where the rates of prevalence are increasing sharply. In Europe and the United States, where the AIDS epidemic has been going on for some time, especially among drug users, the preventive policies adopted have met with variable success. In other parts, such as the Maghreb and sub-Saharan Africa, injection is not yet responsible for much of the contamination, but other drugs such as alcohol are having non-negligible epidemiological effects.
The human immunodeficiency virus (HIV) responsible for AIDS has caused a much more serious world-wide epidemic than it was expected to do ten years ago. UNAIDS and WHO estimated that at the end of the year 2000, there were 36.1 million people in the world living with HIV or AIDS. This figure is 50% higher than that predicted in 1991. Contamination still occurs mainly via sexual intercourse, and “only” 5% of all the contamination is due to the use of intravenous injections. However, when the HIV virus mainly affects a small sector of the population, such as the drug injectors, the number of people exposed will remain strictly limited to this sector for only a short time, since this group will eventually pass the virus on to the population at large via the sexual pathway. In addition, to give an idea of the extent and the gravity of the situation, it should be pointed out that this figure of 5% does not reflect the harsh reality of the epidemiological situation in regions where the epidemic is propagating at a devastatingly fast rate. In 2000, a larger number of new HIV infections was recorded in the Russian Federation than during all the previous years combined. At a conservative estimate, the number of adults and children living with the HIV virus or AIDS in Eastern Europe and Central Asia amounts to 700,000, as compared with 420,000 just one year ago. The majority of the 250,000 adults infected during the year 2000 were males. And most of them were injectable drug users (IDUs). That same year, some new epidemics broke out on the same fringes of the population in Uzbekistan and Estonia. The latter country again reported many more cases in 2000 than during all the previous years.

In South America, where approximately 1.4 million adults and children are reported to be living with the HIV virus and AIDS, contamination occurs largely via drug injection practices. These figures suffice to show how desperately urgent it has become to set up specific information and Harm reduction programmes, the only tools which have significantly slowed down the epidemic so far. WHO and UNAIDS have noted, however, that even in those countries where programmes of this kind have been implemented, “preventive efforts seem to be on the decrease”: in 2000, as many as 30,000 adults and children in Western Europe and 45,000 in North America contracted the AIDS virus. The authors of the same report (1) have stated that it is the consumers of injectable drugs and their families who are now bearing the brunt of this relaxation of preventive efforts. These people are thought to account for most of the new cases of infection occurring in many of the well-to-do countries. To quote the latter authors, “These infections could have been avoided”.

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### Regional HIV/AIDS statistics and features, end of 2000

<table>
<thead>
<tr>
<th>Region</th>
<th>Epidemic started</th>
<th>Adults and children living with HIV/AIDS</th>
<th>Adults and children newly infected with HIV</th>
<th>Adult prevalence rate</th>
<th>% of HIV-positive adults who are women</th>
<th>Main modes of transmission for those living with HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Saharan Africa</td>
<td>late '70s/early '80s</td>
<td>25.3 million</td>
<td>3.8 million</td>
<td>8.8%</td>
<td>55%</td>
<td>Hetero</td>
</tr>
<tr>
<td>North Africa and Middle East</td>
<td>late '80s</td>
<td>400000</td>
<td>800000</td>
<td>0.2%</td>
<td>40%</td>
<td>Hetero,IDU</td>
</tr>
<tr>
<td>South and South-East Asia</td>
<td>late '80s</td>
<td>5.8 million</td>
<td>780000</td>
<td>0.56%</td>
<td>35%</td>
<td>Hetero,IDU</td>
</tr>
<tr>
<td>East Asia and Pacific</td>
<td>late '80s</td>
<td>640000</td>
<td>130000</td>
<td>0.07%</td>
<td>13%</td>
<td>Hetero,IDU, MSM</td>
</tr>
<tr>
<td>Latin America</td>
<td>late '70s/early '80s</td>
<td>1.4 million</td>
<td>150000</td>
<td>0.5%</td>
<td>25%</td>
<td>MSM,Hetero,IDU</td>
</tr>
<tr>
<td>Caribbean</td>
<td>late '70s/early '80s</td>
<td>390000</td>
<td>600000</td>
<td>2.3%</td>
<td>35%</td>
<td>Hetero,IDU, MSM</td>
</tr>
<tr>
<td>Eastern Europe and Central Asia</td>
<td>early '90s</td>
<td>700000</td>
<td>250000</td>
<td>0.35%</td>
<td>25%</td>
<td>IDU</td>
</tr>
<tr>
<td>Western Europe</td>
<td>late '70s/early '80s</td>
<td>540000</td>
<td>300000</td>
<td>0.24%</td>
<td>25%</td>
<td>MSM,IDU</td>
</tr>
<tr>
<td>North America</td>
<td>late '70s/early '80s</td>
<td>920000</td>
<td>450000</td>
<td>0.6%</td>
<td>20%</td>
<td>MSM,Hetero,IDU</td>
</tr>
<tr>
<td>Australia and New Zealand</td>
<td>late '70s/early '80s</td>
<td>15000</td>
<td>500</td>
<td>0.13%</td>
<td>10%</td>
<td>MSM</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>36.1 million</td>
<td>5.3 million</td>
<td>1.1%</td>
<td>47%</td>
<td></td>
</tr>
</tbody>
</table>

* Percentage of all adults (15 to 49 years of age) living with HIV/AIDS in 2000, based on 2000 population statistics
**Hetero = heterosexual transmission, IDU = transmission via drug injection, MSM = male homosexual transmission

   UNAIDS: www.unaids.org
   WHO: www.who.int
One of the main problems resulting from drug abuse is the fact that drug injecting practices are contributing to the spread of HIV/AIDS. Sharing injecting equipment, whether the injection pathway used is intravenous, intra-muscular or subcutaneous, involves a high risk of contracting HIV as well as other blood-borne diseases such as hepatitis B and C.

The most common way in which the virus is transmitted is during sex between men and women but a second epidemic – via drug injecting practices – is spreading to many countries. The sharing or use of contaminated needles is a highly efficient means of spreading HIV. Since injecting drug users often form tightly knit networks and tend to share their injecting equipment, HIV can spread very quickly in these populations.

It has been estimated that about five per cent of the total number of HIV cases are due to drug injection. Over half of all the cases of HIV cases were reported to be attributable to injecting drug use (IDU) in Bahrain, Georgia, Italy, Kazakhstan, Portugal, Spain and Yugoslavia. In the Russian Federation, over 90% of all the new cases of HIV infection occurring between 1998 and 1999 involved injecting drug users.

By now, 114 countries have reported HIV infection among drug injectors. Injecting drug use is the main or one of the main modes of HIV transmission in many countries in Asia, Latin America, Europe and North America.

In 1998, 136 countries reported the occurrence of injecting drug practices on their territory. This is a considerable increase in comparison with 1992, when 80 countries reported the occurrence of drug injecting. This illustrates a worrying trend for drug injection to spread to an increasingly large number of developing countries and countries in the process of economic transition, where these practices were often previously unknown.

Many studies have also shown that drug injectors are highly likely to be involved in the sex industry or to engage in high-risk sexual activities. Drug injecting is also contributing to the increase in the incidence of HIV infection, since the HIV virus is being transmitted to the children of drug injecting mothers, as well as via sexual contacts between drug injectors and non-injectors.

The HIV risk too which drug abusers are exposed does not result only from injecting. Many types of psychoactive substances, whether injected or not, including alcohol, are risky in that they affect the individual's ability to make decisions about safe sexual behaviour. Studies have associated the use of crack/cocaine with elevated levels of high-risk sexual behaviour, as for example in the United States, where crack/cocaine abusers account for an increasingly large proportion of all cases of AIDS.

Deciding to implement strategies to prevent HIV among the injecting drug users is one of the most urgent issues with which policy makers now have to deal. It has been established that HIV transmission among injecting drug users can be prevented and that the epidemic has already been slowed and even reversed in some cases. The HIV prevention activities which have effectively reduced HIV prevalence and risk behaviour include AIDS education, access to condoms and clean injecting equipment, counseling and specific medical treatment.

The UNDCP has stated that implementing strategies to prevent AIDS among the drug injectors has become one of the top priorities with which political decision-makers have to deal nowadays.
Asia

The state of emergency

The 12th International Conference on the Reduction of Drug related Harm was held in April 2001 in New Delhi. According to Pat O’Hare, Chairman of the International Harm Reduction Association (IHRA) which staged the conference, “the epicentre of the HIV epidemic looks as if it will soon shift from Africa to Asia, where drug injection is now one of the main causes of the spread of the infection”. Taking stock of the situation and the harm reduction policies.

India

India, the host country for the 12th International Conference on the Reduction of Drug related Harm, is currently the country with the second highest estimated number of people infected with HIV (between 3 and 8 million), and 89% of all the declared cases of AIDS in this country are between 15 and 45 years of age. The first case of HIV infection among drug users was recorded in 1989 in Manipur, but the results of various studies have shown that the prevalence of the infection in this sector of the population is more than 70% in some regions of the north-eastern states. The rate of infection among drug users was found to vary from 2% in Kolkata to 10% in Mumbai (Bombay), and from 20% in Chennai (Madras) to as much as 80% in Imphal.

In the eighties, the traditional use of opium gradually gave way to the use of heroin (brown sugar), a practice which was first adopted by urban youths but spread to rural areas. Opiates, especially raw opium, heroin and, to a lesser extent, buprenorphine, dextropropoxyphene and codeine are now commonly used by adults. Besides the use of heroin, the latest trend consists in fact of injecting pharmaceutical products. After first appearing in the north-east of the country and spreading throughout south-eastern Asia, this epidemic of intravenous abuse of pharmaceuticals, especially buprenorphine, has been facilitated by the great availability of injectable preparations. The high rates of consumption of injected buprenorphine have surprised a number of observers from Europe, where the drug is used as a substitute for oral heroin, especially in France, where it can be prescribed by general practitioners. Buprenorphine, which was discovered in 1973, was first used for its antalgic properties before being earmarked for the treatment of drug dependency: it induces moderate, heroin-like euphoria without any of the sedative, dysphoric and hallucinatory effects which accompany the use of heroin.

Several Indian studies have noted in this context that the recent increase in buprenorphine abuse has been paralleled by a decrease in heroin addiction. After extending the possibilities available for treatment to be provided in special centres in the framework of general hospitals and placing the management of these centres in the hands of the Ministry of Health, the Indian government, since 1998, has supported a number of pilot schemes in this field, such as those designed to set up SEP’s (syringe
exchange programmes). These initiatives are concentrated for the moment, concentrated in the north-east of the country.

There are more than 25,000 intravenous drug users (IVDUs) living in Delhi, the capital, where heroin is widely used. However, those who inject are usually the least well-off of all the opiate users, and they therefore tend to favour the less costly cocktails of easily obtainable pharmaceutical products.

John Francis at the Sharan mutual-aid association, an organisation that runs an HIV and STD prevention programme in Delhi and 4 other Indian towns, has made an important point, “It isn't easy to create an association to aid the drug users in India because the first priority is food and shelter”.

As David Thapa at the same association has pointed out, the drug users are good communicators, however. “They have never heard of AIDS before the start of the programme but they have passed the message on, and it has even spread to areas outside Delhi. Many come in to the centre every day wanting to help the others. Many of them can’t read, but those who can read the brochures to the others”.

Information written in Hindi might seem essential, but very little back-up material is currently available in that language. “Everyone is afraid of dying, he continues. Why shouldn’t they be too? When someone is feeling ill in the neighbourhood, they come and tell us. They should be encouraged and we should thank them for helping.”

**BANGLADESH (2)**

Most of the drug injectors in this country are in Dhaka and North Bengal.

According to the survey carried out on 1,300 or so users, the incidence of needle sharing used to be extremely high (93% in Dhaka and 96% in North Bengal). However, in the year 2000, most of Dhaka's 7,000 injectors and a quarter of those in North Bengal were targeted by a Syringe Exchange Programme (SEP).

As a result, the proportion of those shooting “safely” in North Bengal rose from 4% in 1998 to 45% in 2000. Nevertheless, 86% of the users continue to share syringes when no such programme is available, as against 32% when a SEP has been set up.

In Dhaka, in the wake of a comprehensive programme (designed to approach people living on the streets to reduce the occurrence of abscesses, treat STDs and change sexual behaviour by encouraging safe sex) a high rate of syringe exchange (82%), was observed between October 1997 and April 2000, along with a significant decrease in needle sharing (which fell from 81% to 25%), as well as a decrease in the number of cases of syphilis (from 28% to 13%) and no significant increase in the incidence of HIV (from 1% to 2.5%).

The practice of injecting cocktails of pharmaceutical compounds increased sharply, however, on the streets of Dhaka during the first six months of the year 2000. This sudden change was due to the disappearance of the “favourite drug”, buprenorphine, when its production by an Indian pharmaceutical firm came to a standstill.

The price of buprenorphine, which is marketed under the various names Hyderabad, Madras and Tidigesic,
increased 4 to 7 fold. The outcome was that users began injecting cocktails of sedatives and antihistamines, intravenous injection increased (previously, half of all the users practised intra-muscular injection), abscesses became more common and there was an increase in petty crime.

For associations such as the “Shakti Project of Care”, this is a new challenge which requires new strategies such as peer education, checking the quality of the buprenorphine in the hands of users, dealing with the problem of overdoses resulting from the injection of cocktails of pharmaceutical products, and possibly teaching safer methods of injecting the aforementioned drug cocktails.

But, as one a project worker asked, “How do you make Harm reduction an acceptable strategy? Hard drug users are discriminated against, stigmatised and marginalised. The only drugs which are socially acceptable are rawopium, alcohol and cannabis for smoking purposes”. In order to respond to the demand among users wishing to overcome their addiction, the Shakti Project has established low-cost, short-term (two-week) “treatment camps”. During their stay, staff members accompany each user night and day to help the person overcome “withdrawal symptoms that can be very difficult to handle during the first 2-3 days”. About 60% of those who have frequented these camps have gone back to using drugs, especially those receiving little family support. The remaining 40% are still “clean” after 6 months and seem to have resumed a normal life.

Other programmes set up in 1999 in two other towns in the north-west likewise confirmed that the “favourite drug” is now buprenorphine and that 90% of the users share needles. However, once an SEP is operating, the rate of syringe exchange and the return of used syringes can be as high as 95%, which shows that real awareness of the risks has arisen among the users. But here again, as the directors of the Shakti Project have pointed out, one has to “deal with political decisions to clean up the streets and close down the shooting galleries as well as addressing public hostility”.

**Indonesia (3)**

Indonesia has around 1.5 to 2 million drug users (out of 203 million inhabitants), the majority of whom live in the big cities, particularly in the shantytowns of Djakarta. During the last two years, there has been an exponential increase in the number of recorded cases of HIV among the country’s drug users, and this number increased twelve and a half fold between 1999 and 2000.

A study carried out in eight towns shows that the majority of the users are aged between 16 and 24, and that 80% of them inject heroin (of a low purity, cheap, and increasingly available grade), while the rest use crystal-methamphetamine. 70% share their syringe with at least two or three other people, while only 5% use clean equipment. 65% are sexually active, but less than 10% use condoms.

Previous studies carried out in two areas of Jakarta also showed that 60% to 70% of the young men between 15 and 25 years of age used narcotics and other “dangerous substances”, and 60% injected their drugs. 70% of the latter had shared their syringes in the course of the previous month, and half of them had done so two or three times that very week. 75% had had sexual intercourse, but only 41% used condoms. Practically none of them had heard of HIV or AIDS. The authors of these studies expressed the view that “Harm reduction programmes continue to come up against numerous obstacles, mainly due to the law which makes it necessary to have a prescription in order to obtain a syringe. People still think that providing free syringes might encourage the use of drugs”.

**Vietnam (4)**

The first case of HIV was reported in Vietnam in 1990. Ten years later, the epidemic had spread to all 61 of the country’s provinces. In the year 2000, 26,333 cases of infection were registered, most of which involved drug users (60% of the total number) and sex workers (4% of the total number). The first aid projects (which were financed by the UNDCP) were set up between 1997 and 2000 at five pilot sites providing needle exchange and free condoms – “after solving a few problems linked to the refusal of the police force to co-operate”.

As stated by a representative of the UNDCP, “The government’s recognition that Harm reduction measures are an important part of the national anti-AIDS campaign has been an important step, and the acceptance of these measures on a smaller scale at family and local community level has also helped to create an environment which is favourable to achieving changes of behaviour”.

**China (5)**

The first case of HIV infection in an IDU was officially diagnosed in Peking in 1996. A high rate of needle sharing (65%) and the lack of availability of condoms led to an increase in the infection rates among these same users, which had risen to 22% by the end of 1997. In Peking, thanks to a peer education programme, where a “trained” user can reach and teach 10 others on average, safe sex and safe injection practices have become more widespread and the rate of needle sharing has decreased considerably. As the spokesman for the project has said, “peer education is feasible in China and seems to be a good way of educating the community. Some initial data have been obtained which suggest that this approach may have reduced the incidence of HIV among the drug users”.

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2• From Tareque Golam et Greg Monica. SAKTI Project, CARE-Bangladesh. Contact: tareque@carebangladesh.org
3• From Surahya P., Sragin F., Sari K. Center of Health Research University og Indonesia. Contact: phitunk@yahoo.com
4• From the United Nations International of Drug Control Programme (UNDCP), 25-29 phan Boi Chou Street, Hanoi. Contact: huongthu@un.org.vn
5• From Wei L., Chen J., Li Z., Li R., Liang Q., Zhu Q., Razak MH, Beyrer C., Yr X., Lai S. Guangxi AIDS Surveillance and Testing Centre. Contact: gastc@public.nn.gx.cn
The starting-point of the alarming spread of AIDS in Asia was the spread of injecting drug use. These patterns are closely correlated with the heroin trafficking routes.

The most distinctive feature of the propagation of HIV and AIDS in Asia is the fact that injecting drug users (IDUs) seem to have been the starting-point of the pandemic*, and that this must be closely correlated with the presence on the Asian continent of the two largest illicit opiate* growing areas in the world. Although the drug consumers inhabiting the drug-producing areas were the first to be contaminated, heroin addiction has spread widely along the narcotrafficking routes, and the spread of HIV/AIDS also shows a similar pattern.

Although the AIDS epidemic arrived relatively late in Asia, where the first cases occurred in 1988, it literally rocketed in 1999, when a fifth of the current total number of infections were contracted. The CIS (1) now has the most rapid rate of contamination in the world and the statistics from Russia, for example, show that 70% of all cases of infection detected between 1985 and 1999 were diagnosed in 1999 alone: the eastern part of the Federation is particularly severely affected (2).

95% of the world’s illicit opiate production is concentrated in the areas known as the Golden Triangle and the Golden Crescent, which overlap the contiguous frontier regions of Burma, Laos and Thailand and those of Afghanistan, Iran and Pakistan, respectively. The existence of these drug-producing areas has contributed during the last few decades to the considerable increase in the consumption of opiates among the respective populations, and this increase is spreading to those inhabiting neighbouring regions and places even further afield.

The outbreak of the HIV/AIDS epidemic in Asia between 1988 and 1990 coincided with the multiplication of the Asian drug trafficking routes and their re-orientation towards the north, as well as with the spread of heroin addiction throughout the Asian continent. Before 1990, heroin from the Golden Triangle and the Golden Crescent was almost invariably transported via the southern routes, until the traffic was suddenly re-oriented towards China, Central Asia and Russia when borders were opened and trading and customs agreements signed at the end of the Cold War: this enabled the narcotraffickers to diversify their shipping routes.

In Asian countries, a correlation can be seen to exist, in both time and space, between the spread of opiate trafficking, the increase in opiate consumption and the explosion, only slightly later, of the HIV/AIDS epidemic (3). China and Russia are extremely telling examples showing how the outburst of drug trafficking heroin addiction and the HIV/AIDS epidemic all tended to occur at practically the same time. The existence of a narcotrafficking route can indeed be inferred from the sharp, significant increase in the number of heroin addicts which occurred along it and the subsequent increase in the HIV infection rates.

On the Burmese frontier, for example, the province of Yunnan is the first stop on the Chinese side of the border. This point on the new narcotrafficking route was, significantly, home to...
The consumption of opium in Asia is not actually as traditional as one might imagine. It has been established that the cultivation of the opium poppy was imposed on Imperial China at the start by the British in the 19th Century, and that opium production also began in south-east Asia around that time, when the part of the population of southern China was forced to migrate to the northern highlands of Indochina.

As studies on the opium societies have shown, the consumption of opium in the area now known as the Golden Triangle probably dates back no farther than the beginning of the 19th century. Burma is a typical example of this historical process, since the first legal references to opium, which is not mentioned in any of the religious texts, did not appear in print until the early 19th Century, when the British promoted the use of opium.

China used to be the country with the largest number of opium addicts in the world before the Communists carried out their large-scale detox and eradication programmes from 1949 onwards, but if one looks back at several thousand years of Chinese history, the so-called “tradition” of opium addiction was not actually all that strong. The only “traditional” aspect to have survived in Communist China was the use of poppy seeds in cooking, which has now been forbidden since 1991.

India is probably home to the most traditional habits of opium use, together perhaps with Iran, where this drug plays a role in some important social customs.

To the West, the only part of Afghanistan where opium consumption has been traditional is Badakhshan, in the north-east, and the country’s present production certainly does not constitute the perpetuation of a long Afghan tradition. This situation is quite different from that which characterised neighbouring Persia, where opium was grown for a long time, and Iran, where some opium-growing has subsisted up to the present day.

Central Asia does have a tradition of opiate consumption. Koknar, a decoction made from poppy stalks, is widely consumed throughout central Asia where most family vegetable patches contain a few square feet of cultivated poppies. But here again, in the immense majority of cases, it is not opium which is used as an ingredient in the local recipes, but only poppy stalk juice.

The parts of Asia which are witnessing an explosion in the consumption of opium and above all heroin nowadays are therefore involved in a perfectly new process, which is far removed from the traditions which the countries in question may have adopted in the course of their respective histories. The road from poppy stalk juice to heroin is long and devoid of all tradition.
begun heading for Russia, once again via Kazakhstan, which lies on the narco-trafficking routes. This has favoured an almost parallel upturn in opiate consumption and the spread of HIV/AIDS. At Temirtau, for example, which is the Kazakh town most severely affected by the HIV epidemic, and one of the main stops on the narco-traffickers’ route, although the first case of HIV was reported as recently as 1996, one inhabitant in ten is now thought to be an IDU (9). Meanwhile in Russia, the oblasts of Chelyabinsk and Orenburg and the Altai region, which are the main entry points into the country for the Afghan heroin imported from neighbouring Kazakhstan, have shown a noticeable increase in heroin addiction and in the spread of HIV/AIDS since the late 1990s.

In the same way, the Afghan heroin introduced into Russia mainly by Tajik traffickers had only reached the Irkutsk region in Eastern Siberia, which is very far from the Golden Crescent, at the start of 1999; just a few months later, however, the first cases of HIV were reported. Opium, which had already been in use there for a number of years was being swiftly and suddenly supplanted by heroin. Since the latter is mostly injected intravenously using shared needles, it soon became the main vector responsible for transmitting HIV/AIDS. In Russia, heroin consumption literally skyrocketed in the course of 1999, increasing four and a half fold between June-July 1998 and the same period in 1999, mainly due to intravenous drug use. However, it has been estimated that the sudden massive increase in heroin addiction and in the incidence of HIV/AIDS in the oblast of Irkutsk, which has by now been deeply penetrated by the Tajik trafficking networks, is probably one of the most serious examples of this process in the whole of Russia.

The rapid spread of heroin consumption in the countries crossed by the expanding narcotics routes is a new and damaging process. At first, the traffickers begin transporting opiates along the main lines of communication, which quickly become new narcotrafficking routes. As they go, they lead to the consumption of opium and heroin, which become widely adopted by the population in these regions, and addictive practices soon take root. The traffic then tends to increase in volume and propagates all the more readily since the countries along the drug route have growing numbers of consumers, who are also potential small-time smugglers. The development of complex distribution networks and the extension and multiplication of the trafficking routes together quickly result in the emergence of a population of IDUs, and these conditions all favour the fast spread of HIV. If one considers the enormous potential which narcotrafficking has to create new drug markets which will then sustain the production and flow of heroin, one can grasp the huge scale on which the AIDS pandemic is liable to develop in the years to come in some parts of Asia and the rest of the world, where economic inequality is on the increase and where prostitution is rife. One has only to realize that the number of countries around the world where the IDUs have become contaminated with HIV has increased by 40% between 1996 and 1998 (10). The upsurge of heroin addiction and the raging HIV pandemic which have accompanied the development of the drug trafficking routes constitute one of the main challenges now facing Asia at the dawn of the 21st century.

1• Commonwealth of Independent States.
3• This correspondence is partly attributable to an increasingly common practice among the petty user/traffickers, which consists of testing the heroin they intend to sell by injecting themselves. This occurs frequently in Vietnam and China as well as in Manipur: Beyrer C et al., 2000, Op. cit.
4• BBC, Aids spreads in China, 14-07-00 ; Associated Press, AIDS Cases Rise in China, 29-03-00.
6• Central Asia – Caucasus Analyst Forum Summary, Drugs, A Threat to Central Asian Security, 15-03-00, Central Asia –Caucasus Institute, Washington, J ohn Hopkins University.
7•牙齿 in Central Asia – Caucasus Analyst, 05-07-00.
9• BBCU, Central Asia’s battle with drugs, 11-11-99.
Russia

Explosion in the East

Alexandre Smirnov
Journalist, Moscow correspondent

More than half of the people infected with AIDS in Russia are injecting drug users. The emergency measures taken by associations and NGOs in collaboration with international organizations to provide medical assistance and sterile equipment aroused some public hostility at first. However, mentalities have been changing and greater awareness has been developing during the last few years.

The first case of HIV to occur in Russia was recorded in 1987: officially, it involved a homosexual male who had just returned from a trip to Africa. Up to 1995, only 1000 new cases were reported annually, and these were contracted via either the sexual pathway or blood transfusion. There were only two recorded cases where the infection was thought to have been due to intravenous drug injection. In 1996, however, a HIV epidemic took hold among the drug injectors. In 1999, 14980 new cases of AIDS were recorded, which brought the official number of cases to 25,842, and 15,000 of these were officially said to have been contracted via intravenous drug use. In April 2001, the government epidemiological watch department estimated that there were as many as 102,000 people suffering from HIV, and that half of them were intravenous drug users (IDU)!

As far as the history of drug dependence in Russia is concerned, opium★ was mentioned by Gogol in 1835, and many members of the more privileged classes were consumers in the mid-19th Century. In 1927, Mikhail Bouglakov wrote “M orphine”, the story of a young doctor-turned morphine addict attempting to kick the drug by using cocaine★ as a substitute. In 1934, the review “Russia Illustrated” published an article entitled “A Love Story with Cocaine”, containing the confessions of a Russian cocaine addict. Many contemporary authors have referred to drugs, including Bayan Shrianov, with his tales based on the lives of Vint★ users (Vint is an intravenous amphetamine similar to Pervitine★).

The opening of the frontiers made drug trafficking easier.

In the mid 50s, an opium trade developed in the USSR along similar lines to that existing in the Central Asian Republics and Afghanistan, where the use of this narcotic plant has cultural roots. During the 60s, cannabis★ plantations were set up in the Krasnodar and Stavropol regions, and during the 70s, the use of narcotics became quite a common habit, although it was not perceived as such by the great majority of the population. Nor was there any official recognition that a narcotics dependency problem had arisen. Apart from alcoholism★, the official 1971 psychiatric
handbook mentions only addiction to morphine and cocaine, although it adds that “in practice, problems of this kind are hardly ever encountered”.

Toward the end of the 80s, a drugs revolution took place, in parallel with the Perestroika and Glasnost reforms initiated by Mikhail Gorbachev. The collapse of the Soviet Union in 1991 made it possible to obtain information about the consumption of drugs in the West, which had previously been kept more or less secret. From 1987 to 1994, an additional factor came into play, namely the national anti-alcoholism campaign initiated by Gorbachev, which was most energetically implemented. The restrictions on alcohol led many people, especially among the young, to look for “alternative highs” and they began experimenting with all kinds of substances affecting the sensory system. The tendency for frontier controls to become more relaxed also facilitated drug trafficking.

The first intravenous drug to enjoy enormous popularity in Russia was Vint, a “kitchen sink” version of Pervitine. The consumption of this drug rocketed at the beginning of the 90s after first appearing in Leningrad in 1985-86. The use of Vint was surrounded by a number of ritual procedures. First the ingredients had to be collected, then a “master chef” had to be sought out, as the preparation process is dangerous and complex. The drug was then injected, usually in a collective context involving the use of a single syringe. The main foci of the virus were Ukraine, Byelorussia and Moldavia, but it was in Russia that the disease propagated most quickly.

At about the same time Ketamine*, which is also known as Kalipsol*, appeared on the market. This intramuscularly injected anaesthetic, which was less popular than Vint, is also a potent hallucinogen. A new sub-culture based on its consumption developed in Russia, Ukraine, Byelorussia and Moldavia. Here again, the drug was usually injected collectively using a single syringe. Although this substance has been classified as “narcotic and psychotropic” it was not on the official drug list used by the police and was therefore easy to procure.

However, the real shock occurred in 1994, when Russia stopped being simply a point of transit on the heroin trade routes, and also began to join in the production and consumption processes. At the same time, the so-called magic mushrooms were all the rage and cocaine, which had been out of fashion since the 1920’s, made a comeback, selling at extremely high prices. Ecstasy*, LSD* and various amphetamines* gradually replaced Vint. In the cities, it was also possible to acquire mescaline and DMT*. And with the increasing demand for heroin, which was subsequently to become the most popular intravenous drug in Russia, HIV began to spread like wildfire.
of drugs was regularly televised in broadcasts arranged by the Interior Ministry. Meanwhile, the statistics from OUBNO all pointed to growing criminal involvement in the drug market.

Many began calling for a change in the law and for the provision of “an alternative to prison for users instead of article 228”. The changes in the penal code proposed were rejected in the Duma by only 25 votes.

Given the highly repressive legislative setting, drug addicts are not in a hurry to declare themselves.

During the last two years, the Ministry of Health has made a change of approach. The former director of the government’s HIV prevention programme, Mikhail Narkevitch, announced in 2000 that “repressive measures will do nothing to halt the epidemic”. Narkevitch encouraged the harm reduction efforts of NGOs targeting IDUs. His successor, Aleksandr Gooliousov has been pursuing a similar policy. The psychiatrist Vladimir Egorov, official advisor to the Ministry of Health on drug related matters, has himself undergone quite a change of standpoint, moving from absolute refusal to collaborate with harm reduction projects, to a recent declaration of “perfect mutual understanding”. Even the Principal Medical Advisor to the Ministry of Health, G.O. nishenko, incidentally reputed to be incorruptible, has become a proponent of a more open-minded approach to drug users. V.Pokrovski, a leading intellectual figure, has been loudly predicting a global epidemic for 2008, and like many experts, substantially revising the official figures giving the number of persons currently infected, since in the context of a repressive legislation, drug addicts are in no hurry to appear on the official registers. They probably number 1.5 million rather than the 209,000 officially recorded.

Since the end of the 90s, a few NGOs have been extremely active. Médecins Sans Frontières-Netherlands has been directing outreach projects in partnership with 40 regional groups. As many as 34 harm reduction programmes financed by the Oktrytoe Obshhestvo institute, a branch of the George Soros fund, are also sponsoring outreach projects as well as syringe
exchange programmes and information campaigns run in partnership with MSF. Meanwhile, UNAIDS, together with the Ministry of Health, is supporting 17 projects across the country. One of the peculiarities of the Russian situation is the fact that most of the funding for these projects comes from abroad, and that all these associations are interlinked. One should however also mention the Russian association Spid Infosviaz, which publishes a specialised review intended for the organisations working in the field of HIV. A large-scale project is also managed by DFID, a financing body linked to the British government. However, in recent times, in some regions and Republics such as Tartarstan and Sakha-Yakoutia, a transition to the self-financing of these programmes is occurring.

A tendency to adopt a more flexible, more humane approach can now be observed.

In St Petersburg, three specially converted buses cruise the streets offering syringe exchange facilities. In Moscow, independent harm reduction projects have been launched, but there is no point in looking for facilities for syringe exchange, which has been prohibited by the municipal authorities. In March 2000, an organisation called Kolodets appeared in the capital. This is an organisation founded by the drug users themselves, and its emblem is a symbol representing a bonfire of used syringes. In a television interview, the members of the local Militia expressed their approval of the aims and activities of organisation. The Moscow region, which is an autonomous member of the Russian Federation, seems to be about to adopt an attitude which would make it possible to set up syringe exchange facilities.

In conclusion, attitudes towards drug use and the spread of HIV in Russia have evolved conspicuously. Although the war on drugs and their users is still going on, medical circles are adopting more flexible attitudes and an increasingly humane approach. At this very moment, there is an ongoing debate as to the relevance of introducing experimental substitution programmes in Russia, mainly based on the use of methadone. A loan from the World Bank is also awaited and a substantial part of this money will go towards funding specific aspects of HIV prevention among IDUs.

A GALOPING INCREASE IN DRUG ADDICTION

According to the figures given by the Russian Ministry of the Interior, there are more than three million drug abusers in the country, and less than 10% of them have been registered. One person out of every five, making 30 million individuals in all, is thought to have a connection of some kind with drugs. What makes the situation even more alarming is the fact that an increasingly young population is becoming involved in drug abuse. 60% of the drug consumers are between 18 and 20 years of age and 20% of them are frequenting educational establishments. According to the Ministry of Health, the first contact with drugs was occurring until quite recently at the age of 15 to 17 years, but it is now tending to occur between the age of 11 and 17 years. The results of a survey carried out in autumn 1998 on secondary school pupils in Moscow and Saint Petersburg indicated that 70% of all the consumers of illicit substances had tried these substances for the first time either at school or when attending night-clubs. According to the National customs committee, the structure of the market changed considerably in 1999. The statistics show that dried poppies (which are used to make home-made heroin), hashish and marijuana are tending to be replaced nowadays by brown sugar (a type of heroin) and sometimes by China white (another type of heroin), as well as by synthetic drugs. In parallel, drug abuse has become the main cause of contamination with AIDS. In approximately 90% of all the cases of AIDS recorded in 1997-1998, needle-sharing among drug injectors was responsible for the transmission of the disease. The towns where this situation has developed most alarmingly in this respect are Moscow and the surrounding area, Kaliningrad, Saint Petersburg and Krasnodar.

Source : Geopolitical Drugs Watch.
www.gdw.org

1 Fonds Soros : www.soros.org
2 DFID : Departement for International Development : www.dfid.gov.uk
The initiators of preventive efforts to protect drug injecters from contamination are nonplussed by the alarming rate at which the epidemic is progressing.

At the end of the year 2000, UNAIDS and WHO estimated that there were 1.8 million people living with the HIV virus in Latin America and the Caribbean. The virus is mainly affecting the most socially and economically deprived populations. The rate of infection in the Caribbean has reached 2.3%, which is the highest figure recorded outside Africa. In absolute terms, Brazil comes first with 540,000 people infected with the AIDS virus (out of approximately 168 million inhabitants), followed by Haiti (210,000), Mexico (15,000), Argentina and the Dominican Republic (130,000 each). The modes of contamination vary from one country to another. In the Caribbean, heterosexual relations are mainly responsible for the epidemic, whereas in Mexico, the HIV virus mainly affects men who have sexual relations with other men, and more than 14% of the gay and bisexual males in that country are seropositive. Although the rate of heterosexual transmission is on the increase, especially in Brazil and Central America, the HIV virus has been propagating at an even more alarming rate among the drug injecters in several countries in the Andes, Brazil, Argentina and Cuba: the prevalence* among this sector of the population is 43% in Argentina, 5% in Chile, 25% in Uruguay, 11% in Paraguay and 35% in Brazil.

In these drug-producing regions, cocaine* plays a pre-eminent role. This drug is injected by 90% of all the Brazilian drug abusers. The results of harm reduction efforts targeting the abuse of cocaine, for which there are no possible substitutes, and which leads abusers to perform increasingly frequent injections, are less sure and less clear-cut than with other drugs. Nevertheless, considerable progress has been made in Brazil as far as both heterosexual contamination and abusers’ harm reduction are concerned (see page 50).

Harm reduction efforts are gradually gaining ground on the field, thanks to the impetus given by the 9th International Harm Reduction Conference which was held in Sao Paulo in 1998. It was in this same city that the first harm reduction programme (involving the distribution of bleach and efforts to reaching out to drug abusers on the streets) was launched by Dr Fabio Mesquita almost ten years previously. The implementation of this project has not gone very smoothly, however, since it has been suspended several times and Dr Mesquita was even taken to court by the State authorities. The Sao Paulo conference gave the Latin American participants an opportunity of comparing their experience, and it emerged that it was necessary to organize a regional network capable of intervening and exerting pressure on each of the governments concerned (see insert). However, harm reduction is still in the early stages and the existing syringe exchange...
schemes are therefore completely microscopic in comparison with the vast needs to be covered. These activities have mainly been carried out by NGOs subsidised by international organizations such as UNAIDS and UNDCP.

The public health systems are often extremely short of means and resources.

In Latin America, as elsewhere, the drug abusers tend to constitute an invisible population of social outcasts with an arbitrary way of life. Helping them to regain their social rights is a major step towards integrating them into the community. The question also arises as to whether some States are able to apply strong policies in a context where the main problems which arise are economic ones, since more than 37% of the population are living under the poverty line and 16% are in a state of extreme poverty. The public health system very often badly lacks means and resources, which prevents it from integrating harm reduction and other policies properly. This integration is essential, however, as it serves to prove governments' true commitment to the cause, and shows that steps have been taken on a sufficiently large scale to ensure that significant results will be obtained in the battle against the epidemic. It is worth noting that several countries are now able to provide patients who have contracted the HIV virus with anti-retroviral treatment. Brazil, for example, spent 300 million dollars in 1999 on dispensing this treatment to almost 75,000 people. In Argentina too, anti-retroviral treatment is available for seropositive patients. This has led to a decrease of more than 40% in the number of declared cases of AIDS. This indispensable public health policy needs to be accompanied by a twin policy targeting the upstream causes which intervene before contamination occurs, and although the overall preventive measures taken in these two countries have certainly been quite successful, Brazil is still the only Latin American country which has really extended its preventive policy to include the injecting drug abusers.

LAHRN, THE FIRST LATIN AMERICAN HARM REDUCTION NETWORK

The Latin American Harm Reduction Network came into existence at the International Harm Reduction Conference which took place in Sao Paulo in 1998. The aim was to make a pragmatic mode of intervention available to all the Latin American countries. The work of the network is based on a civic approach to public health, in keeping with the Declaration of Human Rights. At its creation, the following four specific objectives were defined:

- promoting and publicising effective, valid harm reduction strategies which can be used to approach the problems associated with drug abuse;
- supporting and developing initiatives proposed by individuals as well as by governmental and non-governmental organizations working in the field of harm reduction in the various countries in this part of the world;
- encouraging the creation of drug users' self-prevention associations focusing on peer education schemes;
- creating places of discussion and reflection on themes relating to drug abuse, taking into account the socio-cultural conditions pertaining in Latin America and the experience of other networks of a similar type.

Among its main activities during the last three years, LAHRN has contributed to setting up Colombian and Bolivian harm reduction networks and has promoted local initiatives in Chile and Argentina. The network publishes its own newsletter in three languages (Portuguese, Spanish and English). The eight countries (1) have become official members of the network and benefit from some harm reduction programmes launched by NGOs and civil society groups. None of them are State-financed. According to Sandra Batisteti, who presides over the network, Argentina has set an example by setting up a harm reduction association which benefits from public financial support.

1 Brazil, Mexico, Colombia, Bolivia, Chile, Uruguay, Argentina, Paraguay.

Contact : www.relard.org

Street children in Lima (Peru)
What is the current situation in the United States as regards the prevention of AIDS amongst drug addicts?

Nowadays, the prevalence of AIDS among drug injectors of drugs has stabilised at 10%, after reaching levels of up to 60% in New York. But there are extraordinary differences from one city to another. For instance, the AIDS epidemic did its worst among the injecting drug users in New York, whereas in San Francisco, the gay population were the most seriously hit. And the epidemic never really took off among the San Francisco drug injectors to the same extent as it did in New York.

A number of factors explain these differences: these chiefly involve social practices, such as attending shooting galleries and the way the sex trade is run. The shooting gallery phenomenon was fairly typical of New York: it involved the use of abandoned buildings, where people would pay a couple of dollars to go and inject themselves along with other drug users. These hot spots in the underground economy watched over by managers were of course completely illegal. As they were very popular, the shooting galleries were probably as good as AIDS factories. They didn’t exist in San Francisco, however. There the spread of AIDS among drug injectors was linked to the gay sex trade. Of course, the social practices of the injectors have also contributed to the spread of the disease: sharing syringes and working in the gay sex trade add up to a double risk of infection.

Another factor that has contributed to decreasing the rate of contamination is the change in the type of drug practices which has been occurring. In the United States,
a country that has been built up very much on ethnic lines, it has been observed that young Latinos and Afro-Americans don’t get into injecting drugs to anything like the same extent as young Whites do. Twenty years ago, the reverse was true. However, the black and Hispanic communities were so badly hit by the AIDS epidemic that young people have almost completely turned their backs on the practice of injecting. Their favourite drugs tend to be marijuana and super-strength beer with a high alcohol content. Of course, there is a lot of ecstasy currently being consumed, but this is involving all the social classes and all the youngsters on the rave circuit. Seeing these trends develop, it is difficult to say whether they are simply fads or whether they result from the prevention and information policies that have been implemented. It is certainly clear that people these days are very well informed about the risks involved in drug consumption. In the survey I have conducted among the young injectors in San Francisco, I have discovered that needle sharing has become very much the exception: it only happens when they’re short of money, get sick or in emergency situations.

Can you tell us more about this ongoing study of yours?

It’s an AIDS prevention project, but it’s also aimed at reducing Hepatitis C∗, which is still very widespread in the western USA. We are monitoring a group of about fifty young heroin and amphetamine injectors aged between 16 and 24. In this group, 50% of the women and about 20% of the men have tested positive for Hepatitis C. The infection was usually contracted during their first year on the streets. Most of them are young whites from poor to middle class backgrounds who have left home fleeing abuse of one sort or another. San Francisco with its beatnik tradition seems to attract them.

How do you explain the prevalence∗ of Hepatitis C, which is higher than that of AIDS among the injectors? Doesn’t this prove that needle sharing is still going on? Hepatitis C is a great deal more infectious than the AIDS virus. The changes in users’ habits are not large enough to reduce their exposure to Hepatitis C. Even sharing a spoon (to heat a dose of drug) is enough to cause a risk of catching hepatitis. So it’s difficult to say whether people are catching it because they are sharing needles, which has become quite a rarity, or by sharing a spoon. In addition, women living on the streets seem to be more vulnerable. To survive, they need protection, and will often find this with an older man on whom they depend economically. It’s difficult for them in a situation of this kind to refuse to share a spoon with their companion. Economic, sexual and patriarchal power games are involved here.

Can sexual practices be said to have become safer? The statistics have not provided any evidence that changes have occurred in the sexual practices of injectors. Sex has become in a way more of a taboo subject than the injection of drugs. Injectors, especially heroin users, are unable to function sexually after years of drug use. But in interviews, even people who are known not to be sexually active claim to be having sexual relations... In short, the statistics we have on the use of condoms are not very reliable.

Among the young, it’s a different story. The 15- to 24-year olds are much more active sexually. It has emerged that when they have a regular partnership going, they don’t use protective methods, but the woman working in the sex trade use condoms with their clients. The risk of infection is therefore greatest in the setting of the partnership. In the sex industry itself, you see condom vendors on the street corners, so they are presumably being used a lot.

Under Federal law, it is an offence to carry a syringe, and this law is observed in half of the States. As a result, syringes are hard to come by in California.

Might one say then that public health policies have succeeded in getting the message across about safer practices?

The United States is an under-developed country in terms of public health and harm reduction. San Francisco certainly has a syringe exchange programme (SEP), which also distributes condoms. But federal law makes it illegal to carry a syringe on one’s person and half of the States of the Union observe this law. The result is that in California you can’t buy a syringe in a pharmacy, and since 1993, the city of San Francisco has had to declare a state of “medical emergency” in order to keep its SEP going. It is only thanks to this formal declaration that the police don’t actually arrest drug project workers. Another consequence is that you can’t use government money to buy syringes. In San Francisco, the SEP has to go via a private charity, the San Francisco Aids Foundation, to buy the thousands of syringes needed. On the other hand, some of the small farming States, such as Iowa, which don’t really have a drug problem don’t have laws against syringes, because it isn’t on the political
agenda. To crown matters, our previous President (Bill Clinton) decided at the last moment not to legalise syringes at the Federal level.

• Syringe exchange programmes have also come in for a lot of criticism (see p. 81 for an assessment of syringe replacement programmes around the world). You have studied the Canadian anomaly: in the mid’nineties, statistics showed the existence of a correlation between high rates of HIV infection and attendance at needle exchange programmes. Could you elaborate on this?

This was a case where preventive efforts apparently failed: despite better harm reduction policies, Canada had rates of HIV infection of almost 25% among the drug injectors, whereas this was not the case in the USA! However, I took part in a joint American/Canadian study and it was observed that Canada was undergoing an epidemic of cocaine injection (see also cocaine in Europe and Brazil, pages 94 and 96). It is the most dangerous of all drugs, as it is extraordinarily addictive. Five minutes after injecting themselves, cocaine addicts want to do so again as they are searching for the very brief but ecstatic high which the drug creates. They are capable of injecting themselves twenty times in an evening, whereas a heroin addict will be content to inject three or four times. Furthermore, their practices differ. The cocaine addict’s technique is more messy: the person has to inject directly into a vein and then practices shooting and booting: this means that half a dose is injected, then drawn back into the syringe mixed with blood before being re-injected, which creates a doubly ecstatic experience. There is therefore more blood in the syringe and it becomes more dangerous if it is shared. At the time, epidemiologists did not realize how greatly injected cocaine had contributed to the AIDS epidemic, whereas it has by now been established that cocaine injectors are between 7 and 10 times more highly exposed to the risk of HIV infection than heroin addicts.

• Have things improve at all?

With cocaine injection, nothing really works in terms of prevention. What has happened in Canada since 1995 is that a syringe distribution programme has replaced the syringe exchange programme. If someone turns up with 5 syringes and wants more than 5 syringes in return, then he or she will be given them. This is absolutely essential with cocaine users, because you won’t stop an AIDS epidemic by sticking to the rule of a syringe exchange programme where you can get just one new needle for each dirty one. The compulsion to inject is so much stronger and the number of times that a user injects throughout the day is so much larger among cocaine users, that a massive distribution effort is required. In an entirely informal way, some Canadian drug workers have even tried to persuade injectors to change their habits and to smoke crack instead of injecting cocaine. This was a step taken in desperation because the levels of HIV infection were approaching 25% in the years 1993-94.

Methadone has turned out to be rather disappointing: it’s not the magic potion it was expected to be at first.

• Is the epidemic of cocaine injection still going on in Canada?

Yes, contrary to the US, where it has been superseded by the smoking of crack. This has happened for several reasons: powdered cocaine is no longer sold much in the United States. Dealers sell coke in the form of crack, which is cheaper; and crack smoking gives you the same high but it is easier to do. You don’t need water and there’s no need to inject. But although both drugs have similar effects, injecting cocaine is certainly the greater evil. Of course, with crack, there’s the risk of sexual transmission: many women sell themselves to be able to pay for another dose, but with injection, there’s the risk associated with the syringe in addition.

• What about drug substitutes these days?

There are only a few cocaine substitutes, including anti-depressants and anti-Parkinsonian products, which don’t work for everyone. In the United States, the only available substitute is methadone, which is completely unsuitable for cocaine users. On the contrary, it can be used to obtain the speedball effect, a combination of the
effects of cocaine and heroin. Here again, it all depends on which State you’re in. Some allow the use of methadone, and others don’t. In New York, it’s easy to obtain a prescription for methadone, whereas in San Francisco, you have to be HIV positive, tubercular and suffering from withdrawal symptoms to be able to obtain a maintenance dose. Otherwise, you can join a 21 day methadone-support programme.

That can help if you’re going “cold turkey” as they call it, but it doesn’t work in the long run. In parallel, methadone can lead to an increase in the consumption of benzodiazepines, alcohol and Rohypnol to boost the high. Methadone has turned out to be a rather disappointing product and not the magic potion that it was once expected to be. It certainly works for some people, but it has to be admitted that it fails with others and with some, it just becomes another addictive drug. We will have to try other approaches, using different methods.

Are there any social service support programmes in existence for drug abusers in North America? There is no network of social services of this kind in the USA. Public health care is pretty much confined to emergency cover for indigents, and private health insurance has washed its hands of detox programmes. Prisons are providing the only solution to health care so far. There still some organisations such as Narcotics Anonymous, which stage encounter group sessions, promote faith cures and the like, which work for some. And there are dozens of programmes for the rich, providing psychoanalysis and so on.

But weren’t there some early outreach programmes, such as the CHO W (Community Health Outreach Workers) programmes? This was an interesting model, but you have to remember that the USA has been dealing with drug injection for thirty or forty years, so it’s inevitable that some innovative programmes have come about... But these self-help programmes can only work in a situation where syringe exchange is permitted. Also, there have been at times some mistakes with outreach type projects; at one time, injectors were being told that if you washed your syringe out with bleach then you wouldn’t get AIDS. But it takes 15 minutes for this to work and that’s a long time for someone who’s eager to inject him or herself. The real height of foolishness in America, though, is the syringe ban: it would have been much more effective to distribute syringes than condoms and doses of bleach.

What do you think could be done in the United States to make things evolve in a positive fashion? The traditional programmes, which aimed at destroying the former person and trying to reconstruct a good upstanding American citizen can certainly work with some abusers. But they are mostly tinged with a certain “racism” or at least a specific conception of what is “normal”, whereas programmes which place the emphasis on youth culture (rap, graffiti etc) are likely to attract young addicts and give them an alternative sense of worth, not that drugs provide this, but the prevalent cultural values are not doing so either. Also, those programmes in which these problems are viewed from a much broader perspective, taking education, housing, work, and social and economic integration into account are very worthwhile. Some of these programmes, where kicking the drugs habit is combined with integration into society through work, have been financed by NIDA (the National Institute on Drug Abuse): but these are still far too underdeveloped at the moment.
It has been estimated that there are now 800,000 active drug injectors living in the European Union. Drug injecting, which causes AIDS, is commonly practised among the drug abusers in this part of the world, where it quickly triggered a full-scale endemic of AIDS, HBV and HCV. The various member-countries have responded in different ways. But the rates of infection are still alarmingly high everywhere: they are often above 50%, and in some groups, 90% of the drug abusers have been contaminated with the hepatitis C virus.

**The Heroin Epidemic.** The epidemic of problem drug use in Europe has mainly been a heroin epidemic. It began in the late sixties among small groups of youth or “hippies” and began to increase sharply about ten years later. In the northern Scandinavian countries, however, the drug abusers are mostly amphetamine injectors, and these practices were originally associated with criminal circles. According to the latest estimates, problem drug users now number about 1 to 1.5 million: 1 million of them would meet the standard criteria for dependence. Although it is difficult to compare the figures between individual countries, some significant differences seem to exist. At the lower end of the scale, Belgium, Finland, the Netherlands, Austria, Germany and Sweden have only 2 to 3 drug injectors per 1000 inhabitants in the 15-54 age-group. At the upper end, the United Kingdom (6.6 drug injectors per 1000 inhabitants), Italy (7.7 per 1000) and Luxembourg (8.4 per 1000) have particularly high drug abuse rates.

**Intravenous Injecting Drug Use.** During the initial wave of heroin abuse, injection was practically the only mode used. In some countries, other routes of administration emerged during the late 1970s and the 1980s, such as smoking or ‘chasing the dragon’ (inhaling the vapour of heated heroin), which was introduced into The Netherlands by immigrants from Surinam. During the 1990s, injecting practices declined strongly in The Netherlands and Spain but much less in other countries. The reasons for the declines have not been clearly established, but may include changes in the availability, purity, type and price of heroin as well as fear of AIDS, although the latter factor was probably less decisive than the others (De la Fuente et al. 1997). The data available on the injection rates among opiate users undergoing treatment seem to indicate that these lower injection rates have stabilised.

**Drug-related Infectious Diseases.** The great heroin epidemic that struck Europe coincided with the advent of HIV. There existed at that time a large population of susceptible young heroin users who were just starting to inject. It has been established that young, newly starting injectors run higher risks (Fennema et al. 1997).
This, combined with the fact that nothing at all was known at that time about HIV transmission, may partly explain the high infection rates which occurred among the IDUs in many countries. The countries most seriously affected at first were those in south-western Europe, especially Spain, Italy, and France. Portugal, where the epidemic began later on, now has the highest incidence of AIDS, and is the only country in which the numbers are still on the uprise. In 1990, the IDUs became the largest risk group for AIDS, surpassing homosexual men.

AIDS has declined considerably since about 1996 due to the latest highly active anti-retroviral treatments, and retrospective studies have suggested that the peak in the infection of drug injectors occurred in most countries between 1985 and 1989. However, the youngest age groups continue to be contaminated, despite the overall decrease in the incidence which occurred during the 1990s. Seroprevalence* data on HIV among IDUs in 1996-1998 show the existence of large differences between the infection rates recorded in various countries (EMCDDA 1999a). Although comparisons have to be treated with caution due to the methodological differences, these data suggest that the HIV prevalence may range from 1% in the UK to more than 10% in The Netherlands and Portugal, more than 15% in France and Italy, and possibly more than 30% in Spain.

In some countries, the rates of contamination are still on the increase. A very high local prevalence (48%) was recorded in Lisbon, Portugal, in 1998/1999 (Valle et al. 1999), and the HIV notifications in Finland show that the figures have risen sharply among the IDUs since mid 1998. The situation is even worse as far as hepatitis C infection (HCV) among the drug users is concerned. Although the data sources are not as reliable for HCV as for

<table>
<thead>
<tr>
<th>Country</th>
<th>Syringe exchange programmes</th>
<th>Unrestricted access to syringes in pharmacies</th>
<th>Availability/ distribution of condoms</th>
<th>HIV counselling and testing</th>
<th>HIV treatment</th>
<th>Hepatitis B vaccination</th>
<th>Hepatitis C action</th>
<th>Substitution therapy</th>
<th>Measures available to prisoners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>many, via low-threshold services</td>
<td>yes, sold nationally</td>
<td>via low-threshold services</td>
<td>yes</td>
<td>yes</td>
<td>information and testing</td>
<td>yes</td>
<td>information and condoms</td>
<td></td>
</tr>
<tr>
<td>Belgium</td>
<td>some</td>
<td>yes</td>
<td>yes</td>
<td>via NGO's</td>
<td>yes</td>
<td>yes</td>
<td>some measures</td>
<td>since 1990</td>
<td>HIV testing</td>
</tr>
<tr>
<td>Denmark</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>-</td>
<td>-</td>
<td>testing</td>
<td>yes</td>
<td>information</td>
</tr>
<tr>
<td>Finland</td>
<td>Few, Tampere, Helsinki</td>
<td>yes</td>
<td>yes</td>
<td>mandatory</td>
<td>?</td>
<td>Since 1992</td>
<td>information</td>
<td>limited</td>
<td>HIV testing, HBV vaccination, information</td>
</tr>
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<td>France</td>
<td>86</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>since 1996</td>
<td>experimental in prisons</td>
<td>testing</td>
<td>since 1993</td>
<td>testing, vaccinations</td>
</tr>
<tr>
<td>Germany</td>
<td>in most cities, via low-threshold and outreach services</td>
<td>yes, cheap</td>
<td>yes, including in prostitution projects</td>
<td>yes</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>increase since 1992</td>
<td>methadone</td>
</tr>
<tr>
<td>Greece</td>
<td>yes, and via low-threshold and outreach services</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>testing</td>
<td>since 1996</td>
<td>information plus testing</td>
</tr>
<tr>
<td>Ireland</td>
<td>all regions, mostly from machines</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>information and screening</td>
<td>yes</td>
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<tr>
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<td>yes, via low-threshold services</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes, free</td>
<td>yes (5-6%)</td>
<td>screening (60% tested)</td>
<td>yes</td>
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</tr>
<tr>
<td>Luxembourg</td>
<td>yes, but expensive</td>
<td>yes, via outreach services</td>
<td>yes, via outreach services</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>yes</td>
<td>information plus methadone</td>
</tr>
<tr>
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<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>pilot</td>
<td>experimental treatment</td>
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<td>Portugal</td>
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<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>-</td>
<td>-</td>
<td>yes</td>
<td>information, testing, condoms, methadone, vaccination</td>
</tr>
<tr>
<td>Spain</td>
<td>yes, via low-threshold services</td>
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<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>in prisons</td>
<td>testing</td>
<td>yes</td>
<td>information, testing, vaccinations, methadone</td>
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<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>-</td>
<td>yes</td>
<td>information and HIV testing</td>
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<td>yes &gt;300</td>
<td>yes &gt;2000</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>info, testing?</td>
<td>information for pregnant women</td>
<td>yes</td>
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</table>

Information for Finland amended by Prof Pauli Leinikki. Source OEDT.

This table shows that preventive procedures have been applied in some countries, although less has been done on these lines in some of the most northerly countries (Sweden and Finland) than elsewhere.
HIV, most of them give infection rates well over 50%, peaking at a 92% infection rate in a sample of IDUs in Sweden (Krook et al. 1997).

**A brief review of preventive measures.**

By the late nineties, Harm reduction had become standard practice throughout the European Union (EU). Syringe exchange programmes were implemented in all the member countries, syringes became available at chemists’ shops without a prescription in most of these countries except Finland, Ireland and Sweden, although syringe exchange programmes were only more recently implemented in Finland. In Spain, Portugal, France and Italy, where the IDUs were most seriously affected by HIV, preventive measures were actively implemented during the 1990s. The UK and The Netherlands took appropriate steps back in the 1980s. In the case of the UK, this was done in time to prevent a really large-scale epidemic from occurring (Stimson 1996).

In 1999, all 15 member states of the EU reported having set up syringe exchange programs, 12 reported that needles could be readily obtained at chemists' shops, 14 reported that condoms were being distributed and that HIV counselling and testing were available, 12 reported that HIV treatment was available, 11 reported that free HBV vaccination was available to IDUs, 11 reported the existence of specific HCV actions, 15 reported that substitution therapy was available to opiate users (mainly to reduce injecting practices), and 14 reported that prevention measures had been set up in prisons.

In France, the number of opiate users undergoing substitution treatment has greatly increased during the last few years. As methadone was long illegal, the first substance to be widely used for this purpose was buprenorphine (Subutex®). In the early 1990s, it was estimated that only 50 opiate users were being given methadone as a substitute. Approximately 60,000 opiate users are currently on buprenorphine and another 5,000 are now on methadone (EM CDDA 1999b).

Another useful preventive tool is the ‘Stéricup’, a kit containing sterile injecting equipment, which is available at chemists’ shops. Recently the ‘Stéricup’ has been added to the range of preventive equipment: this is a sterile heroin cooker designed to prevent the spread of hepatitis C and B (O FDT 1999).

Within a period of only a few years, all the Member States of the European Union had adopted preventive measures to minimise the harmful effects of drug injection.

**Prisons: a risk factor contributing to the spread of AIDS.**

Prisons have been called “the motor of the HIV epidemic”, but there is a growing awareness of the need for internal prevention programmes. A European expert network reported that HIV tests are available for prisoners on admission in all the EU countries, and participation is mostly on a voluntary basis. However, large differences were observed between the rates of participation, depending on how the tests were presented. Drug testing is being performed in all the European countries, either as a disciplinary measure or in a therapeutic setting. Prison policies on drug treatment versus substitution programs vary greatly between the EU countries. Pilot studies on needle replacement in prisons are being carried out in Germany and Spain. Bleach and sterilization tablets are available in Denmark, Finland, France, Germany, Greece, Italy and Scotland. Condoms and lubricants are not always available, or only on prescription (England and Wales), which may be a great obstacle for prison inmates.

**Self-prevention for prison inmates.**

Although most European prison inmates undergo HIV screening (from 73% in France to 96% in Spain), the rates of HBV vaccination recorded on the basis of the drug injectors’ declarations ranged from 6% in Sweden to 36% in Spain, while the percentage who declared that they had previously undergone a HCV test ranged from 50% in Belgium to 89% in Spain and Sweden (ENHPP 1998). Other particularly innovative preventive activity involves training active IDUs to recognize signs of readiness to be initiated among non-IDUs and to dissuade these candidates from becoming injectors (Hunt et al. 1998). Other preventive options include ‘transition periods’ via other routes of administration than IDU, such as “chasing the dragon” and anal administration. The experts have concluded that by enlisting the help of drug injectors in this way, it may be possible to reduce the number of people who begin injecting.

**Conclusion.**

Some noteworthy changes have certainly taken place in Europe during the 90s. Within a period of only a few years, all the EM ber States have introduced preventive measures to minimise the consequences of injecting drug use. However, little is still known about either the quantity or the quality of existing services (their supply, the use made of these services, the coverage, etc.).

The least that can be said is that the HIV and hepatitis B and C infection rates among the IDUs Europe are still unacceptably high in Europe.

**REFERENCES**

Patterns of morbidity have changed conspicuously in the Maghreb societies during the last two decades. In addition to the persistent transmissible diseases (syphilis ravaged these countries at the beginning of the 20th Century), diseases originally associated with the so-called “industrialised countries” have become increasingly frequent, due to poor hygiene and the wretched housing conditions generated by large-scale urban development (the French word for slums, “bidonville” was invented in Casablanca). Despite these developments this is a period of economic crisis, and these States are still not giving priority to subsidising public health. Health accounted, for example, for only 2.4% of the whole Budget of the Moroccan State in 1990 (2). As in Tunisia, approximately 30% of the country’s health expenditure is covered in Morocco by assistance from outside the country (no figures are available on Algeria in this respect). The prevention of drug abuse and drug dealing is one of the main themes in the campaign which has been carried out in Morocco since the 90’s.

Based economic context, in which State prerogatives tend to be regarded as relatively unimportant and ‘civil societies’ tend to be promoted (…), AIDS has become an important component of the ‘financial markets’ on which NGOs and associations are subsidised” (3). The second reason is that apart from the use of medico-technical strategies (providing medical care for people with AIDS with the help of the ITSF (4), setting up initiatives to make blood transfusion safe, etc.), it is often difficult to introduce preventive measures into the field of “illicit sex” because of the strict morality being instigated by the Islamic extremists (5).

It is worth noting, however, that in Morocco at least, the prevention of drug abuse and drug dealing is one of the main themes in the campaign to make Morocco a more healthy country which has been carried out since the 90’s (6). Here it is proposed to focus mainly on Morocco, which is the only one of the three Maghreb countries where it is possible to observe “the existence of some political good will” (7), although the results may not have been entirely in keeping with the objectives announced.
Tunisia has the highest rates of AIDS among the drug injectors.

The first cases of AIDS to occur in the Arab-speaking world were due to blood transfusion. People soon began to talk about “contaminated imported blood”. The fact that the disease was transmitted mainly via what were thought of as “Western” practices (homosexuality and drug injection) gave rise to the idea that “AIDS was a Western or possibly black African disease from which Arab societies were immune on the whole” (8).

The impression that AIDS was an imported epidemic persisted up to the beginning of the 90’s throughout the Arab-speaking world. It was one of the stereotyped ways in which the disease was viewed everywhere, as confirmed by the authors of all the studies carried out in some very different places: “in parallel with these local images corresponding to the threatening outsider, the disease was referred to nearly everywhere in terms of Western customs, the perversity of the latter, and what one might call their high degree of contagiousness” (9).

The highest rate of AIDS infection occurring in the context of drug injection was recorded in Tunisia in 1993, where these cases amounted to almost 37% of all the officially recorded cases of AIDS.

Although the prevalence of AIDS seems to be fairly low on the whole, judging from the epidemiological data available, the epidemiological pattern has changed completely during the last decade. After being mainly due to the injection of drugs and homosexuality, AIDS began to be mainly transmitted during heterosexual practices. One of the only surveys available on this point was carried out by the Meknès Aids Prevention Committee (ALCS) in the towns of Casablanca, Tangiers and Tétouan. Although the authors stressed that it was difficult to obtain information from the “hidden” populations involved, the results confirmed that drug injection was quite a rare occurrence: in Casablanca, this practice was restricted to the more wealthy social circles; only 10% of the drug abusers questioned in the north of the country were injecters, and most of them had previously lived in Europe (10).

The great mobility of the drug users is in fact the reason why some observers have stated that drug injection is on the increase (11).

AN ORIGINAL INITIATIVE: the experience of the Nassim association

The Nassim association for the prevention of drug addiction was created in 1997 under the aegis of a psychiatrist who was working on the national programme to control drug addiction, Professeur Driss Moussaoui.

Since the injection mode was thought to constitute only “a minor problem in Morocco”, the association focused its activities mainly on reducing alcoholism, the use of psychotropic drugs and that of hashish. The association also informs members of the health professions and general practitioners about the way these molecules work, and even about “the relevance of their use in the treatment of some mental pathologies”, although these questions have not yet been completely elucidated.

The association publishes a journal and organises an anti-drug abuse day every year in Casablanca. Another of the association’s objectives is to carry out prevalence studies at educational establishments.

The association takes part in radio broadcasts, and carries out radio campaigns based on interviews with real-life witnesses.

Another original initiative was set up in the framework of a partnership with the CTM (the Moroccan Transport Company). This project consisted of displaying audio-visual messages about the prevention of drug addiction and the associated risks in the Company’s 400 buses, each of which has a capacity of 40 seats and makes 10 round trips a day.
Only 10% of all the drug abusers questioned were injectors, and most of the injectors had previously lived in Europe.

Heroin* and cocaine* are both being used in all three towns, however. The locally grown brown heroin (12) sold for 30 to 60 dirhams is cut and wrapped in 1/20-gramme packets and goes under the name of "papelita". The main mode of consumption involves the "plata" technique, which is known as "chasing the dragon" in Europe: this consists of inhaling the substance after heating it on a piece of aluminium foil.

Cocaine seems to be consumed more occasionally (since it is relatively rare and expensive), and this substance is usually sniffed. However, a large proportion of the cocaine users (40%) said that they smoked the drug. The method used here is similar to that used to consume "crack", and those responsible for preventive efforts are therefore afraid that the use of cocaine may be likely to spread. Apart from heroin and cocaine, the drug addicts mainly take pharmaceutical drugs. The main products used are Rohypnol®, and other members of the benzodiazepine family. Since these substances are often absorbed along with alcohol or hashish, multi-drug addiction is tending to become a worrying problem in Morocco, as in many European countries.

A national drug control programme has been set up in Morocco, in which all the sectors in the country are expected to participate (educational, youth and sports organisations, social services, aid programmes, members of the health professions, etc.). Observers have noted, however, that little has been done by way of nation-wide campaigns to inform professional public health and social workers about this initiative (13), and the "lack of involvement of civil society and the NGO's" has been deplored (14).

Harm reduction is non-existent in this country, apart from the Moroccan AIDS Control Association (ALCS), especially the Tangiers branch, where drug abusers have been trained to inform their peers and to distribute sterile syringes.

The therapeutic scene, like that in France towards the end of the 80's, has only abstinence to propose. There are no substitutive policies, and this can have particularly regrettable effects in the case of Moroccan subjects who have started to undergo drug substitute treatment in Europe but have been expelled and forced to return to their own country.

Projects have been developed, however, with European NGOs to set up health care centres involving various levels of financial coverage. The Ministry of Health proposed to open a rehabilitation centre for drug addicts in Tangiers in collaboration with SOS Drug International. ALCS also drew up a project on similar lines with a Belgian NGO with a view to housing and treating AIDS patients in Tangiers. Neither of these initiatives has materialised, however. Although both primary and secondary prevention have made great strides during the last decade, it is true to say that tertiary prevention and the level of general awareness of the problem and its implications still leave much to be desired.

1• Toufik (A.), “Pratiques et mobilité des usagers de drogues: de la dynamique du risque à celle de la prévention, in Journal du sida” Special issue on the Arab World and migrants, December 96-January 97
2• This information was based on the book edited by Kaddar (M.), “Systèmes et politiques de santé au Maghreb”, CIE, 1994
4• An international therapeutic solidarity fund, which has given Morocco access since 1998 to a triple drug therapy for treating patients with the disease, with the participation of the Ministry of Health.
7• Dr Toufiq (J.), Peddro Grant Report, 1998
8• Huxley (C.), Arab governments wake up to Aids threat, Midle East Report, November-December 1989
9• Ibid
10• This was stated explicitly by Professor Youssef Mehti, head of the National AIDS control Committee in Algeria. Quoted by Brunet (C.), Ibid
11• Leborgne (D.), Bakraoui (A.), Recherche-action prévention sida/toxicomanie, 1995
12• Toufik (A.), “Pratiques et mobilité des usagers de drogues: de la dynamique du risque à celle de la prévention”, Journal du sida, the above issue
Sub-Saharan Africa, where 25 million persons have been infected by the HIV virus and AIDS, accounts for 90% of all the cases of AIDS recorded in the world (34.4 million cases in all). At roughly the same time as the AIDS epidemic was starting up in the 1980s, Africa was also beginning to discover the problems associated with drugs, although there was no direct link yet between the two. The background was similar, however, in both cases: in many countries, the socio-economic situation was changing, often for the worse.

The consistently high unemployment rates which resulted from the poorly assimilated free market economy principles introduced on the African continent gave rise to a feeling of social exclusion among the members of these very young populations, where at least 55% of the inhabitants are under 25 years of age. Alcohol is still one of the most frequently consumed drugs in this part of the world. But cannabis is now being grown intensively in many of the African countries, and this continent has become one of the centres of the international drug trade as far as cocaine and heroin are concerned: these illicit dealings have left their mark on the local patterns of drug addiction (1). The figures published in 1996 and 1997 by the UNDCP regional office for Western and Central Africa suggest that the Western African sub-region still serves as a major point of transit between the drug-producing and drug-consuming countries. And those involved in the public health and legal aspects of drug abuse generally recognise that the drug dealers are tending nowadays tend to adapt the drug supply to the context, however poor the countries may be in which the demand for drugs has arisen.

This process has been considerably amplified by the climate of regional conflict and political disorder which has given rise to a general feeling of instability in some countries, such as Sierra Leone and Liberia. These conflicts have increased drug abuse, especially the consumption of amphetamines by soldiers, including child soldiers. In addition, the migratory movements which have occurred -either for economic reasons or because refugees and populations have been forced to flee- have increased the levels of poverty and unemployment.

THE ILLICIT USE OF MEDICINAL PRODUCTS

In this unstable context, the drug supply turns out to include a surprisingly wide range of consumable goods in the urban areas. Multi-drug abuse is a frequent occurrence, since it is possible in some places to procure all kinds of legal and illicit products, whether one is looking...
for cannabis, cocaine, heroin, amphetamines*, benzodiazepines, alcohol or glue to be sniffed - or pharmaceutical substances to be used for illicit, non-therapeutic purposes. There is considerable demand for the latter drugs among the drug addicts, who are becoming increasingly dependent on substances of this kind.

Medicinal products can now be obtained from many sources, which, according to the local specialists, distribute goods which have been either illicitly imported or pilfered from public or humanitarian stocks, such as those intended for use in the framework of emergency aid to refugees from countries in a state of war.

The abuse of psychoactive substances of this kind for non-therapeutic purposes is developing fast, especially among the destitute members of the rural population, who have to put up with quite intolerable working conditions (2).

Owing to the sensitive public health stakes involved, is difficult to fight this illicit drug market, which can have such dramatic effects in terms of drug dependence, drug resistance and therapeutic failure.

**IMAGES CONDUCIVE TO SOCIAL EXCLUSION**

From the psycho-social point of view, both society as a whole and family circles tend to picture drug abusers as people who behave asocially or even irresponsibly, so that they actually end up by adopting the attitudes for which they have been stigmatized by society, from which they cannot escape. After being rejected, they therefore tend to behave as they were expected to, and this leads to a tendency to self-exclusion or even self-destruction. Taking illicit substances can thus revive psychological traumas and aggravate the process of social exclusion.

Many drug addicts thus end up in a vicious circle: the more they are pushed to the fringes of society, the more likely they are to use combinations of substances which are often of very poor quality, and hence all the more dangerous. Their state of health eventually degenerates and they become more susceptible to various infections, especially since these populations are completely cut off from all medical and social structures.

Paradoxically, one might even say that the higher the risks they take, the less contact drug users will have with members of the medical and social professions.

Surveys carried out in Nigeria and Côte d’Ivoire have shown that the only structures catering for drug addicts in these countries are usually psychiatric hospital wards, which are extremely
short of staff and equipment. Religious and charity institutions sometimes help to provide the treatment and social assistance required. However, the methods used in hospitals and the options with which drug addicts are presented are usually rather antiquated (3). Under these circumstances, drug addiction is bound to become an ineluctable, uncontrollable process. Under the present market conditions, multi-addiction tends to develop: the users are driven by their insoluble personal and social problems to try various combinations of the many products available because of the lack of any strict control over their distribution. In this framework, the abuse of drugs and medicinal products alleviates many sufferings: the physical sufferings which accompany disease when there is no alleviating treatment available, those resulting from difficult living or working conditions, and the psychological sufferings caused by social exclusion and lack of confidence in the future. This is all the more true since the population involved in drug abuse seems to consist mainly of social drop-outs, who are often young males, and tend to have no future prospects or achievements to look forward to.

In addition to the ready-made products, there are also the home-made ones: these are often powerful hallucinogens capable of causing vertigo, inebriety and delirium which trigger in those who take them ascocial behaviour and critical states which are extremely difficult to understand from the medical point of view. These drug abusers also tend to take particularly frequent sexual risks (see p.64).

One of the main concerns of those faced with the increasing use of drugs in most of the countries in sub-Saharan Africa has been that of the changing modes of drug administration. The INCB has reported that the most clear-cut tendency has been the recent rise in injecting heroin abuse in urban settings where the consumption of heroin and cocaine was already on the increase (4). Although injection still accounts for a fairly small proportion of all the modes of drug abuse, the fact that it is on the increase is an ominous sign in a region where the rate of prevalence of the HIV virus and AIDS is one of the highest in the world.

Fighting drugs and fighting the AIDS epidemic: these are two fields of activity which overlap and tend to merge, but which have quite different histories. Since 1936, the various States have become aware of the need to pool their efforts to optimise and harmonise their national legislations as part of the fight to prevent the production and possession of illicit drugs and the trafficking of drugs via routes which bypass all frontiers, using every loop-hole available in the systems of law and order. International drug control law is based nowadays on three agreements, which prevail over the laws of the signatory States. During the mid-8’s, however, governments faced with the AIDS epidemic striking the intravenous drug injecters started to support what were known as the risk reduction or harm reduction efforts launched mainly by civil societies. This new pragmatic approach swept away all the previous structures, forging a path which was an attempt to find a balance between drug control and public health. Each of the new schemes launched (the distribution of free syringes, the use of substitutive methods of treatment, etc.) gave rise to much controversy as to whether it was consistent with national and international laws and their interpretation. Harm reduction programmes gradually came to be encouraged and supported by all the international organisations, which were convinced that this was an extremely urgent public health issue. These organisations are now supporting a wide range of projects. However, some of the most innovative efforts are still giving rise to some controversy because a balance has not yet been achieved at the local, national and international levels between reducing the demand for drugs and fighting the AIDS epidemic: these are both necessary and complementary objectives.
To fight the epidemic, the strategies recommended by UNO and the European Union are education, secondary prevention (free or prescription-free syringes) and treatment for drug users.

The spread of the AIDS epidemic among the most vulnerable sectors of the population both directly and indirectly sparked off international responses to the public health issues associated with drug abuse. From this point onwards, drugs, defined as psychoactive substances affecting mental consciousness, ceased to be approached purely in terms of their legal status, and the medical, social, religious and cultural implications were also increasingly taken into account. The context and the effects of drug abuse began to be also better understood and the interventions of various international bodies became both more highly focused (on young people, populations in difficulty, women, prostitutes, etc.) and more comprehensive, integrating various aspects at once (health care, primary and secondary prevention, health education, the social and economic context, etc.).

For example, the European Commission is at present supporting a whole range of drug-related projects. It is providing approximately one hundred countries with aid which is costing more than 100 million euros. This diversity is reflected in the Commission’s action plan for the period 2000-2004. Assessment features importantly her, as it has become necessary to measure the effectiveness of the strategies used, although efforts to fight drug abuse tended for a long time to be scattered, which made it difficult to model their success. Since AIDS is still wreaking havoc in many parts of the world, the European Commission recently voted an annual budget of 20 million euros to sponsor “HIV/AIDS and population” projects. On similar lines, at UNESCO, the Director General, K. Matsuura, recently announced that fighting AIDS was at the top of this organization’s agenda. This was echoed in the appeal made by UNAIDS, the ad hoc organization created by the United Nations in 1996, who asked the highest national instances and those in the framework of the United Nations to make firm political commitments with a view to setting up appropriate long-term programmes, as well as to work in parallel to ensure that sufficiently large resources are put forward both locally and by the sponsors.

The position adopted by the United Nations as regards the connection between drugs and AIDS resulted in the recommendations made by the UN Administrative Committee on Co-ordination (ACC), which is responsible for co-ordinating and harmonising the declarations and activities of the various players who come under the aegis of the United Nations. In 1995, this Committee decided to set up a Drug Control Committee, and this was done shortly afterwards. The latter Committee draws up guidelines and has noted the increasing involvement of civil society in the prevention of drug abuse via education. In view of the close connections observed between the AIDS epidemic and injecting practices, which are known to be a crucial factor, the ACC is developing tools for preventing drug abuse, facilitating access to suitable treatment and enhancing the awareness of the drug users. It is worth noting what a wide range of interventions have been proposed and described in detail. The strategies included in these recommendations go from adapting to the local context and cultural practices (this is thought to be a prerequisite to all such programmes) to the implementation of practical, concrete measures. A wider setting has been defined (promoting and facilitating access to health, education and work), which shows that drug issues are being approached more comprehensively, on various lines including legal ones: one of the legal solutions suggested, for instance, consists of systematically dispensing treatment to those sentenced for drug offences.
More specifically, the effectiveness of needle exchange programmes has been recognised by all these organisations. In this connection, the United Nations International Drug control Programme (UNDCP), which is the focal point of the united Nations as far as drug-related issues are concerned, has noted that risk behaviour involving the use of needles and the transmission of HIV has decreased thanks to these programmes, and approves of these methods since it has been established that they do not encourage injecting drug use or increase other public health risks in the communities involved. The UNDCP is also drawing up interventions which tend increasingly to involve demand reduction and training in self-help among the most highly exposed groups such as young people (see p.119) to promote greater awareness of what drug abuse involves and prevent these practices from spreading among the populations which have already been hit.

The UNDCP has proposed a “lesser evil” preventive approach to individuals and communities, the main advantage of which is the speed with which these programmes can be applied. In this organisation’s “Best Practices”, a wide and comprehensive range of measures are recommended for programmes targeting injecting drug users: from the essential need to supply sterile equipment and condoms to information campaigns and training courses, as well as providing medical care, counselling and coverage. Outreach activities and peer education have been recognised as being particularly effective means of reaching the consumers of injectable drugs. These methods provide the best channel for functional prevention and decrease the incidence of AIDS among the populations targeted.

Substitutive treatment, detox cures and rehabilitation programmes are also being encouraged, as shown by the efforts made by the World Health Organization (WHO) to support people undergoing cures and follow-up treatment. As Dr. M aristella M onteiro, the UNDCP co-ordinator of activities relating to drug user dependency, has explained, “the problems associated with substance abuse are mainly health problems, and dependency and disease can be cured: dependency should never be associated with a lack of morality or will-power”. The public should be educated and informed on these lines to change the image of substance abusers, prevent them from becoming stigmatised, pushed into crime and socially excluded, whatever types of drugs may be involved. Among these initiatives, it is worth mentioning the remarkable epidemiological databases which have been set up on AIDS and drugs by organisations such as UNAIDS (1) and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in Lisbon, another European Union member organisation. The prevention and assessment handbooks published by bodies such as the Pompidou Group (Council of Europe), WHO and the EMCDDA for field workers, health professionals and teachers as well as for State authorities have also undeniably boosted all-round effectiveness.

At UNESCO, the preventive Education section has been responsible for preventive education on both AIDS and drug abuse since 1996. By now, health education has also gained its rightful place. The aim here is to promote health and prevent disease by providing the knowledge, skills and means required to induce and support harm reduction behaviour, improve the coverage and decrease the effects of disease. The ongoing projects also reflect an increasing awareness of how important it is to share knowledge and co-operate. Exchange systems for professional field workers have therefore been set up in the framework of the DAPPA and PEDDRO projects (see the article on “Developing Networks” on p.38). By encouraging co-operation at both regional and international levels and the pooling of knowledge and information, it is possible to promote and support local projects. In conclusion, we quote a statement by the United Nations Administrative Committee on Co-ordination (2) describing the spirit in which projects of this kind are being undertaken: “Preventing HIV/AIDS among the drug abusers is a step towards respecting and protecting human rights”.

1. This database can be consulted at the following website: http://unaids.org

**DRUG ADDICTION OR THE USE AND ABUSE OF DRUGS**

Drug abuse (the official term used by the United Nations) is more than just the use of drugs: drug abuse is a form of use which results in problems. In the case of legal drugs such as alcohol, the distinction between use and abuse is readily acknowledged. The distinction is not so clear-cut when it comes to illicit substances, however, since some people contend that in this case, use equals abuse, whereas others feel that preventive efforts should focus on the problems resulting from the abuse of drugs of all kinds (both legal and illicit), without having to bother about their simple use.

UNESCO tends to prefer the term drug abuse to that of drug addiction, which is often used by French-speaking authors (“toxicomanie”). Drug abuse actually refers to all the harmful consequences resulting from the use of drugs at both the social and individual levels (in the former case, it is the very fabric of society which is damaged).

UNESCO also aims to work on the social factors contributing to abuse. The term drug addiction refers fairly restrictively to individual situations involving the use of illicit drugs in particular. UNESCO intends to adopt a more overall approach to these issues and is attempting to combat the abuse of psychoactive substances in general.
Guiding principles of the UNDCP

The United Nations International Drug Control Programme (UNDCP) is fighting the AIDS epidemic by carrying out drug abuse prevention and harm reduction activities.

UNDCP is working to prevent HIV/AIDS on two levels:
1. To prevent drug abuse, especially among young people, and thus to reduce the risk of HIV infection that is associated with drug abuse.
2. To reach out to those who are injecting drugs and reduce the risks of infection to which they are exposed by providing more accessible services and opportunities for treatment and social reintegration.

At the first level, the projects sponsored by UNDCP are based on primary prevention and focus on specific risk groups. For street children, for example, UNDCP and UNAIDS have sponsored the training of street educators in Asia on the use of the cartoons “Karate Kid” and “Goldtooth” to make street children aware of the dangers of drug abuse and HIV/AIDS.

At the second level, various approaches have been used in the programmes designed to help drug injectors. Providing drug abusers with detox treatment, for example, can contribute to preventing HIV infection. Many large-scale studies have shown that patients participating in drug substitution treatment in the framework of methadone maintenance, therapeutic communities, and outpatient drug-free programmes decrease their drug consumption significantly. Several longitudinal studies on the changes in HIV risk behaviour in patients undergoing treatment have shown that longer periods of treatment, as well as completion of treatment, are correlated with a decrease in HIV risk behaviour and an increase in self-protective behaviour. However, the authors of these studies have also established that these medical programmes reduced the risk behaviour associated with illicit drug use more effectively than that associated with sexual practices.

Drug abusers liable to be infected with HIV do not all decide to undergo treatment, however, which may not seem at all attractive to drug abusers early in their injecting career. In addition, recovery from drug addiction can be a long-term process and frequently requires several spells of treatment. Relapses into drug abuse and risk behaviour can occur during or after successful spells of treatment. Various outreach activities have been designed to reach, motivate and support drug abusers who are not undergoing any treatment and incite them to change their behaviour.
the pressure of taboos. Outside help of the kind provided by international organizations is intended to provide a symbolic means of justification, a stepping-stone which can be used to sustain initiatives which still depend all too often on the pugnacity of their proponents alone. UNESCO and the European Commission soon discovered that the pooling of knowledge was extremely worthwhile, and it was decided to dynamise communications at the worldwide level, on a really vast scale, to launch field-based activities and to set up a strategy where the key-words were cross-communications and solidarity with the people involved. In 1994, PEDDRO, a network for the prevention of drug abuse via education, was created.

By now, more than 200 organizations and persons working in this field in 83 countries have joined the network. The members receive regular information about the experiments carried out all over the world, and they can also apply for information about specific themes or geographical regions, or apply to other members or institutions for assistance with their own projects. The Drug Abuse Prevention Programme in Asia (DAPPA*), another UNESCO programme, was designed to strengthen a pre-existing network in southern Asia, where the statistics have shown the occurrence of a startling increase in the spread of HIV infection among drug injectors. To encourage local initiatives, DAPPA supports co-operative efforts between various local projects carried out in southern hemisphere countries, promotes informal education for young social outcasts, and provides professionals and other people with opportunities of meeting their European counterparts in order to broaden and share their knowledge. The UNDCP, on the other hand, is encouraging the creation of networks by groups of young people involved in peer prevention efforts such as the Global Youth Network Project (see p.119). The UNDCP has also published a directory of NGOs working in the field of drug demand reduction.

Recent findings by research workers have shown that outreach activities organised outside the conventional health and social care frameworks reach drug injectors receiving no medical care, increase the number of referrals for detox treatment, and reduce illicit drug-related risk behaviour and sexual risk behaviour as well as the incidence of HIV.

Several studies on the effectiveness of syringe and needle exchange programmes have shown that they reduce needle risk behaviour and HIV transmission, and no evidence has been found that they increase either the use of injecting drugs or other public health risks. In addition, these programmes have been found to serve as points of contact between drug abusers and service providers, including those working on detox treatment programmes. The benefits of these programmes are even greater when they go beyond syringe exchange alone and include AIDS education, counselling and referral to a variety of treatment options. A comprehensive package of HIV preventive interventions among drug abusers might include the following items: AIDS education, life skills training, condom distribution, voluntary and confidential counselling and HIV testing, access to clean needles and syringes, sterilisation equipment, and referral to a variety of treatment options. UN Drug Control Conventions and the Declaration on the Guiding Principles of Drug Demand Reduction UN Drug Control Conventions and the Declaration on the Guiding Principles of Drug Demand Reduction In the implementation of these approaches UNDCP, together with UNAIDS and other co-sponsors, bases its programmes on the following principles:

I. the protection of human rights among people who are infected
II. the importance of an early start in HIV prevention
III. integrating drug abuse and HIV prevention programmes into broader social welfare and health promotion policies
IV. the need for treatment to be readily available to injecting drug users and flexible enough to be accessible to them
V. the active participation of drug abusers in the development and implementation of the programmes
VI. the need to focus also on sexual risk behaviour among people who inject drugs or use other substances.

UN Drug Control Conventions and the Declaration on the Guiding Principles of Drug Demand Reduction

Section for Demand Reduction
United Nations International Drug Control Programme

*For further information: m.dada@unesco.org
• UNDCP directory of organizations and Global Youth Network Project
  www.undcp.org
• peddro@unesco.org
It has emerged from a legal study published by the Pompidou Group (1), some extracts of which are given below, that harm reduction strategies can sometimes be in contradiction with the international drug control laws. Two experimental harm reduction strategies have come up against legal barriers in this way: drug testing at rave parties and the medical prescription of heroin for relapsed drug users.

**Heroin Prescription**

Heroin prescription is the legally controlled distribution of heroin (for intravenous injection and/or inhalation) (2) to problematic heroin addicts or multi-drug addicts mainly taking heroin, after methadone maintenance or other treatment programmes have failed. The prescription of heroin is just part of a comprehensive program providing these patients with health care, therapy and social assistance (3). Heroin-assisted treatment would therefore be a more appropriate description of risk reduction strategies of this kind, which have been adopted experimentally in a few countries, such as Switzerland and the Netherlands. Several articles in the 1961 and 1971 Conventions oblige governments to ensure that all use and possession of drugs is strictly for medical and scientific purposes only. According to Article 4, subparagraph 1 (c) of the 1961 Convention, along with subparagraph 1 (a) of that same article, it is prohibited to give people free and unrestricted access to narcotic drugs for non-medical purposes. In other words, the Conventions stipulate that narcotic drugs and psychotropic substances are to be used only for strictly “medical and scientific purposes”.

Since none of the international drug control conventions contain definitions of either the expression “medical and scientific purposes” or the individual terms “medical” and “scientific”, it is necessary to consult the Vienna Convention on the Law of Treaties. In this Convention, customary international law on many issues, including interpretation, is codified. In particular, it is stated in Article 31 that “a treaty shall be interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in the light of its object and purpose”. However, neither the ordinary contextual meaning of the expression “medical and scientific purposes”, nor the specific meaning of the term in the framework of the aims and purposes of the three Conventions throw any light on the proper use and significance of the expression. The Conventions do not impose any restrictions on the signatory Parties as to how their activities in these fields should be regulated. (...) Each State is therefore free to reach its own conclusions as to what “medical and scientific purposes” may consist of.

In conclusion, the United Nations Conventions do not specify very clearly what is meant by “medical and scientific purposes” or what kinds of substances can be used for these purposes. In any case, they do not prohibit the socio-medical delivery of drugs, including heroin. Although it is therefore legally possible to prescribe heroin for opiate abusers, the INCB (see insert below) does not encourage governments to legalise heroin prescription, since the study carried out in Switzerland yielded no clear-cut answers to the relevant
THE MEDICAL PRESCRIPTION OF HEROIN IN EUROPE

After an early experiment in 1994-1997 in which heroin was prescribed for chronic drug abusers, mainly in the framework of maintenance programmes, Switzerland is still using heroin as an alternative to methadone. The Swiss experiment gave rise to much debate about heroin prescription in all the member countries of the European Union, and although similar experiments have been envisaged in several of these countries, only the Netherlands actually launched a project on these lines in 1997. In Germany, the legal framework for experiments of this kind was approved in 1999.

(continued on page 42)

questions raised (5), and because heroin actually has very few medical properties. Heroin is listed after all in Table IV, which contains the most harmful drugs with little medical value. The INCB cannot however prohibit medical experiments involving the prescription of heroine, since this organisation is officially responsible for "making sure that (drugs) are made available for these purposes", as stipulated in article 9 paragraph 4 of the 1961 Convention.

THE INTERNATIONAL NARCOTICS CONTROL BOARD

The International Narcotics Control Board (INCB)* set up by the United Nations is an independent body responsible for supervising the implementation of international drug control conventions. As regards the legal manufacture, sale and use of drugs, the Board endeavours to ensure that adequate supplies are available for medical and scientific purposes, and to prevent the occurrence of leakages from licit sources to illicit traffic. As far as illicit drug dealings are concerned, the Board identifies any gaps in the national and international control systems and contributes to correcting them. To this end, the Board maintains close contacts with international organisations and governments in order to make sure that conventions are properly applied and that the information submitted to the Board for analysis is regularly updated. Whenever necessary, the Board negotiates with governments to induce them to fulfill their obligations.

*The INCB publishes an annual report, which is available on the internet at the following address: http://www.incb.org

90 YEARS OF INTERNATIONAL LEGISLATION

• In 1909, representatives of thirteen countries met in Shanghai and placed opium production under international control.
• In 1912, these countries met in The Hague and extended the control to coca production.
• In 1925, about ten nations signed two Geneva Conventions. The one prohibited the use of opium and trading in prepared opium, and the other placed trading in raw opium, coca leaf, cannabis, and their derivatives under international control.
• The 1931 Geneva Convention laid down the principle that narcotics should be used for medical purposes only. It also placed an embargo on the import and export of narcotics drugs to and from countries that did not keep to their production quotas.
• The 1936 Geneva Convention for the Suppression of the Illicit Traffic in Dangerous Drugs was signed by 26 of the League of Nations members. The Convention set up a system of international co-operation to combat the trade and called on governments to set up a central office specially for this purpose. This is the only international law voted created prior to the 1961 Single Convention on Narcotic Drugs that has been kept in force.
• The 1948 Paris Protocol extended the international control to newly marketed synthetic drugs that had comparable effects to those of opium.
• Three conventions drawn up within the framework of the United Nations finally established the basis of a general ban on narcotic drugs for other than therapeutic or scientific purposes.
  - The 1961 Single Convention on Narcotic Drugs, which focused on 99 different plants and substances, was ratified or implemented by most of the governments. Several of its provisions were reinforced by the 1972 Geneva Protocol.
  - The 1971 Convention on Psychotropic Substances was ratified by more than half of the world’s nations. This Convention applies to 103 hallucinogenic drugs, amphetamines, barbiturates and tranquillisers.
  - The 1988 Convention against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances laid down the foundations for controlling drug trafficking and stipulated that 22 specific precursor substances used in the illicit manufacture of drugs were to be placed under control.
Drug testing at rave parties

On-the-spot toxicological pill tests are sometimes carried out at rave parties, where buyers can obtain personal, tailor-made advice about the safety of the tablets they intend to take: the purity and contents of these tablets are tested prior to their use. This controversial practice is carried out in only a few countries, such as Austria, Germany, Portugal, France and the Netherlands, and mainly targets teenagers attending “raves”.

On-the-spot drug testing implicitly condones illicit drug use, which is against the international Conventions, as clearly stated in Article 38 of the 1961 Convention: “parties should pay special attention to the abuse of drugs and take all practicable measures to prevent it”. Article 20 of the 1971 Convention and Article 14 of the 1988 Convention contain similar provisions. Besides, giving information and advice about particular drugs might be felt to amount to inciting or encouraging the public to use illicit drugs. And this practice is prohibited according to the terms of Article 3, paragraph 2, of the 1988 Convention, which requires governments to make this act a criminal offence.

However, countries where the expediency principle is applied may, by virtue of the public prosecutor’s discretionary power, decide not to prosecute people for taking drugs. Since the Conventions were set up in order to prevent drug abuse, this can hardly be said to constitute “loyal enforcement” of their provisions, by any stretch of imagination.
The “social cost” of illegal drugs

Delinquency, justice, repression, disease, health care, prevention, etc.

The English-speaking economists have invented the concept of “social costs”, which makes it possible to calculate how much legal and illegal drugs cost society. This concept can also be used to assess and compare various public policies in terms of their cost effectiveness.

What is the principle of the method used to calculate the “social cost” of drugs?

Drugs entail costs for the community. The consumption of both legalised drugs (alcohol and tobacco) and illegal ones and the trafficking in the latter have a broad range of societal consequences for individuals as the community. In economic terms, it is possible to estimate the “social cost” generated by the consumption of these substances and their trafficking. These calculations are prevalence-based, i.e., they do not include costs with remote origins but only which arise within a given year. These include drug-related deaths, loss of income and productivity, health-related expenses including treatment (in France, an estimated 30% of all drug users are sero-positive), the costs shouldered by insurance companies and public administrations such as the police, the court system, etc. “Social cost” studies in other countries have dealt mainly with alcohol and tobacco in order to fill in the information gap. As far as hard drugs are concerned, we know roughly where we stand even if some deaths are not included, especially the heart attacks resulting from cocaine abuse. It was relatively easy to deduce from the AIDS figures the fraction of cases involved in drug addiction; whereas we are still unable to correctly evaluate the number of correlated deaths among those with hepatitis. The problem with alcohol and tobacco is that these drugs result in a larger number of pathological conditions requiring lengthy treatment, and categorising each case is a complex affair. Since some people both smoke and drink, we have a lot of work to do. The calculations were fairly simple in the case of the consumers of illegal drugs: before the advent of Harm reduction, drug addicts cost very little in terms of health care because they were simply not looked after at all. It was easy to determine how many people died from drugs and how many were in prison: the calculations were perfectly straightforward.

This economic approach originated in English-speaking countries. Does it differ in any way from yours?

One first big difference between the English-speaking economists’ approach and the French one focuses on the term “social cost” is taken to include. One of the main schools of thought, in which I believe, doesn’t include intangible costs, i.e., the monetary equivalent of the psychological suffering caused by drugs. If a man dies from an overdose or in a fight caused by drugs, there is a loss of value since his income disappears, and that’s a tangible cost. But there is also of course the psychological suffering for loved ones, and that’s a non-tangible cost. We don’t include items of this kind in our accounting procedure for reasons of convenience, but also for a theoretical reason.

Traditionally, the only costs included in “social cost” were those that corresponded to some form of...
However, some economists calculate these costs using a method referred to as “willingness to pay”. The principle consists of interviewing people by asking them how much they would be willing to pay to reduce the probability of having one of their loved ones die of a drug-related disease or in a drug-related brawl. This makes it possible to quantify non-tangible costs. It’s an attractive method, but rather complex to apply. People are willing to pay huge sums, but if you specify that the tax-rates will therefore have to be increased, they begin to hesitate because they have all kinds of negative feelings about what the government is doing, etc. In any case, methods that include non-tangible costs obviously yield much higher figures. The question as to whether suffering should be taken into account or not has given rise to much debate among economists. And there’s another stumbling block: some people can be shocked to hear a lost human life spoken of in terms of updated income: this is the total income lost, for example, when death occurs at the age of thirty-five, based on the total earnings lost in comparison with those which would have been earned during the average male life-span. But life is not worth just a person’s lifetime earnings. This idea is offensive because it would mean that the lives of the rich are worth more than those of the poor. And how much would the lives of young people on the dole be worth, I wonder?...

How can determining the cost of illegal drugs to the community be of use to the public authorities? This is just the first step. The second one consists of using these studies to compare the effects of several types of social intervention. American research workers at the Rand Foundation have established for example that it is seven times more expensive to reduce cocaine consumption via imprisonment than via medical treatment! That’s quite a surprising result, for one thing because cocaine is a drug for which there exist no substitutes. Economists have all the ingredients necessary to carry out these assessments. You just take a group of one hundred drug addicts and provide them with treatment: some of them will relapse, some will stop temporarily, etc. Over a period of a few years you can quantify the probability of successfully decreasing their consumption, and at the same time you put another group in prison and compare the figures. This is referred to as a cost effectiveness study. You can also carry out a cost-benefit study: for each franc invested, what benefits are to be expect from a given policy in terms of the “social cost” involved? This gives you a basic frame of reference which can be used dispassionately to assess the efficiency of public policies. Public health policy, which aims to improve the well-being of the community, thus goes hand in hand with the preoccupations of economists, which are fundamentally humanistic.

TOBACCO, ALCOHOL, ILLEGAL DRUGS: THE COMPARATIVE “SOCIAL COSTS”

The total social cost of drugs in France has been estimated at 218 billion francs (for a total population of 58.7 million inhabitants). The per capita expenditure is 3,714 francs, or roughly 2.7 of the GDP.

Alcohol is the drug that entails the highest costs, namely 115,420.91 million francs (1.42 of the GDP) and a per capita expenditure of 1,966 francs: this is more than half of the overall social cost of drugs of all kinds to the community as a whole. These results are quite surprising, since they are quite different from those obtained in studies on other countries. In France, the social cost of alcohol comes first, ahead of tobacco, while in Canada (1.4% versus 1.1%) and in Australia (2.4% versus 1%) it is the opposite way round. As far as illegal drugs are concerned, France is in line with other countries (0.16 of the GDP in France, 0.2 in Canada, 0.2 in Switzerland, 0.4 in Australia and in the United Kingdom). In France, illegal drugs generate social costs of 13,350. 28 million francs, or a per capita expenditure of 111 francs (0.16% of the GDP). Losses in productivity contribute to 45.69% of the social cost of illegal drugs. Their overall amount is 6099.19 million francs, which breaks down to 5246.92 million francs spent on prison sentences for offences involving the abuse of narcotics and 852.27 million francs as the result of premature deaths. The cost of law enforcement comes second (29.3%) with 3,911.46 million francs. Then come health care (11.2%), which costs 1,524.51 million francs, corresponding to hospital stays without surgery (924.51 million francs) and consultancy with general practitioners (600 million francs). In fourth place (7.11%) come prevention and research, the overall cost of which is 948 million francs and lastly, loss of automatically deduced health insurance payments (6.49%) at a cost of 866.24 million francs.
Some studies also include the intangible costs: social costs = the social cost according to COI studies + the intangible costs

The social cost according to COI studies = external costs in the broad sense of the term

The sale of syringes and the prescription of Subutex® of Harm reduction measures such as legalising the figure dropped to 118 in 1999 after the adoption however much these lives turn out to have been worth, even if you're a hundred per cent off the mark, because the figure dropped to 118 in 1999 after the adoption of Harm reduction measures such as legalising the sale of syringes and the prescription of Subutex®, increasing the number of methadone treatments, etc. The consumption may seem to have increased because fewer deaths have occurred, but heroin consumption has actually stabilised or even decreased, since substitutive methods decrease the number of heroin addicts. The cost of substitutive treatment with Subutex® has been estimated to be 15,300 francs a year per patient, and as there are 40,000 people undergoing treatment, the medical costs alone work out at 600 million francs a year. The economic advantages of these treatment programs are a decrease in the health care costs (the care provided for drug addicts and contaminated people) and the legal expenses (court cases due to damage inflicted on others by drug addicts and legal charges for drug addiction and the criminal behaviour with which it is often associated) resulting directly from heroin consumption. These direct costs, amounting to approximately 15.6 billion francs a year, are enormous in comparison with the 600 million francs that Subutex® costs. Financially, substitution policies are worthwhile if they simply decrease the direct costs by 4%: the economic profitability threshold of substitution programmes is very low. Social cost studies in this area have merely confirmed the obvious. It is true, however, that in fighting drug addiction, the main goal is not in fact to decrease health, police and legal expenses. The aim is first and foremost to save wrecked lives, to prevent premature deaths, to reduce dependency, to help addicts to reintegrate society, to restore social mediation, etc. These benefits aren’t quantifiable in terms of money. Perhaps they are not even quantifiable at all.


The social cost of drugs in “Cost of Illness” (COI) studies

<table>
<thead>
<tr>
<th>Types of costs</th>
<th>Drug consumers</th>
<th>+ Non consumers</th>
<th>+ State, National authorities</th>
<th>+ Health care system = The Collectivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct costs</td>
<td>(1) Purchase of drugs</td>
<td>(2)</td>
<td>(3) Public cost of preventive and substitution programmes (detox therapy, methadone centres, etc.)</td>
<td>(4) Cost of medical treatment (overdoses) and substitution treatment (Subutex®)</td>
</tr>
<tr>
<td>Cost of direct consequences</td>
<td>(5) Cost of non-refunded care for drug abusers, not including legal expenses</td>
<td>(6) Cost of non-refunded care for diseases transmitted by drug abusers, cost of damage to objects and private persons</td>
<td>(7) Health care costs budgeted by administrations, legal expenses, jurisprudential aid</td>
<td>(8) Cost of refunded care for drug addicts, cost of returned care for victims of drug addicts</td>
</tr>
<tr>
<td>Cost of indirect consequences</td>
<td>(9) Loss of revenue</td>
<td>(10) Loss of productivity and revenue</td>
<td>(11) Loss of tax, social assistance of various kinds</td>
<td></td>
</tr>
<tr>
<td>Cost of intangible consequences</td>
<td>(13) Loss of comfort due to drug addiction, disease, early death, prison sentences</td>
<td>(14) Loss of comfort due to drug addiction in the family, offences committed by drug dealers, deaths from diseases transmitted by drug abusers, etc.</td>
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External costs strictly speaking = 3 + 4 + 6 + 7 + 8 + 10 + 11 + 12
External costs in the broad sense of the term = external costs strictly speaking + 5 + 9

The social cost according to economic theory = 1 + (5+6)+ external costs strictly speaking = 1 + external costs in the broad sense of the term

Some studies also include the intangible costs: social costs = the social cost according to COI studies + the intangible costs

source: Pierre Kopp “Le coût social des drogues licites (alcool et tabac) et illicites en France”.

You’ve evaluated Harm reduction in France (1). Did you find it had decreased the “social cost” of illegal drugs?

I certainly believe Harm reduction also requires economic calculations, although it was based on activist commitments and its advocates come from a quite different background from the inventors of the social cost theory. One might say there is a strong convergence: on both sides, we have been provided with a rational means of approaching highly politicised issues. Economists have confirmed, at any rate, that if the aim of public policies is to reduce social costs, then the partisans of Harm reduction are perfectly right. However, you don’t have to be a great economist to be able to see that the social record of Harm reduction is positive. In 1994, 564 deaths occurred in France as the result of an overdose. The conclusion is obvious, however much these lives turn out to have been worth, even if you’re a hundred per cent off the mark, because the figure dropped to 118 in 1999 after the adoption of Harm reduction measures such as legalising the sale of syringes and the prescription of Subutex®, increasing the number of methadone treatments, etc. The consumption may seem to have increased because fewer deaths have occurred, but heroin consumption has actually stabilised or even decreased, since substitutive methods decrease the number of heroin addicts. The cost of substitutive treatment with Subutex® has been estimated to be 15,300 francs a year per patient, and as there are 40,000 people undergoing treatment, the medical costs alone work out at 600 million francs a year. The economic advantages of these treatment programs are a decrease in the health care costs (the care provided for drug addicts and contaminated people) and the legal expenses (court cases due to damage inflicted on others by drug addicts and legal charges for drug addiction and the criminal behaviour with which it is often associated) resulting directly from heroin consumption. These direct costs, amounting to approximately 15.6 billion francs a year, are enormous in comparison with the 600 million francs that Subutex® costs. Financially, substitution policies are worthwhile if they simply decrease the direct costs by 4%: the economic profitability threshold of substitution programmes is very low. Social cost studies in this area have merely confirmed the obvious. It is true, however, that in fighting drug addiction, the main goal is not in fact to decrease health, police and legal expenses. The aim is first and foremost to save wrecked lives, to prevent premature deaths, to reduce dependency, to help addicts to reintegrate society, to restore social mediation, etc. These benefits aren’t quantifiable in terms of money. Perhaps they are not even quantifiable at all.

1. Pierre Kopp, Philippe Fenoglio, Le coût social des drogues licites et illicites en France. Observatoire français des drogues et des toxicomanies (OFDT) 2000. (ofdt@ofdt.fr). This study can be consulted at www.drogues.gouv.fr
DISCUSSION

Those inevitable cultural specificities

Michel Koutouzis, an anthropologist and drug problem specialist, analyses the prerequisites for successful prevention: the social and cultural background should not be overlooked by making overly voluntaristic or technical decisions.

Is there any connection between drug addiction and the AIDS epidemic in Africa?
From the epidemiological point of view, the link between drugs and AIDS is the use of injections, and this is mainly a social and cultural practice. Only a very few drugs are actually being injected. Heroin is the main drug injected in Europe, although cocaine is also beginning to be used in this way. Amphetamines★ are being injected in North America, in the Midwest. Drug addiction certainly exists in Africa, but on the African continent, the link between drugs and AIDS does not involve the abuse of heroin, which is more of an Asian and European tradition. Heroin is used very little in Africa, and its adepts do not tend to use syringes. Injection is more of a cultural practice. In some parts of Africa, drug injecting might develop (cf. the insert on injection), especially among populations who go in for scarification... The economic context also has to be taken into account, however, since even the price of a syringe can act as a deterrent. In Africa, the most widely used psychoactive substance which contributes to the propagation of the HIV virus -I do not mean this is the only factor responsible, of course- is alcohol and its common corollary, adulterated alcohol, which is probably one of the drugs which are most harmful to health. Alcohol promotes AIDS indirectly, by accentuating permissive attitudes and carelessness. Any policy designed to prevent AIDS in Africa should take this fact into account. It is common knowledge nowadays that a great deal of contamination takes place in night clubs, for example.

You seem to stress the need to take the specificities of the economic and cultural context into account.
In Africa, as in other places, some populations are managing to survive without the basic requirements which are generally thought to be essential. Condoms are available, but people cannot always buy them. Outside the large cities, there are no chemists' shops and no vending machines. Africa is a continent where there are great differences in the standard of living. You can live in a village where there are no shops and you have to travel several miles to get what you need. This mobility makes preventive efforts difficult, since it reduces the effects of any measures adopted. This cultural fact has to be dealt with by launching information campaigns, which have to be mobile themselves. Time and space do not have the same significance as in Europe. Space is often very restricted, but it takes much more time to go from one place to another. The state of the roads, that of the educational and vocational training system, the long distances to be covered to reach places of entertainment, and people's perception of time and space in general all work consistently against preventive efforts.

Can you give us some examples of drug prevention schemes which seem to have been successful?
I know of three particularly noteworthy examples in Namibia, Mauritius and Tanzania, two of which have been successful, and the third slightly less. These examples
CULTURAL AND CHEMICAL FACTORS EXPLAINING THE LOSS OF POPULARITY OF HEROIN INJECTION

Two modes of heroin administration developed in the Netherlands during the 70s: injection and inhalation. This pattern was most unusual, since drugs were mainly being injected in most of the other countries in the Northern hemisphere at that time. The explanation put forward by the Dutch research workers was based on the role played by the immigrants from Surinam, who were traditionally heroin smokers, and who were repelled by the idea of injecting drugs. Drug abusers were encouraged by these people to learn how to inhale the smoke released by heroin ("chasing the dragon"). This practice was also facilitated by the arrival in 1973 of a special kind of heroin known as Brown Sugar, which lends itself particularly to being inhaled, and from the 80’s onwards, the base form specially prepared for being smoked became available. A retrospective analysis has shown that the majority of the drug addicts were non-injectors in the late 70’s and early 80’s; whereas in Britain, very few of the heroin addicts who started to take the drug during the 60’s used modes other than injection. By the end of the 80’s, the newly addicted heroin abusers were tending to adopt the pulmonary pathway. Authors attempting to explain this change have stressed the importance of a factor which had already played an important role in the case of the Netherlands, namely the high level of purity of the product, which was rarely below 30%. The new drug abusers in Britain gradually began to smoke heroin and stopped injecting themselves. Some American research workers have suggested that the decreasing quality of the heroin available in the USA may be one of the factors responsible for the development of intravenous abuse, as well as constituting the main barrier to the spread of other modes of administration, although the ongoing epidemic certainly ought to induce people to give up drug-taking practices altogether.

To prevent the abuse of heroin by young people, a parallel school system has been set up in Mauritius...

Between 1975 and 1985, a peak in the abuse of heroin occurred on the island of Mauritius. It was proposed to look for the underlying causes. One of the particularities of Mauritian society is the fact that the school system is highly selective: at the early age of twelve, children have to sit an examination on which their entire educational future depends. A large proportion of the young people are suddenly deprived of further education and have no alternative activities, either. The educational system might therefore be partly responsible for young people’s attraction to heroin. A parallel system of education has therefore been proposed (cf. p.113): teachers have been called on to set up schools for the drop-outs to give them a chance of attaining vocational objectives. This system started up with very few people and very meagre resources. The authorities subsequently took an interest in this initiative and started to support it. This has made it possible to integrate into this special curriculum a non negligible proportion of the children excluded from the normal school system. The project has certainly led to a clear-cut decrease in the consumption of heroin, as well as having other positive effects. This example serves to answer the question as to whether it is possible to take the same measures everywhere. The answer is no, since in Mauritius, one of the main causes of the problem is the segregation resulting from the country’s educational system. Another problem still remains to be solved, and that is the complete social exclusion due to poverty, for which there are no technical solutions, and here of course the abuse of heroin still continues and is mainly affecting the most socially deprived communities.

You were talking about a programme in Tanzania which came up against economic and social barriers. In Tanzania, which is one of the rare African countries
where the abuse of heroin is occurring, villages were set up for drug addicts who had undergone treatment (cf. the insert below). This experiment in tertiary prevention shows that there is no point in imposing voluntaristic and technical mechanisms, which only serve to mask reality. The Tanzanian context has its own specificities, such as the fact that drug dealers enjoy a high social status. Twenty years ago, 20,000 to 30,000 Tanzanian sailors joined the Cypriot and Turkish navies and sailed to South-East Asia, Pakistan and India, where they had access to heroin. While earning their living on the seas, they also managed to sell the drug back in Tanzania, and were eventually able to set up a shop or a restaurant. Those who combined a salary earned on foreign ships with the income obtained from the sale of drugs were highly respected by their poor fellow countrymen: they had done well. This naturally created a local drug addiction problem. This was a rather paradoxical situation: since the drug suppliers were highly respected, it was difficult to set up drug control measures, although drugs were generally frowned upon. It was therefore necessary to find a means of removing newly reformed drug addicts from their surroundings, and they were therefore sent to live in villages in the country. But as soon as they returned to their former haunts, they often relapsed. And nobody was doing anything to stop the dealers... The authorities ended up by creating villages which resembled ordinary villages in their form and their activities, except that the drug dealers were kept out. This system worked very well, but the patients tended to stay on for as long as they could after they had been cured because they were much happier there than living with the down-and-outs. When they were sent back where they came from, they would start taking drugs again in order to be re-admitted to the village. The neighbouring villages were all jealous, of course, and their inhabitants were saying:" here we have to work for our living, whereas the drug addicts get free board and lodging and are given vocational training", and becoming increasingly hostile. This interesting experiment, which has been talked about all round the world, was not really designed with the context in mind. One can attempt to solve a drug addiction problem, but this will not solve the underlying social problems.

A study carried out in Tanzania in 1997 showed that 51% of all the city-dwellers in the country regularly consumed alcohol, which used to be reserved for special rituals. Outside the towns, the situation is even worse, since the figure is as high as 65%. Other substances such as cannabis*, tobacco and khat (a hallucinogenic* often used by long-distance truck-drivers to help them keep awake, the use of which is spreading these days among the population at large) are also extremely easy to come by. In addition, drugs of new kinds, such as opium*, cocaine*, heroin*, mandrax* and other synthetic drugs have been entering the territory since 1989. The results of one study have shown that 52% of the homeless youths in Mwanza take cannabis and that 22% of them do so every day, whereas 17% inhale synthetic drugs and 5% of the latter do so several times a day.

Given this situation, the staff at the psychiatric ward of the Dar-es-Salaam Muhimbili Medical Centre is having to deal with increasingly large numbers of patients who are addicted to heroin, alcohol and other substances such as khat. The policy adopted at this Centre as far as follow-up treatment is concerned is in line with the overall Tanzanian drug policy: great reliance is placed on the role of each person’s family, cultural and community links as means of preventing the risk of relapsing. However, homeless patients are very difficult to follow up once they have been treated, and many of them go back to taking drugs. The Vikrutti Psychiatric Rehabilitation Village was therefore created in the heart of Chamazi, near Dar-es-Salaam in response to this problem. The inhabitants of this specially protected village include patients with psychiatric disorders and alcoholics, who are all under the supervision of a nurse, a medical assistant and three craftsmen who pass on their occupational skills to the villagers. A visiting psychiatrist and a social worker call in at the village every week to check whether the programme is running smoothly. At the beginning, people were expected to stay at Vikuruti for anything from three months to two years. But homeless alcoholics who have lost all contact with their families cannot be sent back to join their next of kin. Since they do not want to be left to their own devices back in the towns, they often ask to be allowed to stay on longer at the village, and this raises problems not only because it blocks the intake, but also because the inhabitants of Chamzi think they are being given unfair advantages.

Some Tanzanian addicts have proved to be difficult to re-integrate into supportive family or community structures, but on the other hand, it is certainly worth mentioning the albeit rather two-sided success of the rehabilitation cures run at the village of Vikuruti and other centres of a similar kind.
Some national and local reactions

Some, but by no means all the countries involved have adopted special preventive policies to combat the HIV/AIDS epidemic among the injecting drug users. Each country is trying out different strategies, depending on the local specificities: self-support, solidarity, setting up innovative educational programmes for drug abusers and populations at risk and testing new tools (substitution, etc.). Here we outline some of these schemes, such as that adopted in Brazil, the Latin American country with the highest HIV contamination figures, in absolute terms. Some of the obstacles encountered, the doubts felt and the successful results achieved thanks to these measures are briefly outlined.
Barely ten years ago, the HIV/AIDS epidemic was accelerating in Brazil at a comparable rate to that occurring in African countries. Thanks to the effective policy designed to inform the population at large and to reduce the harm done to injecting drug users (which account for one quarter of the HIV positive population in this country), the rate of contamination has been slowing down considerably since 1999. Brazil has become an example to the other Latin American countries.

In 2000, Brazil had 164 million inhabitants, 500,000 of whom were HIV positive. This is the fourth largest country in the world, the eighth in terms of economic power and one of the most densely populated States on the planet: Brazil is a giant. It is also characterized by extremes of social inequality: 20% of the population are illiterate, suffer from malnutrition and live under unhealthy conditions, with little access to information. The risk of HIV contamination is high, due to both sexual exposure (which was responsible for 52% of all the present cases) and drug injection practices (25%) (1).

Injecting drug users accounted for only 2.7% of all the cases of contamination in 1982, but the figure went up to 18.2% in 1998 and reached 25% in 2000. In view of the epidemiological upsurge, the public authorities decided during the 1990s to back harm reduction projects, which numbered 40 by the year 2000. Most of these projects involved heightening awareness or handing out sterile syringes, condoms and alcohol. In a study carried out by the Ministry of Health in 1999, the following information was obtained about the injecting drug users taking part in these programmes: 70% of them were males between 18 and 30 years of age, who were taking drugs in groups and sharing their syringes. 52% of them were sero-positive and 80% had hepatitis C.

In spite of this alarming situation, there were still obstacles, particularly legal ones, to setting up programmes. Under the present narcotics law (Law 6368 of 1976), anyone who encourages drug use, is liable to prosecution and this, if interpreted too narrowly, can also be taken to mean anyone who hands out syringes (cf. insert).

Three federated States located in areas with the highest risks have eluded the law by drawing up their own harm reduction legislation based on the constitution, which states that in a national emergency involving risks to public health, every individual has the right to health and medical treatment. In a country where 90% of the population are Catholics, the position adopted by the Church has caused rifts of opinion. But behavioural changes are occurring, and injecting drug users themselves are increasingly taking part in harm reduction programmes and changing their practices, as National Harm Reduction Association President Domiciano Siqueira recounts in his interview.

1 In 90% of these cases, cocaine is the drug injected (cf. p.96).
“Saving their bodies so that they can save their souls”

The joint efforts of public authorities and NGOs have resulted in an effective prevention policy because they have been adapted to the local context. This policy was mainly based on a social and public health approach, but efforts were also made to involve other communities and institutions, such as churches, drug users and the police. Legal provisions have also been made to ensure that these measures will be effective.

INTERVIEW

with Domiciano Siqueira
President of ABORDA,
the Brazilian harm reduction association.

Awareness campaigns involving churches, the police and health networks are necessary in order to show people that users must be persuaded to take control over their own consumption if we are to obtain any changes in the patterns of drug abuse.

What is your overall picture of harm reduction projects?
At national level, the HIV rate among the injecting drug users (IDUs) is 25%: in the North, it’s about 4.5%, while in the southern part of the country, from the State of Sao Paulo to Rio Grande do Sul, it’s as high as 35%. That’s the area where the first harm reduction programmes, mainly involving syringe exchanges, sprang up. And that is also where the first laws making specific provision for these programmes were adopted: the pioneer was the State of Sao Paulo in 1997. In 2000, three municipalities also adopted legislative measures on these lines.

Why is it worth adopting a law at municipal level if the federal State is also in the process of legalising harm reduction programmes?
Most programmes are financed by the Ministry of Health. The problem is the status of people working on syringe exchange programmes. What the State law does is to regulate syringe replacement schemes and those for handing out condoms and other harm reduction activities. The municipal law governs the status of the harm reduction workers.

Does the status of programme staff have any effect on how this work carried out?
Among those working on government projects, 40% are volunteers who are in contact most of the time with health professionals with permanent positions. On the other hand, some of the initiatives are non-governmental, although they may be supported by the federal State. These focus on on-the-field involvement, going to the places that are hit hardest by the epidemic or by drug consumption problems.

What does the government’s work involve?
The work of the health units consists of attracting IDUs and those around them in order to provide them with free basic health care (e.g., vaccination and general care). We also offer AIDS testing and if necessary, harm reduction equipment: condoms, syringes, needles, sterilised water, etc. Starting with that first contact, individuals can be referred to hospitals for medical care at a hospital if they so wish. One of the associations’ missions is therefore to make those working in these health units aware of the existence of these services.

Have you noticed any real changes in the behaviour of IDUs?
The programmes, which reach increasing numbers of IDUs (42,000 of them in 2000), have led to users becoming more responsible about the risk of contamination. Studies about changes in behaviour have shown that 70% of them stopped sharing syringes. Some of them want to undergo treatment to stop injecting. They are making increasing
use of condoms and have become environment-conscious by leaving their used syringes in specially designed receptacles (cf. insert).

Do you also teach them to clean their syringes?
In our opinion, it is perfectly obvious that a syringe should be used once and then appropriately disposed of. Teaching people to clean syringes is really a last resort didactic step (cf. insert).

What are the main problems that you encounter?
We have to heighten awareness among the religious confessions and among members of the police force as well as at health centres to show people that changing the behaviour of the IDUs depends on being able to persuade them to take control over their own consumption.

In practice, we are dealing with two religious communities. The first one decides, preaches and prohibits. It is sermonising and institutional in its attitudes and dubious about programmes of this kind. At the second level, there are the grass-roots church communities working close to the people, who are more open to prevention activities. We explain to them that it is about restoring dignity and citizenship, based on the idea that we want to "save their bodies so that they can save their souls." The second problem concerns legal matters and Law 6368. We don't want to encourage drug use, and our programme is essentially a medical one. We have been taken to court a few times, but no one has been found guilty of anything so far. The answer is to make senators and representatives understand that the more repressive the law is, the more of a problem it becomes. Then it's up to the citizens themselves to decide whether they ought to take drugs or not. In some States, the police is one of our partners, as in Rio Grande do Sul, where we present our programmes to the police officers.

One problem, which I would say is a secondary one, is the slowness of the bureaucratic system on which the public health services are based. Then there are financial difficulties and problems with making the equipment required available. On the other hand, the NGOs have more room for manoeuvre, which makes it possible to compensate somewhat for the difficulties encountered at the level of the traditional public health networks.

In the southern part of Brazil, 45% of the country's population is concentrated on 11% of the territory. This is the area with the highest rate of sero-positive IDUs.

Do you also teach them to clean their syringes?
In our opinion, it is perfectly obvious that a syringe should be used once and then appropriately disposed of. Teaching people to clean syringes is really a last resort didactic step (cf. insert).

What are the main problems that you encounter?
We have to heighten awareness among the religious confessions and among members of the police force as well as at health centres to show people that changing the behaviour of the IDUs depends on being able to persuade them to take control over their own consumption.

In practice, we are dealing with two religious communities. The first one decides, preaches and prohibits. It is sermonising and institutional in its attitudes and dubious about programmes of this kind. At the second level, there are the grass-roots church communities working close to the people, who are more open to prevention activities. We explain to them that it is about restoring dignity and citizenship, based on the idea that we want to "save their bodies so that they can save their souls." The second problem concerns legal matters and Law 6368. We don't want to encourage drug use, and our programme is essentially a medical one. We have been taken to court a few times, but no one has been found guilty of anything so far. The answer is to make senators and representatives understand that the more repressive the law is, the more of a problem it becomes. Then it's up to the citizens themselves to decide whether they ought to take drugs or not. In some States, the police is one of our partners, as in Rio Grande do Sul, where we present our programmes to the police officers.

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SHARING EXPERIENCE

Participative democracy was established in Porto Alegre in 1989 by the Workers’ Party, which includes extreme left movements, social democrats, progressive Christians and trade unionists. Local inhabitants form neighbourhood Committees presided by a city councillor, who acts simply as an observer, to decide on investment priorities. Budgetary allowances are divided up during the assembly of all the neighbourhoods, depending on the number of inhabitants they contain and their level of development. The budget is drawn up, signed by the mayor with no amendments, and then submitted to the city council for approval. The city has sixteen neighbourhood Committees of this kind, each involving about three hundred people (this amounts to 10% of the city’s population). The members of these Committees are mostly members of the city’s working and middle classes.

The first budgets approved by the Committees focused mainly on city infrastructure (streets, transport, ecology), violence and security, and were then gradually extended to include items such as education and access to health care for all citizens.

Recent activities include the efforts made to decrease the risk of contamination, for example. For the last four years, under the impetus of a recent law in the State of Rio Grande del Sul, many programmes have been developed in which drug addicts themselves participate. Prevention specialists speak to associations, in schools, social centres, athletic clubs and clinics in order to get the prevention message across. They also distribute syringes and condoms. At public health centres, which are rather reluctant to admit drug addicts, they explain how to clean syringes and carry out HIV and Hepatitis C and B screening tests: these diseases are actually responsible for larger epidemics than HIV in the city. The teams also reach out to high-risk members of the population living on the streets, the prison inmates at the Porto Alegre central prison and other socially vulnerable communities. “We always start with what the subjects themselves have gone through, Mirtha Sendic explains, so that the IVD users can share their experience with their peers. We call it educating equals.”

BREAKING DOWN THE BARRIERS BETWEEN DRUG USERS AND THE COMMUNITY

Participative democracy, whereby drug abusers participating in these programmes are eligible for membership of the neighbourhood Committees, has changed the way people think, and has enabled new players to become involved. Bars and restaurants have set up used syringe receptacles and distribute new syringes. On similar lines, companies have been organised into co-operatives through which drug addicts can find jobs. The aim of all these initiatives is basically to break down the barriers between drug abusers and the rest of the community. “It’s by going to work every day that drug abusers will come to realise that they are the equals of all the other citizens, says Mrytha Sendic. IVD users often do not
want to stop using drugs, but, once they have joined the working world, they learn to use them only in the evening rather than all day long.”

The statistics have not yet shown a decrease in the number of cases of contamination (1), but over 75% of all the contaminated IVD users taking part in the programme have stopped sharing syringes. Another successful outcome is the fact that people on the fringes of society are given a hearing by local inhabitants, which, according to Mirtha Sendic, consolidates and strengthens the social fabric of the city and the feeling that these people belong to a community.

The first harm reduction project in Brazil was launched in the port of Santos in the State of Sao Paolo. It was based on experiments which began in Holland in 1982 and in Australia in 1985. The idea was to make syringes available at health posts. However, the medical team in charge, consisting mainly of doctors specialised in STDs, was soon being questioned by the police. Similar mishaps also occurred to workers involved in harm reduction early in the epidemic in Europe. Dr Tarcisio de Andrade, who currently heads CETADE (the Centre for Drug Abuse Study and Therapy) in Salvador de Bahia, has the honour of having started the first harm reduction project ever tolerated by the police in Brazil. This was the result of long efforts, where discussions with police officials were as important as those with the socially marginalised communities targeted by the programme. In 1994, Tarcissio de Andrade focused his doctoral dissertation on the risks of contamination by the HIV virus run by homeless people and the inhabitants of the favelas, where he discovered that 50% of the IDUs were HIV carriers. He began to work “using whatever means came to hand”. With the help of colleagues and volunteers, he produced local radio programmes to inform people about the precautions they should to take to protect themselves from the AIDS epidemic. The speaker would announce the times at which the mobile teams would be in the favelas to hand out condoms and syringes. In these broadcasts, the issue of morality was discussed, people were informed about the epidemiological situation and above all, they helped to counteract the tendency of locals to reject IDUs.

Making efforts to convince people that this project will not involve selling drugs.

Listeners asked non-stop questions: “the Church doesn’t allow the use of condoms”, “handing out syringes means you’re encouraging young people to take drugs”, etc. The planners had to explain their position clearly: “we’re neither HIV positive nor representatives of the Church: the syringe exchange programme is mainly a response to a public health issue. We’re here to give psychological and medical support to people who have the virus and we want to help both you and your children”. Long talks with the police were still necessary to convince them that the permanent premises were not going to be used to sell drugs. Three years later, CETADE, thanks to funding from the authorities (the Department of Health in the State of Bahia, the city of Santos and the Brazilian Federal government) finally opened a centre providing testing, syringes and condoms.

Nowadays, harm reduction has come to be fully recognised by police officials and locals alike. According to Dr Tarcisio de Andrade, it is time to take things farther. He now wants to undertake programmes that will not distinguish between preventing drug use and abuse, for “sub-dividing people into users and non-users does not give us a very all-round prevention policy”. In his opinion, ways of dealing with everyone have to be found “in order to break down the imaginary lines between people who use drugs and those who don’t, so that the latter are no longer looked upon as diabolical and can be brought back into the fold of the community”.

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1. It has been estimated in one study that the number of new cases of AIDS among the Porto Alegre IVD users is increasing by 36% per year. This percentage is attributable to the high rate of drug consumption in the south and to the geographical position of this part of the country, which is on the route taken by the drug traffickers.

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The main illegal substances used in Argentina are marijuana and cocaine, whereas the use of other drugs such as heroin and LSD is almost negligible. The possession of illegal drugs, even for personal use, is punishable by law. Since there is a stigma attached to drug taking in many circles, drug-users are liable to undergo dual ostracism: they are both engaged in unlawful behaviour and failing to uphold prevailing social values. According to the Pan-American Health Organization (PAHO), Argentina ranks third in Latin America, after Brazil and Mexico, in terms of the number of cases of AIDS. By December 2000, 18,688 cases of AIDS had occurred in Argentina. This figure will have to be updated when the relevant statistics become available, but the latest data given by the Ministry of Health indicate that the present-day figures will be more like 21,000, and this does not include the unregistered cases. Transmission via the intravenous pathway accounts for 39.2% of all the cases of AIDS in this country.

The terms “innocence” and “guilt” should never be used these days in relation to health and illness. However, AIDS is a health problem with strong moral connotations: in the eyes of society, there is a distinction between “innocent” patients (children, and people who have received blood transfusions), and “guilty” patients, who “had it coming to them” (people infected via the sexual pathway or by sharing syringes). Given the confusion which tends to occur between the realm of public health and that of social, moral and even legal values, AIDS is both a public health problem and a human rights issue. Studies on AIDS in various parts of the world have shown to what extent people living with HIV/AIDS lose their rights and/or the possibility of exercising them because of their HIV-positive status: the right to work, social protection, health and dignity. It is the same thing with drug abusers. According to Guillermo Aureano (1), Argentinian law is ambiguous: those in possession of illegal drugs are liable to be arrested, even if they have only a small quantity on them for personal use, but they can opt for a temporary alternative to prison by admitting that they are drug addicts or have problems with drugs. What parliamentarians did not realise here was that obliging someone to carry a label - a label with a stigma attached to it - can seriously affect that person’s life. Having to carry a label with a stigma attached to it and admit to being...
a drug addict not only to various criminal authorities, but also to the family and at the workplace, is a very powerful, decisive experience for individuals to have to go through.

Discrimination and exclusion only increase the risks taken by those stigmatised in this way.

The stigmatisation of drug-taking practices is sometimes thought by users themselves to be quite fair. In a survey on resident drug-users undergoing treatment at three specialised centres in Buenos Aires, the respondents said that they had experienced strong social rejection of drug users and strong prejudice against the physical appearance associated with drug taking (2). According to a survey about AIDS on 1600 people inhabiting four Argentinian cities, the study population ranked intravenous drug use first among the factors responsible for spreading the AIDS virus (3). In addition, 70% of 400 intravenous drug-users agreed that they were the main group responsible for spreading the HIV virus (3). We can see here how society and even the stigmatised groups themselves set epidemiological data against a pre-existing scheme of interpretation according to which drug taking is classified as immoral and seen as a threat to social law and order.

Discrimination and exclusion are factors which actually increase the probability that individuals will behave in a way which endangers their own and other people’s health. Among the 400 drug injectors from four Argentinian cities interviewed (3), 80% said they shared or had shared syringes, although 94% knew that there was a high or very high risk of contracting HIV in this way. Among these respondents, 42% said they shared injection equipment regularly with others (72% with friends, 38% with acquaintances and 22% with their partner); 60% had on occasion done nothing to disinfect their needles and syringes; among the remaining 40%, half washed their needles with water, 28% with alcohol and only 1% with bleach. There is therefore quite a gap between knowledge and concern in the abstract, and actually taking precautions in situations where there are risks. The reasons given for the repeated use of syringes were as follows:

a) priority was given to taking drugs over the risk of infection: “it’s easier to share than to go out to buy them”;
b) the difficulty of obtaining syringes: “You walk round in circles and can’t make up your mind to go to the chemist’s”; “I was ashamed to go out and buy 10 syringes”; “Some chemists won’t sell them to me because they know I shoot myself and I’m afraid they’ll call the police”; c) the pleasure of sharing;

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Abstentionist policies on AIDS are designed to eliminate high-risk behaviour. To prevent sexual transmission, abstinence and stable monogamous relationships are recommended, and to reduce intravenous drug use, it is proposed to stop these practices and prosecute users. Harm reduction policy is based rather on the assumption that drug use will continue despite prosecution and preventive efforts. Instead of proposing to put a complete end to drug taking, the aim here is to reduce the risks and the harmful effects of drugs on health. As far as AIDS is concerned, the focus is on using condoms during sexual intercourse and on using syringes only once when injecting drugs. The measures proposed so far on these lines have ranged from the prescription-free sale of syringes to programmes for distributing drug substitutes.

Harm reduction policies mainly target drug injectors who are practically or completely out of touch with medical and social services. The following hierarchy of objectives has been put forward:

a) don’t start taking drugs;
b) if you have started taking drugs, have treatment to stop or reduce intake;
c) if you can’t cut down, stop injecting and take drugs in some other way:
d) if you inject, use sterile equipment for every injection;
e) if you can’t use sterile equipment, don’t share syringes and needles;
f) if you share equipment, disinfect it with bleach (although it is still questionable whether this procedure is effective).

There are several arguments in favour of harm reduction policies. First, it has been recognised that the spread of HIV is a greater, more urgent threat than drug abuse and that abstentionist policies have not proved to effectively curb the spread of the epidemic. Secondly, risk reduction policies have proved to be at least as effective as abstentionist policies in terms of the numbers of drug users treated and cured. Thirdly, risk reduction policies are comparatively more effective methods of reducing the criminal behaviour associated with drug use and preventing HIV transmission (1). Lastly, contrary to what some people have feared, it has been established in several studies that risk reduction policies have not encouraged drug use (2). In our opinion, harm reduction policies are therefore definitely more effective methods of preventing the transmission of HIV than abstentionist policies.

In addition, effective prevention policies are based on the assumption that drug users are capable of responding rationally to information and public health services. The responsibility of the individual user, who can make decisions (if there are any options available) and change the more critical aspects of his or her drug use, must therefore be recognised. M.P.

N.B. See also “Harm reduction” in the List of terms at the end of this special issue.
Struggling to end stigmatisation in San Francisco

The homosexual activists’ campaign has led the American Federal legislators to set up regional AIDS control committees, which included representatives of the most highly exposed communities. The drug abusers, who have been strongly stigmatised, are thus able to make themselves heard.

San Francisco has the sad reputation of being the city in the United States with the largest number of Emergency ward admissions due to traffic accidents: roughly 200 a year per 100,000 inhabitants. But that’s nothing compared to the number of drug-related admissions to the Emergency ward. In the year 1999-2000 alone, there were 6,034 admissions of this kind in this city of nearly 700,000 inhabitants, which is an increase of 15% over the previous year. More than 3,000 of that number were admitted due to heroin use. The number of regular heroin users in San Francisco is estimated to range between 13,000 and 15,000 people, and only 5,000 of them are undergoing treatment. The presence of drugs is very real when you walk through the streets of downtown San Francisco. Not only do people approach you on Market Street as it crosses the Tenderloin, San Francisco’s traditional drug-dealing neighbourhood, but you often see little plastic bags of white powder exchanging hands, people sleeping on the streets, and brawls and fights going on among the locals.

When asked why San Francisco seems to have more than its share of homeless people and drug-users, Steven Tierney, who is in charge of HIV Prevention at the City and County of San Francisco Department of Public Health replied, “It’s the climate: it’s never too hot and never too cold.” However, the city is attractive for other reasons as well: “The public health and social services are particularly generous, since the waiting lists are very short. In Wisconsin you must prove 18
months of residency before having access to these services. That’s not the case here.” Actually, as Tierney goes on to say, “people of all kinds come here to get away from discrimination or to live in paradise. These people are relatively young and they are in transit. They stay here for only 3 years on the average. You go to New York to get a job in finance. You come to San Francisco to get away from responsibility.”


During the 70s, gays began to join the hippies and other freedom-seekers and the city thus became the first ever to fly the rainbow flag above its City Hall in official recognition of the “Gay Nation”. It was a long hard battle for homosexuals to win the first seat on the town council and become the first sexual minority to use the ethnic minority mode of social activism to obtain democratic representation. The first elected representative, Harvey Milk, was killed less than 12 months later by a homophobic member of the council. This tragic event is thought by many gays to be the point at which their movement crystallised, and surprisingly enough, it was to have long-term effects on health care policies.

Harvey Milk was shot in 1979. In 1981, the gay community used its extensive networks, community centers and recently acquired vocal acumen to start what would soon be known as “AIDS activism”. This activism greatly helped the IV drug using community, which had never had the opportunity of setting up political structures of this kind.

The approach to drug use in the US is traditionally one of punishment, prohibition and attempts to stop drug production. Needless to say, the Federal Government did not suddenly turn into a compassionate provider of health care services for IV drug users in under the Reagan administration in the early 80’s. But in 1990, the Ryan White Care Act was passed, and this was a revolutionary piece of legislation.

Stu Flavell, International Co-ordinator of the Global Network of People with HIV (GNP+), is all in favour of the Ryan White Care Act, which was re-voted last year, 10 years after it creation: “This legislation has enabled hundreds of HIV+ people, heterosexuals and members of ethnic groups to be involved in the process. I was a gay white Planning Council chairperson who was replaced by a Latino IDU... The Act brings people into care who would otherwise be falling into the broad cracks in the American health care delivery system. Our Council had to make sure not only that drug users were being cared for, but also that the health care providers were actually supplying the right kind of care. This meant that we could at last identify the homeless drug-addicts who were not being cared for and to find out why this was the case.”

Homeless drug addicts could at last be identified.
California, a reputedly go-ahead State, adopted needle replacement policies only in January 2001.

One of the policies that the Federal Government has not supported, however, is needle exchange. Although this strategy is known to decrease the number of new HIV infections, a government so intent on punishment could not openly give money to help people participate in an illegal activity. Even under a Democrat government, federal funding was extremely limited and only to be used according to very strict criteria, although several studies were published showing that needle replacement does not encourage the use of drugs. Needle exchange programs are now being set up by local City and County authorities here and there across the country, and number around 60 so far. The State of California, the most populous and traditionally the most progressive of the 50 States, only recently officially adopted State-wide needle exchange policies on January 1, 2001. Shortly afterwards, the Oakland center providing the local Latino community with syringes was burned to the ground, probably by arsons.

So how have things changed for IV drug users since the good old days? According to Lisa O’Connor, a 36-year old HIV+ who was formerly an addict and is now a project co-ordinator working with IVDUs in Oakland, things have changed: “It’s a lot easier now to get sterile equipment because of all the needle exchange programs. Ten years ago, we had to buy them on the streets or make a fake diabetic ID card for the pharmacist. I would say that the rate of occurrence of HIV and Hepatitis C reached a peak among IV drug users during that time.”

However despite the massive changes, Lisa O’Connor believes IVDUs still don’t talk freely about HIV, even to each other: “Some people say that they always tell the person they are having a shot with if they are positive, but I don’t really think many of them do so. There is still too much shame, despair and stigma attached.”
The consumption of drugs, especially cannabis, used to be a commonplace, readily accepted habit in Nepal, where it was tolerated even at public ceremonies and during the religious feasts celebrated by the Hindus, who account for 87% of the country’s population. Until quite recently, these traditional drug consumption practices were not thought to constitute a serious problem, and licences were granted for narcotic crops to be grown all over the country.

It was during the 70’s, when the drug users began to smoke heroin, that the consumption of narcotics became a real problem. The consumers numbered 25,000 at that time, including 12,000 in the Katmandu valley alone, and by now there are as many as 50,000 (1) drug abusers in the country. Public opinion has been focusing on the economic and social consequences, which led in 1986 to the creation of the NGO called Drug Abuse Prevention Association Nepal, after a series of legislative and preventive measures had been introduced by the Government. In the 1976 Narcotic Drugs Control Act, which was designed to reduce both the supply and the demand for drugs, provision was made in particular for treating and rehabilitating drug addicts at specialised centres in order to avoid having to pronounce prison sentences in some cases on drug offenders.

As far as the mode of consumption is concerned, the main changes which have occurred focus both on the method of drug administration, which is now mainly by intravenous injection, and on the substances involved, since a tendency towards multi-drug consumption has been observed here as in most developing countries: the abuse of illegal substances is now being combined with the misuse of pharmaceutical products. During the 80’s, for example, intravenous injection became the main mode of heroin administration, and this substance was subsequently supplanted by buprenorphine at the beginning of 1991. On the other hand, it has become common practice for consumers to share their syringes. Buprenorphine, which is commonly prescribed as a drug substitute in the treatment of heroin addicts, is often misused by addicts who continue to use syringes and are still under the influence of injectable drugs. This substance is largely responsible for the recent changes in the prevalent modes of consumption and has contributed to the spread of AIDS among the...
population of Nepal. Although the number of people with AIDS and HIV infection in this country was reported in the UNAIDS and WHO estimates for 1997 to be 26,000, it has been stated in the latest UNAIDS report that as many as 50% of all the intravenous drug abusers inhabiting the main urban areas are seropositive, and that 75% of all the consumers of buprenorphine inject themselves with this substance (2). The practice of buprenorphine injection has spread fast from Katmandu to other urban areas, such as the tourist resort of Pokhara and the industrial city of Biratnagar. The results of a study carried out in 1999 on the main urban centres located in the south of Nepal (Katmandu, Lalitpur and the Pokhara valley) showed that 72.7% of all the consumers injected the drugs they were taking, and that 65% of them had no hesitation in sharing their needles with other users, since they could not afford to procure new ones (3).

The shift from punishment to prevention.

In view of the risks run by these drug users, some Nepalese NGOs have set up syringe exchange programmes. In 1991, completely unknown to the authorities, the NGO called Lifesaving and Life-giving Society (LALS) launched the first preventive and educational programme of its kind to be implemented in any of the Southern Asian countries, involving a syringe replacement system, training in the sterilisation of injection equipment and medical care. Harm reduction efforts have meanwhile been accepted and recognised as a mode of treatment in this country (4). Local initiatives no longer seem to be frowned upon in this Himalayan Kingdom, and the use of drugs is no longer held to be a legal offence. Drug users are no longer being arrested and imprisoned unless they have attempted to commit or have actually committed a crime. Those working on programmes of this kind often stress the drug users’ lack of knowledge about the preventive measures available and the various possibilities at their disposal for being treated or informed about these matters. An extremely extensive network consisting of around 1,600 NGOs is now working on AIDS in Nepal, but few of these organisations are focusing on the prevention of AIDS via drug demand reduction programmes. The groups which are focusing on risk prevention in particular in Nepal have pointed out that there is a need to promote more intensive interactions between the players working in closely adjacent fields. Further efforts seem to be required to encourage all those responsible to concert their efforts, as well as to incite the authorities to define their policies more clearly drug abuse and addiction are concerned, since no consensus has yet been reached between governmental and non-governmental bodies as to how the concept of Harm reduction should be defined.

LALS (Life saving and life giving society), which was created in 1991 to prevent the risk of HIV transmission among drug users, is at present the only organization in Nepal working with the Katmandu drug users to prevent the transmission of disease via contact with blood. LALS provides some 1,400 drug and Tidigesic injectors with various services free of charge (education, counselling, Harm reduction material, primary health care, etc.). In comparison with those inhabiting some other towns in Nepal, the drug users in the capital city have a relatively low rate of HIV infection, partly due to the efforts of this association, no doubt. But as a representative of LALS stated at the 12th International Harm reduction Conference in New Delhi, “Families, the Government and the local communities must all treat drug users like human beings. There has not been enough commitment at the political level. If we really want to prevent the spread of HIV and reduce the risks, we must start thinking about it seriously and make the necessary commitments”.

LALS: life@lals.mos.com.np
Although injection needles are the main vectors whereby drug abusers are contaminated with the HIV virus, other drug-related factors are also contributing to the spread of the epidemic. Although most of these factors have not yet been properly assessed, some of them will be discussed here. First there is the fact that the changes of consciousness induced by the consumption of psychoactive substances can lead to contamination via the sexual pathway. Then in South Africa, there exists a cultural link between violence, AIDS and drugs. From the preventive point of view, the social context is of enormous importance, along with due respect for human rights at the workplace: these factors have very real and concrete effects. The working conditions described here by Madina Querre at the open-air gold mines and the causal links between these conditions and HIV contamination are a good illustration. In his analysis, Gerry Stimson also discusses some socio-economic interactions.
The abuse of psychotropic substances may increase the risk of HIV infection via the sexual pathway. Unfortunately, very few studies have been carried out so far on the link between drug abuse and sexual contamination. Nor have any preventive campaigns apparently been carried out so far on this specific point.

It is common knowledge that drugs and HIV infection are closely interconnected, since the HIV virus can be transmitted by injecting psychoactive products with infected syringes. This situation arises in those countries where injection is the main mode of drug consumption. Does this mean that there exist no other links between the abuse of drugs of all kinds and the risk of contamination? Certainly not. But the link between the abuse of alcohol, for instance, and the risks involved (those run by the drivers of motor vehicles, in particular) is perfectly obvious and leads to the adoption of preventive policies, whereas little has been done so far to explore what can be done to promote awareness of the link between the abuse of psychotropic substances of all kinds and the tendency to have unprotected sexual intercourse. The connection between illicit drug abuse and HIV transmission via the sexual pathway is certainly much more difficult to assess and to prevent than the risks involved in the sharing of syringes.

People who take drugs can suffer from psychological disturbances such as changes of mood, difficulty in concentrating, anxiety, which affect their behaviour, especially in the context of the social exclusion to which drug abuse can lead. Some drug consumers become generally rather negligent, which increases the risk of transmission of sexually transmissible diseases (STDs), including AIDS. People’s perception of the risk itself seems to change when they are under the influence of these substances. In an exploratory study carried out in Senegal, Kenya and South Africa, Bjorn Franzen, a consultant with the UNIDCP West African Office (1), reported that condoms were not being properly used, if used at all by drug abusers. The male inhabitants of these countries were already rather reluctant to use condoms, and this tendency was exacerbated by the use of drugs.

A study carried out by IREP (Institute for Epidemiological Research on Pharmacodependency) (2), has shown that the current tendency for drug addicts to go in for multi-drug abuse, including amphetamines* and cocaine derivatives, is associated with an alarming increase in the incidence of sexually
transmissible diseases, especially among women. In some parts of the United States, the combined use of heroin and cocaine (speed ball*), like the use of cocaine alone, increases the risk of HIV transmission (3). Drug consumers who take mixed substances, which have stronger behavioural effects, are thought to be more highly exposed to the risk of HIV infection because they tend to have more frequent unprotected sexual contacts.

It has been reported that in the United States, the incidence of STDs, including HIV infection, has increased due to the occurrence of genital ulcers among the crack consumers. This is probably due to the high rate of prostitution and the lack of individual protective measures. Since crack* is taken in frequent doses at short intervals, it weakens the ability of female prostitutes to negotiate the use of condoms with their clients. In addition, the results of a recent study published by IREP have shown that these processes involving both prostitution and the use of crack are now developing in many of the world’s large cities (4).

The tendency to take sexual risks does in fact seem to be due to the effects of these products, although they all have different properties and psychoactive effects. Some studies have been carried out at the international level (5) with a view to explaining risk behaviour in terms of the side effects, as follows: “some drugs depress the central nervous system, whereas drugs such as cocaine, crack and amphetamines not only stimulate the central nervous system but also have anesthetic side effects”.

Kall et al (6) have pointed out that the use of various drugs affects HIV transmission in different ways. It emerged from this study that local cultural differences as far as drugs and drug-related sexual behaviour are concerned probably lead to variations in the way in which HIV infection spreads, depending on the population of drug injectors under consideration. As established in a study by Hudgins et al (7), cocaine injectors run a higher risk of being contaminated with the HIV virus than heroin injectors, not only because they inject the drug more frequently, but also because they have more regular sexual contacts.

In their study on the use of amphetamines, Darke et al (8) concluded that this is a more sociable and public practice than the consumption of heroin; whereas heroin abuse is a more solitary practice, which takes place in a more personal, private context. In addition, amphetamine abusers are more active sexually than heroin addicts, and the latter group also tend to be older. The abuse of amphetamines, combined with the social aspects of this practice, may therefore lead to a higher level of exposure to the HIV virus (9).

Based on neurobiological studies, all emotions, pleasure and enjoyment are known to involve a complex mechanism. The interactions occurring between some neurotransmitters such as dopamine, endorphines, sexual hormones, etc. trigger a set of pleasure reactions in the brain.

The active ingredients of some drugs affect these chemical fluxes, especially those involving dopamine, and can exacerbate sensations of pleasure and enjoyment and even prolong the sexual act. In a study published by UNIDCP (10), health professionals working in sub-Saharan Africa reported that drug users often declared that they consumed cocaine and its derivatives mainly in order to improve their sexual performances. Virtually no efforts have been made so far to prevent the risks of STD and HIV contamination
via the sexual pathway linked to the use and abuse of licit and illicit drugs. And yet the few existing studies on this topic have shown that complex correlations of this kind definitely exist in many cases. Research has been carried out on these lines in a few North American and Western European countries only. It is now vital to extend the geographical scope of these studies in order to determine the effects of contextual factors on the risk behaviour of drug abusers, whatever the legal status of the drugs involved may be. The consumption of alcohol, for example, can have surprisingly strong effects (see the accompanying diagram) on the rate of sexual contamination.

The changes of consciousness induced by drugs may not of course entirely explain this rate of contamination, since age, the social and economic context, the social and cultural background, the level of education and social exclusion also have to be taken into account. However, the fact that the contribution of drug abuse to contamination with the HIV virus and AIDS has not yet been properly assessed should not discourage those responsible for prevention from informing people about the changes which affect drug abusers’ state of consciousness and the resulting behavioural effects. The injectors of heavy drugs have already proved that taking psychotropic substances is not incompatible with adopting behaviour which is conducive to good health, since they have stopped sharing their syringes in many countries.

In setting up preventive campaigns to inform the consumers of legal and illicit drugs about these matters, it is essential that social science research workers and public health specialists should combine their efforts to devise preventive programmes based on what is known about the effects of the various products, the cultural factors associated with their modes of consumption and the level of sociability associated with the practices in question, both before and afterwards.

1 Bjorn Franzen, “Substance abuse.....in Sub-Saharan Africa (et non African)...
2 IREP
3 Neil McKEGANEY, AIDS in Europe 1998, p.81-91
5 Siegal et al., Sexually transmitted diseases, 23(4): 277-282 and Hudgins et al., Cocaine use and risky injection and sexual behaviors. Drug and Alcohol Dependence, 37:7-14
6 Kall et al., Aids Care 1995, p.171
7 Hudgins et al. 1995, p.171
8 Darke et al., Injecting and sexual risk behaviour among regular amphetamine users, AIDS Care , 7 (1) :19-26
9 Neil McKeiganey, University of Glasgow.
10 Bjorn Franzen, op. cit.
what connection between drug addiction and AIDS?

The AIDS pandemic is spreading across South Africa with frightening speed, mainly via the sexual transmission pathway. The wave of violence which has engulfed the country does not facilitate preventive efforts. In addition, although the drug injection rates are still fairly low, they are increasing steadily.

One of the starting points for studying the connection between drug addiction and AIDS in South Africa is how drug addiction links up with violence in African cultures, where the use of psychotropic substances was traditionally the prerogative of the sages and elders.

The distinction should be made here between the long-used traditional drugs, which are usually less expensive and locally produced, and the latest drugs, which are harder, more expensive and imported. The country is a major producer of hashish, which goes under the various names of dag, ganga, DP (which stands for Durban Poison) or grass. During the apartheid years, the National Party government, which was conservative, Christian and racist, was obsessed by the idea of guilt and deviance from Biblical teaching and Christian morality. Hand in hand with institutionalised racial segregation and the economic exploitation of the black work force, officials saw to it that dagga consumers were severely punished. Young white draftees in the army were also expected to confess their drug addiction, if any.

Gradually, the use of dagga spread to younger people, whatever their class and colour. The trade and consumption of drugs are still illegal, in spite of requests that the Rastafarian community has submitted to Parliament in the name of religious freedom, which is mentioned in the new 1994 constitution.

The abuse of alcohol is taking its toll at all social and professional levels, especially the poorest ones. In some remote townships and villages in the former Bantustans (1), many people go to sleep drunk, after binges of debauchery and/or violence. Alcoholism also greatly affects women and younger people. Incidents involving adulterated alcohol made with battery acid and other toxic waste are frequent and cause several hundred deaths every year. Among the wealthier sectors of the population and in highly selective night-club circles, recreational drug use has boomed since the mid-1990s. But this has not led to any real violence among users. On the streets, however, the dealers belong to highly organised Mafia networks and fiercely defend their market prerogatives. This extremely lucrative trade is connected to organized crime, criminal networks and international trafficking. Illegal...
trading, procuring, rivalry between crime gangs are common occurrences. Since the end of apartheid and the opening of the country’s borders, these practices have gained even greater impetus.

The conclusions of published reports are quite clear, however: the South African consumers are often keen to try the latest drugs, but they do not usually practice intravenous injection.

**AIDS AND OTHER TABOOS**

Like cancer, tuberculosis and STDs, black South Africans feel AIDS is a shameful disease which should not be spoken about, or which should be referred to only in euphemistic terms: “He has got the four letters”, for example. The causes of death are never openly explained, or only explained in terms of fate or an evil spell. Sexual and religious taboos, as well as some cultural practices, form a thick screen which the message sent out by prevention and awareness campaigns has no chance of getting through.

AIDS is regarded as a women’s disease. Polygamy means that wives are not allowed to refuse to have sex with their husbands, or to ask them questions about their sexual habits. Dry sex (2) and other social sexual habits mean that women are still sex objects. In some neighbourhoods, tests have shown that 30% of all the 17-year old girls are HIV positive. The myth according to which having sex with a virgin cures illness is difficult to dispel and results in many victims among young girls and adolescents.

The decades of apartheid that followed centuries of colonisation and violent exclusion have left deep scars on every level of society. Urban and rural crime, which once had political roots, became more of an economic issue as from the mid-1990s. This is what has often been referred to as the paradox of the end of apartheid. Rivalries have grown sharper and security problems are on the rise. Xenophobia and suspicion are not decreasing in the least. It has been estimated that 20,000 murders are committed every year and one rape occurs every 28 seconds.

Locally-produced or imported drug trafficking, like procuring (prostitutes are legion in a country where 45% of the black African population are unemployed), are much sought-after sources of easy income involving only minimum legal risks.

The AIDS pandemic increases risk-taking behaviour, however. People with the HIV virus or AIDS will tend to be more depressed and more prone to erratic or desperate behaviour. If they go in for prostitution, there is a risk of contaminating customers, if the latter are not already ill themselves.
FROM HEROIN TO CRACK
Drug injection practices are still quite rare in Africa. They occur mainly in the homosexual community, where there is a heroin tradition, but these practices have not really gained much momentum in comparison with other countries. They seem in fact to be levelling off as the result of heightened awareness of the risks involved. On the other hand, South Africa, where the heroin market is very limited, serves as a point of transit for the traffic between Thailand and the United States. Since 1995, the demand for cocaine, and particularly for crack, has been spreading from the Johannesburg neighbourhoods known as Little Lagos because of the number of Nigerian dealers who work there. Crack is associated in this area with the highest addiction rate of all known narcotic substances, and destroys both families and entire social structures.

PROSTITUTES RUN HIGH RISKS
Female and male prostitution often go hand in hand with taking crack, which tends increasingly to replace mandrax (or “wheel caps”, which cost 30 rands a pill). Crack triggers violent behaviour, even during sex, which promotes the propagation of viruses that are transmitted either sexually or via the blood.

After being first introduced into the country in 1994 by the Nigerian immigrants (3), crack is now spreading fast through the underworld of prostitution. To such an extent that according to studies carried out among prostitutes, the price of one dose of crack (50 rands) has become the prostitutes’ basic rate in the red-light districts (which means that the rates have actually gone down). 50 rands is the price of one night in the cheapest hotel room, and some prostitutes prefer one last dose to having a roof over their heads for the night. Prostitutes “hooked” on crack take less money and cannot afford to be too fussy about using condoms if they want to keep their customers. Competition is tough and prostitutes who are not on drugs are also obliged to decrease their prices. Lowering the prices means that the prostitutes have to take on more customers.

A United Nations Development Program report in 1998 confirmed that “drug injection seems to be limited in South Africa, and sharing infected needles does not appear to be a significant cause of transmission of the AIDS virus”. In the study previously published by Carelse in 1994, intravenous use was rated at 5.4%. This figure is relatively low, but it is probably nevertheless liable to change, since the young people questioned were only between 12 and 18 years of age. It is therefore not unreasonable to predict that intravenous drug addiction may well increase in the years to come, especially among the most vulnerable members of the population, namely the unemployed and/or delinquent youths and prostitutes. Whatever the case may be, AIDS has already taken a considerable toll, since sexual transmission is incomparably more deadly than taking heroin. In 2005, AIDS will kill 600,000 people before the year is out, unless a cure has been found by then.

CRACK
Crack is a powerful stimulant made by mixing cocaine (one gramme of cocaine costs approximately 250 rands) with sodium bicarbonate to obtain solid blocks, or pebbles. Each pebble costs 50 rands, and since eight of them can be made from one gramme of cocaine, this is quite a profitable line of trade. A pebble is introduced into a glass tube or the neck of a bottle equipped with a metal stem. Upon being set alight with a cigarette lighter, it releases the cocaine it contains directly into the user's lungs. The effects are practically immediate, but they wear off within 10 to 20 minutes and give rise to a feeling of fatigue and depression, followed by a period of obsessive hallucinations and paranoia. This leads to increasing the drug intake frequency, and the users sometimes take dagga or heroin to prevent the depressive side-effects.

1• Land that was arbitrarily allocated to black people during apartheid.
2• The vagina must be as tight and as dry as possible to provide the male partner with maximum pleasure. Women therefore use abrasive products, including chemical detergents, which make the mucous linings of the vagina extremely susceptible to infection with the virus. (See the research carried out by the anthropologist S. Leclerc-Madlala, University of Natal, Durban, 2000).
3• The first Nigerian cocaine trafficker was tried in South Africa in 1992; six years later, Nigerians accounted for two thirds of the illegal immigrants in South Africa’s penitentiaries.
Failure to enforce children’s rights and labour laws create conditions conducive to drug abuse and cause the AIDS epidemic to spread. The gold mining environment is a case in point.

Drug consumption during the present AIDS crisis in Burkina Faso is not limited to specific social groups in urban areas, such as wild night-life circles or homeless children living in and on the streets. It is proposed to deal here with places which are far removed from urban circles, but greatly beset by both AIDS and drug addiction: the gold mines. Some of these mines are located in the north-east of the country, where the Essakan mine is one of the largest. No exact figures assessing these risks in epidemiological terms are available, since no studies have been carried out on this subject so far.

No work contracts, no health insurance, no welfare benefits.

According to national estimates, the HIV prevalence rate were 7.17% in late 1997 (1). In the Dori area, the National AIDS control plan reported an HIV infection prevalence rate of 9.7% in 1994 specifically at the gold mining sites. Prevention projects have started to be implemented by organisations such as Save the Children. In addition to the extremely indigent living conditions, the question arises as to what factors may lead individuals to become exposed to drug addiction and AIDS risks, and what attracts people to the gold mining sites in the first place.

A study published by the International Labour Organisation in 1996 showed that 1 out of 10 people in the Sahel were living in a gold mining area, and that women and children were the main targets of disease (dermatitis, conjunctivitis, silicosis, bronchopneumonia, tuberculosis, STD/AIDS, etc.). The working of these freely accessible sites has expanded conspicuously since the 1984 drought. One of the main sites is that of Essakan, north-east of Dori, on the border with Niger, where over 10,000 gold panners live.

Gold panning means taking tunnels that follow the vein of gold. Men and young people go down into these long, dark galleries, which are very narrow and have a single opening, to depths of 15 or even 60 metres. The number of people officially allowed to occupy the pits is between 5 and 12, but there tend to be more than 20, hired without a work contract and therefore without any social or health insurance to cover the frequent accidents that take place. These “mole holes” obviously require great physical stamina, the working conditions are hard, involving close confinement and no preventive measures, and there is a permanent risk of a cave-in, since no supporting structures have been installed for safety. The men who go down into these “death traps” are supposed to be at least 20 years old, but there are also many adolescents between 13 and 15 years of age among them.

It was estimated in 1992 that the children working underground amounted to 8-10% of all the workers...
and that the boys and girls under the age of 15 working on the site amounted to 20-25% of the workers, all activities combined.

To cope with the difficult working conditions, most of the young people - nearly 80% of them according to Save the Children - use narcotics and amphetamines that enable them to look for gold for several hours on end. Drug smuggling has been organised with neighbouring countries. A sixty-year old ranch worker living in the area was jailed in 1996 for amphetamine dealing. Since these drugs are expensive (they cost 250 to 500F CFA a dose), and the average consumption is 5 to 7 tablets per day, children often resort to inhaling solvents because they are less expensive and easy to come by: they come in the form of tubes of puncture repair patch glue. This is the same product that is used by youths and children living in and on the streets (2). Smoked drugs are rarely used and if so, they are taken with something else, with no special logic about it, blending “two coloured”, “blue-blue”, “fourteen” and/or “hub-cap” amphetamine tablets with solvents or alcohol.

“My brother went down into the shaft and stayed down, doped up by the tablets he was always taking, and he couldn’t even come back up. He must have had an accident and couldn’t find the strength to come back up. He was always going back down and kept on taking the stuff even when he was back in the village,” says one youth from Dori.

**The prevalence of HIV/AIDS is thought to be as high as 47 to 60% at the gold mine.**

In addition to the diseases such as tuberculosis and silicosis which often result from the poor living and working conditions, three out of every four prospectors are infected with STDs (especially syphils and AIDS), according to the Essakan health services. HIV infection/AIDS are said to have a 47 to 60% prevalence rate on the site. These figures are only rough estimates, since no exact data are available.

No awareness campaigns have ever been launched about the risk of STD/AIDS, and prostitution is very common, although this is not the only channel whereby the disease is transmitted.

Due to their unstable environment characterised by poverty and the complete lack of State involvement, the local inhabitants, especially the young, frequently end up on these prospecting sites which look to them like El Dorado, a promise of fortune. They run many risks, including that of AIDS and drug addiction. In response to the prevalence rate that has by now reached alarming proportions, preventive measures can still be added to the labour laws that all companies are supposed to obey. Or this could be done by enforcing the Convention on children’s rights, which was ratified by Burkina Faso. As well as in the determined strategies of development organisations, which are nevertheless weakened by the fact that they are only drawn up in emergency situations.

The problems raised by the risk of drug addiction and contamination with AIDS show that a host of multiple factors are contributing to the vulnerability of these populations. Work must be done on many lines, focusing on enforcing human rights. Although only the people exposed to the risk of becoming victims have the means of acting to change the factors that put them at risk, help in political form is a prerequisite for success. In Burkina Faso, little help of this kind has been visible so far at the gold mines. Up to now, only a single pilot project undertaken by Save the Children has been implemented to improve the living and working conditions of the children on the gold prospecting sites.

Gerry Stimson has investigated the spread of drug injecting practices which has been occurring in developing countries since the 60s and 70s. The main vectors involved seem to be user migrations and the fast economic and social changes.

During the last five years, drug injecting practices have spread to many parts of the world. By 1999, they had reached 134 countries, as compared with 80 in 1992, and in addition, 103 of these countries declared that they were undergoing a drug-related HIV epidemic linked to drug injection (cf. figure). In some parts of the world, drug injecting has spread extremely fast and is accompanied by contamination with the HIV virus; this has happened in South East Asia, Latin America and Eastern Europe, for example.

Asia is confronted with a major problem in terms of scale, as are the former Soviet Union countries. In China, only one province recorded having drug users who were HIV positive in 1989. By 1999, every province, with only 4 or 5 exceptions, had drug users on their records. There, as in Russia, HIV infection is propagating at an impressively fast rate: it has been transmitted to roughly 70 to 80% of all the drug users.

In Russia, the official figures - which reflect only the results of voluntary testing - put the number of new cases of AIDS in 1999 at 30,000. By 2000, this figure had increased to 80,000. All the big cities in Russia and the Ukraine, Moldavia and Byelorussia are facing the same problem.

How do you account for this explosion of injecting drug practices in Russia?
A number of factors are involved, due to the rapid social changes, the increasing gap between rich and poor and a certain amount of social dislocation. Alcoholism is very prevalent, violent death is on the increase and syphilis is becoming widespread again - it is 80 times more common today than it was ten years ago... In addition to all that, if you look at the development of the drug market and drug trafficking in a context where people don’t really have much of an opportunity to earn money, the lack of a proper infrastructure, the degradation of the health system and the lack of preventive resources, you can see why the situation has become so explosive.

Do you know of any effective harm reduction programmes in the country?
An excellent Médecins sans Frontières programme financed by the George Soros foundation, The Open...
The spread of injection practices through south-eastern Asia

Society Institute, trains dispensary personnel to deal with the problems associated with drug use and finances projects such as setting up needle exchange schemes (cf. the account on p.87). This programme has attracted the attention of the World Bank, which is prepared to lend Russia funds to finance efforts to stop the spread of AIDS and tuberculosis. Another innovative project is being run by Médecins sans Frontières in the prisons, which are perhaps the hardest place to implement public health initiatives! And in St Petersburg, an association known as Renaissance is engaged in a number of harm reduction activities, including outreach projects, needle exchange schemes, health care and detox therapy.

But the real challenge is how to keep up with the epidemic: forty-four countries are currently running syringe exchange programmes, but how many do we need to really make an impact on the HIV epidemic? According to UNAIDS, we need to reach 60% of the target population in order to begin to make an impact. Another essential point is how to prevent sexually transmitted diseases from propagating. When these diseases go untreated, people become more susceptible to HIV infection. If the spread of syphilis continues to go unchecked in Russia, HIV contamination will increase and will be passed on from the drug users to the population at large. This point is normally overlooked, as people often seem to think drug addicts do not have sexual contacts with any but their own kind. Cynical-minded governments tend to imagine that the addicts harm only themselves, and to wonder why public money should be spent on these people, who are not very good citizens to start with.

Is the situation getting worse in Asian countries such as Thailand which have been undergoing this epidemic for a long time?

Thailand was one of the first Asian countries to recognise the reality of the AIDS epidemic in about 1986-1987, but despite the international support received, the government has not been very inclined to develop preventative strategies. The epidemic began in Bangkok, and before long, had spread to both the North and South of the country.

From Northern Thailand it then reached the Chinese province of Yunan and crossed into Myanmar. From there it spread into the State of Manipur in Northern India. Some highly active local groups, such as the Asian Harm Reduction Network, are developing harm reduction programmes in a context where it is not always easy to speak up for Harm reduction measures, and where drug control and police interventions take precedence over public health. In China, for instance, the government is very hard on drug users and drug
traffickers. However, a programme exists in Southern
China, which encourages users to buy clean syringes.
And in south-east Asia, UNAIDS and UNDCP are jointly
holding seminars at which police officers and public
health workers can discuss their common problems.
These are welcome signs of change.

What was the outcome of the Twelfth International
Conference on the Reduction of Drug Related Harm,
which took place in India recently?
The main theme was that of community development
and of harm reduction, and it was also attempted to
broaden the concept of harm reduction to mean not
only providing services (needle exchange, condoms
and treatment) but also taking the social context into
account. In many developing countries, it is impossible
to even start talking about injecting drugs or sexual
behaviour without considering the social situation.
Community development programmes are therefore
tending to focus on providing housing and incomes
rather than introducing harm reduction initiatives per
se. This is an interesting approach, especially in countries
where resources are limited and where the cost of a
methadone* programme or a needle exchange scheme
would be prohibitive in relation to the average
income... It’s more about trying to figure out suitable
ways of reducing harm when there is a complete
shortage of funds.

Does this involve a change of emphasis as compared
with harm reduction programmes proper?
It is more like an alternative method of harm reduction,
which consists of trying to look at the situation
holistically rather than at strictly localised problems. A
number of sessions focused on the issue of advocacy,
or how to convince governments to act before it’s too
late and the epidemic does its worst. Most countries
suffer from what I call the illusion of national immunit:
for one reason or another, they think that drugs or
AIDS have nothing to do with them because they are
Christians, Buddhists or Muslims, communists or
capitalists.

You have stated that harm reduction is based on
individualism and that the “cultural specificities”
aspect of this approach raises questions as to whether
it can be exported to other countries. Can you explain
this idea in greater detail?
I have not yet given this matter a great deal of thought,
but it is certainly interesting to note that harm reduction
is more strongly supported by some countries than by
others. This may be because they see human rights,
individual worth and responsibility and so on in a
different light. In many countries, this depends on
whether there exists a proper public health system, in
terms of both the concept and the infrastructure. One
of the problems arising in Russia, for example, is the
complete lack of organisation which pervades civil
society and the fact that NGOs are so rare. The State
has been providing most of the services required up to
now. Now in my opinion, associative structures are
necessary to be able to create innovative projects.
Harm reduction works well when it starts on the field
before becoming institutionalised. In the long run,
what matters is setting up the right conditions for harm
reduction policies to be able to function efficiently in
each specific case.

SOME PROGRESS ACHIEVED: COULD DO BETTER!

In an article published in 1995, Stimson notes that “all efforts to discourage the spread of drug injecting practices and
to avoid the social and medical costs involved are being undermined by social, structural, economic and political
factors. These factors include over-investment in efforts to reduce the supply rather than trying to reduce the demand
and the risks, the severity of laws targeting drug users and the fact that it is still profitable for drug producing countries
and countries of transit to continue producing and shipping drugs in ever greater quantities. Other factors include the
lack of education, having no access to the media, means of transport and communication, and the stiff competition for
funding which exists between social priorities and medical ones. Then there is the lack of resources allocated to public
health, medicine, health care and harm reduction programmes. Drug users are being marginalized and punished. In addition,
there are illusions of national immunity, and some people are objecting to any attempts made by the public health authorities
to reduce the personal and social cost of drug use”. According to Gerry Stimson, these numerous and often interdependent
factors call for coherent and well thought-out responses.
If there is one field in particular where fate cannot be blamed for what is happening, that field is the prevention of HIV infection among drug abusers. New public health policies based on outreach activities and education, mobilising the drug users themselves and making them feel more responsible have decreased the rates of contamination to a really spectacular extent. Harm reduction has therefore proved its worth, and the scientific studies quoted here show without a shadow of a doubt how effective this approach can be, while also suggesting its limits. Europe was one of the first parts of the world to introduce harm prevention policies. This has not always been an easy task, and the battle is not yet over: the latest challenge is cocaine abuse (mainly by injection), and there exist no substitutes for this substance. The history of drug substitution is outlined here in the case of methadone. Since new policies depend on personal commitment, we have included a first-hand account by a pioneer working on the field in Russia, and there is also a story about life at a centre in New Delhi (India) which provides syringe replacement services and substitution treatment.
From prevention to care: a new approach to drug use

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The AIDS epidemic is gradually changing the public image of drug addicts. After a few hesitations as to how best to prevent the propagation of the virus, it was decided to appeal to people’s sense of responsibility rather than applying coercive measures. Preventive efforts are therefore being based on a pact of solidarity and individual responsibility which benefits society as much as the drug users themselves.

One after another, the countries threatened by the AIDS epidemic have actively developed drug-related harm reduction programmes. This policy is gradually gaining ground throughout the world. It has been adopted in Canada and the United States, as well as in Latin America, in Brazil, Argentina and Chile, in various countries in Eastern Europe such as Russia, Poland, Czechoslovakia and in Asia, it is being applied in India, Thailand, Nepal or Vietnam. But there are obstacles. Handing out sterile syringes, providing substitution treatment and actually involving users in prevention are all forms of action that go against the grain of traditional ideas as to what kinds of interventions are suitable for use with drug users, whether they be preventive, curative or repressive.

Harm reduction has eventually been accepted due to the fact that it has unquestionably obtained results: studies carried out all over the world have shown that whenever drug injectors are encouraged to use sterile equipment, they show lower rates of contamination by the AIDS virus. From cholera to STDs, the great epidemics of the past have all called for coercive measures, from mandatory declaration of the disease to isolating the patients. AIDS has drawn groups which are already stigmatised, such as homosexuals, drug addicts and prostitute, into the torment. The disease has summoned up all sorts of social phobias, age-old taboos about death and sex and rumours about being completely invaded.

Was it going to be necessary to stop upholding the human rights so dearly acquired in the past? But now, instead of the coercive measures that might have been feared, associations fighting AIDS have implemented a new strategy for dealing with the epidemic, based on individual responsibility. This strategy is now recommended by WHO and UNAIDS, because of one simple fact: constraints often lead to concealment. This has proved to be a really effective strategy with homosexuals in America, Europe and Australia. The majority of these people have quickly taken to using condoms or changing their lifestyles by joining up with stable partners.

When the first cases of AIDS were discovered among drug addicts and it was realised that they had been contaminated via the
bloodstream, public health experts tended to panic. And they had every reason to worry. How can one expect people who are so self-destructive to want to protect their own health? However, as early as 1985, one research group observed that New York street addicts were changing their behaviour. Approximately 60% of them had given up sharing syringes. When faced with mortal risks, the users proved to be capable of protecting their own health.

Scientific studies have shown that almost 90% of those undergoing detox cures will probably relapse.

In many countries in the world, the first reaction has consisted of imposing the most seemingly natural and coherent solution, that which provides the best protection, i.e., inciting people to give up drugs. But studies conducted in the United States in the late 1950s showed that a failure rate of almost 90% can be expected among those who undergo detoxification programmes*. This does not mean that heroin dependence is an incurable disease: follow-up studies have shown that most of the heroin addicts studied eventually gave up taking the substance, but that the detoxification process was gradual and spread out over a ten-year period, with the exits occurring at a rate of 5 to 10% per year. In other words, the remaining 90% were doomed to die of a fatal disease if they could not manage to protect their health. If drug users had been the only ones involved, the only option proposed would probably have been “detox or death”, which is in fact the official policy of many countries. But since there was also a risk of heterosexual contamination, something a bit more humane had to be found.

Harm reduction does not mean there will be no treatment available for dependency. The contrary is true in fact, but given the risk of relapses, drug withdrawal programmes are likely to be a suitable solution for only a small minority. On the other hand, many heroin users can benefit from substitution treatment, using methadone or other products. These treatments reduce injection practices, as shown by the AIDS contamination rates among patients undergoing treatment, which were found to be distinctly lower than those occurring among street users (in New York, the rate of contamination among patients undergoing treatment was 11% versus 45-55% among heroin addicts on the streets). Furthermore, patients undergoing treatment are in touch with health care teams, feel less at bay, and are better equipped to take care of their own health. But even in countries with the will and resources to provide the largest possible numbers of drug users with treatment, some addicts are bound to slip through the net. These include the cocaine and amphetamine injectors and the multi-drug addicts, for whom there exist no substitution treatments. And then there are those who have no desire to quit taking drugs. Some will give it up on their own without any treatment, while others will gradually become aware that they need help, and those in the third group may go on taking drugs throughout their lives.

Paradoxically, the countries where drug use is allowed often tend to be those that have the highest percentage of drug users enrolled in treatment programmes: up to 70% in Switzerland, for example. In most countries, access to treatment is not available for all users, and those not undergoing treatment are precisely the most highly exposed users. Those who continue to take drugs must be able to do so with the least possible risk to themselves and to those around them: they must give up injecting or be sure to use sterile equipment, for example.

Despite their dangerous practices, injectors do distinguish between acceptable and unacceptable risks. But they have their own scale of risks, which differs from that adopted by health professionals and epidemiologists. The most immediate risks usually take priority: withdrawal symptoms, overdoses, sub-standard substances, or getting arrested by the police are to be avoided at all costs. It is wishful thinking to expect drug users to magically conform with the conventions that society would like to impose on them, simply because they risk getting AIDS. On the other hand, they might agree to changing one or more of
their ways, if this fits in with their own personal perception of the risks. Harm reduction means being prepared to adapt the message and the tools to the constraints arising in a specific context. It means actually making contact with drug users.

It is not for nothing that cannabis, the most widely used of all drugs, is also the least dangerous.

Handing out syringes, increasing access to substitution treatment and encouraging drug users themselves to play a role in prevention efforts: are these AIDS-imposed measures in conflict with national drug control policies or not? Dr Stimson, one of the English experts who has contributed most to harm reduction, often reminds us that the basic goal of the fight against drugs is to protect health. Agreeing to hand out syringes means recognising that the main priority is to stay alive. AIDS prevention and drug prevention -whether we are dealing with use, abuse or dependency- therefore both subscribe to a single overall objective. One of the beliefs underlying national drug policies is that “normal people” make rational choices, whereas others obstinately endanger their health by adopting forms of behaviour that can only be explained in psychopathological terms. But saying that is to misunderstand the process that leads us to take risks or on the contrary, to protect ourselves from them. Whether we are drug users or not, the decisions we make depend on our perception of the risks involved. In terms of the statistical probabilities, it is a lot more dangerous to ride a motorcycle or a bicycle or even to cross the street than to use cannabis* or even heroin. It is not for nothing that cannabis, which is the most widely used drug, is also the least dangerous. For a drug to become widely used, it has to have the reputation of being harmless. Ecstasy* once had that reputation, but wrongly, as research workers tell us: they are now finding it hard to convince users who have lost all faith in official talk and prefer to base their actions on their own experience. In France, it took twenty years for young people to become aware of the risks associated with heroin abuse and to turn their backs on these practices after seeing what they did to their elders. Nowadays, these young people are more willing to try stimulants such as cocaine*, crack* or synthetic drugs without knowing anything about the risks involved, unlike the American users who, in twenty years, have learned to know them. A prevention policy is absolutely necessary here, but the message needs to be credible, and based on how people perceive the risks. Knowing how the people targeted by prevention messages think, speak and act, regardless of whether or not they are drug users, is to have a real means of communicating, without which there will be no hope of influencing people's behaviour in the very slightest.

By forcing individuals to take the responsibility into their own hands, AIDS has upset the whole way in which society related to drug users and hence to prevention. Jonathan Man, a former Director of WHO, wrote that “By placing the emphasis on behaviour, perceived within its socio-economic context, the new approach will replace coercion by active support, and discrimination by tolerance and diversity”. If one wants to obtain effective changes of behaviour, then one also has to obtain people’s assent. Indifference, rejection and repression generate irresponsible behaviour, but if people’s rights are upheld then we can appeal to their sense of responsibility in a society based on mutual concern for one another. And that appeal has been found to work. The recent debate on the relapses occurring among people exposed to the risk of contamination, who have abandoned safe sexual practices, illustrates this principle. A more indifferent society generates more irresponsible behaviour. Harm reduction policy is based on a social pact that combines solidarity with individual responsibility -and society can benefit from this approach as much as drug users themselves.
Harm reduction first emerged in the 80’s in Amsterdam and Rotterdam (Holland) and in the Merseyside area (England). Some particularly innovative schemes were introduced in the former two cities, where a team of medical and social workers started to collaborate with the drug users themselves - and with the police! In the Merseyside area, the idea was to prescribe injectable opiates and set up syringe replacement schemes, again with the help and support of the police force. These projects certainly yielded results: a very low rate of AIDS infection among the intravenous drug injectors and a decrease in petty crime (1). These two historical examples took the European drug reduction specialists completely by surprise, and many people were quite astounded by the wide range of players involved in these early experiments, which included administrators, political figures at both national and municipal levels, the police force, and the drug users themselves.

In the Southern European States, it was only in the 90’s that harm reduction came into being, in the form of syringe replacement programmes. By now in the year 2001, the idea seems to have become generally accepted. Comparisons between the ways in which the present policies have been introduced in the four most southerly European countries, namely Spain, Italy, Portugal and France, can be highly instructive. Rather than just signalling successful results as reflected in the auspicious epidemiological trends, comparisons of this kind also enable us to pinpoint the weaknesses and gaps which need to be remedied if further progress is to be achieved.

As far as opiate agonist treatment is concerned, the model adopted in France involves the prescription of buprenorphine in heavy doses for drug abusers by general practitioners in the framework of their own practices. France is the only one of these four countries where this is possible: in the other three countries, drug abusers are referred to special services for this purposed. In Spain and Italy, methadone is mainly prescribed. Spain is the only country in Europe where methadone is available at all prisons, and since 1999, the replacement of used needles has also been recommended at prisons. In Portugal, methadone programmes have been less widely applied, although this was the first country to authorise the prescription of methadone, back in 1976. Portugal also pioneered the use of LAAM (2) in 1994 (this substance started to be used in Spain in 1997). Medical prescription of heroin has not yet been legalised in any of these four countries, although bills have been drafted in France and Spain on these lines. The latter
two countries have both developed low-threshold* structures on a large scale: there are 34 drug posts in France and 19 Social Emergency centres in Spain.

MOBILISING CIVIL SOLIDARITY GROUPS: WILL THIS SUFFICE?
The NGO’s and groups of militants play an important part in these countries. However, since the workers in these groups do not have steady jobs, their projects tend to lack continuity, as they depend on whether or not subsidies will continue to be obtained each year. This weakness tends to reflect the fact that the structures in question are not properly integrated into the public health system’s social apparatus.

Thanks to the French Harm Reduction Association (AFR), which brings together a large number of drug users, professionals and supporters, France is way ahead as regards mobilising its civil solidarity resources for the promotion of harm reduction. There exist no movements of this kind in any of the other countries.

The development of an efficient harm reduction system requires a suitable legal framework. Although people have no longer being legally prosecuted in Spain for practising drug abuse in public places since 1992, offenders are still liable to be fined, as in Italy (since 1993) and Portugal (since 2000). Paradoxically, France is the strictest country in this respect, since even simple drug offenders are liable to be sentenced to prison in this country under the 1970 law.

One of the greatest breakthroughs occurred when France and Spain began to use an approach which had already been widely adopted in some English-speaking countries: they have included tobacco-smoking and alcohol in their action plans to combat addiction. This strategy has opened up new perspectives for preventing abuse of all kinds and reducing the harm it does. It has come as a welcome change after struggling in vain for many years to introduce purely preventive measures which not only left the drug abusers themselves completely out of the picture, but also pushed them into choosing between complete abstinence and exclusion from society, which the most vulnerable members of society are often quite incapable of doing.

SELF-SUPPORT SCHEMES MEET WITH ONLY MODERATE SUCCESS.
Drug users’ associative movements have developed strongly in France, where they are to be found in most of the large cities. In Spain, the groups of this kind which exist are mainly in Catalonia; they are not very strongly supported by the authorities or by the NGOs; they are practically non-existent in Italy and Portugal. Whenever drug users have been actually co-operating with field workers, positive and beneficial results have been reported, however, although all attempts to set up joint schemes between local authorities, drug users and administrations have been purely anecdotal.

Only a few groups in France and Spain have been using the so-called drug-testing methods. In Italy, some isolated groups have attended rave parties, giving the participants advice, but this has never been done in Portugal. None of these four countries seem to have adopted any specific large-scale strategies for dealing with these drug abusers. Nor have any preventive educational programmes apparently been developed on the basis of the existing harm reduction theories for use in schools.

The various ways in which harm reduction has developed in these four countries show how flexible these programmes are, since they are able to adapt to various situations and contexts. It seems inappropriate in fact to speak about the type of harm reduction being carried out in a given country, since it is more a question of how various regions and municipalities are tending to adopt practices of one kind or another.

Throughout the history of harm reduction, the need has always been felt to promote a spirit of team-work between those responsible in various places, so as to be able to optimise interventions and pool the empirical and scientific knowledge acquired. This is still an essential objective, not only in the case of developing countries but also between neighbouring countries on the same continent.

PUTTING AN END TO FUTILE CONTROVERSIES
One of the snags which has to be overcome in harm reduction is the persistent tendency to assume that its proponents are against complete abstinence. In our opinion, there is no justification for making such a hard and fast distinction. The experience acquired in many cases has shown that it is perfectly feasible to run services of several kinds, some of which promote abstinence for users who have decided to stop taking drugs, usually after a fairly long trajectory, while others focus more on harm reduction, helping the people who have embarked on this trajectory not to take risks with their health and their lives and those of the people around them.

One of the strong points of harm reduction is that it sustains not only public health but also law and order. We should not forget that one of the effects of substitutive treatment is that it reduces the number of petty crimes committed. It is therefore particularly important to promote the training of specialised community mediators to act as a link between harm reduction programmes, the community, the local authorities and the drug abusers. One of the main priorities on which the effectiveness of these programmes depends consists of taking steps to help the drug abusers frequenting urban centres and to ensure that the local communities support this undertaking.

2 A synthetic opioid agonist with very long-term effects, which can be used as a substitute for heroin at a frequency of only three times a week; whereas methadone has to be taken in daily doses.

Worth consulting:
Observatorio Europeo de la Drogas y las Toxicomanías. Informe Anual de 2000 sobre el problema de la drogodependencia en la Unión Europea. OEDIT. Luxembourg.
Although we have no definite epidemiological proof that syringe exchange programmes are effective, since it is impossible to perform experimental studies here, as in many other public healthcare situations, there is a growing body of evidence that syringe exchange programmes (SEPs)* generally lead to a decrease in the spread of HIV without increasing the consumption of drugs, the injection rates, the number of injectors or the number of used syringes left lying in the streets. Attending an SEP also tends to lead to a decrease in drug-related, as opposed to sex-related, risk behaviour. Some countries, such as Britain, Australia and the Netherlands, have therefore no doubt managed to prevent the occurrence of an HIV epidemic amongst their injecting drug users (IDUs) by introducing SEPs at an early stage, along with other public health measures, while other countries have fared much less well, and have had to cope with thousands of infections because they reacted too slowly (as in the case of France) or too late and without any political support (as in that of the United States and Brazil). However, the positive effects of SEPs must not blind us to their limitations. For instance, SEPs are probably much less effective means of controlling the spread of the hepatitis C and hepatitis B viruses. This is one of the findings which has emerged from the study on the RAVEN (1) cohort, a group of 1238 intravenous drug users with low rates of HIV and hepatitis B infection (0.2% and 5%, respectively) and a surprisingly high rate of hepatitis C infection. The fact that the classical harm reduction measures are not ver effective methods of combating hepatitis C virus is no doubt due to the high prevalence* of this virus, the existence of as yet unexplored paths of transmission (the sharing of injecting paraphernalia other than syringes, for instance) and to the likelihood that this virus may be more resistant to bleach. In addition, SEPs do not operate in a vacuum, and their biological and behavioural effects no doubt depend on a combination of environmental factors. Among the reasons why SEPs have failed to prevent HIV infection, some authors have mentioned the fact that a lack of availability of syringes can have an impact on the effectiveness of these programmes. This was possibly the case, according to Lurie (2), in Montreal in 1994, where the number of syringes distributed by the SEP was woefully insufficient, as was also probably true in Vancouver, where even the two million syringes distributed annually by the SEP were probably did not match the demand for syringes resulting from the upsurge in the use of cocaine, which was being injected anything between 5 and 10 times a day on average when taken intravenously. In their international review (3), Stadhee et al. speak of “social marketing” to illustrate

Some countries have had to cope with thousands of infections because they responded to the challenge too slowly.
the need for SEP directors to accurately predict the number of injections liable to occur and to reach or sensitise all the sub-populations involved (prisoners and IDUs belonging to various social, racial and ethnic minority groups). This is all the more crucial in areas where there is a high prevalence of HIV, as even low rates of needle sharing can lead to high levels of infection (and this is certainly doubt truer still of the hepatitis C virus).

In this context, young users and new injectors are causing great concern to the authors because of the often high levels of HIV (as well as hepatitis C) occurring among these groups (4), where it is difficult to change attitudes and practices. People in the younger age groups do not encounter the problems which make older users consult or contact harm reduction structures, and in addition, do not even think of themselves as drug addicts of feel that the harm reduction messages circulating have anything to do with them.

Apart from matching the supply of syringes to the demand, SEP action cannot effectively prevent the occurrence of some particularly high-risk scenarios. According to Moss and Hahn (5), whenever an HIV epidemic reaches a peak among the IDUs (as occurred in Vancouver), SEPs do not seem to constitute a very useful response in the short term, probably because lack of access to sterile injection paraphernalia is not the only reason for syringe sharing. Several authors have described how some dealers who are rather unscrupulous about their customers’ health propose ready prepared syringes containing a dose of drugs (6).

A somewhat less cynical cause is the sharing out of a batch of drugs in such a way that the drug comes into contact with contaminated syringes, cups, and even the water used to dilute the drugs becomes indirect an indirect source of HIV transmission (and hepatitis C) not associated with needle sharing per se (7). And rarely, but certainly very dangerously, the blood of one IDU at an injecting session is sometimes diluted and used in cooking up a “kitchen sink” opiate solution (8).

As regards the environmental factors which may contribute to reducing or even abolishing the effectiveness of SEPs on the incidence of HIV, a few writers have underlined the importance of the location of the project, which may be affected by the proximity of a red light area or the absence of a local alternative to the SEP (pharmacies or distributors, for example).

Other authors, in greater numbers, have emphasised the high-risk profile of the IDUs attending SEP’s, and have sometimes taken this feature to be a sign of success (in that they attract people whose lifestyle and behaviour mean that they should be given priority access to the syringes they cannot in some cases obtain elsewhere), and sometimes a source of increased risk.

All-round analyses of the factors and conditions limiting the effectiveness of these programmes have pointed to the conclusion that although they may help to prevent HIV, SEPs can only work in a given situation as a possible alternative to other risk reduction strategies based on more community-oriented interventions (peer groups informing other young IDUs and increasing their awareness, for example).

In conclusion, among the complementary actions required in addition to SEPs as they stand, Stadhee et al (3) have stressed the need to prevent injecting practices themselves as far as possible. These authors mention how little scientific attention has focussed on this point (9), an point out that injecting practices expose their practitioners to a significantly higher risk of morbidity and mortality from overdose, endocarditis, septicaemia and abscesses, apart from the risk of viral infection. They argue that the efforts made on SEP lines have been undermined by the lack of available treatments for drug addiction and by the lack of available cocaine substitutes. Tackling the practice of injection involves studying the underlying causes of intravenous drug use and then combating these processes preventively via actions aimed at community rather than individual level. It has been said (3) for example that a lower level of availability or purity of a product may lead users either to take to injecting (as in the closely related case of the crack explosion occurring in the USA: crack constitutes a more economic alternative to powdered cocaine) or to switch to another injectable product (as with injectable buprenorphine in India: this medicinal product is now being misused by many IDUs who are no longer able to procure heroin).

1• Incidence of blood-born viruses in a cohort of Seattle IDUs, H.Hagan, Department of Public Health, Seattle,USA, XIth International conference on AIDS/HIV, Vancouver, 7-12 July 1996.
8• The first Moscow exchange program, Galybin et al, VIIth International Conference on the reduction of drug related harm, Paris 1997.
The Sharan association in India has created a drop-in center in New Delhi that provides syringes, care, and substitution treatment.

Just a stone’s throw away from the Red Fort, by the holy waters of the Yemuna River, lies the Yemuna Bazaar. There are two parks and a huge slum consisting of shacks built with odds and ends, which are mostly roofed over with tarpaulin. Add to that a labyrinth of alleyways, heaps of refuse, stagnant pools of murky water, a perpetual cloud of flies, the dust, and the odour. Thousands of people live here crammed together, including most of the city’s drug addicts. This is where Sharan set up its Drop-In Center (DIC). The objective of this centre is to make basic care, counselling, needle and syringe exchange programmes, drug substitution treatment and condoms available to the drug users who live in the Yamuna Bazar parks under deplorable hygienic conditions.

A PRAGMATIC RESPONSE

This is the only DIC and the only Syringe Exchange Programme (SEP) in New Delhi, where 45% of the users inject themselves with buprenorphine and various pharmaceutical cocktails. The price is 15 rupees ($0.30) for a shot of buprenorphine, as compared to 60 rupees for shot of heroin (plus 4 rupees for syringes that can be purchased over the counter at chemists’ shops or from street vendors). Only 3% of the users are injecting “brown sugar”*. In India, most medicine can be purchased at chemists’ shops without a medical prescription - in exchange for a little bonus, that is. Injectable buprenorphine (0.3 or 0.6 mg) is widely used by the population for analgesic purposes and is prescribed as a matter of routine. A number of local pharmaceutical companies manufacture it in the injectable form, but only two of them produce tablets.

David is an ex-user, like all those working for the association. After spending 14 months in a rehabilitation center, he joined the Sharan team in 1995. David was born in the mountains of Darjeeling to Nepali parents and came to New Delhi at the age of seventeen. After falling in with bad company at school, he plunged into the world of drugs for 14 years, four of which he spent in one of the Yamuna Bazar parks. “I wound up living completely on the streets. I thought I was going to die, just like that, without a penny to my name.” These days, he is the one who takes people round the Drop-In Center, which opened two years ago.

“At first, 130 to 150 people a day were coming to exchange syringes, and 35 to get buprenorphine,” he says. “Nowadays, 115 come to get oral substitution drugs, and only 30-35 to exchange syringes. The reason why the numbers have gone down from 150 customers for the SEP to 30-35 today is that they have switched to the oral substitution drug and aren’t injecting any longer. They have become rehabilitated, are working, and have gone back to their families.” The Drop-In Center can count that as one of its success stories.

At Sharan, they like to call the DIC “the Outpost”. The first of its three small rooms built of masonry (none of
which are any larger than 2 x 4 metres) is set a bit apart and is used to dispense basic care (antibiotics, paracetamol, oral rehydration salts, anti-diarrhoea medication, etc.). A table, a chair, a washbasin, and an examining table are the only furniture it contains.

**Case by case**
A bit farther away at the Bupre Counter, Kush is waiting for the next “customers”. The only furniture there is a table, on which there is a fan and boxes of Addnok® (buprenorphine)+, in 0.2, 0.4, and 2 mg doses. “The dose depends on the individual,” explains Kush. “When someone new arrives, we explain how the programme works, making it very clear that we’re not an abstinence center, and that we do only harm reduction. Then we send the visitors to the doctor, who helps them to assess their needs and prescribes a dose: 2 to 4 mg on the average.” Each patient has a green card marked with a two-week prescription. At the end of that period, the patient must return to see the doctor. “There are no specific dosage or time limits, but we do try to get them to cut down...” - or even to kick the habit.

Dinesh arrives with his green card. Kush counts out the tablets, places them in a bag, and crushes them up. He hands bag and its contents to Dinesh, who immediately swallows the powder. Dinesh must stay in the room at least five minutes so that Kush can check that he doesn’t spit the powder out to be injected later. Kush explains, “They used to carry off the tablets to shoot them up, and we had big problems with abscesses.” For a long time, the only dose available was 0.2 mg, and that meant handing over 10 to 20 tablets at once.

**A success story from the public health point of view**
“Two years ago, we were treating up to 80 abscesses a day,” remembers David. By now the number has dropped to 20-25 a day: another achievement for the association, which receives no aid from the government. “The only aid we get is from the European Community to finance the purchase of buprenorphine.”

Aren’t the patients being underdosed? The only argument Kush has to explain the difference in comparison with the average daily dose of 8 mg prescribed in France is this: “You come from a country with national health insurance, where there is plenty of treatment and medicinal products. Here we have nothing. So nobody is complaining about underdosing. When some customers leave, they always wind up coming back, because apart from the Rehab Centers, it’s the best we can do for them in this part of the world.”

In the SEP room directly opposite, exchange is on a voluntary basis, and some do bring back their used syringes. The receptacle, a metal box with a hole cut in the top, sits by the table. In one corner, a gloved nurse dispenses topical treatment and hands out antibiotics to those with abscesses, which are lanced by the doctor when he calls in at the centre three times a week. “Some users shoot directly into the abscess.” The five minutes required for his buprenorphine to be swallowed down are hardly up before Dinesh crosses the narrow alley to pick up his syringes (no comment). A few steps away, a group of twenty or so “customers” are chatting and whiling away the time. This is quite a gathering-place, and Sharan is beginning to organise regular meetings. “We give them information about safer shooting practices,” says David, “and about STM’s, HIV and basic hygiene.”

Not far from the centre, the funeral pyres where the Hindi come to burn their dead (an average 50 to 60 a day) line the riverbanks. The bodies of drug users are thrown directly into the water, however, because there is no money to pay for the wood required to incinerate them.
Drug users forming organised self-support groups have become responsible for keeping themselves healthy and act as spokesmen in discussions with the authorities. These groups, which are mostly to be found in Europe, are still unstable, however, and waver between innovation and institutionalisation.

Drug users’ self-support groups, where drug prevention policies are promoted and efforts are made to prevent drug users from being stigmatised and liable to be prosecuted, developed with the advent of AIDS. These groups sometimes call themselves “Junkie Unions”, after the Dutch Rotterdam “Junkiebond”. The fight against the AIDS epidemic enabled these groups to develop, since the proponents of drug prevention no longer treated drug users like sick people or criminals but like responsible, independent citizens.

Studies on the first efforts to make syringes available have shown how fast attitudes have changed, since the image of the irresponsible, suicidal drug addict is no longer up to date. Drug users can adopt a responsible attitude and pay attention to their health when given the means.

Along with this new responsibility goes the self-reliance resulting from the fact that substitute products and programmes are now available. Reports in which methadone programmes have been assessed point to a decrease in petty crime and heroin consumption, as well as an improvement in the state of health of those attending them. Under substitution treatment, drug users become ex-users whose lifestyle is less and less focused on the daily search for the addictive product. Well managed substitution does away with the constraints associated with procuring drugs, and the user has more spare time to acquire some kind of autonomy. Abdalla Toufik, one of the founders of the French self-support group ASUD, makes a parallel between the development of substitution and self-support to explain the disparity between Northern and Southern Europe. The liveliness of self-support groups in the Netherlands, Germany and Great Britain might be partly due to the fact that methadone is more accessible in these three countries.

Self-support groups seek to speak for themselves and object when professionals speak on behalf of the drug users. One of their demands is to have a saying in the matters which concern them so that they can express their opinions about drug policies and AIDS prevention.

The Netherlands, one of the most tolerant countries as far as drug use and users are concerned, became the cradle of self-support groups when the “Junkieborden” were created in the early 1980s, followed a few years later by the “Junkies-Ex-Junkies-Substitutes” (JES) in Germany.
The harm reduction programmes made it possible to evolve from a “culture of survival” to a “culture of progress”.

These groups are much less frequent in the United States and the Southern European countries, however. One of the explanations put forward to explain this difference was based on the opposition between a culture of progress and a culture of survival. In the United States, users surrounded by a culture of survival form a particularly sorely oppressed group, which is both stigmatised socially and liable to legal prosecution. They develop a very negative self-image, which makes it difficult to build any kind of collective sense of identity and virtually impossible to undertake collective political action of any kind.

In France, the harm reduction programmes adopted in the early 90s made it possible to evolve from a “culture of survival” to a “culture of progress” and to create the Self-Support Drug Users group (ASUD), which has become one of the international emblems of self-support. The association has developed greatly in the provinces, sometimes with help from the State. These groups are still shaky, however, and the list of provincial self-support groups varies from one month to the next.

In Germany, JES groups still exist and these are also funded by the authorities. In the Netherlands, however, the “Junkiebonden” period is over and the movement has declined, a victim of its own success in the late 1980s. During that time, risk reduction programmes were being developed and their leaders came from institutional teams. Nowadays, there is the LSD-Project in the Netherlands, which is not as large as the “Junkiebonden”, JES or ASUD. The LSD-Project is a government project that pays a few drug users with a view to initiating self-support plans throughout the country and holding an annual international gathering of drug users.

It is not enough just to say that one has the right to exist when one is a drug user.

As early as the 1980s, drug users’ self-support groups acquired the reputation of being experts on hepatitis and AIDS prevention, given their inside knowledge of current practices. They put their laymen’s expertise to work in the framework of outreach projects, peer support, and the publication of magazines and prevention literature. They took part in local and national commissions, events and symposia, making the users’ point of view heard and defending their fellow “citizen users”.

It is not enough just to say that one has the right to exist when one is a drug user. Self-support groups can only acquire a proper status by collaborating with and being funded by the authorities. Some groups make use of their experience and knowledge (which helps to adapt preventive methods to the people who use drugs), while others rely purely on the status they have been given. These joint efforts give self-support groups an opportunity of practising a form of lobbying, since they express the needs of drug users by making demands on the authorities.

Self-support groups often disappear as quickly as they emerged. They constitute a transient phenomenon that involves only a few dozen users per country, but their very existence is noteworthy because the illegality of using drugs ought to make it impossible for them to exist.

One of the reasons why these groups are so unstable is that it is difficult to recruit activists and keep them. Those who agree to proclaim that they are users and become involved in these groups are activists, and most of them are voluntary workers. If harm reduction structures offer to pay them to carry out similar work elsewhere, they naturally drop their activist efforts. In addition, the fate of these groups depends strongly on that of their leaders, so that if the leader leaves the group, the group is liable to disappear.

Self-support groups also risk becoming victims of bureaucracy and institutionalisation or being manipulated via public funding, i.e., they will tend to speak out less strongly and to adopt less innovative practices in order to secure funding. There is a great deal of ambiguity about self-support, and drug users who become professional workers are in a position where there is much interplay between the forces of innovation and institutionalisation.

A prevention brochure drawn up with the help of drug users.
My name is Anya Sarang and I have been working for MSF since 1998. I am a senior trainer in harm reduction for MSF’s Russian Harm Reduction Initiative. We are running harm reduction training sessions in the framework of regional harm reduction programmes. In 1998-2000, these sessions catered mainly for health service workers - specialists in the fields of drugs, infectious diseases and those who work with drug users- and members of NGOs. The aim was to transmit the knowledge gained from experience in Europe and to teach rapid assessment methods for use on local situations. Representatives of 60 regions attended these sessions. After this, we organized a new training course designed with a view to getting something more concrete done. This made the participants attending eligible to obtain funding from the Otkrytoe Obshestvo (Open Society - Soros Fund) to implement local programmes. By now there are 36 projects being completely funded in this way, and 10 others are supported partly by this fund and partly by federal or local subsidies.

The rapid assessment procedures involved making immediate contact with drug users and rating their awareness of HIV/AIDS. In exchange, thanks to these methods (based on surveys, interviews, focus groups, etc.), the users quickly gained some knowledge about risky practices and learned how risks can be avoided. Statistical information was collected during a period of two months on the number of cases of HIV and the number of registered addicts, the number of drug seizures by the police, and so on.

One of the most difficult problems is how to make contact with drug users on the streets. There are several possible approaches, but this was mainly done via users who are in touch with the public health system. When they are about to leave hospital, for instance, we persuade them to work with us, which incidentally isn’t always easy. Now things have changed. We have outreach experience, meaning peer contact. If we succeed in persuading a single user to work with us as an outreach worker, he will then persuade five others to become volunteers and so it continues.
We quickly realised that users had quite a high level of theoretical knowledge about HIV/AIDS, but that these same users were highly unaware of the risks they were often taking. It should also be pointed out that the virus had not yet spread very extensively at that time. In the regions where HIV was spreading at faster rates, the work was easier because people were aware of the issues involved.

The first steps are always the hardest. This is due to the attendants’ suspicions. From their point of view, any contact with the medical establishment, at whatever level, was thought to constitute a potential risk, as it showed them up as drug users, and if the session was being recorded, they might become known to the police and have to deal with all the problems that can entail. The questions are most frequently asked are “So where are the hidden cameras? Aren’t you going to take our names? What are you going to do with this information afterwards?” And when they realise that nothing unpleasant is going to happen, they ask “What’s all this about if you’re not going to lock us up?”

In Novorossisk, the programme had been running for a long time, but only three people on average were coming each week to exchange their syringes!

One of the conditions for obtaining funding from Otkrytoe Obshestvo (Open Society) is to submit a letter of support from the local branch of the Ministry of the Interior (UVD). These programmes obviously wish to avoid interference from the militia and experience has proved that this is the most effective solution. There were problems at Laroslav and St Petersburg, but these were the first two programmes launched and we had not conducted our rapid assessments or discussed matters with h, who lined up beside the bus and stamped on the sterile syringes we had brought. Of course, there have been various difficulties pretty much everywhere. We’ve had patrols giving chase to a drug user they spotted near one of our centres and so on. But by contacting the higher ranks, we were able to solve the problem. In addition, we give those who attend membership cards, on which the aims of the project are listed and that means they don’t get into trouble with the militia.

A perfect example of how it works is what happened in Novorossisk. We had a programme down there for a long time but only three people a week on average were coming to exchange their syringes! However, we had the support of the local council who asked the militia not to interfere. One day, when a drug user was stopped with syringes on him, he showed his card proving membership of the programme and the militiaman saluted him and let him go. The news spread - information gets around fast in user circles- and the exchange point suddenly became a lot busier. It’s only in Moscow that the local authorities refuse to listen, which means it is the only town where SEPs are still unable to operate. There have even been problems there when our project workers have been stopped in the street themselves.

One of the main weaknesses of these programmes is that their scope is fairly narrow. They operate from hospital annexes, which are not necessarily places where drug users tend to congregate. This failing is somewhat compensated for by mobile services using buses and minibuses, which circulate in towns such as Volgograd, Nijni Novgorod, Saint Petersburg and Kazan, where the users tend to assemble out of doors. But in many other towns, the trafficking and sale of drugs take place inside people’s flats. We have to find ways of getting brochures and condoms and so on delivered to these places. That is where outreach workers take over, going from one sales point to another with bagsful of stuff. But as there are relatively few of these workers, it is difficult to really cover these areas. One method is to use volunteers who have lots of contacts among drug users, such as drug dealers, as syringe exchange workers.

Lately, the only negative media coverage we have received has been about the idea of introducing methadone maintenance programmes, which in any case are non-existent so far. In 1998, the media were horrified: “What? You’re going to give free syringes to those anti-social individuals? When our hospitals are short of syringes, and our old folk have no medicines?” By now syringe exchange has acquired quite a favourable reputation. But the fact that the exchange of syringes has become almost synonymous with harm reduction during the last two years is not at all satisfactory. Now I think it is time to introduce new strategies, especially for informing people. Many regions would like to receive our brochures (1), but they do not have the necessary funds for reprinting them, and they are really delighted if we can send them ten copies of the Mozg magazine for the population of a whole town to read.

When we began our work, we had more funds, and we had a psychologist and even a lawyer at every user contact point. The possibility of consulting professionals like these is often important for users. If we had more money, we would be able to strengthen our teams by hiring more social workers, setting up more centres and providing more syringes and more condoms etc.

“So where are the hidden video cameras? Aren’t you going to take our names? What are you going to do with this information afterwards.”

“You mean you are going to give free syringes to those anti-social individuals?”
But all these programmes are hampered by a lack of financial means. You cannot do everything. Some groups choose to work with opium addicts, others with Vint injected, and so on. In Moscow, the "Bus" association decided to start by working among the students, who are fairly easy to approach. In Pskov, there was a girl who had close connections with the gypsy community, which is involved in the sale as well as the consumption of drugs. Thanks to her, we were able to gain access to this group. Currently we are concentrating on women working in the sex industry, as many of them are drug users as well as prostitutes, and the risks they run are therefore two-fold.

Looking back, you cannot say that we have laboured in vain. At the very least, we have reached a stage where people are not completely taken aback when we mention the need to replace used needles. That has become standard practice by now. The fact remains, however, that we have been unable to stop the spread of the HIV virus in many places. This is not really surprising when you consider the actual scale of our projects, in which only 1000 people are involved on average. The main disappointment is the weakness of State action, particularly the lack of co-ordination between the Health departments and those of the Ministry of the Interior. It's because the position of the Ministry of the Interior is, how can I put it...Locally, we feel we have gained their support, but the positions adopted at Federal level are inscrutable. And the Federal Spid-Tsentr (AIDS centres) and the Ministry of Health have played very little part in our activities. They have contented themselves with giving us tacit support and attending our training sessions. In this country today, apart from our project workers and those with whom they come into contact, few people know that the HIV epidemic is developing at a speed which is matched nowhere else in the world.

I have never wondered why I am doing this job. I have tried unsuccessfully on a few occasions to put it into words. Everybody has his or her own reasons, I suppose. A woman from Kazan once described her own motives for being involved in very strong terms. When asked, "What has all this drugs stuff got to do with you, anyway?", she answered "We live in a society where the rights of any individual cannot only be swept away at any instant, but carry no weight. And as far as that goes I am no different from a drug addict. We are all citizens of the same country and in those terms, we all in the same boat. By defending the rights of drug addicts from the medical point of view, I am also asserting my own rights".

Several NGOs, including Médecins Sans Frontières (MSF) and Médecins Du Monde (MDM), are actively involved in Russia, where they are initiating and implementing many harm reduction projects. The syringe exchange programmes include the Bus programme launched jointly by Médecins du Monde and the “Return” Foundation on January 1, 1997 in Saint Petersburg. During the first two years, 6,500 drug abusers with a mean age of 21.7 years benefited regularly from the services available on this bus. A total number of 80,000 visits were recorded at the 5 points of call: 170,000 syringes were exchanged, and 3,500 medical and psychological consultations were given by the members of the crew. By now, approximately 2,500 people a year are applying to the bus to undergo HIV screening tests. The example of this Bus shows that it is possible to set up links with the drug users' community in Russia. The programme for 2001 also reflects the need expressed by many NGOs to reinforce partnerships with municipal and national institutions, in order to anchor the mission of the Bus to local structures, and in view of the successful results obtained, to apply interventions on similar lines in other regions where there are high rates of HIV infection.

The Rapid Assessment method is a tool which can be used for mobilisation and survey purposes. It provides a fast diagnosis of epidemiological situations, the practices involved and the services available by compiling reports, qualitative information, published data and other documents with a view to defining appropriate interventions. It takes less than one month to apply and is thought to constitute a valid alternative to the methods classically used to assess public health requirements. This method is sponsored by international organizations (UNAIDS and WHO), and is particularly useful in countries and regions where no interventions have been carried out so far in the field of drugs and/or HIV infection. It enables those working on the field to define their objectives and orient their interventions as accurately as possible.

The Rapid Assessment method can be downloaded from the following site: www.who.int/substanceabuse/pages/docs.html

1• The newsletter published by the Moscow branch of MSF is available at the following website: www.ihra.net
While substitution treatments have long proved to be effective, they have also shown their limitations. This is the story of methadone, a synthetic substance with undeniably useful properties for treating drug users.

Substitution treatment for heroin addicts with methadone was widely adopted in the USA some forty years ago after psychotherapy and short-term severance cures had proved to be ineffective. In 1962, Professor Vincent Dole, a specialist in metabolic disease at the Rockefeller University, New York, successfully tested methadone, a substance first synthesised by the Germans during the Second World War as a substitute for morphine, which was in short supply at that time.

The first clinical trials were remarkably successful and methadone cures spread throughout the United States. By the end of the 1980s, 180,000 people were on a methadone treatment programme. However, it was noted with some disappointment that the psychological stability and quality of life of many patients deteriorated seriously when they stopped taking methadone. Many relapses occurred, where patients reverted to their former patterns of abuse.

Without yet knowing much about the neurobiological basis of addiction, Dole and his collaborators believed that they were probably dealing with brain dysfunction due to prior opiate abuse and that the answer was to prescribe long-term corrective medication, namely methadone.

In Europe, substitution treatments were long frowned upon because they were thought to involve the prescription of yet another drug, and it was feared that treatments of this kind might be used tools to control people’s minds or constitute a kind of “chemical lobotomy”. The media-peddled image of methadone as synthetic heroin gave the public the false idea that taking methadone is pleasurable, and this triggered all sorts of contradictory feelings about its acceptability as a therapeutic tool. Doctors were long viewed as partners to crime and were therefore accused of being white-coated dealers, and some were even imprisoned, especially in Belgium.

A number of factors have led during the last few years to a radical change in thinking and to an increasingly medical approach being adopted to the treatment of dependency. As long as drug addicts were harming and destroying only themselves, people took no great interest in them. By contrast, when it was discovered that many of them were infected with the HIV virus and that they were transmitting AIDS to the population at large, much greater interest was shown in developing more efficient strategies for helping these populations.
Once their drugs have been withdrawn, drug abusers become hypersensitive and depressed and try to calm their psychological symptoms by taking drugs again.

The fact that short to medium term drug withdrawal cures often failed, despite psycho-social support and the often desperate efforts of the patients to succeed, also favoured the development of medically based strategies for dealing with drug addiction. It should be noted that the results of numerous studies on ex-heroin addicts have shown that the majority of them relapse into addiction or their quality of life degenerates, sometimes to a debilitating degree, which makes them turn to alcohol, tranquillisers or cocaine.

Short methadone treatments lasting only a few weeks or a few months have also proved to be ineffective, leading to the use of other drug substitutes.

One explanation for the habitual relapses which occurred after severance cures from opiates or opiate substitutes is that a long-term dysfunction of the body's stress management system has occurred. All opioids are powerful anti-stress medicines, and Mary Jeanne Kreek has established that giving up opiates generates an abnormally high sensitivity to stress. The link between stress and depression is well known. The withdrawing addict becomes hypersensitive and depressed, and will attempt to calm his psychological sufferings by turning back to drugs. However, a single dose of heroin or cocaine can immediately rekindle an obsessive craving and trigger a relapse into addiction.

In appropriate doses, methadone does not induce either euphoria or sedation in heroin addicts because of their acquired tolerance to opiates, and because the product is slowly absorbed when taken orally. A group of patients on methadone were once subjected to psychomotor tests designed for airline pilots, and they performed better than the control group because they were less nervous. If the dosage is sufficiently high, a single daily dose suffices for the methadone to bind stably to the endorphin receptors in the brain.

In addition to its stabilising effects on the opioid systems, methadone acts on neurotransmitters such as serotonin, and especially dopamine. Sufficiently high levels of these neuro-hormones are necessary to maintain a stable mood and a feeling of well being. Most drugs of abuse (cocaine, heroin, alcohol, hashish, nicotine, etc) increase the dopamine levels in specific regions of the brain, although they do so in different ways. In short, apart from reducing the craving for heroin, methadone also has remarkably stabilising effects in psychiatric terms and few side effects. These truly therapeutic medical effects therefore play a more important overall role than the strictly substitutive aspects.

Methadone, even when taken in high doses for decades, does not cause any medical complications, unlike many other more “ordinary” medicines.

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Methadone programmes (in which prescription of the substitute drug is combined with psychological and social counselling) are particularly remarkable in that they reduce delinquency and practically abolish heroin use if the dose of methadone is adapted to individual needs. The severity of the drug abusers’ psychological symptoms is the main factor on which the outcome depends.

One can, of course, hardly expect a medicinal product to resolve social and professional problems or cure affective disorders: these require the attention of social workers and psychologists. In the absence of any such attention, when the anxiety symptoms re-appear and when tolerance has developed to the substitute drug, thus blocking any effect heroin might possibly have, these patients are in danger of resorting to alcohol, benzo-diazepines or cocaine in order to calm these symptoms, which they often find intolerable.

In terms of public health, the large-scale prescription of methadone to heroin addicts spectacularly reduces the incidence of overdose, delinquency, medical complications, the risk of AIDS and the financial costs involved in providing social care. When the availability of treatment reaches a sufficiently high level, the heroin trade collapses and, as a consequence, the number of new addicts decreases. This process has been observed in Geneva.

The public authorities have considerable financial advantages to gain from supporting and developing substitution programmes, as they can dramatically reduce the exorbitant medical, and social costs associated with drugs, as well as the legal and judicial costs.

Although costly psycho-social support mechanisms can be extremely useful, and even essential, those countries which are less well off can still make rapid progress in combating heroin addiction by
organising the prescription of a single but rigorously monitored daily dose of methadone for those addicts who need it, for as long as may be necessary for the treatment to be effective. Part of the savings resulting from a policy of this kind can later be used to further fund the therapeutic programmes and enable them to expand their psychological and social counselling facilities.

Some subjects are thought to have a genetic deficit as the result of which a specific endorphine fails to function properly.

All the data available unfortunately confirm that only a minority of all drug addicts are able to successfully give up taking their substitute medication in the long term. It must be understood that for many young people, taking heroin has been a form of self-medication, a means of relieving underlying psychological suffering. To put it differently, why is it that some people are more receptive to drugs and become drug addicts more easily, while others can take drugs occasionally and never become dependent? Most of the American soldiers who became hooked on opiates in Vietnam were able, without too much difficulty, to give them up without relapsing once they had gone back to their country and their families, although others remained prisoners of heroin or were psychologically handicapped as the result of taking it.

Some new hypotheses have been put forward in the field of genetics. Some people at birth have a genetic deficit, as the result of which a particular endorphin or one of the other chemical neurotransmitters manufactured in the brain does not function properly. This deficit might result in a form of depression which remains hidden during infancy, problems in relating to others, introversion, intellectual impairment, difficulty in concentrating or behavioural problems. Adolescents who experience psychiatric problems, borderline depression, psychosis or obsessive/compulsive disorders, for example, feel much better mentally, at least to begin with, when they take heroin and they are tempted thereafter to try and prolong the sense of calm it brings them.

For thirty years now, substitution treatments have proved to be effective. They have allowed a considerable number of drug addicts to avoid physical and moral deterioration and early death by restoring their long-term stability and a decent, good and sometimes excellent quality of life. On the other hand, the cessation of the treatment even after a considerable period of time has frequently impaired the quality of life and led to psychological problems and a lapse into alcohol or drug addiction, particularly among those patients who suffer from an underlying psychiatric disorder in addition to drug addiction. In the case of many of these patients, drug consumption must be understood as an attempt to self-medicate in the hope of dealing with a psychological problem. And it seems to be increasingly likely that problems of this kind are due to functional genetic and neurobiological deficits. The drug substitute thus corrects this biological defect, which is equivalent to a chronic illness. With these patients, substitution treatment is a medical treatment which compensates for the natural imbalance. It has to be maintained indefinitely, just as insulin is prescribed for diabetics and anti-epileptic drugs for those prone to seizures.

It is vital therefore to make a full diagnosis in order to identify the medical, psychological, affective, social, familial and professional problems involved, whether they are pre-existent or secondary factors with respect to drug addiction, and to propose accurately targeted therapeutic responses to these problems. A diagnosis of this kind will also indicate whether a complete end to chemical dependency can be envisaged. In conclusion, the most important message is that all drug addicts should be able to have immediate access to a form of therapy (or forms of therapy, if necessary) which are appropriate to their needs. This will enable them to rapidly recover their medical, psychological and social equilibrium and maintain a satisfactory quality of life for a long time to come, with or without substitute medication.
In Rocinha, the largest favela in South America, which is in the very heart of Rio de Janeiro, harm reduction programme workers have to hide from the drug traffickers.

Early on in our harm reduction work in the favela of Rocinha, we were very surprised to hear the chairman of the local residents’ association say that they had no drug users who injected their drugs. We went to see the physician at the local clinic. He informed us that there were in fact some IDUs in the favela, but that they had to hide. He did not object to our work and we carried out our prevention programme, handing out syringes and condoms secretly to people who had come for basic health care. On the other hand, the present doctor does not want to attract any problems and refuses to let us work there. So we have had to make door to door visits, trying to make ourselves known by introducing ourselves to the inhabitants.

Rocinha, Rio’s largest favela (600,000 inhabitants), which is located in the very heart of Rio near the affluent neighbourhoods, has a rather special status. Harm reduction programmes are frowned on there, whereas they are accepted in the favelas on the city’s outskirts. In the latter, vans proposing vaccination, basic health care, testing, syringes and condoms, can circulate quite openly because their purpose has been clearly understood. But in Rocinha, we have to keep a very low profile, for it is essential that we keep the identity of the IDUs secret, to protect them from being discriminated against within the community, and from attracting the wrath of the drug dealers themselves. In Rio de Janeiro, they have an iron grip on the market. They have a monopoly on cocaine dealing and have split up the territory of Rio’s favelas among themselves. Drug dealers do not allow cocaine to be taken in other ways than by inhaling it. When injected, it has effects that are similar to those of crack, which are uncontrollable and therefore harmful to the way the micro-society of the favelas is organised. Injection practices, like the taking of crack, are therefore unofficially prohibited in Rio, whereas neither of these practices is forbidden in any of the other large Brazilian cities. In addition, injection is associated with the idea of AIDS contamination. In Rocinha, the residents proclaim to all and sundry, “Here we have untainted blood”.

Paulo Telles
Psychiatrist in charge of the harm reduction project in the favela of Rocinha (Rio de Janeiro).
Harm reduction and the cocaine challenge

The increasing use of narcotics in Europe is raising new public health issues in which harm reduction is directly involved. The extremely wide range of cocaine-using audiences mean that programmes focusing on heroin addicts need to be thought back through. This is a difficult issue to handle. But the battle might turn out to be a crucial one.

No other product of abuse illustrates the famous slogan “drug, set and setting” (meaning the product, the personality and the context) better than cocaine. The substance itself is surely the only common factor between the golden boy given to recreational bouts of sniffing the “champagne of all drugs” and the outcast crack addict with his craving and his compulsive, self-destructive habitual use of the smokable variety.

For a long time, cocaine had quite a positive image (it reputedly made users more dynamic, enhanced performance and favoured success) and was consumed by an in-crowd (show business and media circles) or else it was the second choice of drug among addicts whose main problem was making sure they had enough heroin. In both cases, cocaine consumption was virtually invisible and was not really thought to constitute a breach of the narcotics laws. Its socially integrated users did not run up against selective control by the police, the judicial system or health authorities. They had discreet access to the product, and cocaine sniffing raised very few problems because the users were said to be in control of their own use. This was not the case with heroin addicts: their abuse of heroin, with its burden of physical dependency and criminal status, set them apart.

That is precisely what has changed in Europe since the mid nineteen nineties. At roughly the same time, the American craze (which began in the early eighties) reached its apex - with ten million regular consumers - and started to wane.
Belatedly, a new wave of widespread cocaine consumption has swept over Europe, involving four main audiences. These developments can be roughly summarised as follows. In the wake of the AIDS epidemic and the widespread development of methods of treatment based on heroin substitutes, some heroin injectors who were unable to get along without syringes and the strong sensations they induce became heavy cocaine users. With this first audience came the crack (smokable cocaine) epidemics, which up to then had been restricted to some socially precarious groups (such as street prostitutes) or ones with strongly ethnic backgrounds (Africans and West Indians). Some of these users later became hooked on heroin, which they took in order to handle coming off cocaine during the period immediately following the withdrawal of the drug, which is one of intense anxiety and deep depression. These groups were quantitatively quite insignificant, although this could not be said of their levels of consumption, and it is in this context that harm reduction and efforts to prevent the damage resulting from drug use ran into some unusual problems.

The use of cocaine actually developed most strongly among two much larger audiences. The first consisted of young people who liked to attend rave party or tekival-type festivities, as well as night clubs, discotheques and private parties. Cocaine, which was usually sniffed, had fairly logically been added to the list of popular stimulants such as ecstasy or amphetamines* and hallucinogens* such as LSD. So it was in an environment where many different kinds of drugs were being commonly used that the use of cocaine developed, and this drug was all the more popular since tobacco, cannabis* and alcohol had become too commonplace. In addition, the social profile of the young people attending these events had changed: along with the socially integrated smokers (such as high school and university students and young workers), another much less socially integrated group appeared, especially at free parties. These included young vagabonds and youths from the poorer city outskirts, whose drug-taking habits were far more chaotic and out of control. Cocaine consumption is also developing nowadays among the middle classes, but very little is known so far about this invisible audience.

The way the drug is taken plays an essential role. Injected cocaine produces a short but intense flash and the rate at which the injections are performed can become staggeringly high: one hit every thirty minutes until there is no product left. The user’s veins quickly become severely damaged. Transmission of the hepatitis viruses (HBV and HCV) as well as HIV is facilitated. Many studies have shown the existence of a high prevalence* of viruses transmitted via the blood among cocaine injectors. In addition, sniffed cocaine and smoked crack can increase the risk of HCV transmission when users are sharing the same “sniffer” (a straw or a rolled up piece of cardboard) or crack pipe. Lastly, unprotected sexual intercourse, especially among crack users involved in prostitution, favours HIV transmission.

There exist no substitutes for cocaine, and the compulsive craving it arouses often makes health workers feel as if they are having to fight it with their bare hands.

Overdoses of injecting cocaine and the ensuing complications (convulsions, heart attack) are the main causes of drug-related emergency hospitalisation in the United States. These cases are on the rise in Europe, although they are still unfamiliar to medical staff. Cocaine abuse also causes serious psychiatric disorders: hallucinations, paranoid states and violence. These consequences are all the more frequent when the context of drug use itself is problematic and disturbing, or at least disturbs the peace and quiet of those who inhabit the places where open practices have developed.

Now it so happens that although much intensive research which has been carried out, no substitution therapy is yet available for cocaine abusers. There is no such thing as “cocadone”, and the compulsive craving cocaine arouses sometimes gives care-givers the desperate feeling of having to fight this uncontrollable urge with their bare hands. Users themselves, including those who are in contact with the health care system, avoid talking about their cocaine intake, either because they are afraid of not being admitted to a methadone programme, for example, or because they feel that nothing can be done to help them. Some go so far as to say that simply mentioning cocaine to the health providers causes the desperate craving for it to surge up again.

Viral contamination, overdoses, psychiatric complications and social exclusion: these are the problems that harm reduction has to deal with. Let us stress a few main points. Teams working in syringe exchange programmes have to know how cocaine injectors consume the product, and be aware that re-using injection equipment is the rule, that cocaine is often consumed in a group setting and that sharing syringes is often involuntary (people think they are re-using their own syringe, but in fact it has been switched with that of a neighbour). Within this framework, it is rather pointless proclaim the single preventive message: “one injection, one syringe” as can be done with heroin. On the other hand, anything that can help the users to avoid involuntary sharing must be encouraged, including tattooing the syringes, which some users already do spontaneously. On the same lines, distributing straws and information about the harms of HCV transmission via the sharing of straws must feature among the tools used by drug prevention teams.
working at festive events. European health structures, which have long focused on providing care for heroin addicts, are cruelly short of places that would give users in danger a place of shelter. We need fewer post-cures with their long waiting periods, and more places where people could be sent out to the country quickly for short periods to help them to get over their craving and breathe freely (places where they can sleep, eat and get a foothold in reality again). Apart from the inevitable relapses into the habit, time must be allowed to help the process of growth which will one day enable the users to stop.

When they take their first sniff of cocaine, users often have the feeling that this drug is quite harmless.

Lastly, the prevention of cocaine use needs to be thought through again. The task awaiting harm reduction, which is at the cross-roads between those who demonise drug users and those who apologise for them, consists of telling the truth about the drugs themselves so that people who are not yet users can compare their first experience of cocaine with what they have been told about it. When users first sniff cocaine, they often find it rather harmless, and are even a little disappointed at not experiencing any of the spectacular effects they had imagined. That is why it is necessary, even more than with other drugs, to stress the difference between use and abuse, and to make it known that the price to be paid for the energy one gets from cocaine is depression, and that although it is possible to use cocaine with moderation, it is completely wrong to believe that its consumption is easy to control: this has been confirmed time and again by experienced users.

In Brazil, 90% of all drug injections involve cocaine (1). Cocaine was already being consumed in 1910, but its use spread like wildfire in the seventies, and towards the end of the decade, it began to be injected. Cocaine is inexpensive because there is a large supply available and because the market is a competitive one. One gramme costs only 10RS (40FF), which still amounts to 15% of the minimum monthly income (600FF) earned by half of the population. Colombia, which borders Brazil, is the main heroin producer, but the prices in Brazil are five to ten times higher. As the result of the War on Drugs waged by the United States against the main cocaine-producing countries (Colombia, Bolivia, Peru) in the eighties, the latter countries began to export to other neighbouring countries in addition to Brazil, such as Argentina, Chile and Paraguay. The difference between the users’ practices in the developed and developing countries is that the former take it pure, while the latter mix it with other substances such as bicarbonate of soda. Injecting cocaine produces effects that are similar to those of crack, and there are many undesirable consequences. Although dependency on crack occurs faster than with other drugs, injected cocaine produces even faster effects and leads to greater dependency, as well as entailing greater risks of HIV transmission and overdosing. One of the worst problems is the craving: cocaine is injected much more frequently than heroin. The same syringe is used as a rule by the same person as many as 10 to 15 times. There exist no real pharmaceutical substitutes for cocaine. However, tests have been carried out in Bolivia in which the cocoa plant used by Indian communities has been substituted for cocaine. Attempts are being made to repeat this experiment in other countries. The results of one recent experiment carried out at the University of Sao Paulo in Brazil, in which crack was replace by marijuana, were quite surprising. 70% of the subjects tested were reported to have switched from the one drug to the other within a period of one to six months. In view of these results, those who carried out this experiment have suggested that this treatment should be adopted in the framework of harm prevention policy.

1. The remaining 10% are amphetamines, barbiturates, tranquilisers and heroine.
AIDS and drug addiction, two factors which lead to further exclusion, tend to hit hardest at the most down-and-out populations. This fact, which can be confirmed wherever we look, has obliged educators, health professionals and political decision-makers to develop and promote new practical and theoretical approaches. The Outreach method, a community approach to fringe groups, has been very much at the forefront. In this section, three applications will be described - among drug abusers themselves, inside prisons, and with street children - and some other tools for reaching out to these high-risk populations will also be presented. It still remains to find a way of reaching the inmates of prisons, for example, where the rates of contamination are scandalously high, even in Europe. The keyword at the Porto Alegre prison in Brazil has been solidarity. If the state of a society can be gauged from how its fringes are managed, it is no exaggeration to say that prevention and harm reduction policies will not be viable or even conceivable at all if there is no solidarity, especially when dealing with AIDS and drug addiction.
In 1992, the NIDA (National Institute on Drug Abuse), an American research organisation, conducted an assessment on the preventive programmes it had been subsidising since 1987. First it was found that they had been remarkably effective. In San Francisco, for example, within less than a year, the majority of the injectors had learned to sterilize their syringes. Secondly, it was observed that information circulated much more quickly when it passed from user to user. When a user says to his companions “Be careful, that’s risky!” or “For goodness sake, don’t do that!” the other users generally take heed: this of course is how they often prevent each other from taking overdoses and adulterated drugs. The warning is heard because speaker and hearer both assess risks in the same terms. In addition, a drug user does not simply preach: he teaches by example.

Although having drug users participate in preventive measures may be one prerequisite for their success, there is no magic formula giving the procedure. Based on the model of homosexual associations, drug user associations have been created in the Netherlands, Australia and France, where they have been instrumental in the spread of information. However, there are very few of these associations and they often split up (see p.85). Community health projects, on the other hand, have often involved sending mixed teams composed of health workers or volunteers as well as drug users out onto the streets to reach the users on their own turf.

**The birth of the Outreach method**

Teams of street workers or “Outreach groups” have been experimenting since the late sixties. One of the pioneer groups was set up in Chicago, in a poor, Afro-American part of the city hit by an epidemic of heroin use. Experts at the time often stated that drug addiction was an incurable disease. Dr Hughes refused to accept this fatalistic opinion and making use of all available resources, opened a care centre providing severance cures, methadone and residential treatment. To understand what was happening in the area, he launched ethnographical and epidemiological studies. Dr Hughes’ team was supported not only by the municipal authorities, but also by the Black Panther movement, which had many members in the district. But it was among the local addicts themselves, the people targeted in this project, that the members of the team were recruited. At first, the situation was chaotic, with relapses and problems of unreliability among the team members. It was only upon recruiting a well-respected member of the heroin using community that the Outreach team began to have an impact. The efforts made between...
is no doubt one of the main keys to success. And the ability of community projects, and the emergence of leaders who certainly more favourable than others to the development of community projects, and the emergence of leaders is no doubt one of the main keys to success. And the ability of leaders to work in cooperation and to be adaptable to the needs of the team, and this requires detailed knowledge of local customs, cultural values and the context. This method has not yet been defined, and the necessary skills are being acquired by experience.

Fighting AIDS

Subsequent to this first experiment, another team was recruited in Chicago in 1985, to fight the AIDS epidemic. This project based on the Indigenous Leader Model again achieved some immediate results. However, those which have followed in its footsteps have not always been equally successful. The difficulties begin at the recruitment stage. What are the criteria for a suitable user-cum-collaborator? Why might users want to join an Outreach group? A priori, they must be motivated by the wish to help others, but perhaps they may also want to distance themselves from the world of drugs. This perfectly respectable motivation can conflict, however, with the work of the group, which consists of going out onto the field of action. And what is that person’s reputation on the street? Although an individual’s lifetime experience is certainly a source of knowledge, it is not enough to turn that person into a health professional. Ten years of heroin dependence plus five spent in prison or ten years as a prostitute are not the same thing as a vocational diploma, as one sociologist involved in the assessment concluded. “Within the team, we have had to deal with all the same problems as those we are meeting on the streets”, complained one project leader.

A project leader has to make some tough day to day decisions: Should we go into that particular part? Should a user be accompanied? How should we react to violent behaviour? Common sense is sometimes not enough and the initial basic rules often have to be discarded. The working methods have to be constantly adapted to the needs of the team, and this requires detailed knowledge of local customs, cultural values and the context. This method has not yet been defined, and the necessary skills are being acquired by experience.

Why do some groups survive indefinitely, while others quickly fall apart or fail to get properly started in the first place? There is no single answer. Some settings are certainly more favourable than others to the development of community projects, and the emergence of leaders is no doubt one of the main keys to success. And the quality of the relationships between all those involved in the project must surely be a decisive factor. And of course, community health projects of this kind do not work by decree: there have to be people involved at grass roots level to make these projects work. In short, of all the harm reduction tools at our disposal, the Outreach method is perhaps one of the most difficult to put into action.

The Development of a Social Tradition

Since 1985, when the first Outreach projects were launched, little by little, a new professionalism has evolved as the knowledge of street culture, the medical know-how and the logistics have all improved. Experience has been gained all over the world on these lines and the knowledge acquired is handed on from one project to another in the framework of informal exchanges, training courses and national and international conferences. Despite the obstacles and the often hostile and at best indifferent environments, progress is being made. For all those involved in the venture, whether professionals, voluntary workers or users, the success of a project is something almost magical or miraculous: users come out of the shadows and learn to protect themselves against the AIDS epidemic. And that is not all. What really changes, is how people look at the users and how they see themselves.

Apart from the American experiments, the Outreach method, which might be defined as “going out to meet those on the farthest fringes of society” actually originated in Europe. At the time when tuberculosis was rampant, social workers would knock on the doors of the most disadvantaged families. During the fifties, street educators began to be recruited to combat delinquency, and many of these new professionals were former “rockers”. It was soon observed how readily these people were accepted by the marginalised groups. The fight against AIDS among drug users has in fact involved the resurrection of an old method of social intervention: but now the emphasis is even more on the need for marginalised people to get involved in the health issues which concern them. Outreach is not and cannot be targeted at a single problem. It is an approach which it is difficult to theorise about, but which does have a sound empirical basis. Experiments have been carried out all over the place, among prostitutes, migrants, the homeless etc. These are all groups of people who tend to be out of touch with the conventional medicosocial institutions, and are exposed to the perils of drug abuse and AIDS, as well as other mortal risks.
All the European studies have shown that prison populations are much more likely to be contaminated by AIDS and hepatitis than the population at large. But public health systems have tended to overlook this issue.

The total number of people currently detained in prisons in the European Union’s fifteen member States is estimated to be 350,000, or 94 per 100,000 inhabitants (as compared to 940 in the United States). This number has been increasing considerably over the past twenty years. Changes in prosecution policies and the stringent regulations on drug use have both contributed to this increase (Raynal, 1998). The hard-drug users account for variable proportions of the prison populations, depending on the country, ranging between 15% and 65%, according to the estimates available. In France, it has been estimated that 40-45% of all hard drug users have already served a prison sentence (Facy, 1993), and 60% of all injecting drug users (IDUs) serving a prison sentence at any given time have already served a previous sentence (Rotily, 1994). The IDUs in Berlin have been imprisoned 2.7 times on average since they started using drugs (Kleiber and Pant, 1996). It has also been established that HIV seroprevalence is higher at prisons than in the population at large (Gore et al., 1997; Bird et al., 1997; Rotily et al., 1994). A study carried out in a large prison in south-eastern France showed that the HIV seroprevalence was six times more frequent among those inmates who had served a previous sentence than among those sentenced for the first time (Rotily et al., 1994). People who serve multiple sentences are probably more likely than one-time detainees to adopt high-risk behaviour (involving more frequent use of drugs, greater promiscuity) when out of prison. It is also possible that some inmates may have become infected with HIV during a previous prison sentence, due to high-risk practices.

Data have been published showed that while in prison, 13-85% of all convicted drug users inject drugs and 50-100% of them share injecting material. The results agree, whatever the methods used (direct interviews or filling out questionnaires) and the respondent populations (at detention centres, penitentiaries, prisoners and former prisoners) studied. The period immediately following their release appears to be especially risky for drug users (Dye and Isaacs, 1991). It has been established
recently that during the first few weeks following release from prison, the death rates, especially from overdoses, are very high in Scotland (Seaman et al., 1998).

The treatment programmes available for drug users in prison vary depending on the country involved. In Sweden, for example, methadone is not prescribed at all during detention, whereas in Italy and Greece, it is available for inmates who have already undergone treatment before being imprisoned.

**There are no syringe exchange programmes operating in European prisons.**

Many countries are running short drug withdrawal programmes, in which no maintenance treatment is provided, or only for HIV-positive subjects undergoing highly active anti-retroviral therapy (HAART). In Denmark, France, Scotland, Spain and the Netherlands, withdrawal and maintenance programmes are theoretically available to a large number of users. In fact, more often than not, these measures have not yet been properly assessed, and it is impossible to state whether all drug users serving prison sentences have access to programmes of this kind as easily as drug users at large.

There are no syringe exchange programmes in European prisons. This is because many prison detainees are there in the first place because they were using drugs: since drug use is forbidden, the prison authorities consider programmes of this kind to be inappropriate for prisons. To make measures of this kind more acceptable, the programmes will have to be designed in co-operation with the administrative and medical teams working at individual establishments. They will also have to be thoroughly assessed. Now that the first pilot project in Switzerland has proved to be feasible and effective in small prisons (Nelles, 1995), others are being tested in Spain (Basque Region) and Northern Germany, and the initial results obtained have been encouraging.

Since 1993, bleach tablets have been distributed in all Scottish prisons along with video cassettes giving instructions as to how they should be used, especially for sterilising injection equipment. The effectiveness of these measures is questionable, however, given the precarious practical conditions usually existing in prison circles, which crack down heavily on drug use. Bleach is made available in the prisons of most of the European Union countries, but often without any specific instructions as to how it should be used to sterilise injection and tattooing needles. The resistance met by the idea of distributing practical instructions along with the bleach is akin to the resistance met by projects to introduce needle exchange programmes. There are people who still believe that needle exchange amounts to explicitly accepting drug use inside prisons, and who feel that this is incompatible with providing drug users with treatment, as well as being against the regulations.

Access to harm reduction services in European prisons is lagging far behind the actual needs and behind the World Health Organisation's 1993 recommendations. In addition, the prevalence of hepatitis C is much higher than that of HIV infection, and recent data indicate that hepatitis C is becoming an extremely frequent cause of death among drug users.

**There is an urgent need to reinforce harm reduction strategies inside prisons.**

When it comes to explaining why it is impossible to set up real harm reduction strategies inside prisons, the argument most often put forward is that it is so difficult for the administrative and medical staff to acknowledge the reality of forbidden practices in a place where law and order are supposed to reign. In fact, the players need to be more pragmatic and recognise that the main objective of imprisonment is social rehabilitation. And that involves improving the prisoners’ state of mental and physical health.

There is an urgent need to reinforce harm reduction strategies in prison environments and to set up experimental projects that have been well tried and tested elsewhere. These projects should be adapted to the cultural specificities of each country. They also need to be adapted to the organisational constraints and to the current policies applying to the population at large, particularly as regards substitution treatment, needle exchange programmes, family visiting units, and drug-free units. The implementation of these projects must involve truly effective collaboration among the teams responsible for providing inmates with their medical, social, and educational needs.

Since prisoners are an integral part of the community, overall public health policies must also take prison settings into consideration. At this stage in the HIV and hepatitis epidemics, we should remember that priority must be given to the actions targeting the most disadvantaged populations, since those in detention often originate from these particular populations.
Putting prisons on the agenda of public debate

Anne-Lise Schmitt
Journalist specialised in Brazil

The results of a recent study have shown that 80% of all the prison inmates in Brazil are infected with the HIV or hepatis C virus. Although the prison system depends on the State, the city of Porto Alegre encourages the detainees in its central prison to hold discussion groups and to publish a newsletter.

The Porto Alegre central prison is a “transit” prison with 2000 detainees (including 150 women), who are poor, have had little education and are mostly drug users (taking marijuana and cocaine). Very few cases of injecting drugs have been noted. According to prison officials, only one syringe was found in four years. The price of syringes, i.e., 30 to 50 Brazilian cents (1 to 2 French francs) on the black market and 20 Brazilian cents (80 French centimes) at the chemist’s, would be enough to make IDUs give up injecting for sniff cocaine, which is easily available. According to one study, out 32% of the 564 detainees in the Porto Alegre Central Prison who were tested for AIDS were contaminated and between 1998 and 1999, 69% of those who died in the prison died of AIDS. And yet the harm reduction measures introduced so far this context could hardly be more restricted: it is unlawful to hand out syringes and condoms are only made available occasionally. Those promoting the harm reduction projects funded by the city, have fallen back on organising discussion groups between detainees, penitentiary workers and members of the medical profession. Themes such as human rights, access to health care, law, sexuality and sexually transmitted diseases are addressed as much as drugs. These discussions are covered in a newspaper called Arpão (Harpoon). At their own request, prisoners sign the articles with their own names, even when they are talking about problems such as mistreatment in the prison. If they are illiterate, they ask their cellmates to write for them or contribute to producing a group article. The newspaper does not stay within the walls of the prison, but is distributed to all the prisons in the State of Rio Grande del Sul, and even to some prisons in other States.

Circulating the newsletter in the city would be one way of making the facts about the prison and life inside known to everyone in the community from which it has been cut off. At the same time, this would show that what the prisoners themselves have to say is of interest, and it would help to put some important issues (such as prison conditions and the right to be healthy) back on the agenda of public debate. The prison management, which is in the hands of the federal police, is against these proposals. But Mirtha Sendic, who is the city’s harm reduction specialist, is optimistic, for municipal workers have joined in at meetings on harm reduction between prisoners and outside parties. At these meetings, in which judges have also participated, the question sometimes crops up as to whether it is right to enforce a law which, by sending simple users to prison, causes them to be much more highly exposed to AIDS and hepatitis and sets them on the path towards delinquency. “Lots of young people are detained”, stresses Mirtha Sendic, “just because they have taken drugs. They are looked upon in the same way as dealers, instead of being taken care of in special homes with maintenance therapy. They are forced to start playing with the big guys, who set the rules in prison, especially in Brazil. Wh hen they are released, they can no longer function independently and get involved in organised crime.”

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The Porto Alegre prison
Several estimates have been made since 1980, including those published by the independent Commission for International Humanitarian Issues (30 million in 1986), UNESCO and UNICEF (100 million in 1990-1995), the United Nations Economic and Social Commission (140 million in 1996) and the ILO (250 million exploited working children in 1999)(1).

How many children do you think may be living on the streets in the world today?

Children living on the streets, of whom there are tens of millions in the world, are particularly highly exposed to AIDS, drug addiction and other risks.

What is UNESCO’s strategy for dealing with these children?
As far as AIDS and drug addiction are concerned, the main strategy adopted by UNESCO has always consisted of dealing directly with children and young people in the framework of permanent institutions such as the schools they attend. This strategy will obviously be of no use for dealing with street children, however. Since 1997, we have therefore been attempting to reach these children using more appropriate methods, despite their great mobility in the towns. These methods consist of either introducing information programmes at previously existing private centres or creating field centres of a kind which are able to deliver preventive information about AIDS, while other services are responding to this population’s many immediate vital needs by providing food, first aid, and protection from various potential physical and moral hazards. Satisfying these needs is essential to the success of preventive efforts to reduce the risk of AIDS and drug abuse, since one of the barriers which instructors and social workers come up against is the fact that these children exposed to very real risks every day of their lives give the impression that they have nothing more to lose. They seem to devote all their energies to avoiding and managing the immediate risks. Before they can be persuaded to take an interest in AIDS prevention efforts, they have to be able to forget about hunger, thirst, and murder, and the fear of the police force and the law-courts.

Before they will be able to take an interest in preventive activities against AIDS, children have to forget about hunger, thirst, aggression and murder, and the fear of the police force and the law-courts.
authorities in these schemes are indispensable, since they carry the main responsibility for the welfare of the children in their country, as well as being those with the greatest and most durable means at their disposal. Whenever we set up pilot projects, we always attempt to involve as many players as possible, including the State and local authorities, which are required to show clearly and unmistakably that they wish to control AIDS, and during the interim, we set up preventive activities consisting of providing the young people in question with information. This is the procedure we have used in Brazil (Salvador de Bahia), Guinea (Conakry) and Namibia (Windhoek and the Katutura suburbs).

Do there exist any special methods of approaching these children?
There exist no universally applicable methods, apart from paying close attention to the specificities of the context. In Africa, for example, it is possible to mobilise the children themselves to participate in AIDS prevention efforts. This can be done thanks to the tradition whereby the older children are accustomed to looking after the younger ones. If the cultural environment offers possibilities, why not make use of them? It is certainly not an easy job. Children living on the streets have often broken all the institutional links they may have had (with their families, schools and other socialising institutions, such as associations, sports clubs, etc.). They are unlikely in principle to be attracted back to these institutions unless they expect to gain by doing so. This makes the prevention of drug addiction a particularly arduous task, since merely providing information about the risks involved can have the opposite effects to those intended. In the case of AIDS prevention, the situation is a little less difficult to handle, as AIDS is more frightening.

In the course of my work, I have noticed that street children form the group with the strongest will to survive in the whole population. They show very few suicidal tendencies. These children’s will to live is certainly a trump card which should be used for AIDS prevention purposes. We have to explain to them what it means to be contaminated by the HIV virus when there is no treatment available...


For more than ten years now, Moroccan civil society has been earning the reputation of being among the most dynamic in North Africa. Several associations were created during the 90s, especially to assist women with problems (by providing solidarity for women, homes for unmarried women and disabled people, etc.). Since there exists no institutional social network in this country, the associations have to cope with both long-standing and more recent social evils. They are financed mainly by the proceeds of charity galas and by international sponsors. Children living on the streets constitute an increasingly serious social problem in Morocco. Their presence is particularly conspicuous in Casablanca and the other large cities in the north of the country.

A CONTEXT OF VIOLENCE. These children often have similar backgrounds: families which have split up under the pressures of extreme poverty and family violence, and children who have been abandoned or have left home in the hope of finding a better life elsewhere. In 1996, the Bayti association came into being, under the leadership of a woman, Najat M’jid. The first step to be taken was the creation of a centre for the street children of Casablanca.
Addictive practices are often an integral part of these children’s lives. The substances they take are mainly solvents such as Norlatex, a synthetic glue.
In Ouagadougou, the Youth Solidarity association is encouraging young people and children to participate actively in its associative dynamics so that they will have a place of their own to go to where they are safe. On this basis, they can start to re-learn social habits and to obtain some vocational training which may provide them with an income in the future. The older children are encouraged to take charge of the younger ones arriving on the streets and to direct them as quickly as possible towards this centre, in order to prevent them from escalating into delinquency and drugs. Their mission consists of helping the younger ones to realise how much the centre can help them. A programme of mobile care was drawn up and submitted to “M édecins du M onde”, and this organization has provided the necessary funding. Some of the older children have been trained to give basic health care. Every night, riding the motor-bikes with which they have been equipped, they go round all the places in the town where the street children spend the night, dispensing basic care. The street children refuse to go near doctors, but they greet these visitors like elder brothers and welcome them into their midst. Any of the children who are in really poor health are given a letter to take to the Red Cross. Youth Solidarity has signed a free health care agreement with this organization. This system has proved to be highly successful and the older children have proved to be able to acquire a sense of responsibility amazingly fast.

Another approach, which is also based on improving individuals’ self-esteem by involving them strongly in a project, has been used in the Dori area: here the first youth associations were created at the end of 1996, mainly for the purpose of launching programmes and public awareness campaigns about environmental and health, public health and vaccination problems, and especially about the prevention of STDs and AIDS. One of these associations is particularly active. It deals with women and young people who have been or are becoming social outcasts (street children and young unmarried mothers, for example). The association has formed a troupe of dancers and singers, as well as a female football team, which is most unusual in an Islamic setting. The latest programme to be implemented was the creation of a country inn including a restaurant, a bar, and a shop. This structure was created in a region where there had been no bars for five years, apart from those which were owned and frequented by civil servants from other regions. The girls and boys who work there, who used to be living precariously in the towns, have gradually succeeded in being accepted by public opinion. Their new activities are not only giving them a source of income, but also providing them with greater protection, which is even more important. By promoting these people’s social integration, the association is also decreasing their vulnerability to risks such as AIDS and drugs. It is by looking at how other people see us that we acquire a Self, via the image of ourselves we feel we have projected and the way we imagine people judge us, as C. H. Coley has put it. He called this process the Looking-glass self (1).

1 • Charles H. Cooley, Human nature on social order. 1902.

PARTICIPATION IMPROVES SELF-ESTEEM

THE SEA BETWEEN THE STREETS: THE MEDITERRANEAN

normally used to repair air-chambers, which they inhale from rags imbibed with the substance. The amount of violence, sexual aggression and prostitution which accompany these addictive practices are extremely worrying. A study carried out in Casablanca showed that 46% of all the 600 boys questioned had undergone sexual abuse or gone in for prostitution, and that 60% of all the children studied in Marrakech were involved in prostitution. Absolutely no use seems to be made of condoms, based on the findings made in this survey.

Giving a sense of responsibility and a role in society. The aim of this association is to make these children feel more responsible by informing them about the risks associated with their practices and to re-integrate them by encouraging them to re-establish contact with their families and providing them with a place to live where they can also be given medical care. However, the lifestyle and habits they have acquired on the streets make it difficult for them to adapt to living in collective homes with regular time-tables, and also make it extremely difficult for social workers to keep track of these individuals. On the opposite side of the Mediterranean, in France, the “Errant Youths” association in M arseille looks after those who have succeeded in escaping across national borders by stowing away in ships, or in other ways. “Errant Youths” was created in 1995 in response to the fact that several institutions (the legal departments responsible for youth protection, the hospitals and the police) had become aware that many young people with no family ties, and usually with no knowledge of the French language either, were roaming about the city centre. Most of them are squatters of North African or Eastern European origin, who work occasionally as go-betweens for drug dealers, since there is a French law which protects people under age from being expelled from the territory. The social work being carried out on this group is of rather an unusual kind, since long-term integration is simply not a realistic project in this case. Since these young people often have a petty crime record, very few of them are able to obtain regular papers when they come of age and are therefore not able to go on living in France. The association therefore gives priority to informing these youths about the risks associated with their drug abuse and their sexual and other practices. Although this present-day form of nomadism is tightly controlled by the legislative systems of the various Northern countries, preventive efforts are liable to be restricted to providing information, which is a necessary but far from sufficient step.

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Sandrine Musso, Ethnologist

Pedro December 2001
The World Health Organization has developed a prevention kit to help educators to inform young people about AIDS risks and the abuse of psychoactive substances.

This is a plastic case containing 12 booklets with fluorescent colours and 10 lessons. This training kit for helping those who work with street children was designed for educators already working with these children or intending to do so. The main themes are the abuse of psychoactive substances and sexuality, including the HIV/AIDS risks.

Ten lessons for the street children

This kit produced by the World Health Organization (WHO) was developed over a period of several years. The first version was brought out in 1995 and submitted for the approval of more than 700 professionals, including social workers and people working for associations in various countries. The WHO Department of Mental Health and Substance Dependence is now proposing a fully developed pedagogical tool designed to ensure that it can be widely distributed and easily understood by educators all over the world, whatever experience they may or may not have acquired in this field. Although the contents of the course are fairly general, there is also a handbook explaining how to adapt the way in which information is presented, depending on the specificities of the local context.

This course focuses on a clearly defined central theme: the use of psychoactive substances and sexuality, including reproductive health issues and those relating to HIV/AIDS and sexually transmissible diseases. This is the first time a teaching kit has been produced on these lines for training street educators. The kit was initially supposed to deal only with substance abuse, but street workers’ assessments showed that it was necessary to talk about sexuality as well. There are many connections between the two subjects and in addition, this has led to adopting a more overall and hence a more comprehensive approach. The basic underlying principle was not to approach individual and social problems separately. Street children belong to a community, and it is within this community itself that the responses to their needs should be sought. Mediators serve to bridge the gap and it is via these people that a whole set of knowledge and information can be put across. This kit was designed to help them by providing them with concrete means and tools. Each of the ten training modules (see the insert on this page) contains one lesson, specific goals, a set of exercises, some concrete examples and a list of references which can be consulted for further information on the subject. The information this kit contains is all about street children and their education, substance use and abuse, sexuality, health requirements and methods for learning how to heighten street children’s awareness and give them means of improving their quality of life as far as possible.
The battle against the AIDS epidemic has led to the need for really effective preventive measures, which has always preoccupied politicians attempting to curb drug abuse. The few studies available so far have been showing for a while that many programmes have had relatively little effect. Some people feel the whole concept needs to be redefined, while others feel it would be preferable to transpose the use of tools which have proved their worth in the field of harm reduction to broader populations than the drug injectors. The battle against the AIDS epidemic has also shown that it is necessary to adapt the messages conveyed to groups whose social specificities as far as drug-taking goes have been long overlooked, such as female abusers. And that it is also necessary to distinguish for medical and social reasons between use, abuse and dependence and to extend preventive actions to include licit substances such as alcohol and cigarettes. Lastly, preventive and educational campaigns need to be carried out which focus neither on drugs nor on AIDS, but have a wider scope. This would make it possible to carry out both overall and specific prevention at once. One of the main objectives here is to reinforce people’s self esteem, as this is an indispensable preventive tool.
Now that the UN is setting up a new fund for the purpose of reducing AIDS, tuberculosis and malaria throughout the world, the question has come to the fore as to what treatments are available and how widely accessible they are. However, prevention and education are even more relevant than ever before. Because when there is hope, it is possible to imagine sharing responsibility. And because prevention is still much better than any cure. UNESCO, at this crucial point in time, regards this challenging task as a top priority, especially as far as the most defenceless sectors of the population are concerned.

The spread of HIV/AIDS is at the same time the most devastating and the most paradoxical of epidemics. The number who have died -some 22 million- is nearly the same as the populations of Norway, Sweden, Denmark and Finland all put together. The number currently infected -some 36 million- is more than the whole population of Canada. The number of orphans -some 14 million- is already more than the total population of Ecuador. The epidemic is without precedent in the history of mankind, and the worst is still to come: many millions more will be infected, many millions more will die, many millions more will be orphaned. Not only individuals are at risk: the social fabric of whole societies is being threatened. The disease is likely to go on being a scourge throughout our lifetime.

The paradox is this: the greatest killer epidemic in modern history is due to a virus that is not even particularly contagious. Many infectious diseases, such as the flu or children's diseases such as measles or mumps, are highly contagious. Just being near an infected person can suffice to contract some diseases; whereas the spread of HIV is relatively easy to prevent - and it can be prevented by informed and motivated individuals. This is why it is quite safe to have everyday social interactions with infected people and to give them medical care. In addition, it is possible for most people at risk, as long as they are having voluntary sexual intercourse, to decide not to be infected if they are aware how it happens.

THE ROLE OF IGNORANCE
Ignorance is a main reason why the epidemic is out of control. The need for preventive education stems from ignorance of various kinds about the epidemic, especially in the most seriously hit developing countries: most of those with HIV/AIDS are not aware of the fact, very little is known about the disease itself, misconceptions are circulating about possible remedies, and the lack of knowledge is leading to prejudice and discrimination. People everywhere must be made aware that they are at risk and told how to avoid it. The message must be valid and it must get across.

WHAT CAN BE DONE?
Every infection is a devastating loss, first to the people afflicted themselves, and then to all those around them: families, friends, the local community, and even the world community at large. In the international debate, the focus of the last few months has been on providing treatments. UNESCO strongly welcomes the lower prices and greater availability to which cheaper drugs have led. They reduce human suffering and social loss. But treatments are also important because they raise people's hopes: those who fear infection gain an advantage in being tested since they can hope to have a longer and more productive life if they do so. These psychological effects come over and above the medical effects. Treatment can help to conquer fear and social stigma.

Although treatment is important, it is not sufficient. There exists no treatment so far which ensures a complete cure. The vaccination strategies desperately needed are still years away. Preventive education is therefore central to the response. When done right, it works. If done immediately, it will have a long-term impacts. If done massively, it can turn the tide. The critical test is the extent to which key messages reach the grass roots, particularly those who are most vulnerable, and lead to behavioural changes. These changes require cultural understanding and effective communication to get the message across. Well-directed efforts are imperative to reach the young and most highly exposed, whether in or out of school. Improving HIV/AIDS knowledge and awareness - along with improving access to the means of prevention - is central to preventing the spread of the epidemic. Preventive education must make people aware that they are at risk, and why, and
let them know how the number of infections can be reduced. However, knowledge often does not suffice to change behaviour. Preventive education must address mentalities and the culture within which they are embedded in order to generate the attitudes, provide the skills and sustain the motivation necessary for changes of behaviour to reduce risk and vulnerability. Preventive education must reach all via well-targeted messages and by launching the greatest education and communication campaign in human history. This can only be achieved if all institutions become institutions of education and communication: the media, workplaces, and above all schools, colleges and training institutions. Preventing HIV infection is still an essential, first line strategy against the AIDS epidemic. Two decades of experience in countries as different as Brazil, Thailand, Uganda and Sweden have proved that determined prevention efforts do work and that they are most effective when they involve communities and are combined with strong care and support programmes.

**UNESCO’S SPECIAL RESPONSIBILITY FOR EDUCATION**

UNESCO can best contribute to curbing the AIDS epidemic by taking a leading role in preventive education within the global framework of the UN system, especially via UNAIDS. At UNESCO with its mandate to promote both formal and non-formal education, preventive education at all levels has been placed at the top of the agenda. UNESCO’s priority is not just a one-point programme, but focuses on the following five main core tasks:

1. **ADVOCACY AT ALL LEVELS**: in particular, UNESCO will engage ministries, agencies and non-governmental organisations under its mandate, such as those responsible for education, science, culture, communication and sports, as well as civil society and the private sector.

2. **CUSTOMIZING THE MESSAGE**: developing effective and culturally sensitive messages for specific target groups, especially those most at risk.

3. **CHANGING RISK BEHAVIOUR AND VULNERABILITY**: promoting formal and informal education programmes so that all young people will know the facts about HIV/AIDS and how to prevent it and will be able to act on this knowledge, in schools that are safe and environments that are protective.

4. **CARING FOR THE INFECTED AND AFFECTED**: dispensing the knowledge, attitudes and skills necessary to provide care for the infected and affected is a vital part of any program in preventive education. Workers in this field must be actively engaged and they must be supported in their efforts to address the epidemic in communities around the world.

5. **COPING WITH THE INSTITUTIONAL IMPACTS**: the increased demands for care and the loss of professionals are stretching already overburdened health and education systems. Hence one critical task is to protect the core functions of key social, economic and political institutions under the onslaught of HIV/AIDS. UNESCO will therefore develop and disseminate tools for monitoring and assessing the epidemic and responding to its impact in schools, and among students, teachers and those frequenting other key institutions at the national level.

UNESCO’s Director-General has recently declared: “Now is the time not for complacency, but for compassion. Now is the time not for hesitation, but for action. I pledge the full support of UNESCO where it can make the greatest difference and will mobilise all its competences for effective AIDS preventive education for all those at risk around the world”.

Little is known so far about the epidemic, and much is yet to be learned. But we know enough to act, and we know that we must act immediately, decisively and massively: to offer treatment, to provide care and maintain institutions with due respect for human rights for all.

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*The IIEP has just published a report on this subject, entitled “UNESCO’s Strategy for HIV/AIDS Preventive Education “, 2001. See for example page 130.*
“You can stop taking drugs, but if you get AIDS, you die.”

The need to re-invent prevention

Rather than talking about primary, secondary and tertiary prevention, Lia Cavalcanti suggests that prevention should be approached in terms of “overall prevention” and “specific prevention”. This is a conceptual turning-point which means that the achievements of harm reduction are being integrated into a system based mainly on developing self-esteem.

The advent of AIDS seems to have completely revolutionised drug prevention strategies. How has this occurred? One might say that prevention in general is any collective effort conducive to the survival of the species. In fact, it is a relatively recent concept, but it can be said that the first institutions in history to practice prevention were the great religions. When Islam forbade the eating of pork at a time when undercooked pork was liable to cause many diseases, and when the Jews began practising circumcision, the underlying reasons were obviously preventive ones. Bodily ills were assumed here to be the natural allies of spiritual ills. This historical reminder is necessary to understand that prevention throughout the world generally has strong moral connotations, and this is particularly true of the prevention of drug-related harm.

However, the arrival of AIDS made it necessary to redefine the whole concept. You can stop taking drugs, but if you get AIDS, you die. The enormous risks to which the epidemic has exposed society has obliged us to reassess our approach to prevention, and the results can make heavy demands on the social corpus in both ethical and practical terms. All moralising has had to be set aside. It has been recognised that one cannot develop effective harm reduction strategies without coming to terms with the specific cultural context in which patterns of usage and risk are emerging. The AIDS epidemic has thus placed drug users at the centre of social interventions. These people used to be regarded almost like objects, whereas now they have acquired the status of responsible citizens on whose collaboration one can count to obtain results in implementing public health policies. The outcome of this change has been quite remarkable: before syringes became freely available at shops, more than 50% of the French users were sharing their syringes, but nowadays less than 17% of them are doing so. The concept of harm reduction, which no longer imposes complete abstinence on those who benefit from social assistance, has spread throughout the world. There are national harm prevention associations in existence in Brazil, Argentina, Barcelona, India and many other countries throughout the world. It would be a mistake, however, to confine harm reduction strategies to the health-care pigeonhole and to imagine that only drug users are the appropriate targets of harm reduction measures.

How would you define harm reduction, then? Harm reduction has been defined as the “whole set of social and health-related, individual and collective measures designed to reduce the harmful effects of drug use”. This is not intended to mean that the policy is aimed at drug users alone, that is the first point. This was the definition given by Annie Mino, who is now Director General of public health for Switzerland, in a fundamental, groundbreaking text published in the early 90s.

In an attempt at clarification, although the accent is on reducing harm rather than risks, I feel the concept should be extended to include both risk prevention and harm reduction. The risk prevention part would include all those anticipatory social measures designed to reduce the consequences of drug usage not only to individuals but also to given social groups. In the sphere of harm reduction, one
can work not only with the users but also with their families and with the members of their social circles. We need to create interconnections between the users and their environment and to work in conjunction with the police, elected representatives and indeed with anyone who can stiffen resistance to the negative effects of drugs. The other aspect, that of "harm reduction proper", is about health care, syringe distribution, substitution programmes and so on.

How can the change of approach to drug prevention be summarised?

It seems to me that nowadays, subdividing preventive measures into primary, secondary and tertiary prevention is out of date. This model was inherited from predictive medicine in the 19th Century, when it helped to defeat the great epidemic diseases. When a new plague arrived, the appropriate medical measures were applied. This way of thinking was later used as an approach to the drug problem. The three-fold distinction between primary, secondary and tertiary preventive measures was greatly appreciated by the public at large. The idea of acting before the drug problem arose and preventing it without having to confront it head-on was thought to be both ideologically sound and reassuring. The problem was that no one knew what acting in advance actually involved. The classical definition of primary prevention is actually an exercise in virtual reality. Imagine that I have decided to prevent a non-drug-using population from taking up drugs. How can you be sure that this population will not take drugs precisely as the result of my interventions? If you tell a sixteen-year-old that there are substances which produce a flash that is a thousand times more powerful than an orgasm, and that the ill effects come only much later, his curiosity may be aroused and he may take the first step towards drug addiction. This might not actually cause dependency, but it could spark the whole process off. Drug prevention strategies which fail to look at the picture from a broader angle and focus only on giving information about drugs have been found in many analyses to have two-way effects.

Nowadays, in order to be effective, we have to re-orient the debate on drug prevention in terms of initial and secondary effects. Prevention is not designed solely for non-users but also for users. The aim with the latter is to prevent their pattern of usage from becoming more harmful or from slipping into dependency. We are therefore taking a much broader outlook than previously. WHO, in one of its previous reference works entitled "The Prevention of Drug Abuse", states that the aim of prevention is to reduce the rate of occurrence of drug-related problems among specific individuals in a given environment. We can no longer subscribe to this profoundly manichean definition, which separates prevention so trenchantly from the cure.

How do specific and overall prevention work together?

There is much common ground between the two. Specific prevention, which consists of dispensing risk information, is absolutely necessary but does not suffice to bring about long-lasting changes of behaviour. There has to be an emotional angle. The members of the groups at risk who change their behaviour tend to be those who have seen their friends wiped out. Of course, no one is either completely emotional or completely rational: the important thing is to find a way of getting each person to play an active role. To achieve this, we must help individuals to find their rational and affective selves and bring both together, and the key to doing this successfully will be something like self-esteem. This educational approach involves constantly shifting between the two forms of prevention I have been talking about.
 Might one say that specific prevention is that which targets groups at risk?
There has been a lot of debate about the relationship between groups at risk and risk behaviour. By a group, I mean a group which has set itself up as the result of a process of socialisation. When the epidemic began, the idea of a group at risk was somewhat different and the old way of thinking is still with us to some extent. When one speaks of crack, one automatically thinks of black people: we think of the fact that prevention kits in France are designed for people of African or Caribbean origin. In my experience, on the field, blacks, whites and Asiatics are all actually involved. In France, the crack scene was initially a one-colour issue for geopolitical reasons: the trafficking routes reached the French Antilles long before they reached metropolitan France.
In the United States, crack was likewise thought of as an Afro-American issue rather than one affecting marginalized people in general. Do preventive strategies work best by targeting a particular ethnic or social group? It has become increasingly meaningless to define groups at risk solely in terms of sexual practices, ethnic origins or religious beliefs. Risk practices are ingrained in a social context, a local culture or even a micro-culture. And even there, one can distinguish various risk practices. All these micro-social mechanisms have to be understood and taken into account when defining a prevention strategy and assessing its impact.

 Does specific prevention necessarily mean targeting the drug users?
There exist three kinds of preventive knowledge: technical knowledge, cultural knowledge about the area, the language etc., and empirical knowledge, which is the drug users’ own acquired knowledge. There is an unbridgeable gulf between someone like me, who has technical knowledge, and a user. I will never know what taking drugs feels like and I have not mastered any of the drug-taking techniques. However complete the descriptions which I read or hear may be, I do not have that know-how. That is what constitutes empirical knowledge: and it is indispensable when drawing up preventive booklets, for example. But generally speaking, physical proximity suffices for specific messages to be put across successfully. We are dealing with a constantly changing situation involving the arrival of new products, multi-drug use, new practices and new risks developing all the time. You would have to shadow people closely night and day to be able to anticipate the new patterns of usage which are emerging and the new risks they entail. For example, Fermidon®, a female condom, was made available in one of our projects (Structure d’accueil Espoir Goutte d’Or, Paris, France), in which crack users and injecters were the main population targeted. More than a thousand of these items were handed out in a matter of a few weeks. It was realised only after a while that many of the female prostitutes using them were not removing them after each client: they were protecting themselves but not their partners! In the drugs field, as in many others, it is not enough to act with good intentions, you have to carry out check-ups and analyses on each initiative as well. That is what differentiates charity work from preventive action. Preventive action is not motivated simply by the love of one’s fellows but also by the desire to gain knowledge and understanding about a situation. Specific prevention strategies systematically involve setting up groups to monitor behaviour. It then becomes possible to influence the social groups at risk and to develop policies in the public and private spheres with a view to reducing and countering the risks. The sociologist Daniel Defert wrote that in the 19th Century, physicians were the great informers about social issues but that in the 20th Century, the patients themselves have adopted this role. However, the patients’ viewpoint alone will make for a rather one-sided account of reality. How can the experience of the patient, that of the carer and that of the whole social corpus be combined and put into a nutshell? That is the real question. Simply asking this question may enable us to abandon previous controversies and embark on a more consensual way of thinking, for it is only at the confluence between all these points of view that an effective preventive strategy is to be found.

THE TEN PSYCHO-SOCIAL SKILLS AS DEFINED BY WHO
Being a good problem-solver and a good decision-maker. Being a creative thinker as well as having a critical turn of mind. Being able to communicate effectively and handle human relationships skilfully. Having a sense of self-awareness as well as feeling empathy with other people. Knowing how to cope with stress and how to manage one’s own emotions.
Does educational prevention follow the logical steps which make for effective efforts? These steps are theoretically as follows: in the early stages, a research and development team draws up a preventive procedure and tests its validity. The validated procedure is then put to use by field workers.

Reality is a different story. When it comes to preventing problems that frighten society, such as consumption of psychoactive substances or the spread of AIDS, then all social actors join the fray. Especially if young people, the hopes of the future, are running risks. The need to act at all costs overrides everything else. Many socio-educational teams spring into action and hastily design interventions or programmes (1). They do not test them, or if they do so, go about it haphazardly. In the United States, out of $1.5 billion spent on drug prevention, only $14 million directly fund research in this field, which amounts to less than 1%. Linda Dusenbury has noted that only 10 of the 47 drug prevention programmes operating in the United States had been subjected to rigorous scientific scrutiny, and that only 8 of those 10 yielded results (2).

Preventive interventions spontaneously designed by field workers are usually intended to convey ominous warnings, using scare tactics, about products and their harmful effects on health. These warnings are often announced on a single occasion. But it has been amply demonstrated that approaches of this kind have no measurable effects on the abuse of psychoactive substances.

But one must not blame teachers who base their reaction to pupils consuming marijuana at school on the only information available. Teachers know nothing about what alternatives may exist or what the latest results of research in this field may be. More so than elsewhere, there is a lack of communication between research workers and practicians.

Scientific research in health education is a recent field, which started only about forty
years ago. It is being carried out in only a few English-speaking countries (the United States, the Netherlands, Scandinavia and Australia) by interdisciplinary groups of psychologists, psycho-sociologists and epidemiologists. These groups have often worked separately on prevention issues (such as cancer, cardiovascular disease, tobacco, alcohol, AIDS and unwanted pregnancy). Only recently have interdisciplinary exchanges begun to take place between those engaged in research on the prevention of alcohol, tobacco and other drugs, which was more advanced than research on AIDS prevention.

Although the initial interventions effectively improved people's knowledge and sometimes even managed to change their attitudes, causing actual behaviour to change was and is less frequently achieved. However, it is only by adopting healthier behaviour that we can improve health itself, and that is the goal that ought to be set. As Douglas Kirby has pointed out, “It hasn’t always been easy to carry out research over the past 20 years. First there were difficulties and obstacles to be overcome before high-standard research could be carried out. More importantly, most of us felt it was depressing, frustrating and even painful at times to launch programmes we believed in, only to have to tell friends and colleagues subsequently that the programmes hadn’t had the impact we had been expecting.” It is only once programme designers started to analyse the complexity of various kinds of behaviour and to define the factors involved (biological, genetic, interpersonal, social and environmental), that progress could be made (3). Research on the aetiology of psychoactive substance use was needed. Transversal studies brought the risk and safety factors to light. Group studies made it possible to identify some predictive factors.

The most effective programmes are those which help young people to become aware of and to deal with various social influences (interpersonal, media, over-estimation of normal consumption levels) and to increase their repertoire of strategies for handling various situations that often lead to consuming psycho-active substances (anxiety, personal, family and school problems, shyness, personal relations).

Many of the failures have been due to ill-conceived interventions.

Among the most noteworthy programmes, there is the Life skills training designed by Gilbert Botvin’s group at Cornell University, which is reputed for its long-lasting effectiveness. In 2000, Botvin was awarded for 20 years of research when he was awarded the prize for the best substance abuse prevention programme (4). Botvin’s group conducted an educational trial on a randomised sample of subjects with a long follow-up (5). The pilot and control populations were selected at random among the pupils attending schools of 3 categories: schools with low, average and high levels of cigarette smoking. The group of pupils selected was studied from 1985 to 1991. In 1991, 3597 pupils out of the 5594 twelve- and thirteen-year olds questioned in 1984 were questioned again. In the most assiduous sub-group (those who had followed the programme at least 60% of the time), there was a 50% decrease in the rates of tobacco and marijuana consumption and a 50% decrease in the use of tobacco, marijuana and alcohol as compared with the other groups tested. Progress in the actual pertinence and relevance of educational interventions has gone hand in hand with a need to improve assessment techniques. Many of the failures reported in the literature have been due to ill-conceived interventions (they did not focus on any known risk or protective factor, were too short or culturally inappropriate), as well as to purely statistical problems. The work that remains to be done is therefore plain. The most promising programmes should be promoted and adapted to various cultural contexts, for it is unthinkable to attempt to transfer programmes from one cultural environment to another without making any changes. Some authors have estimate that the methodological weakness of the primary and secondary research studies published so far is so great that no general conclusions can really yet be drawn. (6). Improvements must therefore continue to be made to both interventions and assessment techniques. All of which means that scientific research in health education must be developed and pursued not just in a handful of Western countries, but in countries throughout the world.
The island of Mauritius forms a stepping-stone between South-east Asia and Africa and lies at the crossroads of the illicit drug trade. Increasingly large amounts of brown sugar★ (a form of heroin★) have been consumed on the island since 1982. An increase is also tending to occur in the everyday consumption of “gandja”, a local crop plant which used to be part of the Mauritian rites and traditions, and was used only on festive occasions. Based on the numbers of drug addicts recorded in the Mauritian prisons (where they amount to more than 65% of all the prisoners), it was estimated that drug users account for 15% of the whole population, and various preventive structures have therefore been set up by four Mauritian NGOs called the Terre Rouge Care Centre, the Solidarity Centre, the Sangram Sewa Sadan Centre and the Dr. Idrice Goomany Centre. The results of a study carried out in 1998 at the Dr Idrice Goomany Centre showed the existence of a link between the large number of very young drug addicts in the 12 to 13 year-old age-group and the fact that more than 33% of all the children were failing the Certificate for Primary Education (CPE) required to qualify for secondary school entrance. In response to this situation, the Teen Hope project, which was launched in 1992, has set up a programme which caters each year for thirty children or so from Port-Louis who are no longer attending school and are left to their own devices because they have failed the CPE. The social workers and psychiatrists involved in this six-module training programme aim first to improve the young people’s general knowledge and to determine what medical, social, moral and psychological problems they may have. They are also provided with some initial vocational training (often in manual crafts and trades) to improve their self-esteem and to help them to become more socially integrated and to resist the pressures exerted by those promoting drugs and other addictive habits.

In 1995, a comparative study was carried out on young people who had undergone this training and a control group of young people with similar backgrounds who had also failed the CPE, and the results clearly showed how effective the programme was in terms of the trainees’ awareness of the risks involved in taking drugs, tobacco-smoking★ and drinking alcohol★. Nearly all those participating in the project thought drugs, tobacco-smoking and alcohol would damage their health, whereas only 52% of the control group expressed this opinion. The trainees had also taken in what they had been told about public health and social issues, since 100% showed that they had been well informed about AIDS, environmental protection and community problems, whereas only 64% of the control group had any knowledge about these topics.

In practical terms, the 1995 study showed that the
former Teen Hope trainees had fewer problems with the police (7% as against 13%), that a slightly larger proportion of them had found employment (93% as against 85%), and that lower proportion of them took drugs and smoked than in the control group. However, despite the success undeniably achieved by the programme in terms of the trainees’ awareness of the risks involved in addictive practices, this success was mitigated by the rather surprising finding that there was a higher percentage of alcohol-drinkers among the former Teen Hope trainees (31%) than in the control group. Paradoxically, these young people’s increased awareness of their disadvantaged status within Mauritian society may have been one of the factors responsible for their consumption of alcohol (28% of the Teen Hope trainees said they were exploited at work and 69% would have liked to attend secondary school, versus 16% and 48% in the control group, respectively).

In view of the encouraging results obtained on the whole, however, the Teen Hope programme has been granted a further lease and continues to be supported by the Port-Louis municipality.

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Promoting health at school

The FRESH project, which has been joined by several international organizations, encourages State authorities to set up full-scale school health programmes including AIDS and drug prevention.

At the Jomtien World Conference on Education for All (1990) the international education community recognised the negative effects of poor health on educational outcomes as well as the positive effects education can have on the health status of school-aged children. During the 1990s, the increasingly urgent need to combat drug abuse and HIV/AIDS accelerated the adoption of various preventive education programmes at schools. Lessons learned during this period have led to a shift towards a more general approach to school health, and the focus is more on promoting health in general than on preventing specific health-related problems, and health education is being brought into the curricula of schools in order to bring about long-term changes in behaviour.

A common approach to school health was therefore developed by UNESCO, UNICEF, WHO, and the World Bank. The FRESH initiative (Focusing Resources on Effective School Health) was launched at the Dakar World Education Forum (2001). The aim of this inter-agency initiative was to promote greater awareness of the value of effective school health programmes extending beyond physical health and including psycho-social and environmental health issues: this was one of the strategies towards achieving Education for All. The FRESH initiative was subsequently recognized by UNESCO as one of six inter-agency flagship programmes engaged in achieving education for all by 2015. FRESH proposes that a set of four basic core components of a school health programme should be adopted at all schools, with the support of intersectoral partnerships between the education and health sectors, the school and the community. Children and youth should be viewed as important participants in all aspects of these school health programmes and not just as the beneficiaries:

1. Health-related school policies that prevent exclusion and violence and discourage the use of tobacco and other harmful substances.
2. Healthy, safe and secure learning environments that encourage healthy lifestyles and protect children from exposure to negative role models and peer group pressure.
3. Skills-based health education that focuses on the development of the attitudes, values, and life skills needed to establish life-long healthy practices and reduce risk behaviors, with special emphasis on problems such as HIV/AIDS, violence, tobacco-smoking and substance use.
4. School-based health services that are simple, safe and familiar, and which address problems that are prevalent within the community, including referral to appropriate services to cope with HIV/AIDS and drug abuse.

At the international level, FRESH stands for a commitment to working together to create an impetus for school health programmes to be set up in all the countries involved.

“The FRESH initiative is not only a major flagship programme in working towards education and health for all but also in fostering the role of education in building a more caring and equitable world.”

Koichiro Matsuura
Director General, UNESCO
Most prostitutes in Europe have adopted the use of condoms. However, those taking drugs are more vulnerable and more highly exposed to the risks of sexual contamination.

The new ways in which prostitutes are being thought of and reached nowadays differ completely from previous medico-social practices. In the early 80’s, as soon as the information began to circulate that a new lethal sexually transmissible disease had arrived, male and female prostitutes were immediately accused of being responsible for its transmission. The fact that prostitutes were being used as scapegoats for the epidemic because they contributed to the spread of venereal disease back in the 19th. Century gave rise to some heated debate in France as to whether it might not be appropriate to bring back a system of strictly regulated brothels subject to obligatory public health inspection. The social workers’ organisations which had been dealing with prostitutes for a long time (mainly with a view to reintegrating them into society) objected that legal measures of this kind were liable to have stigmatising effects and were likely to be ineffective.

In Europe (1), the results of many surveys have shown that the rumours spread by the alarmists were unfounded: people who go in for prostitution have a relatively low rate of HIV infection, since they make regular use of condoms. The main risks of contamination arise in situations involving “private” partners with whom no condoms are used, and most of all, in situations involving drug addicts. Prostitutes who are drug addicts and often carry out casual prostitution under extremely poor conditions of hygiene and social integration are the most highly exposed to contamination by the HIV virus.

The results of sociological studies have made it possible to establish the links which exist between prostitution, drug abuse and exposure to the HIV virus. Drug addicts who inject themselves intravenously with narcotic substances not only run risks if they share their syringes with others, but they are even more liable to be contaminated if they also go in for prostitution: since they lack the money they need to buy the drugs they need, they are more likely to agree to having unprotected sexual relations, which many of their clients ask for. The altered states of consciousness induced by drugs also make them less capable of refusing their clients’ demands, and are thus more liable to have high-risk practices imposed on them against their will. The latter hazard constitutes a threat not only to those under the influence of drugs, but to all those under the influence of psychoactive substances of all kinds, whatever their legal status may be. The role played by drug abuse in exposing prostitutes to contamination by the HIV virus has led the organisations involved in AIDS

In Europe, the results of many studies have shown that the rumours spread by the alarmists were unfounded.
control to mobilise similar preventive strategies to those used on drug addicts, based on harm reduction*, peer education* and community health approaches.

Educational efforts focus on prostitutes of both sexes

When AIDS first arrived, it was immediately realised that prostitutes could not be reached via the existing system of education. The participation of the prostitutes themselves was required before anything could be done to help this population. Most of the preventive efforts made in Europe these days involve not only health professionals, but also professional drug prevention workers who were formerly prostitutes themselves, and whose knowledge of life on the streets therefore makes them ideal candidates for working with their peers. The idea underlying this mode of intervention is to create a new, less stigmatising picture of prostitution, which is no longer to be regarded as a social blemish, but as a legitimate, freely chosen form of activity. The fact that the term “sex trade workers” is tending to be used increasingly instead of the word prostitute in the context of AIDS prevention indicates that some changes are in fact occurring on these lines.

Reaching out to the streets and pavements

Preventive organisations are also characteristically undertaking Outreach activities. Since they are often dealing with people in highly precarious situations, who do not necessarily identify health problems as such and either do not know about the services available or are reluctant to make use of them, these services have to be highly mobile in order to be able to keep up with their potential users, whose activities are often carried out on the streets. Prevention workers often use camping-cars, which provide a friendly setting where it is possible to discuss any health problems over a cup of tea, to obtain counselling, to find out how to avoid being contaminated, to collect free condoms and syringes and make an appointment to be accompanied during the day to attend a consultation at a health care or social centre. “Boutiques” have also been opened in the hot spots where many prostitutes are plying their trade: these structures have similar objectives and provide similar services to those already catering for drug addicts.

The idea underlying this mode of intervention is to create a new, less stigmatising picture of prostitution, which is no longer to be regarded as a social blemish, but as a legitimate, freely chosen form of activity. The fact that the term “sex trade workers” is tending to be used increasingly instead of the word prostitute in the context of AIDS prevention indicates that some changes are in fact occurring on these lines.

The Tampep network, which is supported by the European Commission, has been acting as a link between the various preventive efforts made throughout the European Community to reach the migrant male and female prostitutes who have been crossing Europe since 1993. The TAMPEP project was launched in 1993 in four European countries and now extends beyond the framework of the European Union. It constitutes a model for multinational community interventions dealing with prostitutes of more than 20 different nationalities originating from Eastern and Central Europe, South-East Asia, Africa and Latin America. The project also includes monitoring activities on the social and legal status of migrant prostitutes and the conditions under which they work. TAMPEP provides its partners with relevant cultural information and preventive material in 10 languages about HIV and other STDs. The aim is to improve prostitutes’ self-esteem and to provide social and medical workers with training and information to enable them deal more effectively with these people’s specific health problems. TAMPEP works in collaboration with cultural mediators, members of the migrant communities who form a link between the community and the social and medical establishments, and peer educators, prostitutes who have been specially trained how to convey information and improve the self-confidence of their peers.

Here are some of the network’s main conclusions and recommendations:

- The prevention of AIDS and other sexually transmissible diseases should be part of each country’s general public health policy.
- Various combined initiatives designed to give migrant prostitutes greater self-confidence can be highly effective means of primary prevention, since they are the only means available for strengthening the position of prostitutes in their dealings with their customers and procurors.

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1 Contrary to what occurs in poorer countries, where people are more liable to be prepared to do anything to earn more money, the statistics on Thailand have shown that one woman and one child out of every two who go in for prostitution have been infected with the HIV virus.
One of the revolutions that took place in the 1990s in the realm of social assistance and public health care was the "low threshold" concept*. Given the likelihood that whole populations might escape all control because they either would not or could not fulfil the conditions of entry to the special schemes available (giving up drugs beforehand, undergoing interviews, complying with certain rules), the conditions of access to these programmes were reviewed. Deviance began to be viewed in the 1980s in terms of social exclusion rather than psychological susceptibility, and this paved the way for a new approach to drug addiction from the social assistance and health care point of view. This approach involves working on the streets, reaching out to people in difficult situations, peer prevention* and teaching self-reliance rather than attempting to tackle the users’ problems from the outside. Low threshold programmes have made it possible to contact users of psychoactive substances who were drifting farther and farther away from institutional prevention and care programmes. Rave missions have made it possible, for example, to address young non-injecting, casual or novice consumers of psychoactive substances (the mean age of this group is 23). The great majority of these young people claim that their drug use is perfectly under their control. Unfortunately, this does not prevent them from taking frequent risks as to which substances they take and how they go about it.

It is as essential to provide the new users of the latest designer drugs with relevant information and the practical means of taking health precautions as it was with the injectable drug users ten years ago.

The first experiments on these lines (syringe exchange programmes (SEPs)* based on buses, working on the streets) were launched by associations. Over the years, the low threshold approach developed with the opening of the first boutiques, syringe exchange points and sleep-ins, and rave missions were eventually set up. These outreach programmes can be said to involve three different stages. The first stage, which is the first step towards complete negotiated immersion in the locality, consists of setting up boutiques, sleep-ins and support centres (SEPs and/or day-time and night-time centres). These places are open to the outside world but are nevertheless highly institutionalised because of their permanent urban location. Although the low threshold approach is supposed to do away with all constraints, the users naturally have to comply with the minimum internal regulations when attending these facilities.

The second stage of involvement, which is that of total negotiated immersion in the locality, results in syringe exchange points, low threshold...
methadone buses and rave missions. The mobility of these structures enables them to actually enter the social gathering points where drugs are being used, whether they are in the town centres or whether they are places of leisure. The presence of mobile units and booths does, however, remind people of the institutional aspects of the operation. Triggering interactions therefore involves a process of negotiation, but less obviously so than in the previous stage. If the users feel they are being manipulated, they are free to leave whenever they like.

**Suspending judgement is a tool which makes it possible to imagine how risks and harm are perceived in the context of drug use.**

There exists only one way so far of achieving the third and last stage of involvement, which is that of total, non-negotiated immersion: by implementing outreach programmes (working on the streets, in apartment buildings, in the places occupied by squatters and those where illicit psychoactive substances are being sold, purchased and consumed). This approach is the one that comes most closely in touch with the whole social context bound up with drug use. With no institutional support to hand, the prevention workers have to adapt to the logic of the places they are exploring. The success of the venture will depend on the workers’ ability to detect, note and make use of whatever seems to be meaningful in a hitherto unknown environment.

What the prevention workers reaching out in this way to the most socially disadvantaged groups are being asked to do is something radically new. It is not just a question of their physical ability to undertake work of this kind. Reaching out to people on the fringes means that the workers have to invest social precints with which they have never been traditionally familiar before.

It is vital that the logic underlying the social context in these places should be properly understood by all these pioneers; otherwise, they might miss the point, resulting in the failure of any action taken. To be effective, low threshold workers therefore need to have detailed knowledge about the neighbourhoods where they are working. They must understand the codes and customs and know how to manage interactions with people under the influence of illicit substances. Although this competence might look like a kind of know-how, there is no need, in our opinion, for workers to have actually taken drugs themselves to be able to acquire this know-how. A non-judgmental attitude is the main tool here, and this enables workers to see exactly how risk, harm, passing time and even pleasure are represented and perceived by users of various kinds.

Those who have acquired the necessary empirical knowledge, showing empathy for the users themselves, have gradually been able to define procedures for building strong, long-lasting relationships based on mutual trust with the people targeted and identifying needs that had not been noticed before, which is most important. Rave missions are interventions which do not focus on a specific group of users but on the specific social arenas in which substance use takes place: these are places of leisure. Although techno circles, with their highly tolerant outlook, were the first to agree to letting prevention institutions into their midst, rave parties are far from being the only places where interventions of this kind are required: large-scale consumption of psychoactive substances has been reported to occur in many other places such as concerts, festivals, clubs and discotheques.

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1 From the Rave mission run by Mutualité Française Alpes-Maritimes/Médecins du Monde, PES Médecins du Monde, Nice, France.

2 From the Rave mission run by Mutualité Française Alpes-Maritimes/Médecins du Monde, Groupe de recherche sur la Vulnérabilité Sociale (GRVS).

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**RAVE MISSION WORKERS FROM MÉDECINS DU MONDE**

what their work consists of

- Running emergency aid posts: these are manned by a team including a qualified doctor and nurses equipped with a basic emergency aid unit.
- Monitoring recent trends in the use of psychoactive substances;
- Public health watch activities: working with the Observatoire Français des Drogues et des Toxicomanies, and affiliated with the rapid warning system set up by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);
- Providing risk and harm reduction services focusing on the use of psychoactive substances: qualified workers provide information and counselling, are available to talk to, test drugs, distribute prevention items (brochures, condoms, water, cereal bars, straws, etc.);
- Working to prevent addictive behaviour: social and health professionals give consultations, diagnosis, orientation, arrange for referral to other structures and subsequent follow-up;
- Running drop-in centres for users previously contacted by the Rave Mission programmes: these centres are permanently staffed during the daytime.
A world-wide peer education experiment

The UNDCP encourages groups of young people throughout the world to develop peer drug prevention programmes by helping them to share their experience and skills.

The United Nations International Drug Control Programme aims to have members of the populations targeted, especially young people, participate in defining these programmes. UNDCP is convinced that these people are part of the solution and not just part of the problem, and that investing in international programmes makes it possible to narrow the gap between young people and decision-makers. In 1998, a drug prevention forum was held in Banff (Alberta, Canada), at which several groups of workers who were fighting drug abuse in their own communities shared their experiences and drew up proposals that were subsequently submitted to various governments at the special session on drugs of the United Nations General Assembly. The embryonic Global Youth Network had taken shape.

By now, more than fifty groups throughout the world (cf. insert) are pooling knowledge and experience with the help of UNDCP: a mailing list on the Internet makes it possible to keep up with innovative and relevant prevention programmes and new trends in drug abuse and to update information via a newsletter, called Connekt (4 yearly issues). Also in preparation are a web site on which all the groups in the network will feature and be able to lend each other a hand, as well as a handbook designed for those who want to become involved in prevention work.

UNDCP does not plan to open a permanent office for this network, points out Stefano Berterame, of the UNDCP Demand Reduction section and Project Co-ordinator: the ultimate goal is to set up independent regional groups.

The specificity of this network based on the peer approach is that it actually includes some drug users’ self-support groups, as well as groups that focus specifically on AIDS prevention. This realistic approach results from the fact that UNDCP and UNAIDS’ have worked together in the regions of the world that have been hardest hit by the epidemic.

For further information: www.undcp.org/global_youth_network

Member Associations of the Global Youth Network Project

North America
United States (1)
Canada (14)

South America
Bolivia (1)
Colombia (1)
Guatemala (2)
Honduras (1)
Mexico (1)

Europe
Germany (2)
Italy (1)
Norway (1)
United Kingdom (1)
Sweden (1)
Hungary
Russia
Ukraine

Africa
Egypt (1)
Ethiopia (1)
Kenya (1)
South African Rep. (1)
Senegal (1)
Tanzania (1)
Togo (1)

Asia
Bangladesh (1)
India (7)
Kuala Lumpur
Sri Lanka (1)
Thailand (1)

Others
Iran (1)
Palestine (1)
Mauritius (1)
New-Zealand (1)
Australia (1)
The specificities of female drug addiction

Female use and abuse of drugs has been studied for only a short time. Its connections with violence, the fact that is rarely brought into the open, and its highly negative social image have served as convincing arguments for developing programmes specifically targeting women.

In the United States, eighteen States have passed laws against pregnant crack or cocaine users. These women run the risk of having their children taken away from them either temporarily or for good, and in South Carolina, of being sentenced to prison for up to 10 years (1). Drug use is stigmatised in all societies, but it is frowned upon even more when the user is a woman. It has been estimated for example that 9 out of 10 women go on living with alcoholic partners, whereas only 1 out of 10 men do so (2). Women have no choice but to hide their addiction. To declare it openly is to sign a social death warrant, and sometimes actually leads to physical death: many women questioned at treatment centres admitted that they had made suicide attempts (3). Men presumably feel less guilt about their addiction than women, and are able to maintain higher levels self-esteem because they are more able to blame their drug abuse on external causes. The medicalisation of women's lives (2) also explains why no one ever notices they are taking drugs. Although they take fewer hard drugs (there is only 1 woman hard drug abuser for every 3 men) and alcohol (there is only 1 woman alcohol abuser for every 2 men), physicians prescribe three times more benzodiazepines* for female patients, thus causing further addiction while confining this "normalised", medically-prescribed consumption to the secrecy of private life.

The fact that women are blatantly in the minority among the patients attending specialised centres seems to be due to their role as mothers. Between 18% and 75% of all the women undergoing treatment have at least one child (4) and are afraid that they will be accused of being irresponsible mothers. They also often have the impression that they are being inspected more than they are being helped (5). One of the arguments put forward to justify setting up centres equipped with child minding facilities is that it is harder for women to talk about the violence to which they have subjected when men are present. The results of etiological studies (3) have shown that the fact of having undergone sexual violence, especially during childhood, is closely correlated with the consumption of heroin, cocaine and alcohol.

On the world-wide scale, physical and sexual violence results in the death or mutilation of more women aged between 15 and 44 than cancer, malaria, road accidents and even war. Given this context, female drug abuse might be regarded as a kind of survival strategy.

(continued on page 124)
WHY HAS RESEARCH ON WOMEN TAKEN SO LONG TO GET OFF THE GROUND?

Medical research in general has not paid much attention to the situation of women. One reason for this lack of interest is a purely pragmatic one: testing new medicines may harm the foetus via the mother’s milk. All pharmaceutical studies were therefore based on a standard subject, the healthy young male, despite the fact that women account for 51% of the Canadian population. An increasing number of studies have recently been trying to make up for this late start. The second reason is that historically, addiction has always been thought of as a problem specific to males. Drug users are assumed to be mostly young men. There was also the nineteenth-century image of women that continued to hold sway. Women are expected to be nurturing mothers who run the home and are responsible for the moral upbringing and education of the children. In 1950, the idea of alcoholic women was still unthinkable. Until quite recently, even smoking a cigarette was a specifically male activity. Nowadays, teenage girls are tending increasingly to smoke cigarettes, even more than men, who have cut back on their consumption.

Manuella Adrian, anthropologist.
Worth consulting:


Surveys carried out in Germany, France and Ireland have indicated that HIV and HVC are on the uprise among female drug consumers (6). This would seem to result from greater risk-taking with injections and unsafe sex. The trend is attributable to the fact that women have less scope to negotiate whether a sexual partner is going to wear a condom or not, while being at the same time more susceptible to all sexually transmitted diseases, including HIV infection. Their sexual organs are more accessible to the virus, and have a more sensitive and more easily damaged surface. Women are usually initiated to drug use by a partner or a member of their family (siblings or elders), whereas men are usually initiated by peers. Female users of hard drugs such as heroin, cocaine and crack, are forced to seek the protection of a partner from street violence: the authors of several studies have reported that drug-consuming couples frequently share their syringes and forego the use of condoms. Since illegal drugs such as cocaine, crack and heroin are expensive, women sometimes barter a dose in exchange for sex, and this leads them into prostitution. According to the latest European studies, 60% of all the women who consume hard drugs go in for prostitution. The risk that these women may contaminate their customers with infectious diseases has always been a cause for concern and has been one of the reasons for the development of harm reduction programmes for prostitutes as well as schemes for treating female drug abusers. A number of local low threshold Outreach projects have been set up in Europe for women, which provide shelter, information and practical advice about safe sex and reducing the risks associated with drug consumption. Mutual aid groups such as Mainline in Amsterdam give women access to various services and activities designed to bolster their self-esteem, such as hairdressers, theatrical activities - and self-defence.

1 • www.lindesmith.org
5 • The “Femmes, dépendances” forum is a group that brings together women from all over French-speaking Switzerland, who are interested in addiction-related issues within a gender context. Under the auspices of the ISPA, also cf. “Points de vue sur les toxicodépendances des femmes en Suisse romande, Enquête sur la demande et l’offre d’aide spécialement destinée aux femmes”. Lausanne, 1998.
6 • Annual report of the OEDT 2000.

A TRANS-NATIONAL SURVEY ON EUROPEAN WOMEN

At the request of the European Commission, the European Institute for research on risk factors in childhood and adolescence (IREFREA) has launched a vast survey on drug dependence among women. In 2000, the network set up for this purpose in Germany, Spain, France, Italy and Portugal published its first findings, entitled “Women drug abuse in Europe: gender identity”, based on interviews with female heroin addicts undergoing treatment. This book addresses two main questions, which can be summed up as follows: what effects do drug abuse and childbirth have on the development of women’s sense of identity? The risk factors involved and some specific preventive strategies are presented in the form of a practical handbook for people dealing with drug abuse problems. A more complete version of this report will become available shortly.

These findings can be consulted directly in French and English at the following website: www.irefrea.org
ABUSE, USE, ADDICTION • Drug abuse, as officially defined by the United Nations, differs from simple use: drug abuse is a problematic mode of use. Use therefore means taking psychoactive substances as long as this does not cause any complications or harm. In the case of legal drugs such as alcohol, the distinction between use and abuse has been widely accepted. The distinction is not so clear-cut, however, when it comes to illicit substances: some people contend that the use of illicit substances equals abuse. Others feel that preventive efforts should focus on the problems resulting from the abuse of all drugs (whether legal or illicit) without having to bother about their simple use. UNESCO prefers to talk about drug abuse rather than addiction (or "toxicomanie", the term often used by French-speaking authors). Drug abuse actually refers to all the harmful consequences resulting from the use of drugs at both the individual and social levels (in the latter case, it is the very fabric of society which is damaged). Addiction refers quite restrictively to situations where dependence on a drug has become a person’s main concern in life, if not their sole concern. This term is often used in connection with dependence on illicit substances. However, UNESCO does not intend to implicate any particular substance, but to prevent the abuse of psychoactive substances in general, using educational tools.

AIDS (Acquired Immuno-Deficiency Syndrome) • the most serious form of HIV infection.

ALKALOIDS • active compounds present in plants.

ALCOHOL • one of the oldest psychoactive substances consumed in the course of history. Alcohol is both physically and psychologically addictive, as well as being highly toxic. Alcohol associated with other products such as cocaine can be particularly dangerous (cf. p.46).

AMPHETAMINES • synthetic stimulants in the form of tablets or powder which can be either snuffed, smoked or injected. These substances can lead to psychological dependence. Their abuse can cause heart problems, aggressive behaviour, paranoia and anxiety, hallucinations and psychiatric disorders in predisposed persons.

BENZODIAZEPINE • a psychoactive molecule with anxiolytic and hypnotic pharmacological effects (depending on the dose) which is often self-prescribed for medical purposes, and is used by drug addicts to alleviate withdrawal symptoms and reduce anxiety. There exist four classes of benzodiazepines: anti-epileptics, myorelaxants, hypnotics (including Rohypnol®) and anxiolytics (including Valium®).

BROWN SUGAR • heroin with a brownish colour imported from India, which lends itself to inhalation practices.

CANNABIS OR INDIAN HEMP • a plant with active constituents known as THCs, listed as a narcotic. Cannabis comes in three forms: weed or marijuana (the leaves, stems, etc.), hashish (resin obtained from the flowering tops of the plant) and oil (a preparation with higher active contents).

COCAINE • a natural alkaloid extracted from coca leaves. There also exists a synthetic form. Cocaine comes in the form of a white powder which can be either sniffed, smoked or injected. Injected cocaine soon becomes habit-forming, and addicts need increasingly frequent doses. Cocaine is one of the most addictive of all drugs. It leads to less physical than psychological dependence, and the latter dependence is particularly strong. The use of cocaine is tending to develop in europe and is becoming a public health issue (cf. pp.22, 94, 96).

CRACK • in the free base form, which comes in the form of pellets which are usually smoked, or more rarely, injected. The effects of crack differ from those of cocaine consumed alone, since crack is inhaled in the form of vapour and acts within a few seconds, whereas drugs which are sniffed require several minutes to take effect. Dependence sets in very quickly and crack is highly toxic (cf. pp.22, 67).

CRAVING • an irresistible, violent need to use an addictive drug (such as heroin, and especially psychoactive substances such as cocaine, crack and amphetamines). This urge can sometimes even be felt by former drug addicts after a long period of abstinence (cf. p.94).

DEPENDENCE • behaviour where the consumption of one or several psychoactive substances becomes an absolute priority and there is a compulsive need to procure the substance(s) in question. The risk of dependence is not exactly the same in all individuals. The vast majority of occasional drug users do not attempt to repeat their first experience, and above all, 90% of all those who use illicit drugs never become addicted. There exist several factors (genetic, social, cultural and environmental factors, for example) which contribute, however, to making some individuals particularly vulnerable to drugs and drug abuse and eventually, to drug addiction.

PHYSICAL DEPENDENCE • according to one of the hypotheses put forward to explain the process of drug dependence, addicts attempt to maintain sufficiently high levels of some substance(s) in their body, not only because of the sensations of pleasure and well-being they procure, but also to avoid the discomfort and physical pain which would accompany their withdrawal. However, most drugs lead to psychological dependence without any physical dependence: only opiates, alcohol, cigarettes and anxiolytics are really associated with a physical withdrawal syndrome.

PSYCHOLOGICAL DEPENDENCE • psychological dependence, which is induced by the pleasure experienced when taking a drug, results from the fact that this drug acts mainly on the reward-response system in the brain. Psychoactive substances such as opiates, cannabis, nicotine and probably also alcohol all directly or indirectly stimulate the neuronal pathways containing dopamine, a neurotransmitter involved, for example, in the control of affective behaviour and the regulation of emotional states, especially pleasure.

DMT • a natural hallucinogenic substance which takes the form of a brown-coloured solid and can be either smoked or inhaled. It has no effect when taken orally, because it is destroyed by a gastric enzyme.

DRAGON (chasing the dragon) • a technique consisting of inhaling the vapour released by heroin which has been heated over a flame, usually after placing it on a piece of aluminium foil.

ECSTASY OR MDMA • ecstasy was originally the name given to a synthetic molecule, MDMA, which was originally developed in 1912 for military purposes. The composition of the pills sold under the name of ecstasy is often extremely dubious. They sometimes contain no MDMA at all, or it can be mixed with other substances such as LSD, ketamine, etc., which increases the risks run by consumers. (cf. p.117).

EPHEDRINE • an alkaloid extracted from the leaves of the ephedra plant, which is widely used for medicinal purposes, but is also known to have psychoactive properties.

EPIDEMIC • an unusually sharp increase in the number of cases of an infectious disease in a given region or population.

EPIDEMIOLOGY • the science which deals with studying the causes of the onset, spread and disappearance of a disease in a given population.

GHB (gamma-hydroxybutyrate) • an anaesthetic with a two-fold action, since it has elevating effects on the mood as well as sedative and amnestic effects.

HALLUCINOGENICS • psychoactive substances which are popular because of the visual or auditory hallucinations they induce. Most hallucinogenics, which include LSD and some fungi, are plants or alkaloids extracted from plants.

HASHISH • cf. cannabis

HEMP • cf. cannabis
Hepatitis • an acute or chronic liver infection caused by a parasite, a toxin or a virus. The hepatitis viruses known to exist so far are the A, B, C and delta viruses. The HBV and HCV viruses, which are transmitted via the same pathways as the HIV virus, are the most virulent. They sometimes give rise to active chronic forms of hepatitis which develop into cirrhosis of the liver. Hepatitis C is an old disease which has only recently been recognised and more fully understood: this form accounts for 90% of all the cases which used to be labelled hepatitis non-A, non-B. The hepatitis C epidemic which is occurring nowadays among drug users constitutes a major public health issue. The impressive rate of contamination by the virus C occurring in this young population and the high rate of hepatic morbidity which it is bound to develop in the years to come are extremely alarming. Epidemiological studies carried out in the member countries of the European Community have shown that in all these countries, 70 to 80% of all the drug users are infected with this virus. Contamination is due mainly to the sharing of syringes, but also occurs via the fabric used to filter the heroin after dissolving it in a spoon, and via the rinse waters used. Nearly all the patients contaminated have contracted the virus by the time they have been shooting drugs for one year.

Heroin • a synthetic opiate obtained from morphine, which takes the form of a white paste or powder. It can be either sniffed, injected or smoked. It is conveyed more quickly than other substances to the brain, where it is transformed into morphine. Heroin is associated with extremely high risks of physical and psychological dependence. Heroin abuse gives rise to major public health problems, mainly because this substance is injected intravenously, and heroin injectors therefore run a high risk of bacterial and viral contamination (by the HIV and hepatitis viruses, for example). Base heroin vapours can be inhaled (cf. “chasing the le dragon” and p.13).

HIV • the Human Immuno-Deficiency Virus, which is responsible for HIV infection and AIDS. The distinction has been made between the HIV-1 (which is the most widespread in the world) and the HIV-2 (which occurs mainly in Western Africa).

Ketamine • an anaesthetic originally used in veterinary medicine, which is misused because of its psychodelic properties. In very high doses, this substance can result in mental disturbances (amnesia) and psychological dependence.

LSD • a synthetic psychoactive substance characterised by its powerful hallucinogenic effects. Its use was strongly associated with the “flower power” movement which occurred during the 1960s.

Maintenance • the early stage in the treatment of subjects who are physically addicted to psychoactive substances. Maintenance can be carried out under either hospital or ambulatory conditions and is designed to reduce the undesirable physical and psychological symptoms which occur when a drug is withdrawn.

Mandrax • a hypnotic substance belonging to the benzodiazepine family.

Morbidity • the number of sick persons or the number of cases recorded during a given period in a given population.

 Morphine • a psychoactive alkaloid extracted from opium, which is used for medicinal purposes as an analgesic. Abuse of this substance can lead to dependence. The pharmacological properties of morphine are similar to those of most opiate agonists, such as heroin, codein, methadone, LAAM, etc. The pharmacological properties of morphine differ considerably from those of opiate antagonists (such as nalorphine, naloxone and naltrexone) and those of mixed agonist/antagonists (such as buprenorphine).

Multi-drug addiction • simultaneous or successive dependence on psychoactive substances of several kinds.

Neuroleptics • psychoactive medicinal substances which have depressive effects on mood, and are indicated mainly in the treatment of psychotic disorders.

Opiates • various products extracted from opium, a substance obtained from the poppy Papaver Somniferum. The natural alkaloids present in this plant are morphine and codein; the corresponding synthetic compounds are heroin and buprenorphine (Subutex®, Temgesic®& Addonal® and methadone).

Opium • a preparation obtained from the latex of the capsules harvested from the poppy Papaver somniferum, which has a high alkaloid content (morphine, codeine, etc.) and has long been used for medicinal purposes.

Pandemic • a particularly disastrous epidemic which has spread throughout the world.

Prevalence • a figure giving the number of cases of a disease at a given stage in an epidemic.

Propylaxis • the part of therapeutic strategies designed to prevent the spread or the aggravation of a disease.

Psychotropic substances • substances which have mainly psychological effects, without systematically causing dependence or addiction in those who take them.

Rohypnol • a hypnotic substance belonging to the benzodiazepine family.

Speed-ball • a mixture of heroin and cocaine which is injected.

Synthetic drugs • products manufactured illicitly from chemical precursors which have much stronger effects than the corresponding natural substances. The consumption of synthetic drugs such as ecstasy, the most popular of these drugs, is on the increase in Europe.

Le vint • a home-made amphetamine based on an extract from the ephedra plant, which has to be injected within one hour of its preparation in a cooking-pot, because of the instability of the mixture. The health of amphetamine abusers deteriorates very quickly.

White horse • heroin of a more highly refined type than brown heroin.

Substitution

Substitution treatment • a neurobiological method of treating pharmacodependent subjects, based on the administration of a medicinal substance (methadone, buprenorphine or LAAM in the case of heroin addicts and nicotine in that of heavy smokers) which has similar pharmacological effects to those of the psychoactive substance to which the person is addicted. The aim of substitution treatment is to reduce, or at least to stabilise the consumption of heroin and other substances without triggering painful psychological and physical withdrawal symptoms, to place the patient in a health care setting, and especially, to provide a sufficiently strong system of psychological and social support to ensure that the patient does not immediately revert to the use of opiates at the end of this usually rather long period of treatment. The aim is always to help the patient to draw up a project for living in which drug addiction can have no place (cf. pp. 79, 90).

Agonist/antagonists • the products used for drug substitution treatment are either agonists, which activate the opiate receptors in the brain, thus mimicking the effects of the drugs, or agonist/antagonists, which not only activate the opiate receptors in the brain, but also simultaneously reduce or abolish the effects of any other opiates or opioids which have been consumed.

Buprenorphine • an opiate prescribed in low doses as a pain-killer and in much higher doses in heroin substitution treatment. Buprenorphine has both agonistic and partially antagonistic effects on the opiate receptors. Its effects last for approximately 30 hours. It partly counteracts the effects of heroin, alleviates drug withdrawal symptoms and there is little risk of tolerance developing during long periods of use, and the dose levels are similar to those used with methadone. Buprenorphine is subscribed for drug substitution treatment in much the same way as methadone. France has been the first country in the world where buprenorphine has been widely prescribed for this purpose. However, the drug is often misused. Some patients have no hesitation in obtaining several prescriptions and injecting themselves with filtrates they have prepared with the pills. Some lethal cases have been recorded where patients have misused buprenorphine by injecting it or associating it with benzodiazepines and alcohol. Risky practices of this kind favour the occurrence of respiratory depression.

LAAM • a synthetic opioid agonist with very long-lasting effects, which has similar pharmacological properties to those of methadone and can be used therapeutically as a substitute for heroin as little as three times a week, whereas methadone has to be taken every day.

Methadone • a synthetic opiate with similar pharmacological effects to those of morphine, which is prescribed in the framework of heroin substitution treatment. Like morphine and heroin, methadone is an opiate agonist, and therefore has similar pharmacological properties.
to those of the latter drugs. It has been in use for several decades by now in drug substitution programmes. It restores deregulated neurobiological systems for 24 hours without having any of the pleasurable, euphoric or sedative effects characteristic of heroin. In addition to the fact that it inhibits the craving for heroin, this substance has anti-psychotic and anti-depressive effects (cf. p.90).

**NALOXONE** • an opiate antagonist used for medical purposes (Naloxone®, Narcan®) to treat acute intoxication by heroin, morphine, methadone and other opiate agonists.

**SUBUTEX®** • buprenorphine prepared in high dose levels. This substance is widely prescribed in France by medical practitioners to treat heroin addicts. (cf. buprenorphine). Sold in some countries under the name Buprenex®.

**TEMGESIC®** • see low dose buprenorphine.

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**Prevention and preventive education**

**PEER PREVENTION** • a method which makes use of the empirical, cultural and social knowledge accumulated by members of a given community (drug users, young people, women, etc.) these special messengers help to inform and train their peers, and thus ensure that preventive messages are properly put across and understood (cf. p.119).

**PREVENTIVE EDUCATION** • the aims of UNESCO’s strategy for preventive education as a means of fighting the HIV/AIDS epidemic were as follows: to promote health and prevent disease by providing the knowledge, attitudes, skills and means required to reduce the risks, encourage careful practices and decrease the impact of the disease. It was based on two essential beliefs: that education is a valid preventive tool and that drug prevention is possible. It consists of providing individuals with the means of dealing with the problems associated with licit and illicit drug abuse by teaching them to think for themselves and make decisions. It is therefore not just a question of providing information about one or several specific products. Preventive education consists mainly of finding means of developing the individual competencies required to cope with the risks people are bound to encounter during their lifetime.

**PREVENTION** • a set of measures designed either to prevent the occurrence of a specific event (primary prevention), to reduce the consequences by taking appropriate steps (secondary prevention) or to treat the effects after the event has occurred (tertiary prevention) (cf. pp.108 and 111).

**PREVENTION AS DEFINED BY WHO** (1966) • primary prevention is designed to limit the overall incidence of a disease by preventing exposure to the known risk factors. Secondary prevention consists of limiting the harmful consequences of the disease by intervening before the onset of the symptoms, or shortly thereafter. Secondary prevention therefore includes both detecting the disease at an early stage (and possibly identifying any asymptomatic cases) and taking appropriate curative measures. The aim of tertiary prevention is to limit the consequences of a disease which has already begun to spread and to make every possible effort to improve the quality of life of those who have contracted the disease.

**GENERAL PREVENTION** • promotes individual autonomy, self-esteem and well-being. This type of prevention deals with risk behaviour of all kinds, including drug abuse (cf. p.108).

**SPECIFIC PREVENTION** • focuses on the analysis of the risk factors associated with drugs and drug practices. An example: specific crack prevention efforts (cf. p.108).

**SELF-ESTEEM** • self-esteem is often said to be one of the personal factors which prevent people from taking multiple risks of all kinds throughout their lives, including those associated with drug abuse. Self-esteem is therefore a factor of great relevance to health education and drug prevention, whether one is dealing with use, abuse or addiction. Self esteem can be defined as the value judgement we make on ourselves in the various spheres of life. Self esteem does not depend on other people’s opinion, since it means being aware of one’s own potential. Every human being has his own worth, an intrinsic worth, which does not depend on what he does, and this distinction is vital. Self-esteem is a dynamic, constantly evolving process which can vary depending on the circumstances. Although the acquisition of self-esteem during childhood obviously depends on the family environment, it can go on being improved as long as one lives. It can also differ from one sphere to another: one can hold oneself in high esteem as a parent, for example, but not in one’s professional capacity. Self-confidence depends on self-esteem (cf. p.108).

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**Some harm reduction concepts and tools**

**HARM REDUCTION** • a set of personal and collective public health and social measures designed to reduce the harm resulting from licit and illicit drug abuse, such as contamination with the HIV virus, in particular. Harm reduction can consist of various measures, including syringe exchange programmes, medical treatment (using opiate substitutes), psycho-social counselling, and strategies for reaching out to the most vulnerable populations and those with no access to health care systems. These schemes were initially designed for heroin injectors, and then extended to include other substances (illicit products as well as alcohol and cigarettes) and practices. When it has not been possible to prevent the consumption of these substances, the aim is to at least reduce the harm they cause at the public health and social levels. Drug abuse is assumed to be a fact of life which cannot be abolished by introducing policies, and the large majority of all drug addicts are thought to be unable or unwilling to give up their drugs at a moment’s notice. Offering to help only those who have decided to stop taking drugs therefore amounts to ignoring the vast majority of the drug users.

The concept of harm reduction is based on a few distinctions which are fundamental, although not yet completely consensual. The four main distinctions are as follows: 1) how harmful various products may be. Cannabis is nothing like as harmful as heroin or crack; 2) occasional use is not the same thing as abuse and dependence on drugs; 3) the distinction should be made between injection practices, which are the most dangerous (they involve the risk of infection and of taking an overdose) and products which are used in other ways (smoked, ingested or inhaled); 4) it is necessary to take the context surrounding the drug use into account: taking leisure drugs in a protected social environment (people who are well integrated into family and occupational circles) is not at all the same thing as taking drugs under extremely precarious and marginal social conditions (nomadism, homelessness, desocialisation). It is mainly in the industrialised Western countries that this preventive approach, focusing specifically on infectious risks, has been introduced (cf. pp.75 to 96).

**BOUTIQUES** • structures open to drug users in highly precarious situations who have not (or have not yet) decided to give up taking psychoactive substances. Boutiques are places where people can have a shower, wash their clothes and obtain preventive items such as sterile needles and condoms. They may also find an opportunity here of applying, if they so wish, for social assistance and medical treatment, via a multi-disciplinary team of specialists (nurses, physicians, educators and psychologists).

**DISINFECTING INJECTION EQUIPMENT** • the first harm reduction message which must always be delivered is that one new needle = one shot. If it is impossible to find an unused needle, but in this case only, it is recommended to disinfect the injection equipment. Disinfection does not provide absolute protection, however, from the HIV virus, and even less from the hepatitis C virus (HCV). It has not yet been definitely proved in the scientific literature whether or not disinfection with bleach is completely effective. In addition, disinfecting equipment with bleach is a fairly complex procedure. The disinfectant must be used, otherwise it is quickly degraded and loses its disinfectant properties. The syringe must be left to soak in fresh bleach for at least five minutes, which may seem rather a long time to wait for somebody in need of a shot. What is more, the hepatitis C virus is much more resistant and less sensitive to disinfectants than the HIV virus. In Europe, approximately 70% of all the drug injectors are already infected with the HIV virus, which has become a serious public health problem. HCV is transmitted not only via syringes, but also via the cotton used as a filter, the water and the recipients in which the mixture to be injected is prepared. The injection kits distributed by associations are designed to prevent contamination with hepatitis C, and in
addition to sterile needles, they also contain small bottles of sterilised water, recipient for preparing the mixture, and filters. All these items should of course be disposed of after being used, and are not to be re-used. The pads imbied with alcohol which are also to be found in these kits serve to reduce the risk of microbial infection which arises whenever injections of any kind are performed: users should wash their hands and disinfect the skin at the injection site both before and after performing the injection.

**INJECTION** injecting is by far the Most dangerous way of taking drugs, not only because of the risk of contamination with HIV and HCV which it entails, but also because of other health risks, such as microbial infection, abscesses, damage to the veins, greater risks of overdose, etc. Harm reduction policies encourage people to give up these practices in favour of other modes of use, and informs users who are unable to give up injecting about the ways of reducing the risks to which they are exposed: using syringes once only, disinfecting the skin before and after injecting drugs, etc.

**INJECTION ROOMS** places created in some European countries for users of illicit psychoactive substances living on the fringes of society. The aim is to provide the minimum conditions of hygiene ensuring that the injection of these substances is carried out safely, and enabling an initial contact to possibly occur which may lead the person to apply for treatment later on.

**LOW-THRESHOLD** a term applied to structures which are accessible without imposing rigid conditions (such as obligatory health care or drug withdrawal schemes) liable to discourage people in difficulty from making use of them. These places are open to the drug users in the most difficult situations. They provide help, somebody to talk to and simple medical care (The so-called “boutiques” are open during the day, and the “sleep-ins” are open at night). High-threshold structures are those which accept only selected patients agreeing to comply with specific constraints, and who have therefore reached a fairly advanced stage on the road to being cured. At methadone centres, for example, the patients who are being treated are obliged to undergo urine tests (cf. pp.83 and 116).

**METHADONE BUS** a mobile unit providing the most socially excluded users of psychoactive substances with “low threshold” substitution treatment.

**PRESCRIPTION-FREE SYRINGES** a scheme making syringes available at chemists’ shops without having to present a doctor’s prescription. This makes for easy access to sterile syringes and thus reduces the risk of contamination which arises when infected needles are shared. The syringes sold at chemists’ shops account for 90% of all those used by drug injectors in France.

**PREVENTIVE INJECTION KITS** ready-to-use injection kits containing syringes and other items, which are sold at chemists’ shops and hospitals and distributed by preventive associations. These kits are intended to reduce the risk of transmission of infectious diseases among the injectors of psychoactive substances.

**SELF-SUPPORT** a movement organised by drug users themselves to prevent social stigmatisation, improve health care structures and promote harm reduction. Whenever these groups exist, they serve as an interface with the public authorities and optimise the delivery of specific prevention messages (cf. p.85).

**SYRINGE EXCHANGE PROGRAMMES** (SEPs) a spearhead preventive service whereby sterile syringes are distributed free of charge or exchanged for used ones (cf. p.81).

**SYRINGE DEPOSITS AND/OR VENDING MACHINES** vending machines where drug injectors can either purchase sterile syringes or obtain them in exchange for used ones.

**TESTING** carrying out tests with chemical reagents in order to determine whether or not a drug contains specific substances. Testing is carried out at rave parties in Holland and France in order to inform the potential consumers about the contents of the pills they are about to take and to warn them about the effects they are liable to have. Rave parties are secretly organised parties held in places which were not initially designed for social gatherings (warehouses, quarries, barns, fields, etc.). These events are attended by young people who dance all night to loud, syncopated music and sometimes consume psychoactive substances, especially synthetic drugs (cf. p. 117).

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**Some useful sites**

**AIDS**

**WWW.AVERT.ORG**

(English) This web site is produced by AVERT, a leading UK Aids Education and Medical Research charity, and contains HIV and AIDS statistics, information for young people, personal stories, a history section, information on becoming infected, and a young and gay section, grants and lots more.

**WWW.UNAIDS.ORG**

(English) Joint United Nations Programme on HIV/AIDS. A site packed with information on campaigns, publications, press releases, best practice and more.

**DRUGS, DRUGS ABUSE**

**WWW.WHO.INTERNET/STANCE_ABUSE/PAGES.DOCs.HTML**

(English) The WHO Substance Abuse Department seeks to promote the concept of Health for All through its strategy of reducing the incidence and prevalence of substance abuse. The achievement of this goal is designed to lead to reductions in the demand for psychoactive substances and to reduce the health and social problems associated with such use. This link includes Rapid Assessment Guides developed by the Centre for Research on Drugs and Health Behaviour.

**WWW.EMCDDA.ORG**

The Lisbon-based European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) was set up in 1993 in response to the escalating drug problem in Europe and to demands for an accurate picture of the phenomenon throughout the European Union. The site provides details of the EMCDDA’s mission, history, structure, work programmes and budget.

**WWW.DRUGSCOPE.ORG.UK**

(English) DrugScope is a centre of expertise on drugs (UK). The aim of the Centre is to inform policy development and reduce drug-related risk. It provides drug information, promotes effective responses to drug taking, undertakes research at local, national and international levels, organises training, and more.

**WWW.INCB.ORG**

The International Narcotics Control Board (INCB) is responsible for supervising the application of international treaties. The INCB publishes an annual report reviewing the various governments’ drug control policies.

**WWW.NIDA.NIH.GOV**

Many publications on drug abuse can be consulted on the website of the National Institute on Drug Abuse (NIDA) in the USA. This site provides students, research workers and health professionals with relevant information. It gives the latest findings on drug abuse and announces forthcoming events at both the national and international levels.

**PREVENTION AND EDUCATION**

**WWW.HOMEOFFICE.GOV.UK/DPAS/DPAS.HTM**

(English) The Drugs Prevention Advisory Service (DPAS) website. This site contains an expanding range of material intended mainly for policy-makers, planners, practitioners, and
other people with a professional interest in tackling drug misuse issues. In particular, this site was designed to provide information that will help Drug Action Teams to perform effectively.

www.ccsa.ca/
The Canadian Centre for the control of alcoholism and substance abuse publishes information and studies on substance abuse prevention.

www.atod.org
This virtual information centre gives a vast amount of very complete information based on the latest studies and surveys on the use, abuse and prevention of alcohol, tobacco and other drugs.

→ UNESCO
www.unesco.org/education/educprog/pead/AccF.htm
www.unesco.org/education/educprog/pead/AccGB.html
www.unesco.org/education/educprog/pead/AccSP.html
This site, which can be consulted in French, English and Spanish, contains information about drug - and AIDS- related preventive education at UNESCO.

www.unesco.org/education/educprog/pead/GB/DrugsGB/CadDrugGB.html
www.unesco.org/education/educprog/pead/FR/DrugsFR/CadDrugFR.html
At the PEDDRO site, which can also be consulted in three languages, you can join the network, to which both NGOs and institutions from 80 countries already belong, and obtain information about its aims in the field of education as a means of preventing drug abuse in all these countries.

www.infoyouth.org
In the framework of UNESCO's INFOYOUTH programme, particular attention is being paid to education, information and communication as means of fighting AIDS via the latest information technologies. The programme has launched projects targeting young people in Burkina Faso and Tunisia, for example.

→ HARM REDUCTION
www.elsevier.nl/locate/drugpo
The International Journal of Drug Policy (in English) presents current research, reliable information and in-depth policy analyses relating to the global drugs debate. Its focus is on the effects of drug policy and practice on drug-use behaviour and its consequences. Tim Rhodes, Editor; Gerry Stimson, Honorary Editor-In-Chief.

www.lindesmith.org/
The Lindesmith Center - Drug Policy Foundation (in English) is a drug policy organization working to broaden and inform the public debate on drug policy and related issues. This site gives news, publications, bibliographies, an online library, research briefs and much besides, including an online library catalogue containing over 3,000 entries on drug policy, use and abuse, and national and international history.

www.ihrc-India2001.net
12th International Conference on the Reduction of Drug Related Harm (in English) Delhi, 1-5 April 2001. The International Conference on the Reduction of Drug-Related Harm moves to Asia for the first time ever. An extremely significant move that comes at a time when Asia is witnessing a major spurt in HIV and other harms related to injecting drug use. Programme Director: Gerry Stimson.

www.ihra.net
The International Harm Reduction Association (in English) is an international professional association for individuals and associations concerned with the development of drug policies to reduce the harmful consequences of drug use. IHRA works with local and international organisations to assist individuals and communities in Public Health Advocacy, Best Practice, and Education, Training and Research. The site includes a library, press releases, and news updates.

www.ahm.net
The Asian Harm Reduction Network (AHRN) (in English) aims to reduce the harms associated with injecting drug use in Asia, especially HIV infection, through a process of networking, information sharing, advocacy, and program and policy development. It is run by programmes for programmes. AHRN links and supports programmes with a range of services, including a resource centre, a newsletter, special reports, training programs and technical assistance. The site also includes information about upcoming events, a list of members, useful links and much more.

www.relard.net
The site of the Latin American Harm Reduction Network (in English) aims to reduce the harms associated with injecting drug use in Latin America, especially HIV infection, through a process of networking, information sharing, advocacy, and program and policy development. It is run by programmes for programmes. AHRN links and supports programmes with a range of services, including a resource centre, a newsletter, special reports, training programs and technical assistance. The site also includes information about upcoming events, a list of members, useful links and much more.

www.relard.net
The site of the Latin American Harm Reduction Network (in English) aims to reduce the harms associated with injecting drug use in Latin America, especially HIV infection, through a process of networking, information sharing, advocacy, and program and policy development. It is run by programmes for programmes. AHRN links and supports programmes with a range of services, including a resource centre, a newsletter, special reports, training programs and technical assistance. The site also includes information about upcoming events, a list of members, useful links and much more.

International organisations

→ European Commission
Health and Consumer Protection Directorate-General
EURO F3164, Euroforum Building
L-2557 Gasperich, Luxembourg
Tel: (+352) 43 01 38 207, Fax: (+352) 43 01 34 945
jaume.costa@cec.eu.int
www.europa.eu.int/comm/health

→ Pompidou Group
Council of Europe, Building B
F-67075 Strasbourg cedex, France
Tel: (+33) 3 88 41 35 66, Fax: (+33) 388 41 27 85
pompidou.group@coe.int
www.pompidou.coe.int

→ EMCCDA
European Monitoring Centre for Drugs and Drug Addiction
Rue da Cruz de Santa Apolónia, 23-25
P-1149-045 Lisboa, Portugal
Tel: (+351) 218 11 30 00, Fax: (+351) 218 13 1711
info@emccda.org
www.emccda.org

→ INCB
International Narcotics Control Board
International Centre of Vienna, Office E 1399
BP500, A-1400 Vienna, Austria
Tel: (+43 1) 26 060 0, Fax: (+43 1) 26060 5867
secretariat@incb.org
www.incb.org

→ WHO
World Health Organization
20, avenue Appia, CH-1211 Geneva 27, Switzerland
Tel: (+41 22) 791 2111, Fax: (+41 22) 791 0746
info@oms.ch
www.who.int

→ UNAIDS
The Joint United Nations Programme on HIV/AIDS
20, avenue Appia, CH-1211 Geneva 27, Switzerland
Tel: (+4122) 791 46 51, Fax: (+4122) 791 41 65
unaid@unaid.org
www.unaids.org

→ UNDCP
The United Nations International Drug Control Programme
International Centre of Vienna, BP500, A-1400 Vienna, Austria
Tel: (+43 1) 26 060 0, Fax: (+43 1) 21345 5866
undcp_hq@undcp.un.or.at
www.undcp.org

→ UNESCO
United Nations Educational, Scientific and Cultural Organization
Section for Preventive Education and Sport
7, place de Fontenoy, 75352 Paris 07 SP, France
Tel: (+33) 1 45 68 1004, Fax: (+33) 1 45 68 56 57
opi.doc@unesco.org
www.unesco.org/education/educprog/

→ UNICEF
United Nations Children’s Fund
3 United Nations Plaza, New York, NY 10017, USA
Tel: (+1) 212 366 7000, Fax: (+1) 212 887 7465
netmaster@unicef.org
www.unicef.org
Por que no fumar ?
M. elero, J.C., Flores, R., 1999
(explicación y portugués) Folletos sobre
derivados del cannabis dirigidos a jóvenes,
diseñado para su distribución en contextos de
consumos
⇒ ED disliked.
⇒ Particular de indautxu 9, E48011 Bilbao,
Espagne

Cannabis in Luxembourg: une analyse
der le problème dans la drogue dans le
contexte de la santé publique
Fischer, C., 2000
⇒ Centre de Prévention des Toxicomanies,
3 rue du Fort Wallis, L-2714 Luxembourg

Evaluation report on the difficulties and
needs of the prevention centers of the
O banner and local authorities
Paraliou, M., Ploumidaki, A., Yotsidi, V.,
2000 (Greece)
⇒ it presents the results (i.e. difficulties
in planning, implementing and evaluation
primary prevention programmes, education
and scientific needs of prevention agents) and
provides concrete suggestions for
policy making in the field.
⇒ University Mental Health Research
Institute
12 Eginisty, 115 28 Athens, Greece

Guide de l’enseignant sur le programme
ducatif de prévention sur les drogues en
milieu scolaire
Sianard, F.D., Kuika-Dinghani-Nkita, G.,
2000 (Kongo)
⇒ M intégrer de l’enseignement primaire,
Secondaire et Supérieur charité de la
chaîne scientifique, Brazzaville, Congo

Investigacion 27: el uso de drogas en
ciudades bolivianas
Alcaraz del Castillo, 2000 (Español)
⇒ CELB,
⇒ Casilla de correos 5243, La Paz, Bolivia

Mélago, las drogas y yo
Garcia Rodriguez, J.A., 2000 (Español)
⇒ «Libro eminente prático para hacer
prevención de las drogodependencias desde
la familia, con herramientas prácticas para
que las madres y educadores puedan
llevarlas a cabo sin dificultad»
⇒ ED, calla (jago) Juan 30, 28001 Madrid, Espagne

Cannabis and patov au Liban : choix du
developpement et cultures de substitution
M. akkouh, H., 2001 (Francés)
⇒ L’Hammattan, 5-7 rue de l’Ecole Polytechnique, F-75005
Paris

Impact de tabaco y alcohol
advertisements on children in mass media
Peris, M., 2001, (English)
⇒ Introduction to the strategies employed by
the tobacco and alcohol industries
targeting children through mass media
and the methodologies that should be
taken in this regard.
⇒ Manjar Peris,
40/48, Park Road, Colombo 05, Sri Lanka

Le travail avec les usagers de drogue
Coutry, P., 2003 (Français)
⇒ Présentation et analyse de la pratique de
soins et d’accompagnement social
d’un centre de soins spécialisés
pour les toxicomanes. Réflexions et
propositions pratiques sur la prévention
et la substitution.
⇒ Editions ASPI, 187-189 Quai Valmy 75010 Paris France

Risk and control in the recreational drug
culture
Calafat, A., 2001 (English)
⇒ Research into the recreational arena
the young inhabit during the week end,
particularly at night.
⇒ Irefrea,
rambla 15, 2ª, 3Ae, 07003 palma de
M alorca, Espagne
(este libro puede ser descargado en
www.irefrea.org)

Women and problem drug consumption.
⇒ Hedrich, D., Council of Europe
Population Group, Strasbourg 2001,
138 pp. (available in English and French)

Woman drug abuse in Europe
IREFREA, 2000 (English)
⇒ IREFREA,
Via O nera 4, IT-30126 Lidio de Venezia

A handbook of harm reduction in Asia
(in English)
⇒ This is the first handbook to be written
specifically for Asia, warning drug injectors
about the risk of HIV infection. It describes
the experience acquired during
the last ten years in the field of HIV
prevention for drug injectors in Asia,
and outlines the main underlying harm
reduction principles and strategies which
have been most successful in Asia.
For more information please contact
the AHRN cleanhouse, or write to:
⇒ The Asian Harm Reduction Network
PO Box 235, Phraesingha Post Office
Chiang Mai 50200 Thailand
Phone: (66 53) 894112
Fax (66 53) 894113

Les consommations de produits
psychotrope à la fin de l’adolescence
en Languedoc-Roussillon (France),
M artique, en Guadeloupe, à la Réunion.
⇒ Peretti-Watel P., Beck F., Legleye S.,
Paris, ODTC, 2001, 30 p. (français)

Tendances mondiales des drogues illicites
2001
⇒ UNESCO, 2001

HIV/AIDS Surveillance in Europe.
⇒ WHO, 2001, 64pp. (available in English and French)

Annual Report on the state of the drugs
phenomenon in the European Union in
2000
⇒ European Monitoring Centre for Drugs
and Drug Addiction, 2000 (available
in all the European Union languages).

UNESCO’s Strategy for HIV/AIDS
Preventive Education
⇒ UNESCO, 2000 (English)
⇒ 7-9 rue Eugène Delacroix
75116 Paris, France
information@iiep.unesco.org

Working where the risks are Drug M. issue
Prevention Programme in Asia
⇒ Working where the risks are Drug M. issue
Programme in Asia
DAPPA. UNESCO Paris. Drug Abuse
Prevention Programme in Asia, 2001
(English)
⇒ m.dada@unesco.org

Conferences

February 2002
IXème congrès mondial PRI
⇒ Le comportement humain et son
interaction avec l’environnement social,
le véhicule et la route.
⇒ Adaptation et stratégies de sécurité
26 février 2002 - 28 février 2002
⇒ M inésito de l’extérieur,
⇒ Direction général de trafico,
⇒ La prevention routière internationale PRI
⇒ Direction general de trafico,
servicio externas c./Josefa Valcarcel,
28 28071 Madrid ; Espagne
⇒ www.dgt.es
⇒ www.iapri.org

March 2002
The 13th International Conference on the
Reduction of Drug Related Harm.
⇒ Social changes:lines of inclusion
and diversity
⇒ 3 - 7 mars 2002 - Lubjana - Slovenia
⇒ andrej.kastelic, Conference President,
⇒ Centre for the Treatment of Drug Addiction,
Zaleksa 29, SI 1000 Lubljana, Slovenia.
Tel +386 1 5421350
Fax +386 1 5421354
andrej.kastelic@guest.ames.si
⇒ www.ihrc2002.net

April 2002
Pride Youth Programs. Safe and Drug-Free
Youth.
⇒ «Pride 2002 celebrate Youth!»
⇒ 10 avril 2002 - 13 avril 2002
⇒ Cincinnati, Ohio, UNITED STATES
⇒ Pride Youth Programs,
4884 South Evergreen, Newayo,
M 49337, UNITED STATES
⇒ Fax : 231-652-2461
⇒ 231-652-4400 / 1-800-668-9277
⇒ prideyouth@ncats.net
⇒ www.prideyouthprograms.org

May 2002
6th World Conference on Injury prevention
and Control
⇒ Injuries, Suicide and Violence : Building
Knowledge, Policies and Practices to
Promote a Safer World
⇒ M ontréal Convention Centre
12-15 mai 2002
⇒ CO PLANOR Congres inc.
⇒ 511 place d’Armées, Bureau 600
⇒ M ontréal O C HY 2W 7 Canada
⇒ Tel: (514) 848-1133
Fax: (514) 288-6469
⇒ trauma@coplanor.qc.ca
⇒ www.trauma2002.com

5th Conference of the European Opiate
Addiction Treatment
16 mai 2002
⇒ Association «M antenance Therapy.
Evidence-based Practice & Integrated
Treatment Approaches».
⇒ Osie
⇒ Norweegen | E. Haga, Kirkevn.
166, 0407 Oslo
Tel: 0047 23016050
Fax: 0047 23016051
⇒ egil.haga@psykiatri.uio.no
⇒ www.med.uio.no/ipsy/skri/conf.htm

Recent publications
I have been reading the February 1998 issue of PEDDRO, which I did not know about before. I feel this newsletter will be most useful to people like me who are involved in the field of drug preventive education. I would be grateful if you could send me the most recent issues and add my name to your mailing list so that I can receive the Newsletter regularly from now on.

Ab. Rashid Bin Mat Adam, Prevention, Research and Planning Division of the National Narcotics Agency, Kuala Lumpur (Malaysia)

The PEDDRO programme has been going through a transition phase, during which the publication of our Newsletter was interrupted for a while. The Newsletter has now started up again, and if you wish to receive it regularly, you need only contact us at the address given below. PEDDRO can also be consulted at our website. Previous issues of our newsletter (“Synthetic drugs: a new challenge for prevention and Sport, drugs and prevention”) are still available in several languages (English, Arabic, Spanish, French and Russian). If you are interested in receiving copies, please contact us.

We would like to congratulate you on your special issue on “Sport, Drugs and Prevention”. Mouna Yazigi, Oum El Nour, Beyrouth (Lebanon)

From the scientific point of view, can you tell me whether there are any new strategies and whether any changes have occurred in the prevention through education approach? I am carrying out research on this approach and have no up-to-date information on this topic. Lya E. Hyppolite, Port-au-Prince (Haiti)

Yes of course, some new approaches have been used and a large amount of literature has been published on this subject. You could start by consulting the handbook “Prevention: alcohol, drugs and tobacco” published by the Council of Europe, which contains a lot of useful information on this subject. I propose to carry out a search for you and will send you any information and documents I can obtain. You can also consult the latest publications quoted in the present issue. If you have any questions about the prevention of drug abuse, do not hesitate to contact us and we will do what we can to help and advise you.

I would be happy to send you reliable personal accounts and information whenever you like about the prevention of AIDS and drug abuse in my country.

Adam Elhadj Mahamat, Association planète Sport, N’Djamena (Tchad)

We would welcome any contributions from you. If you want to contribute material for publication in PEDDRO, we are very interested in receiving reports and personal accounts from our readers. If you could contact us in this connection at a later date, we will let you know what themes we will be dealing with in the near future.

I am carrying out a new research project for which I have not yet been able to obtain any financial support. I am counting on you to help me find some means of funding this project. This would help us to reduce the drug addiction rates in the future.

Rasmiyyah Hamoun, An Najah National University, Nablus (Palestine)

PEDDRO does not deal at present with funding projects. However, PEDDRO does run a programme of grants, which are awarded every year to enable prevention specialists in some parts of the world to spend one month working at another specialised structure located in the same region. PEDDRO will be re-launching this exchange programme in 2002 and you will find further information about it in the Newsletter.

In a forthcoming issue, we plan to publish an article about the various means of financing projects, giving details of the organisations which can be contacted with a view to achieving drug prevention goals.

You can write to us at the following address: UNESCO / PEDDRO

ED / PEQ

Section for Preventive Education and Sport

F-75352 Paris 07 SP

Fax : (+33) 1 45 68 56 21

E-mail : peddro@unesco.org

To join our network, simply complete and return the questionnaire (see overleaf), which can also be obtained by consulting our website at the following address: http://www.unesco.org/education/educprog/pead/GB/DrugsGB/CadDruGB.html
Peddro

Its activities include:

- an international network consisting of more than 200 organizations and people working in the field of drug prevention via education,
- distributing teaching material to members,
- a database and a directory listing the activities of the network members in 83 countries,
- grants to promote exchanges among professionals in the field,
- a newsletter published 3 times a year on special themes in English, Arabic, Spanish, French and Russian.

TO CONSULT Peddro

Peddro is to be found on the UNESCO website at the following address:
http://www.unesco.org
Click on PREVENTIVE EDUCATION ACTIVITIES,
Peddro is listed among the DRUG ABUSE projects.

TO CONTACT Peddro

UNESCO/Peddro
ED/PEQ
Section for Preventive Education and Sport
7 Place de Fontenoy
F-75352 Paris 07 SP

Tel (+33) 1 45 68 07 27
Fax (+33) 1 45 68 56 21
peddro@unesco.org

TO JOIN Peddro network

If your activities relate to the prevention of drug abuse and you would like to become a member of peddro, it is quite simple:
- you can either go to our website, download the application form and return the completed form
- or you can fill in the form below and send it to us, and we will send you an application form.

Name of your organization
Name of the person to be contacted
Postal address

Telephone
Fax
E-mail
Your activities