Harm Reduction Strategy for IDU (Injecting Drug Use) and HIV/AIDS Prevention in Afghanistan

HIV/AIDS Unit, Ministry of Public Health
Demand Reduction Section, Ministry of Counter Narcotics

May 2005

Table of Contents:

List of Abbreviations:

IDU	Injecting Drug Use
IDUs	Injecting Drug Users
DUs	Drug Users
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
BBD	Blood Born Disease
UNODC	United Nations Office on Drugs and Crime
UNICEF	United Nations Children Fund
AHRN	Asian Harm Reduction Network
STI	Sexually Transmitted Infection
ROCA	Regional Coordinator for Central Asia
NGO	Non Governmental Organization
DDTC	Drug Dependency Treatment Centre
CSW	Commercial Sex Worker
MSM	Man having Sex with Man
IDPs	Internally Displaced People
ANF	Anti Narcotic Force (Pakistan)
IEC	Information Education and Communication
BCC	Behaviour Change Communication
TV	Television
HR	Harm Reduction
CHW	Community Health Worker
TBA	Trained Birth Attendant
DDR	Drug Demand Reduction
DR	Demand Reduction
MoPH	Ministry of Public Health
CNM	Counter Narcotic Ministry

Preface

Afghanistan is an impoverished war-torn country surrounded by neighbouring countries with high levels of IDUs and escalating rates of drug-related HIV/AIDS infection. This is a matter of great national concern at a time when all indicators suggest increasing rates of drug addiction in several areas of Afghanistan, including the injection of heroin and a range of pharmaceutical medicines used as intoxicants, and only a few under-resourced services available for those with drug-related problems. For the many Afghan drug users who do not have access to treatment services it is essential that harm reduction measures be taken as part of a public health strategy to reduce the risk of HIV infection and other Blood Born Diseases (BBD). This Harm Reduction Strategy has been developed by the Demand Reduction section of the Ministry of Counter Narcotics and the HIV/AIDS Unit of the Ministry of Public Health with special efforts and contribution from Dr.Naqibullah Safi, Senior Advisor and National AIDS Control Program Manager and Dr.Mohammad Zafar, Director of Demand reduction Department of CNM, with the help of the following, as it is essential that a broad-based approach is taken to IDUS and HIV/AIDS: the office of UNICEF, UNODC Afghanistan, the Asian Harm Reduction Network (AHRN), Nai Zindagi Drug Treatment Centre and the Demand Reduction advisor to the Counter Narcotics Ministry.

Eng. Habibullah Qaderi
Minister of Counter Narcotics

Dr. Said Mohammad Amin Fatimi
Minister of Public Health

Harm Reduction Strategy for IDU (Injecting Drug Use) and HIV/AIDS Prevention in Afghanistan

I. Introduction:

Problem drug use generally carries a series of health related harms, as well as economic, social and legal harms, to the individual, the family and the community (see chart 1). While harm reduction methods and techniques can be used at all levels of intervention with a range of different types of problem user, they are essential for injecting drug users (IDUs) and those at risk of becoming IDUs to prevent the spread of HIV/AIDS and other blood borne diseases like hepatitis and syphilis. In 1988, for example, the UK's Advisory Council on the Misuse of Drugs reported that AIDS was a bigger threat to individual and public health than the misuse of drugs.[1] The government then acted on this and rapidly developed a strategy for reducing the transmission of HIV infections among and from IDUs. To protect individuals, families and the community from injecting drug use and its associated harm, special harm reduction measures and strategies are required in all countries where IDU poses a threat to public health. This strategy paper is intended to provide a guide for the agencies and organisations involved in the area of drug demand reduction, harm reduction and HIV/AIDS/STI control in Afghanistan, and will form part of a larger harm reduction strategy document for Afghanistan.

Chart 1: Typology of levels and types of drug related harm

Type of harm	Level of harm			
	Individual	**Family**	**Community**	**Society**
Health	1. HIV/AIDS/ Hepatitis C 2. Respiratory problems through smoking any drug	Spread of infectious diseases	Health risk from used needles and syringes	Added pressure on health facilities/ services
Social	1. Breakdown in social relationships 2. Social stigma	1. Marital problems 2. Stigma on family 3. Arguments/ violence	1.Violence 2. Prostitution	
Economic	1. Can't find a job 2. No money	1. No money for food/clothes 2. No money for development activities	1.Increase in begging 2. Increased theft/robbery	Unproductive members of society not able to participate in development.
Legal	1. Imprisonment 2. Fine 3. Criminal record	1. Theft from family members 2. Increase poverty, no trust	Increased criminal activities like theft and robbery	Police time and resources diverted
Spiritual	1. Drug consumption against Islam 2. *Haram* behaviour	1. Family stigmatised 2. Tension in family		

1.1 Current situation of problem drug use and possible harms:

[1] Advisory Council on the Misuse of Drugs (1988) *Aids and Drug Misuse*. Part 1, HMSO, London.

1.1.1 Regional level:

According to available information, problem drug use, and particularly IDU, has substantially increased over the last decade among Afghanistan's immediate regional neighbours such as Iran, Pakistan and Tajikistan. All three countries have acknowledged the problem and have initiated harm reduction measures, including health promotion and needle and syringe exchange schemes. Countries in Central Asia have also experienced a rapid increase in number of IDUs and, as chart 2 below illustrates, the majority of drug users are young males in the most productive years of their life. According to the available data from the Central Asian Republics, there is a strong link between problem drug use, its associated harm and education level. The higher the educational level, the lower is the associated harm such as HIV infection and hepatitis B and C. In a country like Afghanistan, characterised by high levels of illiteracy and low education levels, there is likely to be an increased risk of associated problems with drug use, including HIV infection.

Chart 2: Drug users profile and patterns of drug use in Central Asia

Country	**Kazakhstan**	**Kyrgyzstan**	**Tajikistan**	**Uzbekistan**
Gender	2/3rd male	80% male	> 80% male	> 80 male
Age	2/3rd < 30 years	> 50% 25 years	> 50% < 30 years	2/3rd < 30 years
Educational level	80 % sec. Education	2/3rd sec. Education	2/3rd high school education	2/3rd secondary education
Drug used	Primary Heroin 80% Multi drug users	Heroin > 70% Multi drug users	Heroin > 80% Multi drug	Heroin > 90 percent Multi drug users
IDUS	> 90% ever injected	> 80% ever injected	> 50% ever injected	> 80 percent injecting
Sharing	2/3rd ever shared	> 50 percent currently sharing	1/3rd currently sharing	> almost all sharing

Source: Presentation made by Mr. Roberto Arbitrio, Programme Coordinator UNODC/ROCA, at First Regional Workshop on HIV/AIDS control and Harm Reduction Programs between, Iran, Afghanistan and Tajikistan, 6-11 March 2004.

1.1.2 Current situation of problem drug use and its associated harms in Afghanistan:

Afghanistan is one of the world's largest producers of opium, with both opium and heroin abuse appearing to be more severe in areas where those drugs are cultivated and produced, as well as urban areas. There is currently no data on the number of Afghans who inject drugs, although reliable indicators suggest there is an increase in IDU in areas such as Kabul, Gardez, Farah, Herat and areas of Badakshan that border Tajikistan.

Recent reports from Gardez town in Paktia province, for example, suggest that there are over 200 polydrug users who inject heroin, morphine, sosegon (pentazocine), valium and avil, an anti-histamine. Research conducted by John Hopkins Bloomberg School of Public Health on Pakistani and Afghan drug users in Quetta in Baluchistan province of Pakistan at high HIV risk indicates that only 16% of the study participants had heard of HIV/AIDS.[2] Significantly higher proportions of Afghan drug users when compared to the Pakistani research participants were more likely to have used an opiate as the first illicit drug, to have other drug users in the family, to inject drugs and share needles. Furthermore, they were also less likely to know that sharing needles could spread disease. All of the Afghan drug users in the study who had sex had never used a condom. In a UNDCP report[3] in 2000 on Afghan street heroin addicts in Peshawar and Quetta, most reported smoking or inhaling as the main method of ingesting heroin. Still the report warns that there are IDUs in Afghanistan who risk spreading HIV/AIDS.[4] Although only 6.3 percent of the respondents had reported drug injecting, 43 percent of this group had shared injecting equipment, on average with 4 to 6 users at one time. A published study conducted by UNODC in 2003 on problem drug use in Kabul indicated that heroin abuse is spreading in the city.[5] This study found that there is an estimated minimum of 7,000 heroin users in Kabul city, out of which an estimated 500 are IDUs. Though several NGOs are working with drug users, there is currently no information on HIV/AIDS prevalence rates among drug users in Afghanistan.

Estimated minimum numbers of problem drug users in Kabul city:

Hashish	23,995
Pharmaceutical drugs	14,298
Opium	10, 774
Heroin	7,008
Alcohol	6,586

According to data from the Drug Dependency Treatment Centre (DDTC) of Kabul Mental Health Hospital, during 2003, 710 drug addicts have been treated out of which 148 were heroin addicts and only 3 were IDUs. Information from the Nejat Centre states that 178 males who have received residential treatment included 23 IDUs, 3 of whom were females. This means that injecting is already a problem in Kabul, with attendant risks of HIV/AIDS transmission through sharing injecting equipment and engaging in high-risk sexual activities.

1.2. Vulnerability and groups at high risk in Afghan communities:

Based on the situation analysis in the previous section, the following are identified as vulnerable or high risk groups of people for problem drug use and its associated HIV/AIDS risk:

[2] Strathdee Steffanie et al. (2003*), "HIV Knowlege and Risk Behaviors among Pakistani and Afghani Drugs Users in Quetta, Pakistan"*. Journal of Acquired Immune Deficiency Syndromes. April 2003
[3] UNDCP (2000), Community Drug Profile #3. "A comparative study of Afghan street heroin addicts in Peshawar and Quetta", UNDCP Islamabad
[4] AIDS Statistics unknown due to social repression. Ron Synovitz. 11 July 2002. www.reliefweb.int
[5] UNODC (2003), Community Drug Profile #5, "An assessment of problem drug use in Kabul City, UNODC Kabul

1.2.1 High risk behaviour groups

- Injecting Drug Users (IDUs)
- Polydrug users
- Commercial Sex Workers (CSWs).
- Men having Sex with Men (MSM).
- Militia members/ Military Personnel

1.2.2 Other groups of people at risk:

- Women (specially the female spouses of drug users).
- Returning refugees and IDPs
- Unemployed
- Youth
- Ex-combatants
- War disabled
- Opium cultivators/heroin producers
- Long distance drivers
- Medical staff

1.2.3 Risk factors and customs:

- Injecting drug use (no cultural barriers to injecting)
- Low level of literacy among the general population, specifically among women.
- Tattooing is a common custom in some areas of Afghanistan.
- Unprotected sex and prostitution
- Circumcision practiced by traditional healers and barbers.
- Lack of awareness about drug-related harms.

2. Up-to-date responses to drug related harm reduction:

Efforts and endeavours in this connection in Afghanistan are very limited and need to be urgently increased as there is a serious risk of HIV transmission from IDUs to the general population. With the current limited response it is not possible to prevent health related harm and social harm of problem drug use in the society. Currently only the Nejat Centre in Kabul makes some provision for distribution of clean injecting equipment. While all treatment centres provide health and hygiene information for problem drug users, including IDUs, there are no mass awareness prevention campaigns providing information on the relationship between drug use and HIV/AIDS. Urgent and comprehensive measures need to be developed and implemented as soon as possible.

3. Harm Reduction: Goals and Specific Objectives:

Harm reduction is about reducing or minimising the actual or potential harm coming from a damaging activity that will almost certainly occur. Therefore through implementation of this strategy, the possible associated harm related to drug abuse should be reduced by all means possible. While some people consider harm reduction initiatives as a form of drug promotion, they actually constitute realistic methods of protecting individual and public health. According to Alex Wodak in a presentation made at the 15th

International Harm Reduction Conference, "Harm reduction is neither pro-drugs nor anti-drugs, it is anti-harm". It is important to recognise that neighbouring countries like Pakistan and Iran are now far advanced in promoting harm reduction measures among IDUs as a means of halting the AIDS epidemic. In Pakistan, for example, the Anti Narcotics Force (ANF), a department of the military, works in cooperation with NGOs to provide both mobile and static syringe exchanges in the major cities. In Iran both needle exchanges and substitution therapy have been adopted in working with IDUs.

3.1 Goal:

To reduce drug-related health and social harms among individuals, families and communities in Afghanistan.

3.2 Specific Objectives:

- To reduce the vulnerability of problem drug users and their families to HIV infection.
- To reduce the vulnerability of problem drug users and their families to Hepatitis B, C and syphilis.
- To reduce the risk of the spread of HIV and other blood borne diseases to the general population.
- To provide services to IDUs that will reduce the risk of HIV transmission

4. Strategies and interventions:

4.1 The AHRN (Asian Harm Reduction Network) suggests the following general strategy for preventing HIV among problem drug users and a hierarchy of goals for drug users themselves:

4.1.1 HIV Prevention among drug users:

- Start prevention programmes early (before prevalence reaches 5%)
- Provide information to drug users to protect themselves
- Provide drug users with the means to protect themselves
- Implement multiple programmes such as:

    - *Outreach services*
    - *Condom promotion*
    - *HIV counselling and testing*
    - *Drug treatment*
    - *Substitution programmes (e.g. methadone maintenance therapy)*
    - *Needle and syringe distribution and exchange*

4.1.2 Hierarchy of intervention objectives:

- Stop using drugs
- If you must use, smoke or inhale but don't inject
- Use your own needle and syringe but do not share
- Clean injecting equipment using bleach

4.2 Implementation of specific strategies for health related harm reduction of problem drug use.

4.2.1. Information, Education and Communication (IEC) and Behaviour Change Communication (BCC):

For provision of information and education to those groups at high risk (as defined above), it is necessary to implement targeted BCC campaigns. It is advised that IEC/BCC messages should be developed in collaboration with the beneficiaries and target populations. This will help in designing realistic messages in a manner, medium and language that is understandable and acceptable to the people at high risk eg. IDUs, DUs, CSWs, MSM. For implementation of IEC/BCC campaigns multiple channels of communication should be used e.g. TV, Radio, Newspapers, outreach work at the community level through social multipliers such as religious and community leaders and health/social workers. Peer education programmes are also an extremely important and effective strategy for changing the behaviour of problem drug users and other groups at high risk.

4.2.2 Stigma reduction associated with drug use and HIV:

The stigma and social exclusion associated with drug use and HIV is an issue in many societies, including Afghanistan. The use of intoxicants is a cultural taboo and drug users are isolated and considered sinners under Islam for indulging in *haram* (forbidden) behaviour. For the success of harm reduction initiatives, it is vital to work with community and religious leaders to educate people on drugs and HIV related issues to minimise the stigma associated with these behaviours. In turn this will help to implement successful harm reduction initiatives.

4.2.3 Needle/ Syringe exchange:

According to the AHRN there is a hierarchy of intervention objectives for preventing drug-related harm. The most important goal is for IDUs to stop using drugs. If this is not achievable immediately, then the IDUs should be encouraged to smoke or inhale their drugs and stop injecting. If IDUs cannot stop injecting then they should use their own needle and syringe but not share injecting equipment with others. If for any reason IDUs continue to share injecting equipment then they should be shown methods how to clean it before sharing. Implementation of outreach work through peers, community health workers and social workers is an important element for this type of HR programme. Harm reduction kits need to be provided to each IDU on a regular basis, and should include: disposable syringes and needles, antiseptic solution and cotton, condoms, culturally appropriate information leaflet on health and hygiene practices, advice on safer injection; the safe disposal of injecting equipment; advice on vein care; advice on sterilising and dressing infections and abscesses. All members of other high risk behaviour groups should receive HR kits that include condoms and a culturally appropriate information leaflet on health and hygiene practices, including warnings on the dangers of injecting drugs.

4.2.4 Condom promotion and distribution:

Drug use can lead to drug-induced unprotected sex, with higher risk of transmission of HIV infection. Other STIs can also be transmitted through unprotected sexual contact, for example gonorrhoea and syphilis. The correct use of condoms in any sexual contact will

significantly reduce health related harm and prevent the transmission of HIV, syphilis and other sexually transmitted infection. Social marketing strategies that promote condom use should be initiated, strengthened and maintained as a public health measure, although these will have to be acceptable and appropriate within the traditional Islamic culture of Afghanistan.

4.2.5 Other prevention activities

To reduce health-related harm to individuals receiving health services, it is needed to provide safe and screened blood and make all medical procedures safe. The target of such educational activity should not be only trained health workers but also traditional healers such as hakims, TBAs and others involved in delivering services where there is a risk of blood sharing, for example 'barbers' who may perform circumcision and tooth extraction and tattooists. In this regard, special training programmes on universal precaution measures should be designed in order to educate all health workers and health services providers, including traditional healers, to be trained in universal precaution measures.

4.2.6 Drug substitution therapy:

Any proposed drug treatment protocol for Afghanistan should consider drug substitution therapy. Iran, for example, adopts this strategy with methadone therapy while Pakistan does not. Currently, many heroin addicts in Afghanistan develop a very crude self-administered substitution programme by using a wide range of drugs easily available over-the-counter from pharmacies and other retail outlets if heroin is not available. The use of the analgesic sosegon (pentazocine) is important in this regard, although valium, anti-histamines and other analgesics are also reportedly used. Given the present situation in Afghanistan it may be difficult to control and regulate a drug like methadone if it was used in substitution therapy, with the added risk that this might create an illegal market in methadone. However methadone maintenance therapy is considered to be one of the most effective substitution therapies. Work must be done in developing a reliable system to administer methadone substitution therapy for drug users.

5. Principles of success:

Implementation of any HR strategy aimed at IDUs and HIV/AIDS prevention without the support of the community and religious leaders, policy makers and other sectors is not possible, therefore it is essential to design a multi-sectoral and broad based response. Apart from health services, involvement of religious leaders, policy makers and other sectors in the planning, implementation and evaluation of any HR programme is essential. It is important to ensure this wider participation and involvement at the very early stage of any programme. A technical taskforce should be established consisting of all stakeholders, donors, implementing agencies, governmental and non-governmental organisations to develop and design appropriate HR programmes for Afghanistan. The implementation of any HR strategy should be closely coordinated and monitored through the DR section of the Ministry of Counter Narcotics and the HIV/AIDS Directorate of the Ministry of Public Health.

6. Next steps:

- Wider distribution and review of the Harm Reduction Strategy document with policy makers and partners such as the Demand Reduction Working Group.
- Organising a workshop to review the strategy and finalise it.
- Printing the document and making it available to all stakeholders.
- Organising a planning workshop for the development of a 5 years plan of action for HR activities.
- Identifying coordination, monitoring and evaluation mechanisms for the implementation of the HR action plan.

Dr.Naqibullah Safi, Director, HIV/AIDS Unit, Ministry of Public Health
Dr.Mohammad.Zafar, Director, Demand Reduction Section, Ministry of Counter Narcotics

January 2005