



AIDS
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Proceedings

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Coverage of HIV prevention programmes for injection drug users: what does it mean?

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Presentation Outline

- **Conceptualising coverage**
 - How important is it ?
 - How can it be defined?
 - How much is needed and what does that depend on?
 - Can it be measured in HIV prevention programmes for injecting drug users?

Is it a useful concept?

- Theoretical robustness of applying a concept which has emerged from communicable disease control to a largely behavioral disease, deeply influenced by structural and contextual factors.

Coverage is an epidemiological concept used in communicable disease control. Unfortunately its strength as a concept is somewhat lost when it is transferred to services for injecting drug users, as we are mainly looking at behavioural phenomena.

What is coverage to us today?

- ‘Coverage’ has become a call to action and a spur to move beyond small scale demonstration projects which continue to persist in many regions
- An explanation for the failure of interventions in preventing HIV epidemics such as the extremely high incidence of HIV among injecting drugs users during the 1990s in Nepal in the presence of some harm reduction activity
- A vehicle for advocating for more resources as it serves as a reminder that unless countries scale up demonstration or pilot projects they are unlikely to prevent or reverse epidemics

What is coverage to us today?

- A useful concept for purposes of monitoring and evaluation in public health interventions, even though the methodologies used to measure it remain poorly developed in the case of HIV prevention interventions
- An example of a poorly developed methodology is simply counting service contacts among injecting drug users
- An opportunity for donors and service agencies to package uncertain and complex factors into a single number – unfortunately this reductionist approach can be misguided

What is coverage?

- Refers to the proportion of individuals or a services reaching a particular population
- Can refer to the proportion of a population engaging in a certain behaviour - for instance, the percentage of injections with a clean syringe by an injecting drug user
- Can be at the level of the individual (for example the ‘dosage’ or intensity of intervention) or the population level (geographical) or both
- Can refer to the timeliness or duration of the action or intervention - the “effective contact” with a target population.

Definitions of coverage:

- WHO defines the term in a manner that intrinsically links effectiveness with coverage – ‘the proportion of the population in need of an intervention which has received an effective intervention’ (WHO, 2001).
- With regard to needle syringe program (NSP) coverage: “The number of sterile syringes provided to an injecting drug user divided by the estimated number of injections during a specified time frame” (UNAIDS, 2006)
- With regard to preventing transmission from sharing injecting equipment: the number of injections in the last 30 days with a sterile needle or with a needle used previously only by the injecting drug users themselves

What does coverage usually refer to?

- Harm reduction coverage usually implies some measure of needle and syringe program use, and generally not to high risk sex events or drug dependence treatment – but there is no agreement that this should actually be the case
- An appropriate and simple definition is needed

What level of coverage is needed?

- We don’t know – there is a lack of available scientific data on in this area
- In the context of NSP, a 60 percent figure -based upon a retrospective analysis of the proportion of injecting drug users that would have been covered in New York (Des Jarlais and Freedman, 2001) has become a mantra. Recently, Hickman and Heimer have argued that lower levels are needed.

What does the level of required coverage depend on?

- Depends on where your epidemic is and what level you want to bring it down to
 - **The stage:** is it early (low prevalence such as Bangladesh) or relatively mature (such as South West China)
 - **The mix:** the demographics and the affected groups
 - **Drug use patterns:** the primary drug driving the HIV epidemic e.g. heroin (multiple occasions of use daily) compared to ATS (bingeing pattern of use)
 - **Social networks:** the size of the interacting group and the pattern of sexual behaviour

- **The local context:** coverage and its effects are very much determined by the local context so requirements need to be worked out at the local level rather than the international level
- **Dosage of interventions** required depend on the extent of protective/risky behaviours and environments – different for a homeless person compared to someone who shoots up in the privacy of their home.
- If the maxim of ‘one needle one shot’ is followed then it is possible to arrive at a definition of coverage

Measuring coverage – the challenges

- Need extensive baseline information such as estimates of:
 - Number of injecting drug users
 - Number of injections per day per injecting drug user
 - Number of available needles and syringes (including those from additional sources like pharmacies and friends).
- Parameters of models of coverage are also highly vulnerable to changes in drug use patterns such as a shift from heroin to cocaine injection

Does it make sense to try and measure ‘coverage’ then?

- Should there be one ubiquitous coverage indicator?
- Is it possible to break down coverage indicators for HIV prevention among injecting drug users by availability, accessibility and utilisation of services?
- Possibly follow the example of coverage assessments in immunization where the purpose of measuring up-to-date immunization coverage determines the way that it is measured? – for example the concept of herd immunity

Concluding comments

- The science and evidence related to ‘coverage’ is very limited and we should acknowledge this.
- Donors urgently need to fund operational research that helps gets some answers.
- The utility of ‘coverage’ as one composite indicator for reach, dosage and regularity should be debated, and the practicality of measuring it in this form should be reviewed.

The range of community coverage by syringe exchange programs in the United States

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Objectives

- To provide concrete metrics to measure the coverage of syringe exchange programs (SEPs).
- To correlate the coverage to measurable changes in HIV and hepatitis virus transmissions.

Evaluating SEPs

- Take an operations research approach -- investigate the link between the operations of a program and its effects.
- Minimize reliance on self-reported data, especially the kind that introduce socially desirable response biases.
- Account for the impact of secondary in addition to direct syringe exchange.

Community-wide impact

- What percentage of the injecting drug users are served?
- What percentage of syringe need is met?

Comparing Chicago and New Haven mobile programs

- Although both mobile, there are significant differences
- New Haven
 - Operations mandated by state laws
 - There is a strict 1-for-1 exchange policy
 - The number of syringes exchanged per visit limited
 - Has remained an exchange
 - NS policy
 - 1990 to 1992 -- cap of 5 syringes per visit
 - 1992 to 1999 -- cap of 10 per visit
 - 1999 to present -- cap of 30 per visit
 - Maintained a strict 1-for-1 policy
- Chicago
 - Operating policies set by the SEP and flexible
 - Exchange policy was never 1-for-1 and the number of syringes per visit was never limited

- Has transformed into a syringe distribution program
- Needle syringe policy
 - 1993 to 1997 -- 2-for-1 for first 5, then 1 for 1
 - 1997 To 1999 -- nearest 10
 - 2000 to present -- “How many do you need?”
- Moved to a policy to promote secondary exchange

Calculating coverage in terms of people

- In New Haven:
 - Estimates of from drug treatment -- 2550.
 - Estimates from AIDS cases -- 2250.
 - We used the average -- 2400 injecting drug users.
- In Chicago:
 - We use the estimate provided by Friedman *et al.* (Journal of Urban Health. 81:377-400, 2004): 33,432

To calculate coverage in terms of syringes needed

- In New Haven:
 - Data from interviews of more than 1500 injecting drug users place the average at 87 syringes per month per drug user
- In Chicago:
 - Data from Ouellet *et al.* (personal communication) and Heimer *et al.* (Addiction, 97:1277-1287, 2002) place the average at 72 per month per drug user

How many syringes are needed?

- New Haven needs to circulate 209,000 syringes per month.
- Chicago needs to circulate 2,375,000 syringes per month

Key points on coverage in these two cities

	New Haven		Chicago	
	Coverage*	Syringes**	Coverage*	Syringes**
Period 1	10.30%	1.26%	3.30%	4.22%
Period 2	6.38%	1.16%	2.17%	4.70%
Period 3	7.91%	1.59%	3.20%	7.48%

* Coverage = % of estimated population of injecting drug users reached by program in that period

** Syringe coverage = % of estimated number of syringes needed per month (as calculated above)

- Higher coverage in New Haven did not translate into better provision of syringes.
- Liberalizing exchange policy in New Haven had little effect on increasing provision of syringes.
- Transition from exchange to distribution in Chicago had the biggest impact on provision of syringes.

Measuring the community impact

In New Haven, it is possible to analyze the effects of syringe exchange on HIV prevalence among injecting drug users and on the percentage of new AIDS cases associated with injection drug use.

- **HIV incidence in SEPs customers in New Haven before and after the SEP**
 - HIV prevalence in injecting drug users reduced by 10%
 - Number of AIDS cases reduced by 10%
 - SEP reduced the prevalence of potentially infectious syringes by 40%.(Heimer R et al. Amer. J. Med. 1993;**95**:214-220)
 - Incidence further reduced by decreases in syringe sharing among customers (Khoshnood K et al. Publ. Health Rpts. 1994;**110**:462-466)
 - Mathematical models suggested a decline in incidence of up to 75% among customers.(Kaplan EH and Heimer R J. AIDS 1994;**7**:182-189)
- **In New Haven**
 - The impact of the SEP was restricted to its customers.
 - Baseline reduction contributed 4% of the difference.
 - Reduction among customers could contribute as much as 7.5% of the 12.3% difference.
 - Reduction among non-customers contributed less than 1%.

Conclusions

- It is possible to develop metrics to evaluate the impact of policy changes at an individual SEP and to compare SEPs.
- Program operations have a large impact on coverage, syringe provision, and disease transmission.
- Low coverage does not mean little impact, but rather restricted impact.
- SEPs operating with restrictions are unlikely to have effects beyond the programs' direct customers.
- The Chicago secondary exchange program is a good model.

Measuring coverage – model projections on the required coverage of syringe distribution to prevent HIV among injecting drug users

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Modelling Coverage

- This is taken from :
 - Vickerman P, Hickman M, et al Model projections on the required coverage of syringe distribution to prevent HIV epidemics among injecting drug users. JAIDS (in press)
- Coverage Definition
 - Number (proportion) of sterile syringes provided per injection per injecting drug user
- What level of coverage is optimal to reduce HIV epidemics?
 - Maximal
 - 60% as previously recommended by UNGAS/UNAIDS/WHO
- Evidence unclear
 - Few countries have or could achieve 60%
- Sharing Definition
 - Estimated number of injecting events not covered by syringe distributed by programme or average re-use

Modelling coverage: an illustration

The key issue is the rate of syringe reuse – this determines the effect of coverage on endemic HIV prevalence

- Homogenous injecting drug user population in Svetlogorsk, Belarus and London, UK
 - Estimate endemic HIV prevalence (S)
- Coverage –components:
 - Proportion of injections covered by syringes provided (ϵ) and personal re-use of syringe (δ)
 - Estimated prevalence of injecting drug use, injecting frequency, and distribution acti
 - Shortfall in syringe availability given reuse = sharing events
- Endemic HIV prevalence (p) – components:
 - Sharing (proportion IDU sharing (s), average number of IDU share with and sharing events (mn))
 - Transmission probability per sharing event (β)
 - Cleaning efficacy (frequency and success of cleaning (ec))

- Injecting frequency (T) and duration (D)

$$R_0 = mD(1 - (1 - \beta(1 - ec))^n)$$

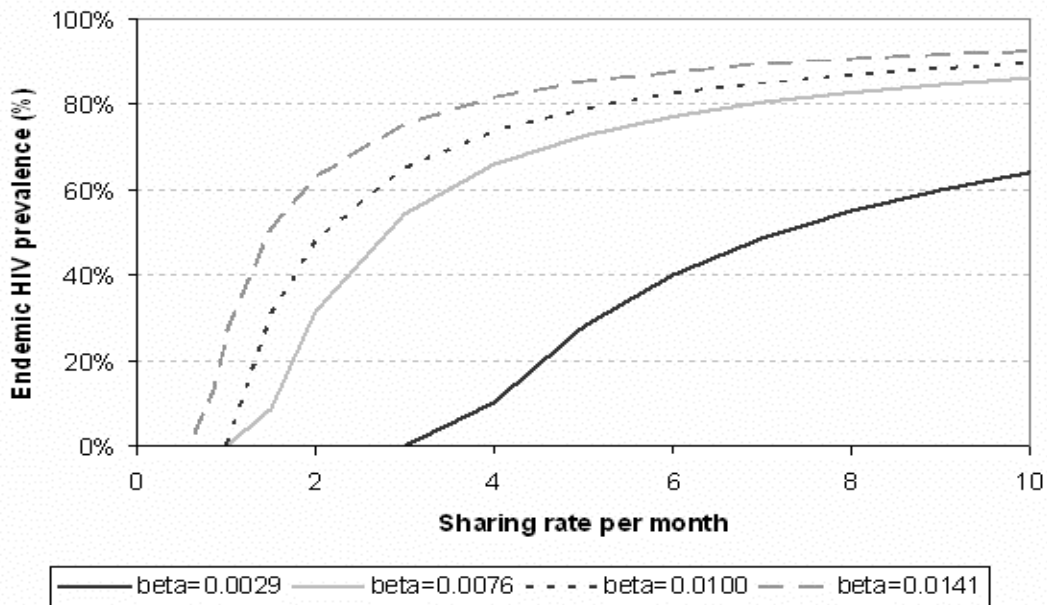
$$\frac{\varepsilon}{T} = \frac{1}{\delta} \left[1 - \frac{S}{\beta(1 - ec)DT(S - p)} \right]$$

Modelling coverage:

Scenarios Svetlogorsk, Belarus and London, UK

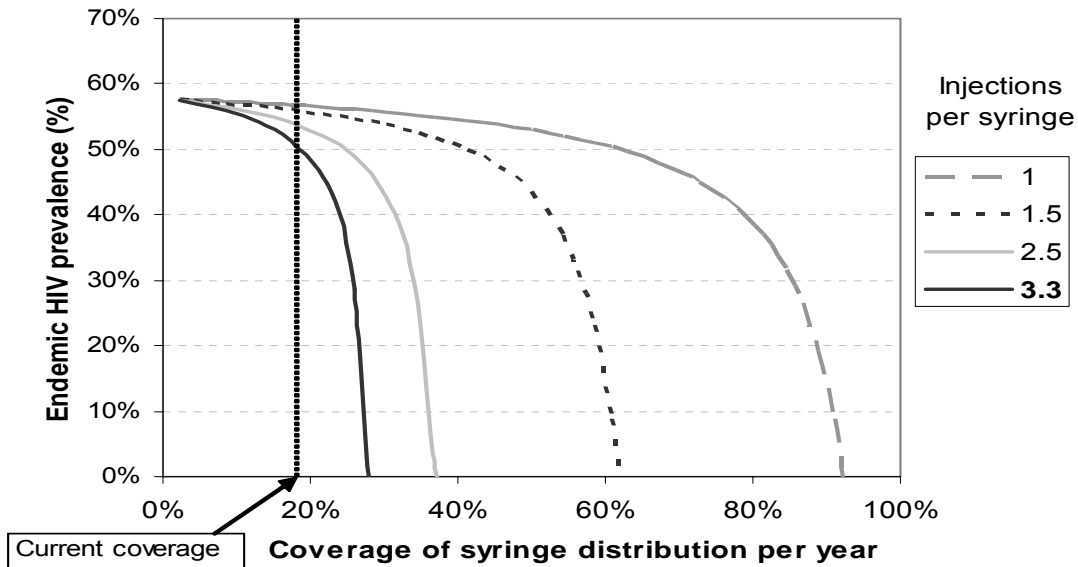
- Key components of the modelling are
 - Size of sharing group
 - Re-use of syringe
 - Injecting cessation rate
 - Injecting frequency
 - Efficacy of syringe cleaning

Endemic HIV prevalence: low HIV prevalence can only be achieved with low rates of sharing



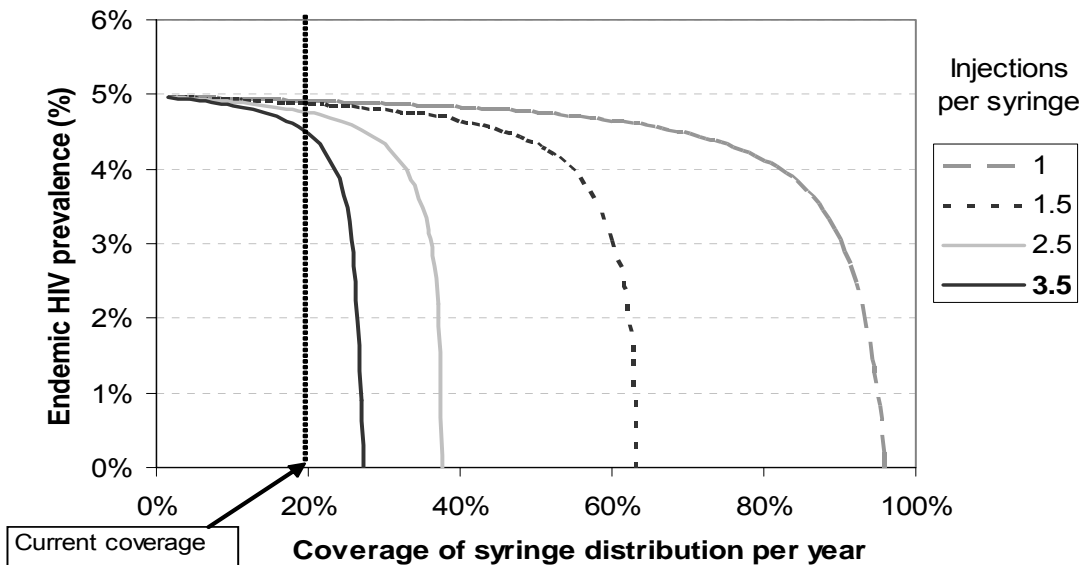
The endemic rate of HIV increases with increasing rate of sharing in a parabolic fashion

Coverage and re-use of own syringe, Svetlogorsk, Belarus: step like function between endemic HIV prevalence and coverage “assuming other factors remain equal”



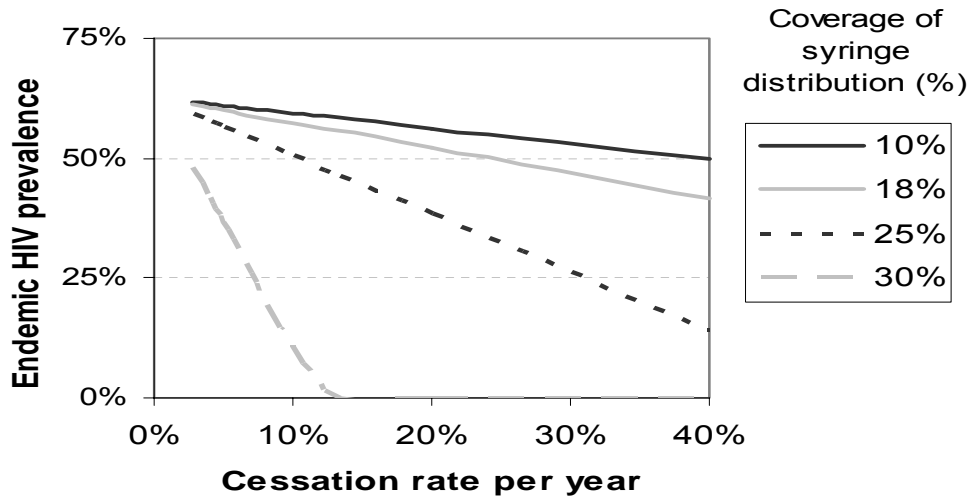
The higher NSP coverage, the higher the rate of syringe reuse that is needed to maintain a particularly endemic HIV prevalence among injecting drug users

Coverage and re-use of own syringe, London: step like function between endemic HIV prevalence and coverage “assuming other factors remain equal”



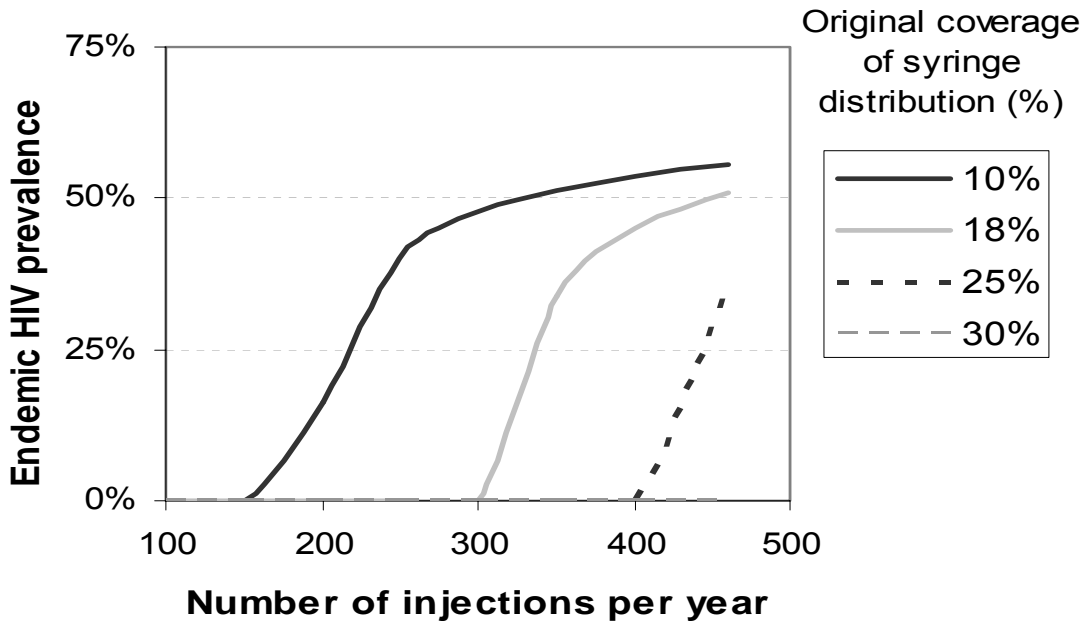
The higher NSP coverage, the higher the rate of syringe reuse that is needed to maintain a particularly endemic HIV prevalence among injecting drug users

Coverage – impact of increasing rate of cessation of injecting drug use (e.g. through treatment) on HIV infection depends on achieving reasonable levels of coverage



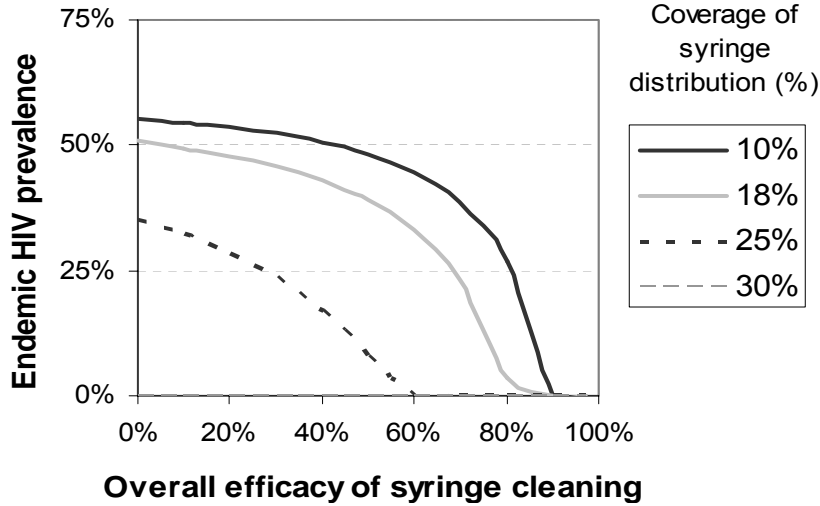
*NSP and drug treatment programs are synergistic - high NSP coverage results in reduced endemic HIV prevalence at a given rate of cessation of injecting drug use. Low coverage results in cessation rate having a reduced impact on endemic HIV prevalence. **The greatest impact of other interventions is when coverage is highest.***

Coverage – impact of decreasing injecting frequency (e.g. through treatment) on HIV infection



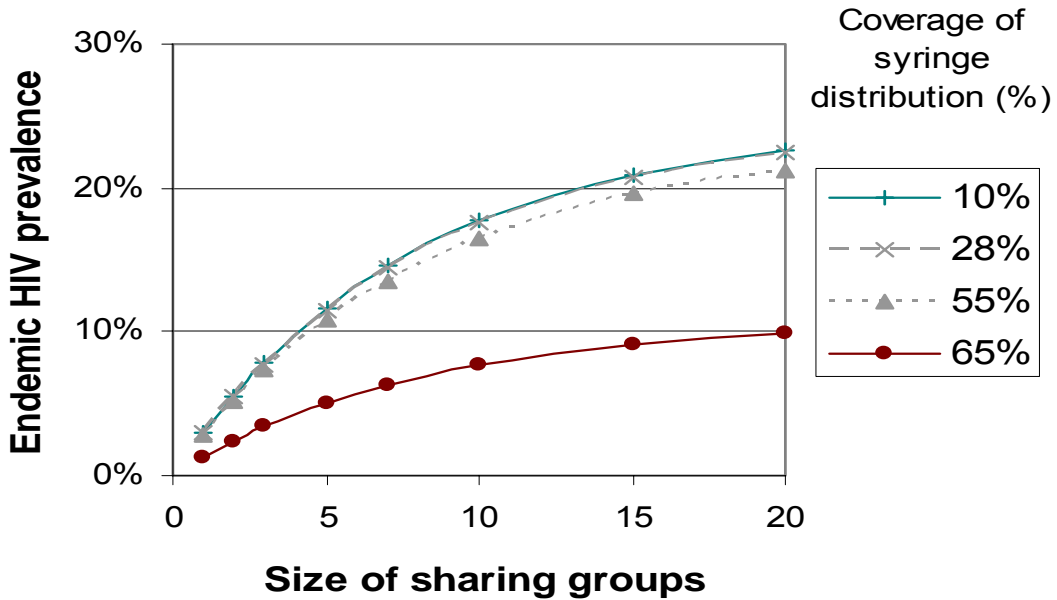
The greater the coverage the greater the frequency of injecting that can be supported without increasing the rate of sharing

Coverage – efficacy of cleaning (frequency and efficiency) on preventing HIV depends on achieving reasonable levels of coverage



High levels of coverage can support poor cleaning utility without increasing HIV prevalence

Coverage – size of sharing group, London. Size of sharing group matters when HIV prevalence is low. To maintain low prevalence sharing groups need to be small or coverage very high.



Greater coverage means that larger sharing groups are supported without increasing endemic HIV prevalence. The size of sharing groups does not matter as much if endemic HIV prevalence is high, but it does particularly if it is low

Coverage threshold – “rule of thumb”

- Product of transmission probability, cleaning effectiveness, injecting duration and frequency is relatively small (<0.1) in both settings.
- Coverage threshold approximately the inverse of the number of times a syringe is safely used before disposal ($1/\delta$)
- And coverage needs to be high enough at frequency of syringe re-use to reducing syringe sharing events to low level (<~2 per month)

$$\frac{1}{\beta(1-ec)DT}$$

Coverage – public health action and monitoring

- This is a simplified model which provides useful insights into role of coverage but should be used cautiously for quantitative projections.
- Public health importance of encouraging re-use and small sharing groups (key behaviours)
 - “rule of thumb” models imply critical coverage threshold related to level of re-use
 - Policies that prevent safe re-use or increase potential sharing group size detrimental to public health
- Other factors impact near coverage threshold
 - Cessation rate, injecting frequency, efficacy and frequency of syringe cleaning
- Prevention feasible at < maximal coverage but needs to be sustained

Coverage – public health action and monitoring

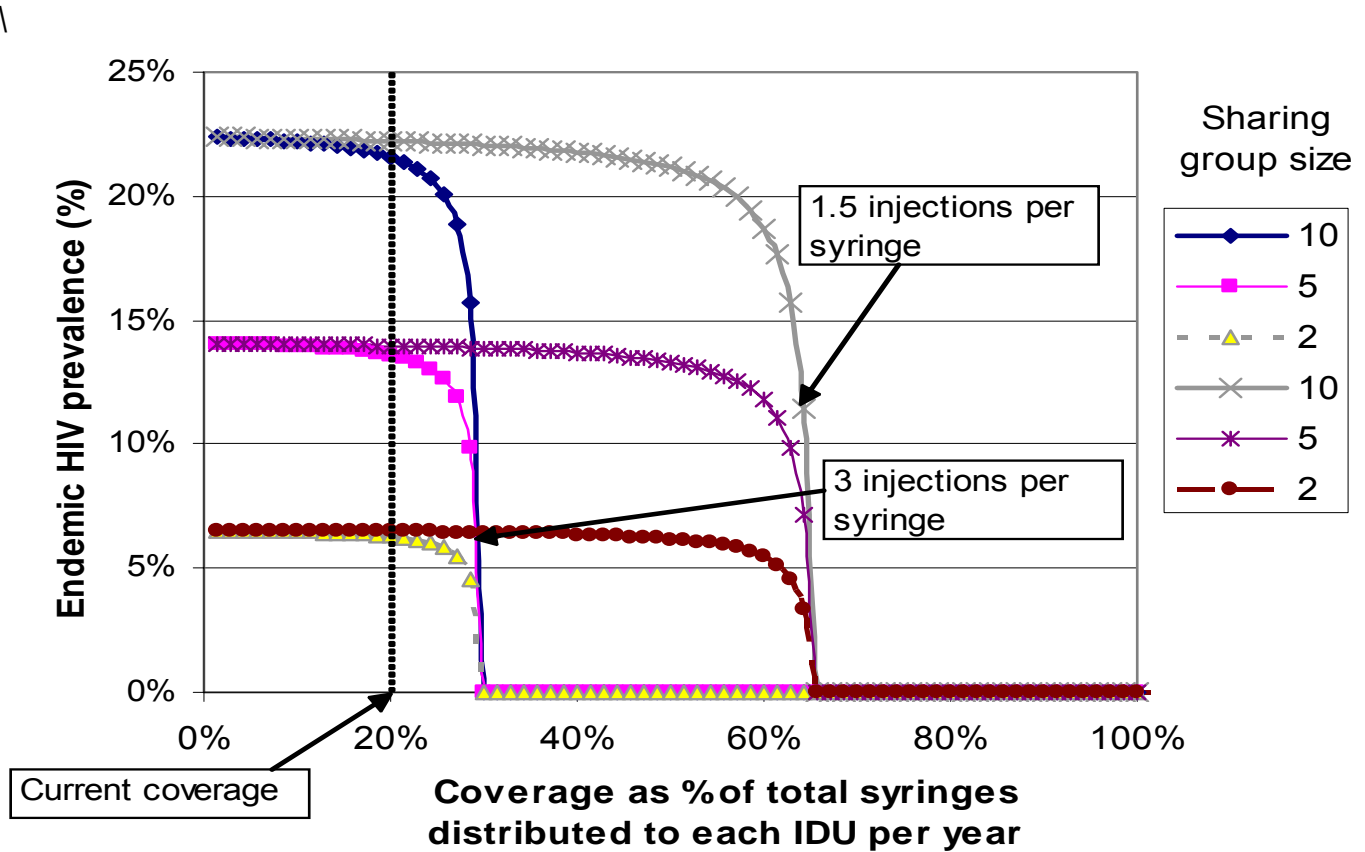
- More complicated than simply measuring coverage
 - The 60% mantra is not evidence based
 - Necessary coverage is approximately the inverse of the rate of reuse of syringes – e.g. 3 x = 33% coverage is necessary
- Public health importance of behavioural surveillance
 - Syringe availability (SEP and bought)
 - Syringe re-use
 - Number of sharing partners
- Better understand relationship between syringe distribution/availability coverage and syringe re-use and IDU syringe sharing
 - What impact do increases in syringe availability have on re-use and sharing?
- We need to aim so that sharing occurs at least < 2/month

Model developments – critical coverage threshold

- Fit/ test with other sites
- Compare to other IDU/coverage models
- Consider optimal combination of range of interventions (injecting cessation/frequency, cleaning, re-use & coverage)

- Model incidence/prevalence over time (and time to reduction in prevalence/ sustainability required)
- Introduce heterogeneity in injecting behaviour/ characteristics
- Introduce sexual transmission

Coverage – size of sharing group, London. Size of sharing group matters at low HIV prevalence and needs to be small.



A complicated graph illustrating the interacting components needed to maintain certain endemic HIV prevalence – higher levels of coverage support reduced syringe re-use and larger sharing group sizes without increasing endemic HIV prevalence

Scaling Up in Central Asia – Recent Advances & Some Thoughts

Robert Gray

Deputy Regional Coordinator
Population Services International
Tashkent, Uzbekistan

This presentation focused on the extremely low levels of coverage in Central Asia in 2003 and a PSI initiative to track client utilisation of an essential package of services to injecting drug users including peer education, outreach, counselling and condom social marketing. The target group for initial use of indicators was high-risk youth in 10 sites on drug trafficking routes in Uzbekistan, Tajikistan and Kyrgyzstan.

The process was:

- Determining target behaviours using behavioural indicators such as condom use at last sex
- Creating a Minimum Package of products & services to achieve targeted behaviors
- Developing a tracking system to monitor client utilization of the essential package of services
 - Collaborative design of computer program with APMG and PSI
 - Allows the service to know the number of clients that are being reached
 - OSI and Global Fund projects in the region are also using the same program now which allows a greater degree of accuracy in assessing coverage among the target populations
 - Provides the ability to track client flows across different intervention modalities
- PSI's TRaC Survey System is performed every 6 – 12 months. It is a KAP (knowledge, attitudes, behaviour) instrument.

The coverage figure that is generated is relatively meaningless without some notion of behavioral change (effectiveness) being incorporated into the figure. A proposed definition of coverage is therefore:

“Coverage refers to the minimum package of products and services needed to produce measurable changes in targeted behaviors.”

Thus we need to know what ‘package’ produces behaviour change – this package will vary from site to site thus coverage definitions will always differ. Despite this, best package guidelines (such as from WHO and UNAIDS) can help determine the package

Key points

- Adequate monitoring and evaluation systems are needed for programs, but shouldn't be limited to just counting numbers – effect needs to be measured too
- It is helpful if service providers working in the same geographical area have compatible monitoring system so that a coordinated approach to assessing need, coverage and effectiveness can be taken
- Donor organizations and other international organizations need to come together in a coordinated approach to 'scaling-up' – this is particularly the case in Central Asia – a fast growing epidemic in a region with a large population (50 million)
- Coverage also needs to be measured and boosted at a local level by service providers
- Development of this tracking tool allowed PSI to having coordination meetings with other large service-providing and donor organizations
- High coverage of adequate interventions is better than low coverage of perfect interventions
- Action, not talk, is needed.

Spectrum of services approach

Andrey Zheluk, Dave Burrows

AIDS Projects Management Group
Sydney Australia and Geneva Switzerland

AIDS Projects Management Group (APMG) has been working on a 5 year USAID funded program called the Drug Demand Reduction Program, or (DDRP) in Central Asia. The program has produced number of innovative approaches in response to an emerging injection driven HIV epidemics in the region. In assisting in the monitoring and evaluation of DDRP activities – and in the design role APMG has played in the DFID-funded Central Asian Regional HIV/AIDS Program – we have developed an approach to defining coverage that we call the Spectrum of Services.

The Spectrum of Services (see separate Spectrum of Services diagram) is a framework to address injecting drug use and related HIV infection in a specific geographic region. The **rationale** for developing the Spectrum of Service is:

- HIV epidemics continuing to expand among injecting drug users – in Central Asia it is estimated that between 60 – 90% of people living with HIV/AIDS are injecting drug users, with some geographic variation
- Harm reduction is widely perceived to be only needle syringe programs (NSP) or methadone. True comprehensive harm reduction also includes many other modalities.
- Harm reduction services in the West are in many cases examples of the spectrum of services approach – new services such as NSP were very quickly linked to drug treatment and other health and social services which had existed for years or decades
- Developing countries often have no/ few other services when harm reduction programs are introduced
- Breadth of services (the range of services available to injectors) is an important factor in high coverage (according to UNAIDS Best Practice report to be released in 2006)
- Injectors have a wide range of needs and thus require a wide range of services
- Injecting/ sex work overlap in many countries means IDU/SW services need to be integrated.

The Spectrum of Services is a framework to address injecting drug use and related HIV infection in a specific geographic region.

- There are 16 components: each component includes a set of activities; those shown are illustrative, other activities can be added (see figure below)
 1. Needle-syringe programs
 2. Condom use/ safer sex programs (especially for drug injecting sex workers)
 3. Programs in closed settings, including rehabilitation centres & prisons (including pre-release programs)
 4. Post-release programs

5. Police/ Public Security Assistance
6. Treatment readiness
7. Drug treatment (non substitution)
8. Opioid substitution drug treatment
9. Socio-legal support
10. STI treatment
11. Primary Health Care/ overdose prevention
12. Safe spaces (especially for drug injecting sex workers)
13. Voluntary Counselling and Testing
14. Self-support for PLHA
15. HIV/ hepatitis treatment, care and support
16. Prevention of drug use/ injecting

- Different components have different target groups
- Many components can be provided by an agency but no single agency can provide all components
- All components need to be linked in an active referral network so that a drug user (or pre-injector/ at-risk youth) and/or sex worker can:
 - Enter the Spectrum at any point
 - Participate in the relevant services from an agency
 - Then be assisted by that agency's staff to participate in any other component of use → that is to be referred on.

Aim of the Spectrum is to reach 100% of injecting drug users and sex workers with at least one component on a regular basis (at least weekly)

All components require staff training in specific content and other faculties such as non-judgmental approach. In most countries in Central Asia, substantial capacity building is required to ensure:

- All components are in place
- Reach and quality of activities are at appropriate levels
- The whole Spectrum is managed to maximise impact on reducing transmission and treatment of HIV.

The Ring of Services is a practical example of the application of the APMG Spectrum of Services

The APMG Ring of Services (see separate Ring of Services diagram) demonstrates how the Spectrum of Services can be used as an audit tool, easily defining gaps in services and proposing ways to scale up through adding components to existing agencies.

In Osh city, in the Central Asian Republic of Kyrgyzstan, the city administration has become actively engaged in implementation of the spectrum of services. The Ring of Services is thus the mapping of the Spectrum of Services framework in that specific region.

- Ring of Services diagram describes Osh, Kyrgyz Republic in late 2005
- 7 agencies provide 13 components in total
- 3 components not currently in place
- All agencies can add components to increase attractiveness to drug users/ sex workers

- Breadth of services is vital to comprehensive response
- Reach (including regularity of reach) still requires measurement (How much needs to be done?)
- Quality remains the most neglected area of harm reduction (How good is good enough and how do we know?)

Coverage for HIV Prevention among IDUs

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- b. AIDS Projects Management Group, Sydney Australia and Geneva Switzerland
- c. National Development and Research Institutes Inc, New York, USA

This presentation covered a survey of key experts in harm reduction to gain consensus on what level of coverage is necessary to prevent, stabilize and reduce HIV transmission among injecting drug users.

The Problem: What types of programs are needed, how large?

- Many types of programs are effective in reducing HIV transmission among injecting drug users
- No program is totally effective in eliminating risk behavior
- Pilot programs do not stop community-wide epidemics
- Constraint of limited financial and human capital resources
- Constraint of time - the sooner the better
- The timing of the intervention is often more important than having all the available knowledge of the exact need – high levels of transmission often occur during this planning stage.

There is a need for Expert Opinions

- In assessing case histories of HIV transmission in individual cities
- In assessing assumptions used in formal modeling
 - Delphi Technique
 - Surveys a group of experts
 - Feeds back collected data to experts (and additional experts)
 - Re-surveys experts, looking for consensus or stable disagreement

Survey of coverage using the Delphi technique

- First long, then short questionnaire
- First email survey, then in-person interviews
- 12 experts, recruited primarily at international meetings
- Survey Questions
 - What types of interventions are “very important” for HIV prevention for injecting drug users?

- What level of “coverage” is needed for each intervention?
- Should coverage vary across low vs. high HIV seroprevalence?
- Operational Definitions
 - HIV prevention for injecting drug users as stabilizing seroprevalence--not getting worse
 - % of injections with a new sterile needle/syringe for needle/syringe programs
 - % of injecting drug users reached monthly for outreach programs
 - % of injecting drug users in treatment at single point in time

Results

“Very Important” Interventions

- 12/12 respondents referred to needle/syringe programs
- 12/12 referred to outreach programs, with user groups included
- 12/12 referred to drug abuse treatment programs

“Don’t Know” Insufficient Data for Estimating Coverage Targets

- 2/12 respondents
 - Both suggested modeling analyses

Coverage for Needle/Syringe Programs

- 10/12 respondents said the % of injections to be reached with a new sterile needle/syringe should be in the range 15% to 60%
- Central tendency 7 respondents estimated 20% to 33%

Coverage for Outreach Programs, including User Groups

- % of injecting drug user population contacted at least once per month: range 20% to “almost 100% (but no time frame)”
- No central tendency

Coverage for Drug Treatment Programs

- % of injecting drug user population in treatment at any one point in time: range 20% to 50%
- Central tendency: 7 respondents estimated 20% to 33%

High vs. Low Prevalence Areas

- 8 respondents noted more coverage needed in high prevalence area
- No central tendency on how much more

Implications

- Types of Programs
 - Needle/syringe programs, outreach, drug treatment known to be effective in reducing HIV transmission: NIH Consensus Development, WHO Evidence for Action
- Needle/Syringe Programs
 - May be necessary for reducing HIV transmission

- 20% to 33% lower than previous 60%
- Perhaps we need a different definition of coverage
- Greater appreciation of individual re-use and sharing within small stable groups?
- Outreach Programs
 - May be necessary
 - No central tendency
 - How much initial contact is needed to educate injecting drug users about AIDS?
 - How much repeated contact is necessary to change social norms among injecting drug users?
- Drug Treatment Programs
 - May be “very important” for many reasons
 - Not likely to greatly reduce transmission unless targeted
 - Can facilitate community efforts among users
 - Can provide hope/reassurance to both injecting drug users and community as a whole
- Drug Treatment Programs
 - May be “very important” for many reasons
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Outstanding issues

- What dose of intervention is necessary to produce change?
 - E.g. the social influence model suggests that outreach contact at least 1 x per month is necessary to have any effect
 - The intensity of the drug treatment depends on the primary drug use in question
- Necessary levels of coverage may not be as great as previously thought
 - E.g. small stable groups of individuals using may result in higher effectiveness of interventions despite reduced coverage
- We need concrete definitions of what coverage is by type of intervention
- Expert opinion is that there is an informed belief that we need more information – i.e. we don’t know.

Symposium outcomes

The floor was thrown open to questions. The discussion that ensued highlighted the main points of the talks presented. Dave Burrows then briefly summarised some of the main findings that:

- There is consensus that more work needs to be done in this area, and that widely accepted, precise definitions are needed to replace the global (and widely misunderstood) single term “coverage”.
- Definitions of coverage are needed to ensure everybody is “on the same page” so discussion is informed
- A consensus statement on coverage is necessary
- A special issue on coverage will feature in the *International Journal of Drug Policy* some time in 2007, to be edited by Dave Burrows, Mukta Sharma and Ricky Bluthenthal.

A listserv will also be established on the APMG website to facilitate ongoing discussions about coverage. APMG will investigate the possibility of holding a follow-up satellite session on coverage definitions and targets at the 18th International Conference on the Reduction of Drug-Related Harm in Warsaw, Poland in May 2007.

For further information on APMG’s work on coverage of harm reduction interventions, please contact Dave Burrows: dave@aidsprojects.com