

Assessment to improve the Harm Reduction Program in Thailand

Assessment Report submitted by

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1. List of Acronyms

ART	Anti-retroviral treatment
ATS	Amphetamine-Type Stimulants
BCC	behavior change communication
CSO	Civil-Society Organisation(s)
DAC	development-aid-criteria
DIC	Drop-in Centre
FSW	female sex worker(s)
GFATM	Global Fund to Fight Aids, Tuberculosis and Malaria
HCV	Hepatitis-C Virus
KP	Key population
MMT	Methadone maintenance treatment
MSM	men who have sex with men
MSW	male sex worker(s)
NAMC	National AIDS Management Center
NFM	New Funding Model
NSP	Needle and syringe exchange programs
OECD	Organisation for Economic Co-operation and Development
ONCB	Office of the Narcotics Control Board
OP 2015-2019	Thailand Operational Plan to Accelerate Ending AIDS 2015-2019
OST	Opioid substitution therapy
PR	Principal Recipient
PWID	Person(s) who inject(s) drugs
RRTR	Reach, Recruit, Test, Treat and Retain
RTF	Raks Thai Foundation
SR	Sub-recipient
STAR	Stop TB and AIDS through RRTR
STI	Sexually transmitted infections
TB	Tuberculosis
TDN	Thai Drug-users Network
ToR	Terms of Reference
VCT	Voluntary counselling and testing

2. Executive Summary

Thailand has only recently undergone **major changes in its drug policy**. The Thailand Operational Plan to Accelerate Ending AIDS 2015-2019 (OP 2015-2019) consolidates and refocuses key interventions among key populations in high priority geographical areas, with the specific purpose of addressing gaps between the current response and a targeted, optimized response needed to achieve Thailand's goal of ending AIDS by 2030. It focuses on 30 priority provinces, mostly in the Greater Bangkok Area, where modelling and epidemiological studies suggest that nearly a quarter of new infections are occurring. A clear framework for service delivery is set linking prevention, treatment, and care. The **OP 2015-2019** addresses critical gaps in linkages in the system by connecting the five critical components of the prevention, **care and treatment continuum**: 'reach', 'recruit', 'test', 'treat' and 'retain' (RRTTR). It also defines a tailored service packages for each KP, and lays out criteria for the intensity with which services should be delivered at the provincial level. The activities outlined indicate political support for the Harm Reduction approach in the country, but to what extent the responsible policy makers actually will support a comprehensive Harm Reduction approach sustainably, is hard to predict. Government-run responses still mostly aim at abstinence (Methadone -detox, Matrix-model, therapeutic communities, community camps) and continue to use compulsory methods. Ownership, political will and capacity for programming and sustainable cross-sectorial steering with a clear view to Harm Reduction are still weak in this field.

In 2015, also a **national drug law reform process** was initiated and the latest draft presented in January 2017. It provides recommendations for adjustments for several drug-related statutes that could facilitate Harm Reduction service delivery in the future. In any case, the new drug law draft foresees that drug abuse will be increasingly treated as a health issue rather than a criminal offence. According to the Office of the National Drug Control Board (ONCB), measures to scale up and diversify voluntary and rights-based services to persons who inject drugs (PWID) are foreseen, but processes to come from strategy to action take a long time and ownership for a comprehensive, human rights and needs based drug policy is still low among the crucial stakeholders.

Since 2015, **Raks Thai Foundation (RTF) is the principal recipient (PR)** under the new funding model (NFM) of the Global Fund. Within the Stop TB and AIDS through RRTTR (STAR) Programme, the **Harm Reduction program** is active in 12 provinces, providing 14 drop-in centers (DICs), outreach activities, distribution of needles and syringes (NSP), information packages and condoms, referral to testing for and treatment of HIV and sexually transmitted infections (STI). Other health services include referrals to Methadone maintenance treatment (MMT) for PWID. According to program data from Raks Thai, the Harm Reduction program reaches about 7,000-9,000 PWID per year in the 12 provinces, which is approximately 16-20% of the national estimate of PWID. Though precise data on PWID is not available, all interview partners during the assessment mission agreed that the status of the Harm Reduction program does not sufficiently meet the needs of the target group. An unknown number of PWID are scattered in small numbers across the country, making it difficult to deliver services to everyone in need and to estimate exactly whether the program's target (70% and 80% of all PWID in year 1 and year 2 respectively) are reached.

The **aim of the assessment mission**, conducted by Patricia Kramarz and Susanne Schardt in January 2017, was to evaluate the current Harm Reduction program in Thailand and provide specific recommendations on the strengths and areas of improvements for drop-in centers, outreach activities, and the provision of community-led services for PWID.

Data regarding **the number of PWID in Thailand** varies considerably: while some sources state that the total number of PWID in Thailand is 71,000, others estimate only 40,300. The latter number was provided by the National AIDS Management Center (NAMC) in 2011 and used in the OP 2015-2019. According to Thai government sources, commonly used **illicit drugs** are Heroin, Opium, Amphetamine-type stimulants (ATS), Methamphetamine, Cannabis and Kratom. **Licit drugs**, such as Midazolam and

other Benzodiazepines are often procured without a prescription and mixed with illicit drugs. **Increasing ATS use** may become a significant health and social problem like in other countries in East and Southeast Asia. Potential populations at risk are female sex workers and other workers in the entertainment/hospitality industry (clubs and casinos), youth (e.g. homeless, unemployed and incarcerated youth), migrants, and men who have sex with men (MSM). Although a majority of ATS users does not inject, ATS use is associated with a range of communicable diseases such as HIV, Hepatitis B and C infections and other sexually transmitted infections (STI), tuberculosis (TB) and mental health problems. There is an urgent need to scale up prevention, treatment and Harm Reduction services to avoid the further spread of these potentially life-threatening infections. However, to-date, prevention, treatment and Harm Reduction strategies in this field are still in their initial phases. While opioid injectors in Thailand tend to be between 25 and 45 years old, non-injecting drug users – especially **ATS-users** - are usually young and many of them are young women. Consumption takes place in private homes, at clubs, parties, or other settings that are not easy to reach by staff of the existing Harm Reduction services. Hence, it is not easy to provide services to young non-injecting users through the Harm Reduction program as it is today. However, Harm Reduction service providers could team up with civil society organisations (CSO) that work with young people to exchange knowledge about relevant issues; e.g. behavior change communication (BCC) to prevent shifting to injecting, promote safer use and safer sex, etc.) and to promote this knowledge among young people in these settings.

Detoxification and long-term MMT is provided free of charge since 2014, as it is included in the universal health insurance as well as in the social security scheme. Methadone treatment is currently available only at district-/province-level hospitals and at a few remote drug treatment centers, reaching no more than 10% of people who require opioid substitution therapy (OST) in the country. There are currently 147 Methadone sites in Thailand. However, the number of patients in the programme is quite low. This seems to be due to shortcomings in the accessibility, the quality, and the regional distribution of services. In some provinces, necessary Methadone sites are not available at all, in others they are hard to access for patients due to long distances and travel time (e.g. Chiang Mai, Trang). Although national guidelines exist and define key interventions, they do not seem to be followed in all sites, resulting in different regulations (e.g. on take-home dose, maximum dose, etc.). With changing drug use patterns, MMT sites may also not be located where they are actually needed. This should be assessed more realistically and regularly and DICs should be available to provide psycho-social support where MMT sites are.

According to the OP 2015-2019, the **HIV epidemic** in Thailand is mature, declining, concentrated primarily in key populations (KPs) – including PWID. The prevailing mode of transmission is through unprotected sex (90%), with unsafe injecting drug use as a second most important transmission route. According to the latest report of Harm Reduction International, HIV prevalence among PWID is 21%. Uptake of Hepatitis counselling and testing (HCT) among KPs is limited: Only 43% of the PWID reported being tested. Hepatitis-C Virus (HCV) prevalence is 89%.

Voluntary counselling and testing (VCT) is free, but only available in hospitals or through mobile clinics coming to DICs or in some provinces (e.g. Chiang Mai) to remote villages to offer testing free of costs for non-Thai nationals. Latest reports state that 8,062 PWID were actually reached and tested, which is only 60.6% of the expected target. According to interviews during the assessment mission, clients mainly take tests if these are mandatory (in the Methadone programme) or if an incentive is provided (e.g. In Chiang Mai 300 Bath per test). Otherwise, clients are reluctant to get tested. This seems to be due to the high stigma and discrimination from hospital staff, but also among peers. We learned from DIC volunteers that stigma and discrimination among peers is even higher than among hospital staff. To improve testing, the referral system and case management across different services needs to be improved. Measures to encourage PWID to get tested may also include providing transportation and accompanying clients to sites (“testing buddies” and “risk networks”). Such measures are mentioned in the OP 2015-2019, but do not seem to be implemented everywhere. Rapid tests should be easily accessible, ideally offered at DICs on a regular basis, either through mobile clinics or through skilled

staff of the DICs. Activities (including trainings and sensitization workshops) to reduce stigma and discrimination among hospital staff, but also among peers and social networks of PWID should be implemented. Advocacy campaigns aiming at normalization of HIV testing and community awareness generation should be conducted on a regular basis.

However, getting people in need of treatment on anti-retroviral treatment (ART) seems to be an even bigger challenge: currently, **ART coverage among PWID** is low (2%). Clients with a positive test result often do not want to enroll in treatment and disclose their status due to fear of stigma and discrimination from their peers. Therefore, counseling and motivation skills of outreach workers (and peer volunteers) need to be improved to increase the knowledge about the importance of testing and the benefits of ART among PWIDs. In addition, PWID still face high stigma and discrimination in the general public and police continues to arrest PWID and hinder access to services, since no consistent information and guidelines exist. There is an urgent need for advocacy measures on all level in order to reduce this stigma.

Recruitment, adherence to medical or social services and follow-up of clients could be greatly enhanced by a functioning referral system and case management using all forms of useful and feasible means to keep contact between service providers and clients. As mentioned in the OP 2015-2019, this may also include providing transportation and accompanying clients to sites (“testing buddies”). In order to improve reaching out to PWID, agreements need to be made with local police and neighbours to allow access to all services available for PWID and to let outreach workers do their work undisturbed. In areas with PWID living in remote and hard to reach areas, satellite-DICs in places that are easier and less risky to reach (e.g. in Patthalung) can function as support units for outreach teams and as gathering points for PWID living in the vicinity.

Women who use drugs differ from male users in reasons for using drugs, patterns of use, and psychosocial needs – especially when they become mothers. Therefore, CSOs play a crucial role in reaching out to these women and in providing first-level psychosocial support according to their special needs, including childcare and legal support. During our talks at the sites, it became obvious that service staff has only very little knowledge about **drug abuse patterns of women** and their special service needs. Knowledge about the special needs of this target group and skills how to reach out to them and provide appropriate services needs to be built.

A **broader range of Harm Reduction services** (increased and needs-based outreach, intensive work with the communities, drop-in facilities with attractive and needs-based offers, social support, specialised support to women who use drugs, and a case management of clients within a mutually coordinated referral system) is needed to enable service providers to better achieve the objectives and targets of the program. Talks with CSO service staff during the assessment mission revealed that many of the current gaps in service provision are due to a lack of funds, skills and knowledge among the service providers. Services should be based on rapid situation assessments (RSA) and targeted to the needs of the potential clients where drug use is high. Outreach and support to female drug users needs to be increased. There is an especially urgent need to work more intensively with the police to come to solutions that enable clients’ free access to Harm Reduction services and security for outreach and peer workers.

Feedback gathered by the mission team was that current **capacity development** measures (esp. trainings) do not fit the individual needs and existing capacities and knowledge of the trainees. Often, service staff lacks important basic knowledge, like the basic principles of Harm Reduction approach. Thai trainers should receive skill building on needs-oriented and participatory training techniques and backstopping from international master trainers. Existing international and regional trainings/manuals should be adapted to the needs of Thai services providers in cooperation between international and Thai experts, then trained by international trainers to Thai „master trainers“ to establish a broader expert pool and pool of national trainers.

3. Context

3.1. DEMOGRAPHIC BACKGROUND

According to the Harm Reduction International 2016 Global State of Harm Reduction report, the recent estimated total number of PWID in Thailand is 71,000. An estimate of 40,300 PWID in Thailand was provided by the National AIDS Management Center (NAMC) in 2011. The estimations were obtained late 2010 using three direct and in-direct, population-based surveys. This number is currently used by all stakeholders. The estimate of 40,300 is also provided in the OP 201-2019 and is used as baseline in the NFM. On the contrary, a network scale-up study in 2014 provided an estimation of 71,083-75,441 PWID. These estimates were verified by the NAMC consensus working group on IDU estimations early 2015.

An epidemiological analysis based on disease burden and new infections showed that 30 provinces in Thailand account for 75% of total burden of HIV and 76% of total size of KPs including MSM, transgender, male and female sex workers (MSWs and FSWs), and PWID. The highest burden is in the Bangkok and peri- Bangkok provinces area. According to the OP 2015-2019, 19 high burden provinces were identified for PWID.

3.2. PROBLEM DRUG USE

Commonly used illicit drugs include Heroin, Opium, ATS (“yaba”), Methamphetamine (“Ice”), Cannabis and Kratom, while licit drugs such as Midazolam and other Benzodiazepines are often procured without a prescription and mixed with illicit drugs.¹ However, only limited data is available regarding drug use patterns in Thailand. According to a report from Dr. Amramrattana, Head of the Department of Family Medicine Faculty of Medicine at the Chiang Mai University, heroin is still the most commonly used drug among drug injectors getting into drug treatment services nationwide, although the number is decreasing in the last years. The number of drug dependence patients who inject methamphetamine is increasing at an accelerating pace since 2011. Heroin, methamphetamine tablets/ crystal (Ice) and Midazolam/Benzodiazepine are the most common drugs used in alternate or combination. It is observed that female PWID patients use Ice in higher proportion than male. Recently, there are evidences suggesting increasing trends of methamphetamine/Ice injection among PWID especially in Bangkok and north-eastern areas. This occurred in both old heroin PWIDs and young methamphetamine users. High heroin injection frequency is found in the southern areas while opium injection is common in the north. Frequency of injection seems to be higher in old heroin poly-drug users than young methamphetamine users.²

Project data also indicates that patterns of drug use in Bangkok are changing, with approximately 50% of clients in the central region injecting ATS and pharmaceuticals in 2014, compared with 70% who were injecting Heroin in 2009 in the same region.⁴ National experts working in the field estimate that up to 70% of PWID in Bangkok are injecting ATS and pharmaceuticals (like Midazolam; often in combination with Methadone).

¹ PSI Thailand, INNOVATIONS, BEST PRACTICES AND LESSONS LEARNED - Implementation of the national response to HIV among people who inject drugs in Thailand 2009-2014, *June 2015*

² Aramrattana A, Consolidation of evidence related to substance use in Thailand to improve and strengthen programming for People Who Inject Drugs (PWID); *July 2015*

3.3. HIV/AIDS

According to the OP 2015-2019, the HIV epidemic in Thailand is mature, declining, concentrated primarily in KPs of MSM, MSWs and FSWs, and transgender people, PWID as well as other vulnerable populations including spouses of KP and people living with HIV (PLHIV), migrant workers (MWs) and prisoners. The prevailing mode of transmission is through unprotected sex (90%), with unsafe injecting drug use as a second most important transmission route.

There were an estimated 459,688 PLHIV in Thailand in 2013. The estimated adult HIV prevalence was 1.1%. There were an estimated 8,135 adult new infections in 2013, of which 799 were among PWID. Uptake of Hepatitis counselling and testing (HCT) among KPs is limited. Only 43% PWID reported being tested and knowing their results in the preceding 12 months². Of the estimated 459,688 people living with HIV in 2013, 388,833 are registered for care. At least, 62,425 people are yet to be diagnosed and linked into care, and intensified HCT in community settings is essential to meeting this objective. Despite considerable progress in reaching and delivering HIV prevention and treatment services to these individuals, programmes continue to struggle with access to some of these populations (e.g. PWID), and residual risk behaviours continue. Early diagnosis and high quality ART is outlined in the OP as an important tool in reducing transmission. As most new infections continue to be among KPs, the focus of HCT remains on these populations and their sex partners. According to the latest report of Harm Reduction International HIV prevalence among PWID is 21% and HCV (Anti-HCV) prevalence is 89%. The ART coverage among PWID is low with estimated 2 %.³

3.4. HARM REDUCTION MODEL IN THAILAND

Since 2015, Raks Thai Foundation is the PR under the NFM. Under their *Stop TB and AIDS through RRTTR (STAR) Programme*, the Harm Reduction program is active in 12 provinces, providing 14 drop-in centers (DICs), outreach activities, distribution of needles and syringes, information packages and condoms, referral to HIV and STI testing and treatment and other health services and referrals to Methadone maintenance treatment for PWIDs. The service providers are RTF with two DICs, O-Zone with 8 DICs, and Thai Drug Users Network (TDN) with 4 DICs. NSP is only available in the DICs and through outreach of these centers; the number of NSP has been reduced due to the close down of DICs and the termination of partnerships with local pharmacies under the NFM. The number of needles distributed per person per year is 14⁴. According to program data from RTF, the Harm Reduction program is reaching about 7,000-9,000 PWID per year in the 12 provinces or around 16-20% of the national estimate of PWID in need of Harm Reduction services.

Detoxification and long-term maintenance with Methadone has been provided free of charge since 2014, as it is included in the universal health insurance scheme as well as in the social security scheme. Methadone treatment is currently available only in district-/province-level hospitals and at a few remote drug treatment centers, reaching no more than 10% of people who require Methadone in the country. There are currently 147 Methadone sites in Thailand.⁴

According to experts working in the field, the transition to the Global Fund NFM had a negative impact on the quality and coverage of Harm Reduction services. Investments to facilitate collaboration with law enforcement have been completely suspended, multiple service delivery sites have been closed

² Niramon Pansuwan et al., The 2012 Integrated Behavior and Biological Surveillance (IBBS) of HIV, Sexually Transmitted Infections and Associated Risk Behaviors

³ Bergenstrom, A. et al. (2013), Overview of epidemiology of injection drug use and HIV in Asia. Presented at the International AIDS society meeting, Kuala Lumpur, June 2013

⁴ Harm Reduction International "Global State of Harm Reduction 2016"

without transition plans, services in prison settings have been interrupted, pharmacy-based commodity distribution is no longer funded, and various activities to address barrier to access services have been terminated. Under the NFM, only basic services can be provided with a very limited coverage, there has been only a limited uptake of service funding by the government.

3.5. POLICY DEVELOPMENTS

The focus of the latest National AIDS Strategy (2014-2016) is on KPs and their partners, including PWID (also PWID, MSM, transgender, sex workers, prisoners). The strategy's key concepts are translated into actions and interventions in the OP 2015-2019. The target set out to achieve in the strategic plan is comprehensive, integrated prevention covering at least 80% of the Thai and non-Thai sex workers, MSM, PWID in the priority provinces. The OP 2015-2019 adds value to the strategy by translating new scientific evidence that became available in 2012-2013, into programmatic action. With the aim of fully utilizing this new evidence, the OP 2015-2019 consolidates and refocuses key interventions among key populations in high priority geographical sites, with the specific purpose of addressing gaps between the current response and a targeted, optimized response needed to achieve Thailand's goal of ending AIDS by 2030. The OP 2015-2019 focuses on 30 priority provinces, with the most intense focus on the Greater Bangkok Area (where modelling and epidemiological studies suggest that nearly a quarter of new infections are occurring). It sets out a clear framework for service delivery that breaks down the traditional barriers between prevention, treatment and care. It addresses critical gaps in linkages in the system by connecting the five critical components of the prevention, care and treatment continuum: 'reach', 'recruit', 'test', 'treat' and 'retain' (RRTTR; c.f. chapter 4). It also defines a tailored service packages for each KP, and lays out criteria for the intensity with which services should be delivered at the provincial level. The tailored service package for PWID includes activities such as:

- Rapid community assessment (every 2 years),
- Outreach through social networks and MMT sites,
- Peer educators involvement,
- Regular meetings with local stakeholders,
- Provision of sterile injecting equipment and MMT,
- Improvement of DIC services
- Couple counselling and testing of partners,
- Extension of MMT to the community at DIC or sub-district health promoting hospital or community primary health post ;
- HCV and TB screening,
- Same day result HIV tests,
- Referral to ART,
- Case management by CSOs,
- Real time monitoring,
- Incentives to motivate safe injecting and HCT.

To effectively implement the activities outlined in the OP 2015-2019, political support for the Harm Reduction approach and ownership, commitment and capacities are needed among relevant ministries and stakeholders. Government-run responses still mostly aim at abstinence (Methadone -detox, Matrix-model, therapeutic communities, community camps) and continue to use compulsory methods. In addition, PWID still face high stigma and discrimination in the general public and police continues to arrest PWID and hinder access to services, since no consistent information and guidelines exist.

Previous investments from Global Fund in Round 8 made significant contributions to the development of an enabling environment, including the national Harm Reduction policy, formally approved in 2014, expired in October 2015. Despite this important setback, a national drug law reform process was initiated in 2015, which in its latest draft presented in January 2017, provided recommendations for adjustments for several drug-related statutes that could facilitate Harm Reduction service delivery in the

future. Drug abuse will be increasingly treated as a health issue rather than a criminal offence.

The reform momentum was driven largely by serious problems with prison overcrowding and a burgeoning prison population. Thailand has the largest prison population in Southeast Asia and the 6th largest in the world, along with the world's highest rate of female incarceration, mostly in relation to minor drug offences. In 2016, both the President of the Supreme Court and the Minister of Justice have publicly demanded that Thailand should consider modernizing its drug policies to achieve improved health and human rights objectives, aligning its approach with the international community.

The policy draft includes Harm Reduction measures as a component of a more human rights and health based approach. The 16 Harm Reduction services according to the draft policy as of 16 January 2017 are: Information and knowledge on drugs; Methadone maintenance (MMT); Naloxone for Overdose prevention; Rehabilitation; Raise awareness and assess own risk from HIV, STI, TB, HEP B and C; counseling and VCT testing and referral to ARV; Test and referral to HEP B and C; needle and syringe exchange (NSP); provision of Condoms; STI testing and treatment; Prevention, screening and diagnose for TB; Psychological care; Individual home visits; Group support for PWID; Drop in centers; Legal counseling. It is a very positive development that the government seeks to scale-up voluntary and harm-reduction oriented approaches, but ownership, commitment and capacities are still low and need to be strengthened.

4. Objectives and Criteria of the Assessment

Thailand has a long experience in working with PWID supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria. In 2015, Raks Thai Foundation (RTF) was commissioned to be the PR under the NFM STAR-program.

Based on the OP 2015-2019 the STAR-program goal is to end AIDS in Thailand by 2030 (reducing annual new infections to below 1,000 cases from the current 8,134 estimated new infections annually) and to reduce the prevalence of TB from 159 per 100,000 to 120 per 100,000 between 2015 and 2019.

1. To prevent the transmission of HIV and TB by sustaining intensive behaviour change activities, appropriate use of prophylaxis and the strategic use of anti-retroviral drugs.
2. Actively find HIV and TB cases in the community and health care settings by recruiting 'at risk' and 'vulnerable populations' into HIV testing and TB screening.
3. To ensure early and accurate diagnosis of both diseases by improving diagnostic capability, and reducing turn-around time (by using rapid HIV testing and molecular diagnostic techniques for TB)
4. To provide early treatment and ensure retention in care for all those diagnosed with HIV and/or TB.
5. To foster collaborative activities across HIV and TB programs at national and sub-national levels, and ensure sustainability by strengthening linkages between community and health systems.
6. To normalize HIV/TB and reduce stigma and discrimination.

The program includes drop-in centers and outreach activities involving former or current PWID as peer educators and outreach volunteers. It focuses on Reach, Recruit, Test, Treat and Retain (RRTTR) among PWID:

Reach and Recruit: reach new PWID and recruit them to participate in the programs, identify service needs and encourage the use of condoms, sterile needles and syringes.

Test: refer PWID to take VCT, HCV, TB, STI testing and providing friendly services.

Treat: refer PWID to receive treatment (esp. ART).

Retain: maintain contact with PWID, encourage them to take VCT and other health testing regularly.

The objective of the assessment was to help RTF and its sub-recipients in improving the quality of the program. Therefore, the assessment-team tried to identify areas in which the various key stakeholders could improve the community based Harm Reduction program including social and health related benefits for PWID, especially female, their families and the communities as a whole.

According to the Terms of Reference (ToR), recommendations from the assessment team were to include specific areas of improvement at different service levels and to provide good practice examples from other countries regarding drop-in center and outreach management, capacity building, project management, data utilization, and service provision.

At the briefing workshop of the mission in Bangkok, RTF staff provided seven priorities for the assessment mission to provide recommendations and suggestions for:

1. Activities and techniques for reaching PWID
2. Needs for the improvement of services at the DICs
3. Integration of interventions between communities and DICs
4. Specific service needs to achieve the RRTR and the official Harm Reduction package (16 interventions) in Thailand
5. Improvement of the Harm Reduction model (policy) in Thailand
6. Service implication to increase the accessibility of women who use drugs and young drug users to the service system
7. Improving the quality of the access and adherence to the services

5. Methodology

Based on the objectives outlined in the ToRs, the assessment comprised the following steps/tasks:

Task according to TORs	Methodology used
1. To assess the current Harm Reduction program under the STAR program and provide specific recommendations on the strengths and areas of improvements in terms of drop-in center, outreach activities, and ability to provide RRTR services and community led services.	Review program documents, reports, and data Review relevant national, international, and Global Fund documents Conduct site visits, site observations, individual semi-structured interviews and/or focus group discussions with service staff, and semi-structured interviews with clients (to assess clients' needs and satisfaction with services)
2. To identify areas that the various key stakeholders may want to consider in improving community based Harm Reduction program including social and health related benefits for the PWID, especially female, families and society.	Hold meetings, interviews and focus group discussions with all relevant stakeholders (needs assessment) Conduct a "strengths/weaknesses/opportunities/threats" (SWOT) analysis of the program elements (esp. DICs in different areas)
3. To recommend improvement models and processes for the implementing agencies in Thailand regarding to drop-in center, outreach management, human resources training and capacity building, management	Review international and regional good practices and make recommendations how to adapt them to the Thai context.

practices, data utilization and performance management.	Present good practice examples from programs and countries with similar situations as in Thailand Conduct a capacity needs assessment among relevant stakeholders and propose a mid to long-term capacity development plan
4. To recommend approach to long term sustainability of the Thai Harm Reduction program in all level.	Analyze the performance of the program according to the Organisation for Economic Co-operation and Development (OECD) development-aid-criteria (DAC) (<i>relevance, effectiveness, effectivity, impact, an sustainability</i>) and give recommendations for improvement

5.1. METHODS USED IN THE ASSESSMENT

The assessment was conducted according to ethical standards and the core principles of victim protection thereby taking into account the sensitive nature of the beneficiaries' (PWID) situation. In particular, preserving the anonymity and – if asked for – confidentiality of informants is essential to provide a certain amount of protection and to ensure the evaluation process does not create security problems for the people involved.

Desk review of relevant documents:

Thailand National AIDS Committee, THAILAND NATIONAL OPERATIONAL PLAN ACCELERATING ENDING AIDS 2015-2019, (November 2014)

16 HR SERVICES ACCORDING TO THE DRAFT HR POLICY IN THAILAND *as of 16 January 2017*

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<http://idpc.net/blog/2017/01/a-push-for-decriminalisation-and-harm-reduction-approaches-to-methamphetamine-in-thailand>

Site visits and observations:

Thanyarak Hospital – MMT ward

Raks Thai DIC in Mitsampan, Bangkok

O-Zone DIC in Prachacheurn, Bangkok

O-Zone DIC in Fang, Chiang Mai

O-Zone DIC in Chiang Rai

TDN – DIC in Trang

TDN satellite DIC in Patthalung
RTF DIC at Samut Prakan Hospital

Individual semi-structured interviews:

Raks Thai DIC in Bangkok – with one male PWID
O-Zone DIC in Fang, Chiang Mai – with one female and two male clients
RTF DIC at Samut Prakan Hospital – with one male client and three male peer outreach workers

Focus group interviews/discussions:

Thanyarak Hospital, Bangkok - with **Dr. Viroj** and staff of the ward
ONCB – with **Pabhasi Kaiyanunta** (director of drug treatment and rehabilitation coordination subdivision) & **Tanittha Poonsin** (Plan and policy analyst)
Raks Thai DIC in Mitsampan, Bangkok – with DIC staff
O Zone DIC in Prachacheurn, Bangkok – with DIC and O- Zone staff
O-Zone DIC in Fang, Chiang Mai – with DIC staff and volunteers
O-Zone DIC in Chiang Rai – with DIC staff
TDN – DIC in Trang - with DIC staff and volunteers
TDN satellite DIC in Patthalung - with DIC volunteers and peer outreach workers
RTF DIC at Samut Prakan Hospital – with staff, volunteers and peers

Capacity (needs) assessment

Talks with ONCB as well as with the staff of all sites (except Tanyarak hospital) included also questions about knowledge and skill-building needs at three levels:

- I. System level (structure, coordination, regional coverage of the STAR-programme)
- II. Organizational level (knowledge about HR methods, skills in project management – only to be assessed at the sites visited – not for the whole organization)
- III. Individual level (different staff members, e.g. permanent staff, outreach coordinators, volunteers, peers etc. have different capacity needs and knowledge & skills to build on)

6. Main results of the Assessment

6.1. REACHING AND RECRUITING PWID

According to the mission team's sources, injecting drug use is most common in the north and at the southern border, because Opium and Heroin are being produced nearby and trafficked through these areas, but only a realistic situation analysis conducted together with peer-outreach workers can produce the necessary data to plan and coordinate the elements of the program. To reach the overall target, there might be a need for services in provinces not yet covered by the program.

Centres visited were used and deemed useful by clients, but there were still reports that unknown numbers of PWID could not be reached. In all services, outreach teams (volunteers & staff) play a crucial role in reaching out to PWID – more than the centres themselves, which mostly function more as a support centre for outreach teams and peers than as true drop-in facilities for PWID in the area.

The OP 2015-2019 acknowledges several gaps in service provision and lists a number of key interventions and innovations:

“Key gaps in reaching: Thailand has had a large outreach programme which has successfully reached out to KPs in community settings to provide information and health ‘hardware’. Condoms and IEC materials have been successfully provided at a large scale as part of these outreach efforts. However, the focus on promotion of HIV testing was limited. Outreach activities also focused on face to face communication only, and were not designed to use the many opportunities offered by social media and mobile phone technology.

Outcomes: increased risk perception; consistently use of condoms; safe injection; increased knowledge about the importance of testing, the benefits of ART and STI screening and case management; increases in intention to HCT; increased knowledge about service availability

Core principles: Reaching KP at higher risk in priority sites to create demand for HCT and STI services

Key innovations: Scaling up reaching KPs through their social networks and use social media including websites, group as well as individual electronic communication. Create pharmacy network as the outlet for HIV information and where to get the HCT services”⁵.

Though precise data on PWID are not available, all interview partners agreed that the status of the Harm Reduction program does not sufficiently meet the needs of PWID. An unknown number of PWID are scattered in small numbers across the country, making it difficult to deliver cost effective services to everyone and to say exactly whether the target (70% and 80% of all PWID in year 1 and year 2 respectively) was reached. It is also unclear whether the targets are realistic and some outreach teams feel overburdened with a target of reaching 70 new PWID/year. Since recruiting PWID for testing and treatment is a major task of the outreach services, reaching and recruiting PWID are closely related and outreach activities play a major role in both. The National Operational Plan states that there are certain crucial gaps in recruiting PWID into such services and lists a number of key interventions and innovations:

“Key gaps in recruitment: Even though all Thai citizens are eligible to free HTC, STIs and OST services, the inconvenience and KPs-unfriendly services are main barriers for KPs to be recruited for services. Fear of positive results also brings about the reluctant of KPs to seek for the services.

Outcomes: increased recruitment of target populations to needed services; including pre-HIV test counselling, or STI screening, diagnosis and treatment; or OST

Core principles: Recruitment at scale into pre HIV-test counseling, STI, OST at scale by focusing in priority provinces and KPs

Key innovations: Branding of services; peer- driven intervention using incentive schemes and RDS to target those at highest risk; integration of the private sector; online appointment services, QR-code based membership cards”⁶.

The Operational Plan also mentions that there is a need for an enhanced referral system in which pharmacies should be integrated and smart phone applications should be used to enhance clients’ access and adherence to the services. Such activities had been part of the CHAMPION-IDU program, but don’t seem to be followed up under the STAR-program.

Recruitment, adherence to medical or social services and follow-up of clients could be greatly enhanced by a functioning referral system and case management using all forms of useful and feasible means to keep contact between service providers and clients. As mentioned in the Operational Plan, this may also include providing transportation and accompanying clients to sites (“testing buddies”).

⁵ National Operational Plan Accelerating Ending AIDS 2015-2019, p.22

⁶ Ibid., p.23

6.2. SITING HARM REDUCTION SERVICES

Opening services in the right places is crucial to reach out to all PWID in need of support. But experience – also at some of the DICs visited during the assessment mission (e.g. in Chiang Rai) – shows that PWID do not „drop in“ at such facilities, if they are located too far away from where PWID live, buy drugs and/or consume them.

Even where facilities are located close to such places, PWID are reluctant to use them, if they have to fear harassment by the police around the centres. In some places, also neighbors disapprove of having such a facility in their neighborhood and start acting against them. The DIC in Chiang Rai is such an example where neighbors convinced the property owner of the DIC to cancel the contract because they rejected the DIC.

Coming to an agreement with the local police („discretion policy“) is also crucial for enabling PWID to enter and leave the DICs untroubled. In all centres we learned that there is trouble with police-harassment and humiliation of drug users and the peer-outreach staff. Agreements need to be made with local police and neighbours to allow a true drop-in service for all drug users seeking help and to let outreach workers do their work undisturbed. In areas with PWID living in remote and hard to reach areas, satellite-DICs in places that are easier and less risky to reach (e.g.in Patthalung) can function as support units for outreach teams and as gathering points for PWID living in the vicinity.

6.3. SWOT ANALYSIS OF DROP-IN CENTRES

During the mission, the assessment team found two main models of DIC-based services to PWID, which we would like to analyse according to their strengths, weaknesses, opportunities and threats (SWOT):

Model 1: DIC near/in the MMT hospitals (e.g. in Chiang Mai and Samut Prakan)

<p>Strengths:</p> <p>act as social support units for MMT clients may intervene when problems with MMT arise</p>	<p>Weaknesses:</p> <p>only few PWID who are not on MMT come to the centres Outreach staff finds it hard to reach all PWID in need of services (too remote or too mobile)</p>
<p>Opportunities:</p> <p>There is a good opportunity to enhance the links between first-level services (DIC, outreach) and second-level services (testing, MMT, ARV, medical aid, etc.) and create a referral system with a better case management</p> <p>There is some opportunity for useful leisure time activities (in Samut Prakan there is a TV and some books; in Chiang Mai there is a small garden) which could be scaled up</p>	<p>Threats:</p> <p>PWID who come to the centres are at high risk of being harassed by the police (in Chiang Mai)</p> <p>PWID from remote villages have to travel very far to receive services (DIC, MMT, etc.) which involves high costs and is very risky (accidents)</p>

Model 2: DIC at “hot spots” (e.g. Trang, Prachacheurn and Mitsampan - Bangkok)

<p>Strengths:</p> <p>act as real <i>drop-in</i> centres that are open for all PWID</p> <p>Sterile injecting equipment is provided, coffee is available</p> <p>PWID find the atmosphere and staff welcoming</p> <p>outreach goes to the places where PWID buy (and consume) their drugs</p>	<p>Weaknesses:</p> <p>In some DICs (e.g. Mitsampan, Bangkok) the facilities are not very welcoming: not enough space for clients, troubles with neighbours, no other attractive offers than NSP and coffee</p> <p>Outreach staff finds it hard to reach all PWID in need of services (too remote or too mobile)</p> <p>In Trang, it is still unclear whether all PWID in remote villages are covered</p>
<p>Opportunities:</p> <p>Close cooperation with and information (advocacy and de-stigmatization) activities in the communities enable better service provision for PWIDs</p> <p>Involving PWID from the communities in community activities (cleaning, painting etc.) reduced stigma and intolerance against PWID</p> <p>In Trang, the DIC developed some leisure time activities (printing T-shirts, embroidering flip-flops, etc.) which may eventually lead also to small income-generating activities</p> <p>In Trang, the sub-DIC in Patthalung is a good model to service PWID in remote areas and enhance peer-outreach</p>	<p>Threats:</p> <p>PWID who come to the centres are at high risk of being harassed by the police</p> <p>Some communities are officially “drug free” and won’t accept outreach</p> <p>PWID from remote villages have to travel very far to receive services (DIC, testing, MMT, etc.) which involves high costs and is very risky (accidents)</p>

At the O-Zone DIC in Chiang Rai, we learned that the centre works closely with MMT doctors from the hospital to bring Methadone doses to clients in remote areas (Santikili) where single doses are consumed by clients daily in front of an outreach/peer-worker. Though this method seems to work well with regard to keeping clients in the OST program and in reaching out to them, it also puts the responsible outreach/peer-workers at a considerable risk. In most cases, the peer workers are either also MMT clients or they have only recently overcome their addiction; handling Methadone in large quantities every day contains risks for relapse, and misuse of Methadone – and last not least there is always a risk of Methadone being stolen.

6.4. ANALYSIS ACCORDING TO OECD-DAC CRITERIA

Relevance – is the program doing the right thing?

The STAR-program is relevant in following the objectives of the OP 2015-2019, in which five operational objectives and key strategic interventions are being listed to end AIDS in Thailand by 2030; they also follow the logic of RRTR:

Operational Objective 1: reach 90% of all KPs with evidence based prevention services by 2017,

Key strategic interventions: delivery of high coverage prevention services to KPs including information provision including using social media, BCC, condom provision and promotion, needle syringe programs, and Methadone maintenance.

Operational Objective 2: recruit 90% of all reached KPs into HIV testing by 2019,

Key strategic interventions: Demand creation for HIV testing, branding of service sites to increase user recognition and confidence, STI diagnosis and management, normalization of HIV testing, and community awareness generation.

Operational Objective 3: achieve a coverage of 90% for testing among all recruited KPs by 2019,

Key strategic interventions: Implementation of decentralized same day testing; Provision of mobile and community-based testing; HCT integration into primary care services

Operational Objective 4: provide treatment for all HIV infected KPs by 2019,

Key strategic interventions: ART treatment initiation at any CD4 level; decentralization of ART and follow-up services; effective of linkages to antenatal care to eliminate vertical transmission

Operational Objective 5: retain 90% of infected KAPs in treatment services by 2019,

Key strategic interventions: Adherence support and delivery of electronic and mobile based adherence support over life of treatment; case management at the community level⁷

In 2016, both the President of the Supreme Court and the Minister of Justice have publicly demanded that Thailand should consider modernizing its drug policies to achieve improved health and human rights objectives, aligning its approach with the international community. First amendments to the Thai drug law were adopted and took effect on 16 January 2017. But as the new Justice Minister Suwaphan Tanyuwardhana stated at a conference hosted by the Kamlangjai Project (*"Inspire Project"*) in January 2017: *"legal reforms alone are not enough, and social measures, appropriate to the Thai context, are needed to help curb the impacts of drug use and dependence on communities."*⁸ Acting in a time of change where many officials are still reluctant – or lack the capacity – to work together on a Harm Reduction approach, the STAR Harm Reduction program still lacks political support and ownership, commitment and capacities are rather low among relevant ministries and stakeholders.

Effectiveness - is the program reaching the objectives?

There are several open questions regarding an assessment of the effectiveness of the program: The first is how many PWID currently live in Thailand – and where exactly? Some sources say there are 70,000, others say there are only 40,000. The most recent government estimations (for 2014) state that there are 40,300 PWID living in the country⁹ without giving further details about how these are regionally distributed.

The most recent report by the Principal Recipient (PR) to the Global Fund indicates that reaching the ambitious targets of the HR Program is a challenge: as an example, the target for PWID to be reached and tested between October 2015 and December 2016 was 13,306 PWID. However, only 8,062 PWID were actually reached and tested, which is only 60.6% of the expected target. During the interviews and focus group discussions at service facilities it became very clear that reaching the set targets is very difficult and creates a considerable burden for service staff – especially for outreach workers and peers who find it hard to reach the expected number of clients for various reasons. The effectiveness of the program is certainly also hampered by the closing down of many services running under the CHAMPION-IDU program until 2015 – especially the reduction from 19 to 12 provinces – which resulted

⁷ Thailand National Operational Plan Accelerating Ending AIDS 2015-2019, p. 30

⁸ Patcharavalan Akbar and Gloria Lai, A push for decriminalisation and harm reduction approaches to methamphetamine in Thailand, in: IDPC blog, January 17, 2017 <http://idpc.net/blog/2017/01/a-push-for-decriminalisation-and-harm-reduction-approaches-to-methamphetamine-in-thailand>

⁹ National AIDS Committee, Thailand Ending AIDS – Thailand AIDS Response Progress Report 2015, p.49

in fewer service sites although the targets defined by the STAR program have remained the same as before¹⁰.

On the other hand, all clients interviewed reported that first access to the program had been relatively easy and they had been well informed about available Harm Reduction and MMT services. Most clients learned about the program through friends.

A broader range of Harm Reduction services (such as increased and needs-based outreach, intensive work with the communities towards de-stigmatisation of PWID, drop-in facilities with attractive and needs-based offers, social support, specialised support to women who use drugs, and a case management of clients within a referral mutually coordinated system) is needed to enable service providers to better achieve the objectives and targets of the program. Services targeted to the needs of the potential clients should be established where drug use is high. Outreach and support to female drug users definitely needs to be increased and services for female clients should be established. There is an especially urgent need to work more intensively with the police to come to solutions that enable clients' free access to Harm Reduction services and security for outreach and peer workers. So far, harassment and human rights violations by the police are one major obstacle in reaching the objectives and offering a continuum of care.

Efficiency - is the program cost and time efficient?

With regard to cost effectiveness, the National AIDS Committee gives a fairly clear statement in its Progress Report 2015, which states that despite the change to the New Funding Model (NFM), much of the funding for Harm Reduction services in Thailand still comes from the Global Fund. In 2015, the GF provided support to civil society organisations (CSO) providing DICs and outreach work in 12 provinces while the MMT services are funded by the Thai government. The report states that the *"(...) current status of Harm Reduction is not consistent with the needs and context of the local community where PWID live. There are gaps in outreach by the Civil Society groups, and gaps in static services in the public sector. There is a need for more integrated effort among the government and Civil Society groups to link outreach with government clinics, ensure better coverage of clean needle/syringe distribution, and spur greater uptake of MMT services in the community and clinic settings."*¹¹

Talks with CSO service staff during the assessment mission revealed that many of these gaps are due to a lack of funds, skills and knowledge among the service providers.

Impact - does the program contribute to higher benefits?

The program does make some contribution to the health sector in the country, but in order to contribute to achieving the Sustainable Development Goals, a lot more action needs to be taken. There is good potential to make positive contributions to cross-cutting issues and overarching policies, such as human rights, rule of law, and different dimensions of poverty alleviation – including improving the living conditions of the target groups and these issues should be tackled within the overall drug policy reform in the country.

Necessary budget allocations for a more comprehensive drug service enhancement need to be made if a true impact is to be made for the benefit of PWID in Thailand. It should be borne in mind that in order to improve the living conditions of PWID, MMT can only be one contribution and that a broader range of services to people who use drugs, but do not inject (yet), should be developed (or scaled-up) around it. This includes a range of coordinated services from low-threshold Harm Reduction services,

¹⁰ Ibid., p.23

¹¹ National AIDS Committee, Thailand Ending AIDS – Thailand AIDS Response Progress Report 2015, p.23

needs based treatment options (other than MMT), to long-term rehabilitation to support client's stabilization, psychosocial wellbeing, livelihoods, and reintegration into their families.

The program has potential to meet local and national dynamics, but what is lacking is a sound assessment of where exactly which services should be offered to enable better access to quality services for drug users and to ensure their human and civil rights. There is potential to contribute to more social justice, equal opportunities and equal access/equity, if the Harm Reduction approach is firmly embedded in the national laws and policy (social dimension of sustainability) and in needs-based integrated local approaches. The benefits of this rights-based approach for communities should be advocated more prominently on the community level and among local stakeholders – above all the police.

According to the ONCB, measures to scale up and diversify voluntary and rights-based services to PWID are foreseen, but processes to come from strategy to action take a long time and ownership for a comprehensive, human rights and needs based drug policy is still low among the crucial stakeholders. What seems to be lacking also, is a wider coordinated concept that comprises a variety of services across the country and strategies for a comprehensive and coordinated response across all relevant actors in this field.

Sustainability - *will the changes last?*

Thailand has only recently undergone major changes in its drug policy. To what extent the responsible policy makers actually will support a comprehensive Harm Reduction approach sustainably, is hard to predict. As mentioned before, ownership and political will as well as capacity for programming and sustainable cross-sectorial steering are still weak in this field. The formulation of the 16 Harm Reduction elements in January 2017 covers many crucial elements of a comprehensive package of services for PWID, but only few of them are firmly in place yet. However, the national drug policy together with the STAR-program has good potential to stem HIV and HCV among PWID and to contribute to more social justice, equal opportunities and equal access/equity - if it is based on a clear needs assessment, diversified, scaled up, decentralized, and embedded in a wider national approach that also involves law enforcement and judiciary (social dimension of sustainability).

6.5. CAPACITY NEEDS ASSESSMENT

Capacity needs at system level (structure, coordination, regional coverage):

- Methods to monitor impact and outcome (change) down to the community level,
- Multi-stakeholder cooperation and coordination of activities
- Building a referral system (involving both public services and CSOs) and case-management for PWID
- General knowledge about the comprehensive Harm Reduction approach (rationale/philosophy, comprehensive package of services, their aims and core objectives)
- knowledge about treatment options (“Treatment literacy” as it is called in the OP 2015-2019)
- Knowledge about methods for rapid situation assessment, needs assessment, etc.
- Skills in explaining the benefits of HR to a broader public (advocacy, tolerance enhancement)

Capacity needs at organizational level (knowledge about HR methods, skills in project management)

- Knowledge (and practice examples of their implementation) about state-of-the-art HR services for different target groups
- Knowledge about needs assessment methods and methods to assess client satisfaction
- Skills in needs based project planning, management, reporting and documenting progress/success
- Skills in developing outreach plans together with peers

- Skills to communicate and coordinate better with other stakeholders (esp. Community elders & police)
- Skills in building a referral and follow-up system (case management, division of roles, cooperation and coordination between public and CSO sectors well as between health and psychosocial sectors; social support for PWID in police custody and prison – aftercare for PWID who are released from prison)
- Skills in developing services for women who use drugs (assessing and meeting special psychosocial and health needs of women who use drugs in different settings)
- Knowledge about siting HR services and working with the community
- Knowledge about the needs of opioid users who shift to ATS (and other drugs) injecting regularly.

Capacity needs at individual level (different staff members, e.g. permanent staff, outreach coordinators, volunteers, peers etc.)

The assessment team recommends to conduct a capacity needs assessment among all staff members (including volunteers and peers) at all centers and to tailor trainings according to the special needs of service staff, volunteers and peers. These trainings should be conducted regularly and feedback on the learning progress should be collected. It is also important to tackle topics such as

- BCC skills towards PWID (esp. with highly stigmatized and hidden PWID)
- Knowledge about treatment options (“Treatment literacy” as it is called in the OP 2015-2019) – including good practice examples from other countries
- Knowledge about comprehensive health care needs of PWID
- Knowledge about the needs of women who use drugs
- Counseling skills (e.g. basics in motivational Interviewing) and case management
- Motivation skills for outreach workers to motivate PWID to access services

The latest report of the PR lists the following capacity building measures held in 2016:

- Ten re-orientation meetings to introduce and explain the STAR Program at central and regional level (March-May 2016).
- Refreshment financial trainings for sub-recipients (April 2016).
- Four HIV/VCT trainings (five days) on testing to all SRs (July - August 2016).
- Real Time Cohort Monitoring under PWID, MSM, MSW/FSW for initial pilot testing (August 2016).
- Four Training of Trainers (October- November 2016) on RTCAM

Feedback gathered by the mission team was that trainings are outdated, always delivered by the same trainers, did not fit the individual needs and existing capacities and knowledge of the trainees and lacked important basic knowledge, like the basic principles of Harm Reduction approach. Thai trainers should receive skill building on needs-oriented and participatory training techniques and backstopping from international master trainers. Existing trainings/manuals should be adapted to the needs of Thai services providers in cooperation between international and Thai experts, then trained by international trainers to Thai „master trainers“ to establish a broader expert pool and pool of national trainers.

7. Specific Issues

7.1. HIV TESTING

The most recent report by the PR indicates that reaching the ambitious targets of the HR Program is a challenge: as an example, the target for PWID to be reached and tested between October 2015 and December 2016 was 13,306 PWID. However, only 8,062 PWID were actually reached and tested, which is only 60.6% of the expected target.

However to get people in need of treatment PWID on ARV seems to be the even a bigger challenge. ART coverage among PWID is estimated to be 2%. Testing is free, but only available in hospitals or through mobile clinics coming to DICs or in some provinces (e.g. Chiang Mai) to remote villages to offer testing free of costs for non- Thai nationals.

According to DICs staff and our interviews with patients, clients mainly take tests if they are mandatory (in the Methadone programme) or if an incentive (e.g. In Chiang Mai 300 Bath per test) is provided. Otherwise clients seem to be very reluctant to get tested. This seems to be due to the high stigma and discrimination from hospital staff, but also high stigma and discrimination among peers. We learned from DIC volunteers that among peers stigma and discrimination is even higher. Often clients, who took a test and have a positive test result, do not want to enroll in treatment and be open about their status due to fear of stigma and discrimination from their peers.

To improve testing among PWIDs the counseling skills and motivation skills of outreach workers and to a certain extent among peer volunteers need to be improved to increase the knowledge about the importance of testing and the benefits of ART among PWIDs. As also recommended in the Operational Plan, face to face outreach activities should be complemented by the use of social media and mobile phone technology.

Further the referral system and case management needs to be improved. As mentioned in the Operational Plan, this may also include providing transportation and accompanying clients to sites (“testing buddies”). Rapid tests should be easily accessible, ideally offered at DICs on a regular basis, either through mobile clinics or through skilled staff of the DICs.

A focus should be on risk networks: partners and social networks of positive tested PWID should be reached out to and motivated to get tested. Activities (including trainings and sensitization workshops) to reduce stigma and discrimination among hospital staff, but also among peers and social networks of PWID should be implemented. Advocacy campaigns aiming at normalization of HIV testing and community awareness generation should to be conducted on a regular basis.

In addition, the Operational Plan states that policies and guidelines need to be reviewed and updated to address new service delivery models (i.e., rapid, same day result testing, decentralization and the required task shifting for this to occur). Laws related to the age of consent for testing and criminalize certain behaviours (such as substance use and selling of sex), need to be reviewed and interpreted in ways that support public health goals.

7.2. METHADONE PROGRAMME

Although MMT is mentioned in the OP 2015-2019 as one of the main interventions for PWID and the national MMT programme consists of 147 sites, the number of patients in the programme is quiet low. This seems to be due to a number of reasons.

Quality of service

- No standardized psycho-social support offered to MMT patients; in some sites there are linkages with DIC centres, but not in a standardized way
- Although national guidelines are in place, they do not seem to be followed in all sites; this results in

different regulations on take-home dose, different regulations on a maximum dose (in some places 60 mg) etc.

- Often patients are enrolled in the MMT although their main drug of use are ATS and other pharmaceuticals with on and off injecting of heroin (based on field staff experiences; mainly in the Bangkok and Central region)

Accessibility of services

- In some provinces Methadone sites are hard to access for patients due to long distances and travel time (e.g. Chiang Mai, Trang)
- In some provinces (which we did not visit during our mission), services are not available at all.

Regional distribution of services

Drug use patterns, esp. in the Bangkok and Central region have changed (see also point 3.2.). Many PWID shifted from opioid injecting to injecting of ATS and pharmaceuticals, and with this service needs also have changed. As a result, many MMT sites either have a very low number of patients or many patients with high injecting side use (often daily) of ATS and other pharmaceuticals.

In order to increase access to OST in remote areas, O-Zone has implemented in the context of the PSI CHAMPION IDU project a peer-led, community-based Methadone delivery service in the mountain village of Santikhiri in Chiang Rai province, where peer outreach workers operate Methadone delivery at a drop-in centre with supervision from Mae Chan Hospital. Initiated in 2013, the initiative attracted media attention and support from government agencies and has been replicated in Huay Pung in Chiang Rai province. In partnership with Thanyarak Hospital, O-Zone also facilitated the development of a slightly different community-based Methadone service model in Tak province. Though the model was also developed to overcome logistical challenges associated with reaching a community home to numerous PWID in a mountainous region along the Burmese border, the model differs from the one implemented in Santikhiri in that the Methadone delivery takes place in government-operated community clinics. In Tak, O-Zone facilitated expansion of government coverage where project workers recruit, educate, and support clients enrolled in the Methadone service, through regular home visits. Clients accessing Methadone are regularly provided with a quantity to last up to 14 days. These pilot projects could play a crucial role in scaling up MMT services and serve as a model countrywide to make MMT accessible for PWID living in remote locations with difficulty accessing government MMT services.

To improve the MMT programme the assessment team recommends the following measures:

- Distribution of services should be rearranged based on a RSA and based on drug use pattern and needs of the patients
- MMT sites should be scaled-up in provinces with high burden of opioid use; including satellite sites in remote areas; in these areas different models of MMT dispensing should be implemented according to the needs of PWID; e.g. MMT dispensing provided through NGOs in cooperation with hospitals (O-Zone community based models)
- National guidelines, standardized regulations (e.g. take-home, dosing) should be deployed in every site
- All MMT patients should have access to psycho-social support either provided through the hospital or in cooperation with DICs by skilled staff
- DIC staff (field staff and volunteers) should receive specific training to provide psycho-social support to MMT patients
- Patients should receive comprehensive health care in MMT sites (referral to relevant services).

7.3. YOUNG DRUG USERS

While opioid injectors in Thailand tend to be between 25 and 45 years old, non-injecting drug users – especially ATS-users - are usually young and many of them are young women. Consumption takes place in private homes, at clubs, parties, or other settings that are not easy to reach by staff of the existing HR services. Hence, it is not easy to provide HR services to young non-injecting users through the Harm Reduction program as it is today. However, Harm Reduction service providers could team up with CSOs that work with young people to exchange knowledge about relevant HR issues (prevent shifting to injecting, promote safer use and safer sex etc.) and to promote this knowledge among young people in these settings.

Young people using the traditional and indigenous plant Kratom is a relatively new phenomenon in the country. Traditionally, Kratom-leaves are chewed or powdered leaves are swallowed in the field, at teashops or at festivals mostly by men over the age of 25.

“Eating kratom is a tradition that has been practiced for centuries in southern Thailand and up to 70% of the male population in some districts use kratom daily. Indeed, many people in southern Thailand consider chewing kratom similar to drinking coffee”¹².

Although Kratom is an integral part of southern Thai culture, it has been criminalized for many decades until the ONCB started an initiative to reconsider the criminalization of Kratom and its users in 2010.

Only recently, a new pattern of Kratom-use emerged among adolescent Thais – not only in the rural south, but also in urban areas, such as Bangkok. A large quantity of Kratom leaves is used to produce a cocktail together with cough syrup, Coca-Cola, and ice cubes. This target group is also hard to reach since Kratom use is still a legal offence in Thailand but not considered a health risk due to its traditional use. Neither ONCB nor other experts put a high priority on this use at the moment, but continued criminalization may lead to risky forms of consumption and the use of high dosages of Kratom among young people may entail health risks.

7.4. ATS ON THE RISE

According to the UNODC, East and Southeast Asia have one of the most established methamphetamine markets in the world displacing traditionally plant-based drugs such as heroin, opium and cannabis¹³

“Thailand has one of the largest markets for methamphetamine in the region. While methamphetamine pill use remains the most common form of drug use in the country, the use of crystalline methamphetamine has become increasingly widespread.

Domestic manufacture of methamphetamine in Thailand is limited to small-scale manufacture (...) located in the outskirts of Bangkok and in surrounding provinces as well as in the northern province of Chiang Rai, indicating that pill pressing operations are taking place in the area bordering Myanmar”¹⁴.

ATS-use is increasing and may become a significant health and social problem like in other countries in East and Southeast Asia. Potential populations at risk are female sex workers and other workers in the entertainment/hospitality industry (clubs and casinos), youth (e.g. homeless, unemployed and incar-

¹² Pascal Tanguay, Kratom in Thailand - Decriminalisation and Community Control? in: Transnational Institute Series on Legislative Reform of Drug Policies Nr. 13 (April 2011), p.2

¹³ 2011 Global ATS Assessment, United Nations Office on Drugs and Crime (UNODC), August 2011; http://www.unodc.org/documents/ATS/ATS_Global_Assessment_2011.pdf

¹⁴ Ibid. P.21

cerated youth), migrants, and MSM. Although a majority of ATS users does not inject, ATS use is associated with a range of communicable diseases such as HIV, hepatitis B and C infections and other sexually transmitted infections (STI), tuberculosis and mental health problems. There is an urgent need to scale up prevention, treatment and Harm Reduction services to avoid the further spread of these potentially life-threatening infections.

However, to-date, prevention, treatment and Harm Reduction strategies in this field are still in their initial phases. In Thailand, there is a lack of professional expertise and counselling training and little experience in dealing with psychosocial and mental health problems (mostly through the Matrix method in government facilities). On the other hand, HR services still focus on (male) injecting heroin users and have little to offer for ATS users who also cannot be reached in the same settings nor by the same outreach workers.

Although evidence for HR interventions for this target group is not yet as substantial as that for Harm Reduction interventions among opiate users, there are first experiences with HR interventions for ATS users (e.g. in Czech Republic, USA and Australia) and some publications summarize first good practice examples. In any case, it is important to expand the range of services available to ATS users that may be used as a basis for further knowledge and skill building activities. In any case, HR service providers should link up here with other CSOs working with people at risk in clubs, the entertainment business or with MSM.

7.5. WOMEN WHO USE DRUGS

Service staff reported that only about 10% of their clients are women. Whether this reflects the actual percentage of female PWIDS remains unclear, because especially in rural areas female PWID are even more hidden than male. Due to traditional gender roles, women use drugs secretly. Thus, they are less visible and more difficult to reach through helping services. They are more likely to engage in income-generating activities that further impede their health (commercial sex work, transactional sex) and women who use drugs fear further stigmatization when accessing the health (public) system. Women drug users differ from male users in reasons for using drugs, patterns of use, and psychosocial needs – especially when they become mothers. Therefore, CSOs play a crucial role in reaching out to these women and in providing first-level psychosocial support meeting their special needs. Such needs also incorporate childcare and legal support.

According to service providers interviewed during the mission, women who inject drugs mostly live in partnerships with male PWID and consume together with them, but it is mostly the male partner who come to the DIC and uses the NSP and information services. However, female drug users face more health problems than men do: Their veins collapse faster and they are more likely to develop abscesses. Women in general are more vulnerable to STI, but often take longer to realize they are infected – thus they have a higher risk of attracting HIV and at the same time tend to refuse testing more often than male PWID. Peer injecting is a health risk still left untackled.

During our talks at the sites, it became obvious that service staff has only very little knowledge about drug abuse patterns of women and their special service needs. In some places, female peers have been engaged to reach out to other women who use drugs, but their capacity to meet the special needs of drug using women is very low and they meet even higher stigma, discrimination and harassment than their male colleagues. Knowledge about the special needs of this target group and skills how to reach out to them and provide appropriate services needs to be built. The assessment team therefore recommends to conduct trainings on this issue to develop a pool of trained „master trainers“/experts on this issue in Thailand that can provide „cascade trainings“ to NGO staff according to their capacity needs.

8. Recommendations

8.1. GENERAL RECOMMENDATIONS

Diversify Harm Reduction services at DICs according to the assessed needs of the target population (e.g. food, social support etc.)

Scale up outreach and social support for PWID in remote areas and around the penitentiary system and rehab (aftercare)

Advocacy / sensitization of the public – about human rights aspects around drug use and for national drug policy (testimonials, success stories, etc.)

Install and **train standards** for behaviour towards PWID (rights based, welcoming, trustworthy, outgoing, and supportive) – for CSOs, medical staff, police, judiciary system, etc.

Diversify service offers for people who use drugs to **reach also non-injectors** with HR measures and prevent them from injecting – in **cooperation with other CSOs and activist groups** that have easier access to these populations

Allow more **flexible needs-based trainings** for different service staff levels by adapting state-of-the-art training manuals on relevant issues and establishing a pool of national trainers (e.g. through trainings of trainers).

Improve data production, management and dissemination including improved management information system and data collection. Collect data from clients and documenting own activities, regular monitoring and evaluation. Strong data collection and verification mechanisms are critical to continuous project improvement, successful negotiations with donors and partners, as well as the production of credible and reliable local evidence. Such reports are essential advocacy tools to support mobilization of technical, financial and political support from donors, national authorities, implementing partners and other key agencies and stakeholders.

8.2. RECOMMENDATIONS REACHING, RECRUITING AND RETAINING

A broader range of **Harm Reduction services** should be implemented according to the needs of the potential clients in the area covered. Such services should include

- **Outreach** activities involving more peers,
- **intensive work with the communities** towards de-stigmatisation of PWID,
- drop-in facilities with **attractive and needs-based offers**,
- **social and legal support to PWID** – also to those in custody or prison,
- **case management** of clients within a mutually coordinated **referral system**

Outreach and support to female drug users definitely needs to be increased and services for female clients should be established. Although all sources claim that injecting drug use among women is low, they equally confirm that only very little information about their true situation is available so far. The **peer-information and outreach system** that has been installed in some places should be scaled up and **cooperation with CSOs working with FSW, dancers and women at Karaoke bars** and nightclubs should be established to reach out to those in need.

There is an especially urgent need to **work more intensively with the police** to come to solutions that enable clients' free access to Harm Reduction services and security for outreach and peer workers. So far, harassment and human rights violations by the police are one major obstacle in reaching the objectives and offering a continuum of care.

DICs should **define a realistic region (area) of coverage** by conducting **regular RSAs** involving outreach teams and PWID-peers to define the real number of PWID in need of services, realistic targets in the area of coverage.

Based on this analysis, **outreach/coverage plans** should be defined that include satellite sites (or sub-centres) in remote areas where needed.

Activities to **enable outreach teams to go into remote villages** should be planned to **reduce stigmatisation of PWID in their communities** (e.g. activities of outreach teams with PWIDS from the communities to help the community as a whole)

A **needs assessment of opioid users who shifted to injecting ATS** (and other drugs) should be conducted and services adopted if needed

8.3. RECOMMENDED BENCHMARKS FOR SERVICE MODELS

UK Drug Policy Commission: GETTING SERIOUS ABOUT STIGMA: THE PROBLEM WITH STIGMATISING DRUG USERS - AN OVERVIEW, *briefing and the accompanying research reports published in 2010*

International Harm Reduction Development Programme of the Open Society Institute, SKILLS TRAINING AND CAPACITY BUILDING IN HARM REDUCTION, 2004

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), GUIDELINES FOR THE EVALUATION OF TREATMENT IN THE FIELD OF PROBLEM DRUG USE - A MANUAL FOR RESEARCHERS AND PROFESSIONALS, 2007

Open Society Institute, ANTIRETROVIRAL TREATMENT FOR INJECTING DRUG USERS – PUBLIC HEALTH FACT SHEET

Canadian HIV/AIDS Legal Network, DO NOT CROSS: POLICING AND HIV RISK FACED BY PEOPLE WHO USE DRUGS, *March 2007*

World Health Organization, EVIDENCE FOR ACTION: EFFECTIVENESS OF COMMUNITY-BASED OUTREACH IN PREVENTING HIV/AIDS AMONG INJECTING DRUG USERS, 2004

8.4. RECOMMENDED STATE-OF-THE-ART TRAINING MANUALS

Name of Training	Topics/Modules	Developed for	Author/trainer
Harm reduction for local drug policies	Forming integrated, multi-stakeholder alliances for Harm Reduction Useful tools and methods (stakeholder analysis, power-interest analysis, problem/actor analysis, etc.) Community involvement in Harm Reduction planning and implementation Advocacy for Harm Reduction	European Harm Reduction Network (EuroHRN)	Susanne Schardt
Training curriculum for staff in psychosocial support units	Role and tasks of Social Support Units Basic understanding of drugs and dependence, HIV, TB and Hepatitis	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) - Harm	Heino Stoever Dirk Schaeffer

	<p>Harm Reduction/OST Basics OST: Initial social assessment, planning and case management, monitoring, dose management and management of irregularities in therapy</p> <p>Other forms of treatment Operation user-friendly, high quality services; Do`s and Don`ts for social workers, advising and counseling, motivational Interviewing</p> <p>Working with families and women</p> <p>Referral, outreach work and quality assurance</p>	Reduction Project in Nepal	
Developing services for female drug users	<p>reasons for a gender-sensitive approach</p> <p>Important cross-cutting issues that affect FDU in particular (e.g. pregnancy, domestic violence, peer-injecting, sex work and transactional sex, prison)</p> <p>Outreach, referral and adherence to services</p> <p>Integrating services for women / developing special services for women</p> <p>Useful tools and methods Planning, monitoring and evaluation</p>	GIZ	Susanne Schardt With contributions from Sophie Pinkham for the Eurasian Harm Reduction Network (EHRN)
Communication skills for trainers and facilitators	<p>Planning trainings and workshops Learning styles and appropriate teaching methods</p> <p>Facilitation techniques Workshop/training “fertilizers” and methods to engage learners</p> <p>Handling critical situations Useful tools and methods</p>	GIZ Moldova and Palestine	Susanne Schardt
Training Curriculum for Service providers: Comprehensive Health Care and Opioid Substitution Therapy	<p>Basics of Substance Use Disorder Interventions Complementary to OST</p> <p>OST Basics, Initial Assessment, Enrolment to OST, End of Treatment</p> <p>Overdose and withdrawal in OST: causes and consequences</p>	GIZ Harm Reduction Project Nepal Nepal Ministry of Health and Population; National Center for AIDS and STD Control, Nepal	Dr. Jörg Gölz Till Kinkel

	<p>Detoxification as Therapeutic Option for Opioid Use Disorder</p> <p>Pregnancy, prevention of mother-to-child transmission of HIV, Neonatal Abstinence Syndrome</p> <p>Treatment of Co-existing Mental and Psychiatric Diseases</p> <p>HIV: Diagnosis, Treatment & Care for people who use drugs, basic knowledge, monitoring and treatment, AR-drugs and adverse effects, opportunistic infections</p> <p>TB and HCV</p> <p>Safety and Caution: Handling of Contaminated Materials, Vaccinations and Post Exposure Prophylaxis</p>		
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