

MAKING A DIFFERENCE

A Long-term Strategic
Plan for the
International Harm
Reduction Development
Program of the Open
Society Institute

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Introduction

In recognition of the changing landscape of drug use and HIV/AIDS in Central and Eastern Europe and the former Soviet Union, OSI's International Harm Reduction Development Program (IHRD) undertook a long-term strategic planning review over the course of 2002. The goals of this process were: to critically review IHRD's successes and challenges since its establishment in 1996; to assess and understand the environmental changes that have taken place; and to provide a roadmap for how to most effectively refine our strategies and direct resources in coming years.

To date, IHRD's work has been organized around three components: harm reduction services, capacity building, and advocacy initiatives. The most important result of the strategic planning process is the recognition that IHRD will redirect the emphasis of its programs so that their over-arching goal will be to advocate for policy change in support of harm reduction. While services and capacity building will continue to play a vital role, this strategic plan explicitly aligns these efforts toward policy change and integrates them with a broader advocacy agenda around the needs of drug users and people at risk for, or already living with, HIV/AIDS.

Throughout its history, IHRD's programs have been underpinned by the pressing need to develop a supportive public policy environment. At the program's outset, harm reduction services were nonexistent in most CEE/FSU countries, and the first pilot projects had to be established in an often hostile political climate. Seven years on, this goal has been accomplished: an unprecedented number of harm reduction projects now provide vital services and support for the most marginalized members of society in more than 20 countries in the region. And where once the Soros Network was the sole supporter of harm reduction in CEE/FSU, programs established by IHRD have recently begun to receive millions of dollars in funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria, the UK Department for International Development, USAID, and others. This achievement is unmatched elsewhere in the developing world.

In 2001, IHRD established its Policy Initiative in order to expand the range of activities and resources to support systematic advocacy efforts around harm reduction. A vast array of new programs were born across CEE/FSU, which have included support for local advocacy by drug users and HIV+ people; training police to collaborate with harm reduction service providers; building a network of legal service advocates; promotion of drug substitution therapies; mounting challenges to repressive drug laws and policies; and the documentation of discriminatory health practices.

The strategic plan reflects the further maturing of IHRD's advocacy efforts, which will now focus on a smaller set of countries and well-defined issues in order to maximize our impact. Concurrently, IHRD will further the process of reducing its support for direct services, which will be accomplished through attrition of projects that have completed their 4-year funding cycle, expansion of technical assistance around fundraising and sustainability issues, and continued leveraging of donor funds.

This document provides a detailed discussion of the results of the strategic planning process, as well as an overview of the process itself. It is meant to serve as the foundation and guiding principle of IHRD's programs for the next five years. In many ways the strategic plan continues the course of IHRD's development in recent years. However, several significant changes in direction are presented:

- **Central focus on advocacy.** All IHRD programs will be oriented to actively advocate for policy change in support of harm reduction. Direct services will incorporate advocacy components; technical assistance will target building advocacy skills among local partners; and IHRD's own advocacy programs will be focused and expanded. Three sets of issues will receive special emphasis: (1) the inclusion of harm reduction strategies into national drugs and HIV/AIDS plans, and an increase in national financial support for harm reduction services; (2) equal access to HIV/AIDS treatment and care for drug users; and (3) promotion of harm reduction oriented drug policies, including decriminalization of drug possession for personal use and access to high-quality, user-friendly substitution therapy programs and other drug treatment. In order to broaden support for these goals, IHRD is collaborating with an increasingly diverse range of stakeholders. In particular, IHRD will deepen its ties with human rights organizations, the international drug policy reform movement, and community leaders in and beyond CEE/FSU.
- **Focus countries.** Our region continues to face the steepest increase in new HIV infections in the world, with an estimated 1 million infections in Russia alone and a 1% infection rate in Ukraine. The terrible scale of the HIV/AIDS epidemic in many of these countries poses an imminent threat to social and economic wellbeing. The tenuous harm reduction capacity that has been built may soon be overwhelmed if trends continue. In response, IHRD will seek greater impact from its limited resources by directing its advocacy work toward an initial set of seven focus countries: Georgia, Lithuania, Kyrgyzstan, Poland, Russia, Tajikistan, and Ukraine. These countries represent a range of conditions and geographic regions, but in all there exist solid partners on the ground, opportunities for policy breakthroughs, and the potential to leverage developments to neighboring countries. IHRD hopes to maintain a long-term commitment to the focus countries, but will evaluate the results of its work, substituting or adding other countries as is appropriate.
- **Global leadership.** Increasingly IHRD is called upon to provide leadership and technical assistance beyond the scope of our traditional geographic region. Close cooperation with the International Harm Reduction Association, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, the United Nations, and others has raised IHRD's profile and created a demand for its expertise. IHRD's success in establishing a large scale service network and building support from numerous stakeholders offers a wealth of experience that may be shared outside of our traditional region. IHRD will now seek a greater role outside CEE/FSU, directed toward advocacy efforts in line with the expanding global mandate of OSI as a whole.

Executive Summary

This long-term strategic plan charts the direction and priorities for the work of the International Harm Reduction Development Program (IHRD) of the Open Society Institute (OSI) over the next five years. The plan is a product of a strategic planning process involving partners inside and outside of Central and Eastern Europe and the former Soviet Union (CEE/fSU), the region in which IHRD has worked for the past seven years.

Achievements

In this time, IHRD has produced some remarkable achievements, pointing to a number of key program strengths. Through its direct service support and capacity building activities, the program has significantly expanded harm reduction services across the CEE/fSU region, at the same time as pushing innovation in harm reduction practice. The program's education and policy activities have helped to build a 'bigger tent' for harm reduction. By defining policy agendas on injecting drug use and its related harms, especially HIV/AIDS, at the same time as facilitating dialogue on them within and between diverse stakeholder groups and constituencies. IHRD has been instrumental in leveraging increased funding for harm reduction in the region, and has strengthened the capacity of institutions and individuals to provide technical assistance on harm reduction programming and policy work and to take leadership on harm reduction issues.

Problems

But significant problems and challenges remain. Available evidence suggests that drug consumption, especially drug injecting, and drug production and trafficking are increasing. These trends are exacerbating a range of drug-related harms. The HIV/AIDS epidemic, largely linked to the sharing of contaminated blood in injection equipment, is growing faster in parts of the CEE/fSU region than anywhere else in the world. This public health crisis is compounded by, and linked with, rising rates of tuberculosis, sexually transmitted infections and hepatitis among drug users and their sexual partners and social networks. Punitive drug laws and policing, combined with a lack of health and social welfare services for drug users, and negative social attitudes toward drug use, contribute to these public health problems at the same time as depriving drug users of their basic human rights.

Challenges

Overwhelming international evidence points to the efficacy of harm reduction approaches in reducing the individual and social harms associated with drug use, especially HIV/AIDS. But developing harm reduction in the CEE/fSU region brings a number of challenges. The hostile policy environment, together with negative social attitudes toward drug users, inhibits the expansion of harm reduction services to the requisite scale. Current services are often unable to meet the range of needs presented by drug users, especially the increasing number of HIV-positive drug

users. IHRD's work notwithstanding, the region continues to lack capacity in technical assistance provision, research and evaluation, and leadership development, especially among drug users themselves.

Mission

This strategic plan refines IHRD's mission. This revised mission focuses on policy change as the optimal way in which the program can address the most critical challenge facing harm reduction while maximizing its impact on the basis of its comparative strengths in policy change work and the opportunities it has to reduce its direct service support because of the increase in other donor funding for harm reduction. The new mission also makes explicit IHRD's global role as a leader in the development of harm reduction, as well as its commitment to addressing the rights and needs of its core constituency – that is, the people who are most directly affected by drug use and public policy.

Goal

In light of this revised mission, IHRD's goal will be to create a public policy environment that reflects harm reduction principles and that supports a broad range of harm reduction services provided by and for affected communities. One of the key decisions of the strategic planning process was that IHRD must focus its efforts in a smaller number of countries in order to maximize its impact on the policy environment. Targeting a selected group of countries not only enables the more intensive use of resources to produce policy change in those countries, but can, through documentation and dissemination of lessons and successes, generate policy change elsewhere in the region as well.

Outcomes

IHRD will pursue its overall goal by seeking to achieve a set of program outcomes at the global, regional and national level respectively by the end of 2007. At the global level, IHRD will work to ensure that the policy positions and funding priorities of relevant global institutions promote and protect the human rights of drug users. The program will also work with donors and funding mechanisms to ensure that HIV/AIDS funding allocations for work with drug users are commensurate with the scale and impact of the HIV/AIDS epidemic as it affects drug users and their communities.

Within the CEE/FSU region, IHRD will focus on regional policy-making structures and processes to ensure that relevant policy protocols reflect harm reduction principles and respect drug users' human rights. The program will support networks and coalitions of harm reduction service providers, researchers, human rights advocates and community activists at sub/regional levels to actively develop and act on common policy change agendas. IHRD will also strengthen capacity within the region to provide technical assistance on harm reduction, especially in the areas of

harm reduction practice, working with vulnerable groups, program evaluation, fundraising, and policy change work.

At the national level, IHRD will prioritize its work in seven 'focus' countries within the CEE/FSU region, selected on the basis of explicit criteria. Specific outcomes for IHRD's work in each country will be determined in 2003, in consultation with national consultative groups of partners. Indicative outcomes for IHRD's work in its focus countries will include: an expansion of harm reduction services, including initiating or expanding methadone programming; drug law/policy reform and human rights advocacy in relation to drug users; and improved access to HIV/AIDS care and treatment for drug users.

IHRD will seek to improve and sustain harm reduction services in other countries in the region through the provision of open trainings on a range of topics, including program evaluation and fundraising, as well as through resource mobilization with donors. The program will continue to support drug user organizing and other community activist initiatives. Outside of the region, IHRD will seek to transfer lessons learned on initiating and improving harm reduction practice in hostile policy environments to appropriate countries on the basis of need and opportunity.

Strategies

The new mission, goal and desired program outcomes will require changes in strategy. IHRD will increase its emphasis on direct policy analysis, development and advocacy by program staff and consultants. Direct service support activities will be scaled down, and focused on supporting harm reduction service providers and other organizations to carry out policy change work primarily in the 'focus' countries. Increased emphasis will be placed on providing and funding technical assistance on policy change skills and strategies, and the pool of technical assistance providers within the region will be expanded and strengthened. IHRD's current work on harm reduction education for key stakeholders and in promoting policy dialogue and influencing policy agendas will continue, as will its resource mobilization work with multi/bi-lateral donors. The program will increase its funding and technical assistance in relation to activist organizing, coalition building and leadership development, and will increase its emphasis on documentation and communication strategies.

Evaluation

IHRD will support project-level evaluations in 2003-2005, in order to draw lessons learned and to support project fundraising. Consultations with a range of partners during 2003 at global, regional and national ('focus' country) levels will be used to develop an operational plan for 2004-2005 with measurable indicators and targets. Progress under this plan will be evaluated in 2005, leading to a second operational plan for 2006-2007. An end-of-plan external evaluation in 2007 will make

recommendations on continuing needs and priorities in the CEE/FSU region, and IHRD's role in developing harm reduction globally.

Organization

These changes in goal and strategies imply significant changes in the functions performed by IHRD staff. There will be a need for staff capacity building in relation to specific areas of policy concern and to the skills required for policy change. There may also be a need to reconfigure staff roles and responsibilities vis a vis the program's work at the global, regional and national level. Given its declared commitment to addressing the rights and needs of its core constituency, particular attention will be given to developing mechanisms to improve the program's accountability to the lives of the people for whom it is working.

1. Overview of Strategic Planning Process

Rationale

Since its inception, IHRD has operated with short-term strategic and operational plans, within the overall framework of OSI's mandate and mission. After over five years of operation, it was considered timely to take stock of IHRD's progress and continuing challenges in order to develop a long-term strategic plan for the next five years of IHRD's work. It was envisaged that this longer-term plan would chart the strategic course for the program over this period, and determine priorities and indicative outcomes for the work of the program. Within the strategic framework provided by this long-term plan, IHRD could then develop shorter-term operational plans.

Having begun the strategic planning process, major changes to OSI's programming and focus were announced. These changes, and the importance of determining their implications for IHRD's work, provided a further impetus for the task of developing a long-term strategic plan. IHRD recruited a consultant to assist in developing and facilitating this process of long-term strategic planning.

Desk Review

The first step in the process was to conduct a desk review of the work of other actors in relation to the problems of drug use and HIV/AIDS. The purpose of the desk review was to clarify gaps in the current response and identify strategic opportunities for IHRD.

Stakeholders

The consultant also conducted phone interviews with a range of stakeholders, both inside and outside of the CEE/FSU region. These interviews discussed the problems facing the development of harm reduction, the strategic priorities for IHRD's response to these problems and the potential partnerships that IHRD should look to strengthen in order to pursue these priorities. A list of those interviewed is attached as annex 1.

Advisory Group

IHRD's Advisory Group met on June 17-18, 2002, and discussed IHRD's strategic roles and priorities in relation to the findings from the stakeholder interviews and Advisory Group members' own perspectives on the development of harm reduction, both in the region and globally. A list of Advisory Group members is attached as annex 2.

Staff retreat

The discussion and initial conclusions from the Advisory Group meeting were carried forward to a staff retreat on October 1-2, 2002. IHRD staff was joined by several external participants, from inside and outside of the CEE/fSU region, in order to contribute to the process of strategic thinking and decision-making. A list of retreat participants is attached as annex 3.

Drafting

On the basis of the discussions and decisions made at the retreat, the consultant then drafted a strategic plan. A first draft was reviewed by senior staff in the program, and a subsequent draft was then circulated to all retreat participants for comments. Incorporating feedback, this version of the strategic plan was then prepared.

2. Problems, Responses and Challenges

This section describes the key problems that IHRD is confronted with in its harm reduction work in the countries of Central and Eastern Europe and the former Soviet Union (CEE/fSU). It also briefly surveys current responses to these problems by a range of actors, and outlines the challenges facing the development of harm reduction.

2.1 Injecting Drug Use

Overwhelming evidence now confirms a massive increase in drug use - particularly of heroin and similar opiates - in most countries of the CEE/fSU region during the past decade. Recent estimates suggest that there are currently between 2.3 and 4 million injecting drug users (IDUs) in the region and that the number of users is growing, especially in urban areas.

While injecting drug use has increased throughout the region, three countries - the Russian Federation, Ukraine and Belarus - have been particularly affected. In Russia alone, estimates of injecting drug users range from between 1 and 2.5 million. Central Asia's emergence as a drug trafficking hub has led to a dramatic rise in injecting drug use in the region. Drug trafficking throughout CEE/fSU has increased the availability and dramatically lowered the cost of heroin. According to some estimates, there are now believed to be upwards of 300,000 injecting drug users in Central Asia, whereas a decade ago there were virtually none. On average, across several studies of cities and countries in fSU, an average of about 1 percent of national populations are injecting drug users, with levels as high as 5 percent in some cities.

In the wake of the fall of communism, the drug economy in the region has flourished. People hard hit by unemployment and poverty have turned to producing and selling drugs in order to survive. Many more have started using drugs, or turned to injecting to seek escape from economic hardship, personal disillusionment, and social dislocation. Millions of refugees, uprooted by war and conflict, have also contributed to this surge in drug use. Drug availability has increased as organized crime networks have expanded their operations.

Meanwhile, the capacity of law enforcement agencies to control this illegal activity has been reduced by a lack of resources, low morale and corruption.

Contexts

The social and economic indicators that mark the context for this increase in drug production, trafficking and consumption in the region are stark. Absolute poverty levels are up while living standards and life expectancies are falling. According to UNDP's 2002 Human Development Report, the CEE/fSU region was the only part of the world to experience a significant increase during the 1990s in the number of people living on less than \$1.00 a day, rising from seven

to seventeen million. The same report finds that well over half of the countries in the region are “far behind” or “slipping back” in relation to achieving one of the key Millennium Development Goals agreed by the UN General Assembly in 2000 – namely, to reduce under age five mortality by two-thirds by 2015.

The impact of these social and economic conditions on individuals, families, and whole communities has created the context in which an ‘epidemic’ of injecting drug use has flourished in Central and Eastern Europe and the former Soviet Union. In turn, the impact of this ‘epidemic’ has been a host of individual and social harms, including increasing crime rates, family and community dislocations, and the spread of infectious diseases such as hepatitis, tuberculosis and HIV/AIDS.

2.2 HIV/AIDS in the Region

For three successive years, UNAIDS has reported that the HIV/AIDS epidemic is growing faster in the CEE/FSU region than anywhere else in the world. Accurate data on HIV/AIDS in the region remains difficult to come by, but the trend is both clear and alarming. Peter Piot, the executive director of UNAIDS, emphasizes that:

“Because relatively few cases are reported, the number of infected Eastern Europeans and Central Asians is probably four to five times as high as the official figures.”

Box 2A: HIV/AIDS in specific countries

By the end of 2002, there were over 200,000 officially registered HIV infections in Russia. But the total number of people living with HIV is estimated to be much higher – at least one million. 90% of them are injecting drug users. Poland, with one of the oldest HIV epidemics in the region, continues to see 1,000 new infections each year, 55 percent directly related to drug use. In Kazakhstan, health officials have reported that 85% of new HIV infections are IDU-related. Uzbekistan, 71% of new HIV cases have been linked to injecting drug use

In 1995, the number of HIV infections in the region was estimated at below 30,000. At the end of 1999, this estimate had climbed to 420,000. A year later, and the estimated number of HIV infections had almost doubled to 700,000 (see box 2A for specific country details).

The factors driving the HIV/AIDS trends are clear. The sharing of contaminated injection equipment has fuelled the explosive increases in HIV sero-prevalence. The UNAIDS 2002 “Report on the global HIV/AIDS epidemic” states, *“In Commonwealth of Independent States, the vast majority of reported HIV infections are among young people – chiefly among those who inject drugs. [...] Sentinel surveillance in St. Petersburg in 2000 ...revealed an increase in HIV prevalence from 12% to*

19.3% among injecting drug users in one year.”

Unauthorized possession of needles and syringes is illegal in many countries in the region. Lack of access to clean injection equipment forces many users to

share and puts them at risk of contracting HIV. In some Ukrainian cities, the rate of needle sharing has been estimated at upwards of 80 percent. Many users of illegal drugs refuse to visit health care professionals for fear of contact with state agencies or the police. Consequently, they lack knowledge about the health risks of injecting drug use in general, and their own health situation in particular. In many countries, deteriorating health care systems struggle to provide the public with even the most basic information on HIV/AIDS.

The link between drug use and HIV/AIDS is exacerbated by punitive drug policies that have filled prisons in many countries in the region. Occupation rates in Romania's prisons run from 150 percent to 700 percent, according to the General Directorate of Penitentiaries. The number of people imprisoned for the non-medical use of drugs had increased 500 percent over three years at the end of the 1990s in Russia.

Drug use is widespread in prison. A recent study by Médecins Sans Frontières found that in seven Russian prisons, 43 percent of the inmates had injected drugs and, of those, 13.5 percent started in prison. Other risky behavior in prison includes forced or voluntary unprotected sex between men, self-mutilation, piercing, and tattooing. The consequences have been dire. Some 20 percent of Latvia's known HIV cases are in prison, and half of the new cases reported annually are coming out of the prison system. Nearly 90 percent of these new cases may be IDUs.

Sex and gender

The HIV/AIDS epidemic in the region has also been driven by the connections between the expanding sex industry and drug use. It has been estimated that between 25 to 35 percent of sex workers in the Russian cities of Moscow and Volgograd, the Belarus capital of Minsk, and the Ukrainian cities of Odessa and Donetsk inject drugs. HIV prevalence among sex workers has now reached an estimated 15 percent in some of these cities. While more research is needed, it is apparent that condom use among sex workers is low and usually determined by the client.

The limited information available on people's sexual attitudes and behavior suggests that both perception of HIV risk and actual condom use is low. Gender inequalities heighten women's vulnerability to HIV infection. Without the power to insist on condom use, female sex partners of injecting drug users are at particular risk. Gendered drug injecting practices (e.g. men inject first and then inject their female partners) increase the risk for women injectors.

The risks of HIV infection produced by these drug using and sexual practices, and underlying gender norms, are heightened for members of ethnic minorities. The Roma are especially vulnerable. Not only has social and economic marginalization fuelled injecting drug use, it has deprived them of access to the most basic health and social welfare services and prevention education.

Impact

People who inject drugs and their sexual partners, and the social networks and communities in which they live, are being devastated by the HIV/AIDS epidemic. Drug injectors are often discouraged or informally prohibited from receiving the most basic primary health care services, according to a recent report from the Central and Eastern European Harm Reduction Network (CEEHRN). Bearing a double stigma, HIV positive drug injectors face even more discrimination in accessing treatment and care. UNAIDS estimates that antiretroviral treatment (ARV) reaches less than ten percent of those that need it in Eastern Europe and Central Asia. While access to ARV treatment of any kind is extremely limited in the region, the CEEHRN report notes that, *“Access to ARV is even more sharply limited for IDUs, who account for 82% of all HIV/AIDS cases in CEE/SU countries but only 23% of those receiving any form of ARV.”*

The sharpest disparities in relation to drug users' lack of access to treatment is found in triple combination therapies, considered by WHO to be the standard of care. The result is early illness and death, and the aftershocks of this within families and social networks. Anecdotal information confirms that discrimination against people living with HIV/AIDS is exacerbating social fragmentation. A harm reduction worker in Georgia reports that it is still acceptable for some people to "say that we have to burn or kill or isolate" all HIV-infected people. As HIV-related morbidity and mortality increases, these social impacts will be compounded by economic impacts on families, communities and society.

2.3 Drugs, Public Health and Drug-related Harms

The nexus of injecting drug use, HIV/AIDS and overcrowded prisons is responsible for the explosive tuberculosis (TB) rate in Russia—up 80 percent since 1990. HIV and TB are closely linked. About 13 million people worldwide are infected with both HIV and the germ that causes TB. Up to 50 percent of people living with HIV can expect to develop TB, which is now the most common killer of HIV-infected people in the region.

Needle and syringe sharing also exposes drug users to a range of other blood-borne diseases, including hepatitis C. Conclusive data on the hepatitis situation in the region is not yet available, but evidence from elsewhere in the world would suggest that prevailing conditions are ripe for an epidemic among injecting drug users and their social networks.

Sexually transmitted infections (STIs) are another challenge confronting the region's overstretched and under-funded public health infrastructure. Before 1989, the countries of Eastern Europe and the former Soviet Union were almost syphilis-free. Now Russia, Belarus, Ukraine, Kazakhstan, and Kyrgyzstan report overwhelming increases in the number of syphilis cases. More conclusive data is needed, but it is apparent that the links between drug use, sex and sex work, combined with drug users' lack of access to health care, means that their risk of STI infection is high.

Many drug users are young and do not receive accurate, nonjudgmental information about the potential harms of drug use and how to reduce them. Those who inject may turn to injecting in the neck or groin to avoid developing 'track marks' which police look for when they do 'sweeps' for suspected drug injectors. In this situation, the risks of injection-related complications (including abscesses and septicemia) as well as drug overdose are extremely high. Arrest and incarceration heightens these risks while further damaging an individual's prospects of gaining more choice and control over their drug use, and being able to reduce the harm it is causing in their life.

2.4 . Current Responses

Repressive laws and policies and punitive policing are the most common responses to drug use and drug users in the region. A number of countries have recently passed legislation inspired, in part, by the 'zero-tolerance' approach that dominates current U.S. drug policy. In general, official policy across the region continues to be guided by international conventions on drug use that emphasize drug interdiction and drug user incarceration approaches. Police harassment of drug users is widespread. It is reported that, in some countries, police round up young people suspected of drug use to search for signs of injecting or force them to be tested for HIV. Those who test positive have their drug use and HIV status registered.

These and other human rights abuses are compounded by the failure to provide needed services to drug users. The few official drug treatment programs that do exist often share the punitive approach to drug users that characterizes official drug policy. Counseling, peer support, and other approaches that address the psychosocial needs of people trying to deal with their addiction are rarely used. Substitution treatment is unavailable in many countries in the region, and illegal in some, despite the evidence that it is proven to reduce drug-related crime, HIV infection, and other diseases.

Health care systems are under-funded and demoralized, rendering them hard-pressed to cope with concurrent epidemics of drug use and HIV infection. Providers of primary health care often discriminate against drug users, whose access to HIV/AIDS treatments is limited or non-existent.

The most energetic and enlightened response to the needs of drug users has come from within civil society. Numerous community-based organizations have started up in recent years, many of them supported by IHRD, offering advice, referrals and comfort, as well as clean needles, syringes and condoms. The growing threat of HIV/AIDS has been the stimulus for many of these organizations, as well as for the increased funding for and interest in harm reduction within the region.

Box 2B: UNGASS and beyond

The United Nations General Assembly Special Session on HIV/AIDS (UNGASS) was held in New York City in June 2001. It was a landmark meeting. For the first time in an international venue, the realities of injecting drug use and HIV/AIDS in the region were acknowledged. This was a major step forward for government officials who had long refused to acknowledge the growing drug use and sex work within their countries' borders. Representatives from 24 countries in CEE/fSU described the social problems driving HIV/AIDS in their countries.

The Declaration of Commitment recognized the very rapidly rising infection rates in the CEE/fSU region and called on all governments to develop (by 2003) and implement (by 2005) vigorous and comprehensive HIV/AIDS interventions. Sadly, the social conservatism of some participating governments ensured that marginalized groups most at risk of infection (such as drug users) were not identified in the final declaration. HIV/AIDS may help to explain anecdotal evidence pointing to the limited progress in the region since UNGASS.

makers, national program managers/leading specialists in the areas of AIDS care, venerologists and narcologists, and people living with HIV/AIDS. It concluded with a statement of principles agreed by conference participants, representatives of IHRD, UNAIDS, and the Ukrainian Ministry of Health, one of which concerned "Recognition of the needs of drug users" and stated:

"Injection drug use is the principal means of HIV transmission in the region, and HIV/AIDS care and prevention efforts that fail to recognize their needs cannot be effective. Key needs include availability of drug treatment services, substitution therapy, sterile syringes and injection equipment, as well as an ability to access the same medical and support services as other patients with HIV."

The failure of political leaders to speak out directly on the epidemic has been noted by many, but this is beginning to change. UNGASS marked a significant shift in the public acknowledgement of injecting drug use and HIV/AIDS in the region (see box 2B on the following page). Harm reduction is appearing on the policy agendas of some countries in the region, especially those hardest hit by HIV/AIDS. In April 2002, the Lancet reported that, "[I]n countries such as Bulgaria, Romania, Russia, and Ukraine, the budgets of national AIDS programs have increased substantially."

Increased funding for harm reduction from bilateral (such as DfID, USAID) and multilateral (such as the Global Fund and the World Bank) sources is also more available, a further sign that harm reduction responses are becoming more viable.

This growing acceptance of harm reduction in the region is evident, too, in the deliberations and conclusions of a recent regional conference co-sponsored by IHRD. The meeting "Care, Support and Treatment for People Living with HIV/AIDS – Fundamental Elements of an Effective Response - Regional Conference for Eastern Europe and Central Asia," was held in Kiev, Ukraine, in November 2002. Organized with the support of the President of Ukraine, the conference brought together high-level policy

The conference was also noteworthy for being the first time in the region that people living with HIV/AIDS came together to prepare and present a statement to the whole conference, and to which all present, including the Minister and Deputy Minister of Health of Ukraine, rose to express agreement. The statement called for immediate action throughout the region of the former Soviet Union on a range of issues affecting people living with HIV/AIDS. This direct advocacy by people who have hitherto been subject to severe stigma and discrimination marks a significant step forwards in the regional response to HIV/AIDS and, given the regional dynamics of the HIV/AIDS epidemic.

2.5 . Summary of Challenges

Despite the progress noted in the previous section, a number of critical challenges confront the development of harm reduction in the region, which may be summarized as follows:

Policy

The policy environment across the region continues to inhibit the development of harm reduction. Punitive and repressive drug policies continue to be the norm. Harm reduction remains, in general, politically unpopular. In a context of under-funded basic health and social welfare services for the 'general' population, it is difficult to mobilize political support for programs that address the needs of stigmatized sub-populations of injecting drug users. Many public health professionals and law enforcement officials continue to be resistant to what they perceive as a western 'import', which, for some, is associated with drug legalization.

Public health concerns about HIV/AIDS are the fulcrum on which political support for harm reduction policies and programs has been leveraged. There are signs of progress, and harm reduction is at least now on the policy agenda of countries most severely affected by HIV/AIDS. In countries and locations where HIV sero-prevalence is low, it remains difficult to insert harm reduction into the policy dialogue.

Scale

This unsupportive policy environment helps to create problems of scale. Needle exchange programs (NEPs) continue to operate far below the 60% scale of coverage that UNAIDS suggests is needed in order to have an impact on the HIV/AIDS epidemic. Lack of funding detracts from NEPs' abilities to provide more comprehensive services. In the case of drug treatment, the ratio of services to needs is far worse.

Funding

Inadequate funding is clearly a major obstacle in going to scale. While the increasing amount of donor support for harm reduction in the region is welcome, continued reliance on external donor funding is problematic. In the face of

competing demands for public expenditure, governments in the region are unlikely to integrate significant harm reduction funding into their national budgets in the short term. IHRD continues to offer a maximum of four-year project funding cycles for a large number of harm reduction service providers, knowing that it would be difficult to replace this funding when it came to an end. Priority was given to initiating harm reduction in the region. As the bulk of IHRD's direct service support tapers off, the challenge is now one of sustainability.

Services

More comprehensive services are needed. Harm reduction programs are unable to meet the range of needs that are currently presented to them. In countries with a more advanced HIV epidemic, there are growing numbers of drug users living with HIV and AIDS who are presenting to harm reduction programs, which often lack the training and the resources to deal with their care, support and case management needs. Other issues and needs which harm reduction programs are typically ill-equipped to address include:

- ▶ Overdose prevention
- ▶ Prevention of sexual transmission of HIV
- ▶ Sexual health
- ▶ Mental health

Maintaining and improving the quality of harm reduction practices at project level continues to be a challenge that demands more attention. A lack of practice guidelines, service standards, regular supervision, and peer support all constitute problems of quality assurance.

Leadership

IHRD has supported organizing efforts among drug users and other marginalized groups (e.g. people living with HIV/AIDS) but, in general, drug users face a range of human rights violations and often deteriorating socio-economic conditions that limit the possibility of taking leadership on the issues that most directly affect their lives. National and sub-regional networks of program staff and activists have emerged in recent years, once again supported by IHRD. But, overall, harm reduction workers and service providers lack the resources and opportunities to identify, coalesce around and take leadership on a common agenda, whether at local, national or regional levels.

Capacity

For IHRD and others, capacity building work in the region has concentrated on direct technical support to service providers. But other key capacities remain in need of strengthening, namely:

Research – a lack of skills and experience in ethnographic and behavioral research means there is a lack of locally-generated information on which to base decisions on harm reduction policy-making and program development.

Technical assistance – IHRD has expanded its pool of local Technical Advisers and local training institutions. But in general, there is insufficient capacity in the region, at both individual and institutional levels, to provide technical assistance (TA) on harm reduction program development and policy change.

Isolation

All throughout the world, harm reduction programs and initiatives remain too isolated, not only from each other but also from other social movements and reform efforts. Potential synergies between emergent human rights movements and organizations within the region, as well as health care sector reform initiatives, are only beginning to be explored and exploited.

In the case of human rights, there is a lack of partnerships on the ground between harm reduction programs and human rights organizations, and a mutual lack of exposure to each others' issues and interests. Harm reduction staff lack training in human rights advocacy practices, and human rights organizations as a rule, have yet to properly address drug users as a constituency and drug-related human rights violations as a priority.

3. IHRD: Strategies, Achievements and Opportunities

In 1995, the Open Society Institute (OSI) founded IHRD to support the development of harm reduction programs and policies, including HIV prevention and other social care efforts targeting drug users, in Central and Eastern Europe and the former Soviet Union.

3.1 Strategies

IHRD's strategic response to the problems outlined in the previous section has comprised three principal elements, namely:

- ✓ Direct service support
- ✓ Capacity building and education
- ✓ Public policy advocacy

3.1.1 Direct Service Support

Box 3A: Supporting harm reduction on the ground

The *Initiative for Health Foundation* started as a harm reduction project in 1999 in Sofia, Bulgaria, with a few outreach workers. They identified themselves by carrying distinctive bags as they did outreach to drug users in a city park and certain neighborhoods. With funding from IHRD and others, the project equipped a van and now provides mobile needle/syringe exchange in Sofia and local Romani communities. It offers referrals to drug treatment programs and to clinics.

The *Vilnius Substance Abuse Treatment Center* in Lithuania began the first methadone treatment program in the former Soviet Union. In addition to methadone, the project offers a wide range of services including outpatient detoxification, psychiatric treatment, general medical care, and referrals to employment agencies. Methadone clients at the center established a self-help group in 1999. Stable methadone clients, some with HIV, are employed as outreach workers.

IHRD, in partnership with the network of Soros Foundations located in most countries in the region, has funded a huge expansion in the number of harm reduction projects in the region. In its short life, IHRD (in collaboration with the National Foundations) have been instrumental in initiating and expanding harm reduction services in a total of 22 countries. The National Foundations have provided tremendous leadership in terms of advocacy, fund leveraging and oversight. Together, IHRD and the NF's have provide these harm reduction projects with a maximum four years of funding, which is largely coming to an end within the next two years.

From the outset, it was always clear that the restricted funding environment for harm reduction and other pressures could cause projects to struggle to replace their IHRD funding at the end of the cycle. Over the past six years, IHRD's funding of harm reduction in the region has undoubtedly helped to mobilize other donors' support to harm reduction by demonstrating its viability. IHRD has also provided individual projects with training and technical assistance on fundraising. This being said, the purpose of IHRD's direct service support was never to secure the long-

term sustainability of a large number of harm reduction projects but rather to demonstrate the need for and effectiveness of harm reduction responses to HIV/AIDS and other drug-related harms in the region.

The vast majority of the harm reduction projects that IHRD has supported provide needle/syringe exchange, while fewer than ten offer substitution therapy since it remains too controversial, and in some cases illegal, in most countries. Through its direct service support, IHRD has also targeted the needs of the most vulnerable and marginalized. In May 2000, IHRD launched a dual initiative to fund the inclusion of services for sex workers in harm reduction projects and to include harm reduction services in projects already working with sex workers.

The program awarded grants to 34 projects in 13 countries. Most of the projects include needle/syringe exchange and outreach for sex workers; training for outreach workers on the special needs of sex workers; the development of health education and HIV prevention materials; and legal and medical treatment referrals for women and men engaged in sex work.

In response to the high rates of drug use and HIV transmission among prison inmates, IHRD also launched a series of pilot harm reduction and HIV prevention projects in prisons, funding 10 governmental and nongovernmental programs. These projects offer varied services, including counseling for drug users and HIV education for prisoners and prison staff. In countries where needle/syringe exchange

is already legal and politically feasible, HIV-prevention materials and equipment, including condoms, bleach, and needles, are distributed to prisoners. Where needle/syringe exchange in prisons is technically illegal, groups are working to create a more receptive environment for harm reduction interventions. IHRD has also funded the development of harm reduction work with highly vulnerable groups and communities, including the Roma in Central and Eastern Europe and 'street kids' in Central Asia (in partnership with a Canadian organization called Street Kids International).

Box 3B: Partnering with network programs

IHRD has worked in collaboration with other OSI network programs to better meet training needs in the region. In partnership with the Palliative care program, IHRD has provided training and literature on end of life issues for people living with HIV and their HIV-infected children.

IHRD has also entered into a cross programmatic working agreement with the Mental Disability Advocacy Program (MDAP), focusing on bringing together needle exchange projects supported by IHRD and centers providing services to people with mental health problems supported by MDAP for shared training.

3.1.2 Capacity Building and Education

The second core strategy used by IHRD to date has been capacity building and education. IHRD has nurtured a cadre of Technical Advisers from the region and a

number of regional training institutions to provide its grantees with a package of technical assistance and training workshops on key aspects of harm reduction practice, program management and organizational development. The 'East-East' technical support facilitated by IHRD marks significant progress from even a few years ago when the region largely relied on 'importing' technical expertise from the 'West'.

In addition to providing technical assistance and training programs for its grantees, IHRD has also sponsored study tours, site visits, round table discussions, conference attendance, research papers, practice guidelines and policy initiatives to strengthen local capacity in addressing drug use and HIV issues through harm reduction. These efforts have been targeted not only at harm reduction practitioners and activists, but also other stakeholders who are critical to the development of harm reduction in their area. For example, police representatives from Kazakhstan and Kyrgyzstan visited drug treatment programs in Poland (where harm reduction measures are better established) to learn how they can improve their own practices.

IHRD has also worked in collaboration with other OSI network programs to better meet training needs in the region (see box 3B on the previous page). Increasingly, IHRD is taking on a global role as a provider of technical assistance, especially on issues relating to initiating harm reduction programs, by drawing on lessons learned from its work in the CEE/FSU region.

3.1.3 Public Policy Advocacy

Policy change has always been central to the work of IHRD. It was clear early on that the program's efforts to support harm reduction services on the ground had to involve work with a range of policy makers at local, provincial and national levels. At the same time, it was evident that information and experience gained from harm reduction service provision, concerning both the nature of the problems of HIV/AIDS and other drug-related harm and the value of a harm reduction response to these problems, was invaluable in advocating for broader policy change.

Recognizing this interdependence of service provision and policy change led IHRD to formalize public policy advocacy as the third major component of its program, with the inception of its policy initiative in 2001. The establishment of the policy initiative, which included the hiring of two dedicated policy staff to be based in OSI Budapest, also reflected a recognition of the complexity of policy change on drugs issues in societies transitioning from communism to more open, pluralist policy and decision-making.

The initiative has focused on the inclusion of harm reduction interventions in all national AIDS programs and ensuring that repressive drug policies do not impede the expansion of harm reduction efforts. Some of the key issues on which the initiative has focused include:

- ▶ Drug policy reform
- ▶ Substitution therapies and drug treatment as an alternative to incarceration
- ▶ Human rights of drug users
- ▶ Community attitudes towards drug users and social norms in relation to drug use
- ▶ Access to high quality HIV testing and counseling for drug users
- ▶ Sexual health education and needed referrals for drug users and their sexual partners
- ▶ Advocacy around treatment access for drug users with HIV/AIDS (including prophylactic treatment for opportunistic infections)

The policy initiative has five main components, which are summarized below:

Skills-building

Advocacy skills-building has focused on the skills-building needs of harm reduction practitioners, drug users, people living with HIV/AIDS, their families, and other relevant groups. Development of advocacy and organizing skills among these groups has included: training to enhance knowledge and skills around policies, laws, organizing, and fundraising; support of harm reduction leaders to participate in international events dedicated to progressive drug policies; and promotion of harm reduction drug education as an alternative to abstinence based models.

Education

Providing education about harm reduction principles and practice is a key tool for influencing policy development. IHRD has instituted study tours and participation in conferences and local seminars that target policy makers, police and custodial staff, doctors, lawyers, and others with the ability to help or hinder harm reduction efforts in the region. Specific examples of recent activity include: the development of a harm reduction advocacy training program, in cooperation with the WHO and International Harm Reduction Association; a Human Rights Watch program to assess human rights abuses against HIV+ people in Kazakhstan (with match funding from OSI's Central Eurasia Project); the development of a police training module on drug issues and harm reduction (with match funding from OSI's Constitutional and Legal Policy Institute); and a harm reduction study tour for Polish prison health officials (with the support of Canadian HIV/AIDS Legal Network).

Networks

Network and coalition building has included grant making and activities to support and develop networks of people living with HIV/AIDS (PLWHA), drug users, families, doctors, and others who can most effectively advocate for progressive drug, HIV/AIDS, and harm reduction policies. Examples of recent activities include: 13

grants to organizations of people living with HIV/AIDS; 7 grants to organizations of drug users; Landelijk Steunpunt Druggebruikers (LSD) received an important grant for technical assistance to drug user organizations; and the Central and Eastern European Harm Reduction Network (CEEHRN) and the Romanian Harm Reduction Network both received grants for the development of their activities.

Responding to needs in the region, the policy initiative has placed special emphasis on legal assistance. Examples of recent activities include: a Hungarian Civil Liberties Union project for legal assistance and analysis related to harm reduction; the Drug Law and Health Policy Network Training Program - a program designed to train participants to evaluate and determine legal and policy barriers to public health and medical treatment for IDU and HIV/AIDS communities; commissioning research studies which examine legal and other impediments to harm reduction efforts in the region; and support for the development of a Czech Legal Network, which will provide monitoring of Czech drug laws and legal services to harm reduction programs.

IHRD launched a request for proposals to identify legal or human rights NGOs that have an interest to provide legal assistance to harm reduction programs and related organizations. These grants will support the provision of free legal advice to harm reduction project staff, PLWHA, and drug users; information on issues concerning data protection; free legal representation to drug users and PLWHA whose rights have been violated; and legal advocacy and public education.

Media

Targeting both service providers and advocates, IHRD continually develops needed communications tools and media outreach programs so that information and ideas are regularly exchanged between interest group members in any single country and across perspectives, borders, and languages. Examples of recent activities include: support for the CEEHRN to establish a communications center to provide up-to-date information on policy developments; and publishing and distribution of materials relevant to harm reduction practice and advocacy.

Partnership

The policy initiative has also focused on actively partnering with other OSI programs. Concrete activities have been agreed upon with: the Central Eurasia Project, COLPI, East-East Program, Mental Disability Advocacy Program and the Network Women's Program. Active co-operation with other programs (e.g. Local Government and Service Sector Reform Initiative) are being pursued. The policy initiative is also making efforts to bring harm reduction into the mainstream, through for example, co-operation with the UN and active participation in the 2002 International AIDS Conference. The Policy Initiative is actively seeking funds from external sources, including: DfID, CIDA, USAID, WHO and others.

3.2 Achievements

While the impact of IHRD's strategies and activities has not yet been formally evaluated, there is clear evidence of the program's achievements. In determining the priorities for IHRD in relation to the challenges already described (sub-section 2.5), it is important to articulate the program's achievements, and thus its relative strengths, as one guide to the optimal response that IHRD can make to these challenges.

These achievements include:

Establishing and significantly expanding harm reduction services in the CEE/fSU region. Where five years ago harm reduction services were few in number and often underground in nature, IHRD has directly supported the development of harm reduction projects in some 22 countries across the region in the face of considerable opposition from many sectors of society. In no other region in the world has there been such a rapid and broad mobilization of a harm reduction response to the linked problems of drug use and HIV/AIDS. This achievement has given the program a unique credibility with a diverse array of stakeholders and places the program in a leadership role in the development of harm reduction, both inside and outside of the CEE/fSU.

Creating and strengthening an extraordinary web of relationships across many different sectors, from the grassroots to centers of power, throughout the region. IHRD's work is building a 'bigger tent' for harm reduction by bridging different constituencies and interests (for example, public health and law enforcement) and linking often divergent discourses (for example, human rights, public health, public safety, social development) within a harm reduction framework to address some of the most pressing social problems facing the region. The program is also forging essential links between those most affected by such problems and those with the resources to address these problems, between service providers and policy makers; and activists and decision makers. This web of relationships affords the program a rare ability to shape an enhanced and expanded response to the individual and social harms of drug use and drug policy.

Inspiring innovation in harm reduction practice. Through its training and technical assistance activities, its support to integrating harm reduction with other services (for example, through the sex worker initiative) and its partnership with other OSI network programs (for example, in the fields of mental health and palliative care), IHRD has pushed harm reduction practice in the region to be more responsive to the range of needs of its core constituency – that is, those people who are most directly affected by the harms of drug use and drug policy.

Defining policy agendas and facilitating broad dialogue on them. IHRD has played a key role in defining critical policy issues (for example, HIV/AIDS care and treatment for drug users, substitution treatment, drug policy in the context of a public health emergency) and in bringing together diverse stakeholders and constituencies to address these issues. The measure of this achievement is evident in the conclusions and recommendations emerging from regional conferences co-organized by IHRD on “Health Security in Central Asia: Drug Use, HIV and AIDS” (Dushanbe, October 2002) and on “Care, Support and Treatment for People Living with HIV/AIDS – Fundamental Elements of an Effective Response in Eastern Europe and Central Asia” (Kiev, November 2002). IHRD’s ability to push the policy ‘envelope’ is not only the result of its credibility and relationships with a broad range of stakeholders.

It is also the product of its comparative advantage as a program of OSI, whose independent status enables it to take risks in its programming and policy positions that few other institutions can take. Being able to take risks has allowed IHRD to initiate harm reduction in the region at a time when it was deeply controversial, and will continue to serve the program in pursuing its objectives under this strategic plan. Its independence means that it can fund more ‘controversial’ interventions and initiatives where other donors cannot or will not. Its support to user organizing efforts and its financing of clean injection equipment in USAID-sponsored projects are examples of this independence.

Helping to leverage increased funding for harm reduction in the region, and to influence donor priorities in allocating funds for drug use and HIV/AIDS issues. IHRD’s work with the Global Fund to Fight AIDS, TB and Malaria (the Global Fund) and bi-lateral donors such as USAID (in Central Asia) and DfID (in Russia) are examples of its achievement in leveraging and influencing donor funding allocations. This leverage ability enables IHRD to have an impact much bigger than its own programs.

Beginning to strengthen the leadership of drug users, people living with HIV/AIDS and other vulnerable groups in harm reduction program development and policy-making. IHRD has pioneered funding and technical support to organizing and networking efforts among drug users and other vulnerable groups and is pushing policy-makers and other stakeholders in the region to recognize the legitimate leadership of those who are most directly affected by the harms of drug use and drug policy in determining responses to such harms. The groundbreaking statement by people living with HIV/AIDS at the Kiev conference (see 2.4) is one indication of this growing recognition. This achievement gives IHRD, as an international institution, a rare credibility and relationship with community activist groups, and thus a comparative advantage in ensuring that the voices and interests of those who are most directly affected by the harms of drug use and drug policy are involved in shaping programs and policies.

Strengthening individual and institutional capacity within the region to provide technical assistance and take leadership on drugs and HIV/AIDS issues. Five years ago the region was dependent on external harm reduction expertise. Through its development of a pool of Technical Advisers from the region, its collaboration with regional training institutions and its support to and partnership with harm reduction networks, IHRD has helped to create an 'infrastructure' of mutual learning and support that provides the foundation on which a regional harm reduction 'movement' can establish itself.

3.3 Opportunities

As is clear from this overview of IHRD's achievements, the program is already addressing, and making progress in relation to, a number of the challenges described in sub-section 2.5. But the fact that problems of policy, scale, funding, capacity and leadership are still evident is a reminder not only of the severity and durability of such problems, but also of the challenge that confronts IHRD in mounting a strategic response to such problems.

Determining IHRD's most strategic response involves consideration of not only its achievements and strengths, but also the opportunities that are and will be available to the program to make a real difference in relation to these problems.

OSI mandate

OSI's mandate is changing. In pursuing a revised mission to create a global open society, OSI has committed to changing its resource allocations in ways that affect IHRD's work. In the short term, National Foundations in the eight EU accession countries face significant budget reductions, as do those in the Balkans in the medium term. The role that such foundations have played in providing matching funds for harm reduction and the necessary support this investment requires may have to change as a result. In line with these changes, IHRD faces a declining budget in real terms over the term of this strategic plan and thus faces the challenge of adjusting its program accordingly.

But this changing OSI mandate, and its intention to bolster its role as an advocate in global public policy debates on harm reduction, does allow IHRD the opportunity to re-think its strategic approach and priorities within an overarching policy change framework. It also affords IHRD an opportunity to think more globally about its work and its priorities.

Donor funding

The growing interest of other donors in funding harm reduction in the region allows IHRD to re-consider its existing role as a significant direct funder of harm reduction services. The fact that other money is increasingly becoming available from other

sources, and that its own budget will decline in real terms, presents the program with the opportunity to think strategically about other roles it can play in order to maximize its contribution to the reduction of harm related to drug use and drug policy.

Window

Explosive increases in HIV/AIDS infection, worsening trends in both drug use and drug trafficking, combined with political uncertainties and economic insecurities in many parts of the CEE/FSU region make it imperative that effective action is taken urgently on a sufficient scale. Many people, both in and outside of the region, recognize that the window of opportunity for such action is closing. The severity and urgency of the situation, however, creates an opportunity for IHRD, with its credibility, leverage and relationships, to mobilize the concerns and commitment of the broad range of constituencies that will be required if harm reduction is to be institutionalized within the region.

4. Mission and Goal

4.1 Mission

Over the course of the last five years, IHRD's program has evolved in response to needs 'on the ground', its comparative strengths and advantages, and the opportunities it has had to apply them toward making its contribution to the development of harm reduction in the CEE/fSU region. The severity and urgency of the problems of HIV/AIDS and other drug-related harm make it more important than ever that IHRD think strategically about the future evolution of the program. This evolution must be guided explicitly by IHRD's mission.

In revising IHRD's mission with the aim of providing the program with a strategic direction for the future, the strategic planning process considered the challenges facing harm reduction, together with IHRD's achievements, strengths, advantages and opportunities in addressing these challenges. This consideration has identified the following emphases and priorities for IHRD's mission.

Policy change

Advocacy for policy change has become an increasingly vital part of IHRD's work in response to the fundamental importance of public policy in determining both the possibility and nature of harm reduction development in a given area. The hostile policy environment remains the most significant impediment to harm reduction in the region. At the same time, IHRD's comparative strengths in policy change work (its leadership role, credibility, relationships and leverage) now take on an additional significance in the context of the changes in OSI's mandate, IHRD's declining budget and the increasing availability of other funding to support harm reduction service provision. Given this, it makes strategic sense for IHRD to center its mission on policy change, as the optimal way in which the program can address the most critical challenge facing harm reduction while maximizing its impact on the basis of its comparative advantages and opportunities.

Global focus

The effectiveness of IHRD's work in the CEE/fSU region, and the many lessons it has learned from such work, have led to the program playing, and being called upon to play, a significant role in the development of harm reduction globally. IHRD's involvement in shaping the policy agendas of global institutions (for example, through involvement with the Global Fund) and fora (for example, in being involved in the planning of international conferences on harm reduction and HIV/AIDS), and in sharing lessons learned with other regions, are evidence of this emergent global role. OSI's changing mandate and the increasing involvement of other donors in harm reduction in the CEE/fSU region now present the program with an opportunity to define its global role and leadership in more explicit terms. Clearly, IHRD's

closest partners to date have been the National Foundations. Shifts within the network must be accommodated and new relationships sought. IHRD's revised mission offers the chance to provide leadership in new arenas.

Human rights

IHRD's operational practice and institutional location securely ground the program within a public health paradigm. The ability of IHRD and others to mobilize political and community support for harm reduction in the region has usually depended on the public health framework within which problems of drug-related harm, and especially HIV/AIDS, have been defined. But the limitations of a narrow public health perspective have become clear over the course of IHRD's work.

Such a perspective has often failed to conceptualize and mobilize responses to a whole range of problems and harms confronting drug users and their sexual partners and social networks, including the double stigma faced by female drug users, the lack of access to HIV/AIDS treatment, mandatory drug and HIV testing, non-confidentiality, and law enforcement and incarceration practices. Drug users continue to face human rights abuses on a daily basis, sometimes in the name of public health. The importance of integrating public health and human rights was a lesson learned early on in responses to HIV/AIDS in many parts of the world, not least as a result of the pressure from AIDS activists. At the same time, the history of the region's transition to more open societies attests to the potency and resonance of a human rights discourse in energizing the momentum toward significant social change.

The need and opportunity to integrate public health and human rights in its work have both been clarified by IHRD's understanding of harm reduction as an approach to addressing the needs and rights of the people most directly affected by drug use and drug policy. In practice, this means drug users and their family networks, and, more broadly, the communities in which they live. This emphasis on developing harm reduction not merely in terms of a set of interventions (e.g., needle exchange, substitution treatment) and the policies that support them, but as an approach to serving the constituency most vulnerable to drug-related harm has been critical in shaping IHRD's commitment to addressing the rights, and not only the service needs, of its core constituency. The program's support to user organizing and community activist efforts are the product of this commitment. IHRD's revised mission reflects this commitment to integrating human rights and public health and to defining harm reduction in relation to its core constituency.

Statement

The outline of this revised mission statement was agreed at IHRD's strategic planning retreat in August 2002.

The mission of IHRD is to reduce the harm in the lives of people most directly affected by drug use and drug policy. IHRD will work to create a global public

policy environment that reflects harm reduction principles and that supports a broad range of harm reduction services provided by and for affected communities. IHRD defines harm reduction as a pragmatic approach to diminishing the individual and social harms associated with drug use and drug policy, especially the HIV/AIDS epidemic, based on human rights, public health principles and scientific evidence.

4.2 Goal

The overall goal of the program in this long-term strategic plan will alter as a result of the changed mission. Whereas in the past, the three major components of IHRD's work (direct service support, capacity building and education, and public policy advocacy) were regarded as separate but interdependent areas of work, this strategic plan shifts IHRD's strategic emphasis to one of pursuing policy change as its over-arching goal. While such policy change will continue to be dependent, in part, on continuing direct service support and capacity building activities, this plan orients these components of IHRD's work explicitly to its policy change efforts.

Focus

In developing the new goal for the program, participants in IHRD's strategic planning process also emphasized the importance of a greater focusing of program resources in order to increase program impact. To date, IHRD has attempted to work across the whole of the CEE/fSU region, responding where possible to both

Box 4A: Focus country selection criteria

- ❖ Potential for quick success, linked to the potential to build on existing momentum for policy change
- ❖ Urgent need to act now to have future impact
- ❖ High levels of drug use and HIV/AIDS
- ❖ Country is regionally influential
- ❖ partners and co-funders

expressed need and presenting opportunity. The broad scope of its work has enabled IHRD to stimulate harm reduction programming and initiatives in most countries in this region.

But such breadth has inevitably limited the depth, and thus the potential impact, of IHRD's work. The strategic planning process concluded that IHRD must focus its resources in order to maximize its impact. With an increasing acknowledgement of the problems of HIV/AIDS and injecting drug use in the region, and a growing acceptance of harm reduction approaches to dealing with these problems, there is now an opportunity to make a real impact on changing the policy environment if resources are focused appropriately. The increasing involvement of other donors and actors in harm reduction in the region (which IHRD itself has worked to mobilize), also gives the program the opportunity to focus its own resources more strategically.

Thus, in order to maximize its impact, IHRD will focus its resources at the national level in a small number of 'focus' countries, grouped in three categories as follows:

Group One: Tajikistan, Kyrgyzstan, Georgia

Group Two: Lithuania, Poland

Group Three: Russia, Ukraine

These countries have been prioritized on the basis of several selection criteria (see box 4A).

Given the rationale for focusing resources, IHRD will concentrate its direct service support on a reduced number of harm reduction projects in each 'focus' country. As current grantees progress toward the end of their IHRD funding cycle, a small number in each 'focus' country will be selected for continued funding. Given IHRD's overarching policy change goal, the main criteria for continued IHRD funding will be to provide direct support to harm reduction services with the capacity to contribute to the national policy change agenda. Other criteria for continued IHRD funding will be a project's track record in providing holistic services to marginalized populations and its ability to raise additional funding (i.e. not requiring 100% funding from IHRD). Project funding will also be provided to support community organizing efforts among groups/networks of drug users, people living with HIV/AIDS and other marginalized groups (e.g. sex workers) to carry out policy change work.

IHRD is clear that streamlining its resources in this way will have a global impact, and not merely maximize its impact in its 'focus' countries alone. Careful documentation and analysis of its work in the 'focus' countries, dissemination of lessons learned and the demonstration that policy change is both feasible and essential will all have an impact on harm reduction both within and beyond CEE/FSU.

Statement

Based on its revised mission, and the strategic decision to focus its resources primarily within a select number of countries, the goal of IHRD in this strategic plan is as follows:

The goal of IHRD is to create a public policy environment that reflects harm reduction principles and that supports a broad range of harm reduction services provided by and for affected communities. Within the program's global mandate, IHRD will focus its resources primarily within selected countries in the regions of Central and Eastern Europe, Central Asia, and the former Soviet Union.

5. Program Outcomes

IHRD will pursue its overall goal at the global, regional and national level. In order to achieve this goal, the work of the program over the course of this long-term strategic plan will be directed toward achieving a set of program outcomes at each level. The cross-cutting strategies that will be used to produce these outcomes are listed in box 5A and described in detail in section 6.

5.1 Global Level

5A: IHRD Strategies

- ✓ Direct policy advocacy
- ✓ Building local capacity for policy advocacy
- ✓ Building local capacity for training and technical assistance
- ✓ Activist organizing, network/coalition building and leadership development
- ✓ Harm reduction education for key stakeholders
- ✓ Facilitating policy dialogue
- ✓ Information, documentation and communication
- ✓ Resource mobilization

IHRD is playing an increasingly global role in legitimizing and supporting services for drug users. This strategic plan acknowledges the global leadership that is being asked of the program. In formalizing IHRD's global role, the plan recognizes both the continuing and pressing needs of the CEE/fSU region and the program's success in mobilizing other actors and donors to work in the region. Thus, while IHRD will continue to prioritize its efforts and resources in focusing on countries within its existing region, it will take on a more explicit global role in line with OSI's expanded global mandate. The program will focus on global policy-making institutions and funding mechanisms in order to produce the following outcomes by the end of 2007.

Outcome 1

Global institutions that are responding to problems of drug use and HIV/AIDS (such as the UN, multi/bilateral donors, and international civil society organizations) actively promote and protect drug users' human rights in their policy positions and funding priorities.

There has been a significant shift over the last five years in the support given by global institutions to harm reduction as an appropriate response to the linked problems of drug use and HIV/AIDS. IHRD's work in the CEE/fSU region has played a key role in legitimizing harm reduction within and beyond the region, and in reconciling perceived tensions between public health (HIV/AIDS prevention) and public safety (drug control). Whereas five years ago, harm reduction was not on the agenda of institutions responsible for global drug control such as UNODCCP (formerly UNDCP), it is now recognized as an important component of an integrated response to enmeshed issues of public health and public safety.

But if harm reduction as a public health response to drug use and HIV/AIDS is becoming more accepted, the greater challenge lies in grounding such a response in an understanding of, and respect for, the human rights of drug users. IHRD will work to ensure that not only does harm reduction remain on the policy agenda of the key global institutions responding to problems of drug use and HIV/AIDS, but also that this policy agenda actively promotes and protects the human rights of people who use drugs as a key to an efficacious and ethical response to these problems.

IHRD's strategies to produce this outcome will include direct policy analysis, development and advocacy, facilitating policy dialogue across sectors and constituencies, enabling the participation of community activists within global institutional policy-making processes and fora, and supporting, collating and disseminating documentation of human rights abuses against drug users.

Outcome 2

Global HIV/AIDS funding allocations to support work with drug users are commensurate with the scale and impact of the HIV/AIDS epidemic as it affects drug users and their communities.

In the context of the growing pressure on HIV/AIDS funding (as is clear from the shortfalls in national contributions to the Global Fund), it may be difficult to ensure that the HIV/AIDS-related needs of marginalized communities of drug users are adequately addressed. As a global leader in harm reduction and a global advocate for the rights and needs of drug users, IHRD will work with global institutions, donors and other funding mechanisms to ensure that the share of global HIV/AIDS funding that is allocated to targeting the needs of drug users is proportionate to the scale and impact of the HIV/AIDS epidemic as it affects drug users and the communities in which they live. Precise targets for this funding will be agreed upon with key stakeholders, including networks and coalitions of harm reduction leaders, activists and service providers.

Strategies to produce this outcome will include: synthesis and dissemination of cost-effectiveness findings from operations research on and program evaluations of interventions; direct advocacy on global HIV/AIDS funding priorities in relation to the needs of drug users with global institutions, donors and other funding mechanisms; and supporting the contribution of community activists to global decision-making processes and fora on HIV/AIDS funding.

5.2 Regional Level

IHRD will pursue its goal by working to achieve a number of outcomes at the regional level. The program's regional-level work will prioritize the CEE/fSU region. Within the **CEE/fSU region**, IHRD will produce the following outcomes by the end of 2007:

Outcome 3

Regional and sub-regional policy-making structures and processes develop policies and protocols on drug use and HIV/AIDS that reflect harm reduction principles and respect drug users' human rights.

Given its independent, 'outside' status, and the strength of its relationships with wide range of partners throughout the region, IHRD is particularly well placed to engage government, civil society and multi/bi-lateral actors, across a range of sectors (public health, public safety, human rights, development) and representing differing constituencies, in a policy dialogue on key issues at the intersection of drug use and HIV/AIDS.

It is also uniquely able to connect such dialog to realities 'on the ground', through its experience of direct support to harm reduction services and its ability to bring service providers and community activists to the policy-making 'table'. But IHRD faces the twin challenges of broadening such dialogue by including an ever wider range of actors, sectors and constituencies and expanding the scope for consensus across differing agendas at the same time as deepening the dialogue by ensuring that drug users' voices and interests are meaningfully heard.

IHRD's strategies to produce this outcome will include: building regional capacity for policy advocacy through funding and technical assistance; activist organizing, coalition building and leadership development; harm reduction education for a range of policy makers and professional cadres; and information and communication activities focused on human rights abuses against drug users, policy change models and successes drawn from IHRD's 'focus' countries; and cost-effectiveness findings from specific operations research on and program evaluations of harm reduction interventions.

Outcome 4

Networks and coalitions of harm reduction leaders, service providers, researchers, human rights advocates and community activists at sub/regional levels are actively developing and acting on common policy change agendas.

IHRD's funding and support has been instrumental in the emergence of a nascent harm reduction 'movement' in the region. Through its support to the harm reduction networks, and to a range of organizing and activist initiatives among drug users, people living with HIV/AIDS, sex workers and other groups impacted by drug use and HIV/AIDS, IHRD has already succeeded in strengthening leadership on harm reduction in the region among those who are most directly affected by the problems of drug use and HIV/AIDS.

The challenge for the program is to strengthen networks and coalitions of often isolated harm reduction leaders, service providers, researchers, human rights advocates and community activists at sub/regional levels and support them in developing and acting on common policy agendas. The precise nature of these agendas, and the policy change objectives to be pursued, will be determined by

network and coalition members. But IHRD has an important role to play in brokering relationships between different groups and constituencies (such as drug treatment, HIV prevention, HIV/AIDS treatment, and human rights) and in developing and articulating an analysis of the issues that can serve as a 'connective tissue' among these groups.

Through funding and technical assistance, IHRD will strengthen sub/regional harm reduction networks and coalitions and networks of community activists (including drug users, people living with HIV/AIDS and sex workers). The program will also seek to mobilize a range of social change and social justice groups (including human rights organizations, treatment access campaigners and health care reform groups) in order to increase their involvement in sub/regional coalitions and networks for harm reduction policy change. IHRD will also implement leadership development activities for individuals and groups emerging as leaders in the movement, including leadership trainings and placements, as well as individual mentoring and organizational twinning arrangements.

Outcome 5

The capacity of individuals and organizations in the region to provide harm reduction training and technical assistance is strengthened, notably in the areas of comprehensive harm reduction practice, working with vulnerable groups, program evaluation and fund-raising, and policy change work.

Through its capacity building and education activities, IHRD has provided its grantees with a package of training and technical assistance, at the same time as supporting a pool of individual Technical Advisers and training institutions within the region to implement this package. Expanding and strengthening this regional capacity to provide training and technical assistance, at the same time as focusing such training/TA on specific skills and topics, is critical to IHRD's policy change goal. An expanded and strengthened training/TA capacity is necessary in order to create and sustain the critical mass of skilled harm reduction programs and leaders that can push for policy change. At the same time, such capacity helps to generate the program lessons on harm reduction best practice that must inform policy discussions.

A key strategy will be to identify and document lessons from project evaluations and selected demonstration sites (in 'focus' and other countries), and codify them in training curricula, good practice guidelines, and recommended program models and policy protocols. IHRD will also expand its pool of training/TA providers, with an emphasis on recruiting providers with expertise in the skill and topic areas prioritized in the outcome statement. The program will fund and facilitate skills-building, information exchange and networking among the pool of training/TA providers, including the provision of international TA to contribute to this skills building where necessary.

Other regions

In line with OSI's expanded global mandate and the evident need to develop harm reduction policy and program responses to emergent and worsening problems of drug use and HIV/AIDS outside of CEE/fSU, IHRD will selectively focus resources in a small number of countries in other regions. Priorities for this selection will be based on level of need and extent of opportunity, especially in relation to the opportunities for co-financing and partnership. On the basis of these criteria, it is currently envisaged that IHRD will support the development of harm reduction policies and programming in Burma, Indonesia, China (especially those regions close to Central Asia) and Iran.

Opportunities for IHRD to support the development of harm reduction in other countries will be considered as they arise during the course of this strategic plan, and reviewed in the mid-term evaluation at the end of 2005. The end-of-plan evaluation in 2007 will consider the global needs and opportunities for harm reduction development and make recommendations for IHRD's roles in responding to these needs and opportunities.

During the next five years, the program will seek to work in partnership with others to replicate the process, albeit on a smaller scale, that took place in the CEE/fSU region, including advocacy for harm reduction implementation; direct support to programs on the ground; and further policy work to ensure scale-up and sustainability. The lessons learned by IHRD through its experience in its current region will be invaluable in countries where HIV/AIDS is being driven by drug use but where harm reduction services are non-existent or 'underground'. Specific outcomes for this work in other regions will be agreed upon with regional stakeholders and implementing partners. Indicative **objectives** for IHRD's work in other regions will be to:

- ▶ Foster supportive regional and national policy environments, as IHRD is beginning to do, for example, through its support to a joint initiative of the Asian Forum of Parliamentarians of Population and Development and the Asian Harm Reduction Network to explore policy approaches to the prevention of HIV/AIDS among drug users.
- ▶ Stimulate and sustain harm reduction services by sponsoring and providing sub/regional and national trainings, and interregional exchanges and study tours, drawing on its documentation of lessons learned from its work in the CEE/fSU region. IHRD's current work on methadone in Iran is an example of this.
- ▶ Develop leadership on harm reduction among service providers, researchers, human rights advocates and community activists. Opportunities for interregional learning exchanges and collaborations among harm reduction

networks and coalitions around core policy issues (such as drug law reform, access to drug treatment, and access to HIV/AIDS treatment) will be exploited.

5.3 National Level

Specific outcomes for IHRD's work in its 'focus' countries will be developed in consultation with national, regional and global stakeholders during the course of 2003. It is envisaged that a national consultative group, will be convened in each 'focus' country no later than the second quarter of 2003 to advise IHRD on the development of specific outcomes for its work in each country and of an evaluation plan describing process and outcome indicators and how such indicators will be reviewed and analyzed. These outcomes and indicators will be specified in operational plans for each 'focus' country (covering 2004-05 and 2006-07). But in broad terms, the kinds of outcomes that IHRD will work toward in each group of 'focus' countries are described in the following sub-sections.

Group One

Tajikistan, Kyrgyzstan and Georgia have been selected on the basis that, although drug use is increasing and an HIV/AIDS epidemic has clearly started, it is possible to have a significant impact if urgent action is taken now. Through existing partnerships with OSI National Foundations and bi-lateral donors (such as USAID), and the potential to forge new partnerships with multi/bi-lateral agencies to work in these countries, IHRD will be able to leverage additional resources and relationships in order to maximize the impact of its work.

In these countries, IHRD will use its mix of policy change strategies (described in Section 6) to:

- ▶ Scale up existing harm reduction services (all of the countries have needle exchange programs) by bringing other donors 'to the table' and ensuring support from the national governments.
- ▶ Scale up methadone services in Kyrgyzstan and start methadone programming in Georgia and Tajikistan, through legal/policy change and funding for pilot programming.
- ▶ Stimulate a policy dialogue on drug policies and how they affect HIV/AIDS prevention efforts; policing; drug trafficking through Tajikistan and Kyrgyzstan; and human rights, to promote policy change in these areas.
- ▶ Conduct and support advocacy efforts for HIV/AIDS care and treatment for drug users, with an emphasis on issues of equity and human rights.
- ▶ Engage the three countries in an international dialogue on policy issues related to drug use and HIV/AIDS (through policy makers' participation in conferences etc.)

Group Two

The forthcoming scaling-down of the Open Society Fund-Lithuania will be counterbalanced by the opportunities for partnership and policy change afforded by the EU accession process. In Poland, IHRD's working relationship with UNDP and other local partners will similarly be enhanced and complimented by the country's greater integration with the West. With established methadone and needle exchange programs, and the potential to mobilize coalitions of service providers, community activists and human rights advocates in pursuit of policy change and drug law reform, these two countries can provide demonstration sites for innovative harm reduction practice as well as the potential to secure policy and legal reform and to learn valuable lessons about its process.

In these countries, IHRD will use its mix of policy change strategies to:

- ▶ Scale up existing harm reduction service delivery (needle exchange and methadone programs) through resource mobilization with donors and national governments.
- ▶ Promote drug law reform, with an emphasis on strengthening institutional capacity within each country for policy analysis, development and advocacy.
- ▶ Stimulate policy dialogue on drugs, drug users and drug-related harm (especially HIV/AIDS) throughout Eastern Europe by documenting and disseminating lessons learned from the policy development and advocacy process in these countries.
- ▶ Conduct and support advocacy efforts for harm reduction services for minority communities (such as Roma communities).
- ▶ Conduct and support advocacy efforts for HIV/AIDS care and treatment for drug users, with an emphasis on issues of equity and human rights.
- ▶ Engage the two countries in an international dialogue on policy issues related to drug use and HIV/AIDS

Group Three

Russia and Ukraine have rapidly increasing HIV/AIDS epidemics among drug users, and their sexual partners, and both countries are regionally influential in terms of harm reduction practice and policy. Both countries have established needle exchange programs but no methadone services. Establishing methadone programs in these countries would not only have a significant impact on their local epidemics and the lives of drug users, but on regional thinking and policy on substitution treatment. The severity of the epidemic, and this regional influence, mean that the potential for partnership is strong.

In these countries, IHRD will use its mix of policy change strategies to:

- ▶ Scale up existing harm reduction service delivery through resource mobilization with donors and national governments.
- ▶ Establish methadone programming through legal/policy change and funding for pilot programming.
- ▶ Promote informed policy dialogue, in part by strengthening institutional capacity within each country for policy analysis, development and advocacy.
- ▶ Change policing and prison practices to improve the way that these systems deal with drug users.
- ▶ Disseminate documentation of human rights abuses against drug users, by partnering with human rights groups.
- ▶ Conduct and support advocacy efforts for HIV/AIDS care and treatment for drug users, with an emphasis on issues of equity and human rights.
- ▶ Engage the two countries in an international dialogue on policy issues related to drug use and HIV/AIDS

5.3.1 Other Countries

Given the strategic decision to concentrate its efforts in a select number of 'focus' countries, this plan will not specify concrete outcomes for IHRD's work in other countries. But IHRD will continue to support the development of harm reduction in other countries in the CEE/fSU region, through sharing lessons learned from its 'focus' countries and through involvement in regional activities.

While the program's work with other countries will respond to both need and opportunity, the indicative **objectives** of such work will be to:

Help to sustain harm reduction services. In the period 2003-05, IHRD's four-year cycle of direct service funding will come to an end for most, if not all, of its grantees. Those grantees that are not in 'focus' countries, and those that are but are not selected for continued funding, will be given training and technical assistance on project evaluation and fundraising to support them in transitioning out of direct IHRD funding. Lessons from these project evaluations will be used in sub/region-wide training and technical assistance activities and in sub/region-wide policy change activities.

In this same period, IHRD will prioritize donor development activities for the countries and areas in which grantees are transitioning out of IHRD funding. While increasing the amount of donor funding available for harm reduction in these areas, IHRD will also educate and advocate with donors to expand their funding to include less mainstream and in some cases more controversial harm reduction activities such

as leadership development, user organizing, HIV/AIDS care and support, and methadone maintenance.

IHRD's success in expanding harm reduction throughout the CEE/fSU region has relied heavily on its partnership with respective National Foundations. Changes within OSI will entail significant shifts for many of these National Foundations but IHRD is committed to continuing its partnership with such foundations during this process of change. For foundations in non-'focus' countries that are committed to providing ongoing support for harm reduction initiatives, IHRD will seek to match its funding to such initiatives.

Support activist organizing and leadership development. Given the significant role that IHRD funding has played in supporting organizing efforts and activism within affected 'communities', and the likelihood that such efforts may be too controversial to attract much other donor funding, IHRD will consider on a case-by-case basis the continuation of funding to such groups that are not in the IHRD 'focus' countries.

Improve the quality of harm reduction practice. As already noted, IHRD will support sub/region-wide trainings (on harm reduction practice, working with vulnerable groups, program evaluation, fund-raising and policy change work) that will be open to participants from the region, irrespective of whether they receive IHRD funding.

6. Overview of Program Strategies

IHRD's experience in policy change work, and lessons learned from its partners and the work of others, suggests that policy change on the highly charged issues of drug use and HIV/AIDS requires a mix of strategies. This mix reflects the need to generate constituencies of support for such policy change across diverse sectors and levels, applying both persuasion and pressure and supplying both the information/documentation and the resources that are required to not only make the case for such changes but also to implement the changes. Given the importance of this mix of strategies, they can be regarded as cross-cutting in terms of their relation to specific program outcomes.

IHRD's mix of program strategies will include:

Direct Policy Analysis, Development and Advocacy

As already noted, IHRD has considerable influence and credibility as a leader in supporting harm reduction. The program will use this influence and credibility with a wide range of stakeholders in its direct policy analysis, development and advocacy. IHRD will build on its existing experience in conducting and commissioning research and analyses of current policies and their implications for HIV/AIDS and other drug-related harm. Such analyses will inform the development of policy recommendations and position statements, which will be used in a variety

of direct advocacy activities (such as seminars, high level meetings, press conferences). An example of this strategy is the work IHRD has done in assessing the potential for improving medical treatment for HIV-positive clients at harm reduction sites in the former Soviet Union, and in generating a set of HIV/AIDS care guidelines on the basis of this assessment that have been presented to senior officials. IHRD's direct policy change activities, through their example, will play an important part in mobilizing the involvement of other actors in policy change work.

Building Local Capacity for Policy Analysis, Development and Advocacy

In addition to its direct advocacy work, IHRD, and its national partners, will also strengthen local capacity in policy analysis, development and advocacy. This will include the provision of funding and technical support to a select number of harm reduction projects in each 'focus' country to enable them to carry out policy change activities (see 4.2 for more on this). Some of these will serve as demonstration sites that can generate documentation to inform policy makers and program planners on issues such as substitution treatment and HIV/AIDS care and treatment for drug users.

IHRD will partner with organizations in select 'focus' countries in order to strengthen their capacity to carry out policy analysis and advocacy on drugs and HIV/AIDS issues. These will include human rights organizations, legal service organizations, and media organizations. This strategy will build on the program's existing work with the Hungarian Civil Liberties Union project for legal assistance and analysis related to harm reduction; the Drug Law and Health Policy Network Training Program - a program designed to train participants to evaluate and determine legal and policy barriers to public health and medical treatment for IDU and HIV/AIDS communities; and support for the development of a Czech Legal Network, which will provide monitoring of Czech drug laws and legal services to harm reduction programs.

Building Local Capacity for Training and Technical Assistance

The longevity and scale of IHRD's involvement with harm reduction in the region mean that it has a wealth of experience from which to draw lessons on harm reduction best practice. In the next two to three years, in which direct funding to the majority of its grantees will come to an end, IHRD will emphasize support for project evaluations, best practice case studies and analysis of lessons learned. These lessons will be collated and codified in training curricula, good practice guidelines, and recommended program models and policy protocols for use in national and regional training activities that will no longer be restricted to IHRD grantees.

IHRD will also expand its pool of training/TA providers from the CEE/fSU region, with an emphasis on recruiting providers with expertise in harm reduction practice, working with vulnerable groups, program evaluation and fund-raising, and policy change work. The program will fund and facilitate mutual skills-building, information exchange and networking among the pool of training/TA providers,

including the provision of international TA to contribute to this skills building where necessary.

Activist Organizing, Network/coalition Building and Leadership Development

IHRD will continue its pioneering support to organizing efforts among drug users, people living with HIV/AIDS and other marginalized groups at local, national and regional levels. Given the significant role that IHRD funding has played in supporting organizing efforts and activism within affected 'communities', and the likelihood that such efforts may be too controversial to attract much other donor funding, IHRD will consider on a case-by-case basis the continuation of funding to such groups that are not in the IHRD 'focus' countries. IHRD's funding and technical support to activist organizing within affected 'communities' will be oriented toward agreed policy change agendas at the national and regional level.

IHRD will also give greater emphasis to breaking the isolation in which many harm reduction programs and technical assistance providers currently operate. It will create more opportunities for networking, mutual support and movement building at local and national levels. It will continue and expand its funding to harm reduction networks at the national and sub-regional levels. It will also explore ways of supporting its pool of Technical Advisers to take on more explicit leadership roles in their respective geographical areas and fields of expertise, as well as in their relationship with IHRD and OSI as a whole. This will involve creating processes for involving Technical Advisers more closely in the strategic thinking and program planning of IHRD.

IHRD will also implement leadership development activities for individuals and groups emerging as leaders in a nascent regional harm reduction 'movement', including leadership trainings and placements (as it is doing with advocacy fellowships with Gay Men's Health Crisis in New York). Mentoring and twinning arrangements will also be supported.

Harm Reduction Education for Key Stakeholders

An important component of IHRD's current policy initiative has been harm reduction education for multiple stakeholder groups (e.g., individuals and organizations with the ability to assist or hinder harm reduction activities) in order to improve their understanding of the philosophy and aspects of harm reduction that are relevant to their profession or interest, and provide active assistance to current harm reduction programs and policy change. This work will continue with law enforcement and prison professionals, , public health, drug treatment, HIV/AIDS care and treatment specialists, legal and human rights groups, media organizations, faith-based groups, as well as all tiers of government. Workshops, study tours, site/exchange visits and integration of harm reduction into existing training programs and curricula will be used to carry out this education.

Facilitating Policy Dialogue

IHRD has successfully facilitated and shaped the policy dialogue across a range of sectors and constituencies. Its recent work on the drug and HIV/AIDS policy conference in Dushanbe and on the HIV/AIDS care for vulnerable populations conference in Kiev were examples of IHRD's ability, in partnership with other key actors, to define policy issues and facilitate the place and the people to discuss them. IHRD will continue this work, focusing on issues such as:

- ▶ The impact of drug policies on public health and identifying drug policy reform as a public health strategy
- ▶ The impact of law enforcement practices on harm reduction services
- ▶ Policies for scaling up harm reduction, as other donors are coming into the CEE/fSU region
- ▶ The need for drug replacement therapy, as an integral part of harm reduction and HIV/AIDS care
- ▶ The need for HIV/AIDS care for drug users, as an integral part of HIV/AIDS prevention efforts
- ▶ Bringing together harm reduction and human rights agendas regionally and globally

6.7 Information, Documentation and Communication

IHRD will support and commission a range of information gathering, documentation and communication activities. These will include ethnographic and behavioral research on drug use and drug users, operations research on harm reduction program effectiveness, documentation of human rights abuses, information gathering on the nature and extent of drug-related harm (as the program did recently with regard to drug overdose). IHRD will work closely with OSI's media program and communication department to share lessons learned with a broad range of policy makers, donors and other potential partners.

6.8 Resource Mobilization

Scaling up services to their required level, and implementing programs on the basis of changes in policy (for example, methadone programming) will require significant resource mobilization with external donors and national governments. The program will continue to advocate with donors and governments to increase their spending on harm reduction. Importantly, this advocacy work will include donor education on harm reduction, focusing on the rights and needs of IHRD's core constituency.

Partnership

All of these strategies will be implemented in collaboration and partnerships with other actors at national, regional and global levels. The story of IHRD's success to date is in many ways the story of its successful partnerships. Within the period encompassed by this strategic plan, IHRD will emphasize partnership-building with organizations and initiatives working for policy and social change.

7. Evaluation Plan

7.1 Project Level

Resources for evaluation tend to be scarce and intensive efforts (especially sero-prevalence studies of used syringes) are very expensive. The fact that, in many places, there is no baseline data about the number of drug users or the number of HIV-infected individuals renders it difficult to assess the impact of harm reduction efforts from a quantitative perspective.

Extensive research conducted all over the world, however, has shown that harm reduction strategies are effective, and there is no reason to believe that these results cannot be extrapolated to the communities in which IHRD-funded projects are active. IHRD is particularly interested in the development of qualitative research and evaluation efforts that explore the "culture" of the drug using community within the society at large. This enables providers to better develop strategies that target and deliver appropriate services within their unique context.

Training/TA

Over the next three years (2003-05), IHRD will provide trainings, and direct technical assistance where feasible, on data collection, monitoring and evaluation and documentation to grantees as they come to the end of their four-year cycle of direct service funding. Such training/TA will be provided in a timely manner, allowing sufficient time for grantees to carry out their project evaluations and use the documentation arising from these evaluations in fund-raising activities for their projects. Lessons from these project evaluations will be used by IHRD in sub/region-wide training and technical assistance activities and in sub/region-wide policy change activities.

Focus countries

Projects that are selected for continued funding in 'focus' countries will be required, in line with current practice, to specify objectives with measurable indicators for their work and a plan for evaluating the process and outcomes of their work. Some of these projects will serve as demonstration sites of critical harm reduction practice in order to influence policy change (for example, demonstration sites for methadone treatment, HIV/AIDS services and user organizing). Project objectives will reflect the policy change outcomes that are determined for each country by IHRD and the national consultative groups. Annual project reviews will be conducted as part of the national review process to be conducted by the national consultative groups. Dependent on the duration of project funding, it is envisaged that the work of these projects will be evaluated as part of the program's mid-term evaluation scheduled for the second half of 2005. Projects funded after 2005 will be externally evaluated as part of IHRD's own end-of-plan external evaluation in 2007.

7.2 Program Level

IHRD's plan for evaluating its program emphasizes participation and representation, reflexive learning and accountability to all partners. Evaluation activities, whether looking at process or outcome measures, will emphasize stakeholders' participation in discussing and analyzing data (as opposed to supplying data for IHRD to analyze).

Particular attention will be given to developing mechanisms to ensure the representation of IHRD's core constituency in evaluation activities. At the national level, it is envisaged that the national consultative group in each 'focus' country will be such a mechanism, with seats reserved for representatives of community activist groups. At the regional level, representatives from harm reduction networks, coalitions of community activists and IHRD's pool of Technical Advisers will be involved in periodic review and external evaluation processes. At the global level, IHRD will determine in 2003 the ways in which its core constituency can be represented in review and evaluation activities, one possibility being through representation on its Advisory Group. Such participation and representation will help to ensure that program evaluation serves as a means of accountability.

Review and evaluation processes will also be designed to maximize reflexive learning, through scheduling opportunities for feedback and discussion of evaluation findings with stakeholders, and through analyzing such findings to draw out policy and programmatic lessons and recommendations.

7.2.1 Program Level: Outcome Indicators

As already noted, further consultation with stakeholders is required in order to specify outcomes with benchmarks and targets, and develop indicators against which progress can be measured. During 2003, meetings with global and regional stakeholders will be held to work on and refine outcomes 1 and 2 (global) and outcomes 3-5 (regional) respectively. Indicative indicators for these outcomes are described below.

Outcome 1

Global institutions that are responding to problems of drug use and HIV/AIDS (such as the UN, , multi/bi-lateral donors, and international civil society organizations) actively promote and protect drug users' human rights in their policy positions and priorities.

- **Incorporation of a human rights framework into problem analysis**
- **Articulation of policy responses in relation to specific human rights conventions**
- **Programmatic/policy priorities in relation to human rights issues**
- **Funding priorities in relation to human rights issues**

Outcome 2

Global HIV/AIDS funding allocations to support work with drug users are commensurate with the scale and impact of the HIV/AIDS epidemic as it affects drug users and their communities.

- **Level of allocation in relation to data on drug users and HIV/AIDS (epidemiology, vulnerability and impact)**
- **Level of allocation in relation to targets set with stakeholders**

Outcome 3

Regional and sub-regional policy-making structures and processes develop policies and protocols on drug use and HIV/AIDS that reflect harm reduction principles and respect drug users' human rights.

- **Articulation of policies and protocols in relation to explicit reference to harm reduction principles and human rights conventions**
- **Proportion of regional policy recommendations that are translated into national policies and protocols**

Outcome 4

Networks and coalitions of harm reduction leaders, service providers, researchers, human rights advocates and community activists at sub/regional levels are actively developing and acting on common policy change agendas.

- **Level of involvement of such networks/coalitions in both planning and participating in sub/regional policy-making structures and processes**
- **Visibility of networks' and coalitions' policy agendas in media coverage of drugs and HIV/AIDS issues in the region**
- **Proportion of networks' and coalitions' policy agendas that get adopted in sub/regional policy-making structures and processes**

Outcome 5

The capacity of individuals and organizations in the region to provide harm reduction training and technical assistance is strengthened, notably in the areas of holistic harm reduction practice, working with vulnerable groups, program evaluation and fund-raising, and policy change work.

- **Size, composition and expertise areas of the pool of training/TA providers**
- **Proportion of training/TA providers' own capacity building needs that are met within agreed timeframe**
- **Level of satisfaction expressed by beneficiaries with training/TA (through workshop evaluations etc)**

- **Level of implementation of learning from training/TA (through workshop follow ups, project monitoring etc)**

Focus countries

At the national level, national consultative groups, composed of key partners, will be convened in each 'focus' country no later than the second quarter of 2003 to advise IHRD on the development of specific outcomes for its work in each country and of an evaluation plan describing process and outcome indicators and how such indicators will be reviewed and analyzed. Notwithstanding the different specifics of outcomes across the three groups of countries, IHRD will be interested in information on the following in order to assess its progress toward its goal in these country contexts:

- **Scale and coverage of harm reduction services**
- **Level of funding for harm reduction**
- **Degree of legal/policy change**
- **Level of reported human rights abuses against drug users**
- **Level of minority/marginalized groups' access to harm reduction services**
- **Level of drug users' access to HIV/AIDS care and treatment**

7.2.2 Program Level: Process Indicators

IHRD has systems in place to track a range of process indicators relating to the implementation of strategies. Quantitative information is collected, for example, on: the number of training workshops, study tours and exchange visits; the numbers and range of participants in each; the number of funded scholarships to international conferences, seminars, meetings; and the number of studies commissioned. Some qualitative information is also collected, for example, by:

- ▶ Evaluating each workshop for skills and confidence acquired in advocacy and related activities
- ▶ Evaluating conference/meeting participation by reports from participants/organizers
- ▶ Evaluating study tours and round-tables by surveys of participants and hosts

Based on the above, during the first half of 2003, program staff will discuss and refine a set quantitative and qualitative program indicators for each of its program strategies. IHRD will monitor the implementation of its operational plans through a monitoring system that tracks these agreed upon process indicators. Besides regular monitoring of activity implementation and impact, particular attention will be given to documenting the process of policy change work being conducted in each country. IHRD's on-going documentation and drawing of lessons being learned, will be fed back to the countries concerned and disseminated regionally and globally to guide and inform policy change elsewhere.

7.2.3 Program Level: Plan

IHRD will conduct an annual reporting and review process. This will include gathering reports from its grantees, Technical Advisers and national consultative groups in 'focus' countries. These reports will be supplemented by information gathered on process indicators and data on outcome indicators that can be tracked through program monitoring and official epidemiological data. Program staff will review the information and data collected, provide feedback to relevant stakeholders and refine program strategies in light of the findings from the review.

2003

Evaluation activities in this year will focus on refining program outcomes with specific targets, benchmarks and indicators, and developing a two-year operational plan for 2004-2005 that specifies these precise outcomes for its work at the global, regional and national level. In order to inform this operational plan, IHRD will also conduct a review of the implementation and achievements of its current policy initiative. While the initiative is funded until 2004, it makes sense to review its progress at this stage in order to identify lessons that can inform IHRD's work toward its new policy change goal.

2005

A mid-plan evaluation will be conducted, focusing on progress in relation to outcome indicators. This will involve gathering information from stakeholders and informants at all levels and making recommendations on the choice of and work in 'focus' countries, strategic priorities, and strategy improvements. In cases where external circumstances are hindering work in selected countries or where exceptional progress is being made, this evaluation may lead to other countries being selected for IHRD focus. Based on these recommendations, IHRD will develop an operational plan for the final two-year period 2006-2007.

2007

An end-of-plan external evaluation will be conducted to identify the impact of work, the achievement of program outcomes and progress made toward the program goal. This external evaluation will make recommendations on:

- ✓ Future priorities for policy change in CEE/fSU
- ✓ IHRD's role in addressing priorities for policy change in CEE/fSU
- ✓ Needs and opportunities for the development of harm reduction globally
- ✓ IHRD's role in addressing these needs and opportunities for the development of harm reduction globally

8. IHRD Organizational Development

Focus

The shift in focus to an overarching goal of policy change has significant implications for IHRD, in terms of its internal functions, capacities, and structures and processes of accountability. Further discussion is needed within the program and between the program and its key institutional partners to work out these implications, and this is a priority for 2003. At this stage, it is possible to make the following observations.

Functions

The balance of functions performed by program staff will clearly change as a result of this strategic plan. The decision to work with a smaller number of 'focus' countries implies a reorganization of responsibilities within the program, such that staff are dedicated to working with specific countries. As grantees come to the end of their funding and a smaller number are selected for continued funding in 'focus' countries, the volume of grants management work currently performed by IHRD staff will decline. At the same time, there will be a significant increase in the amount of work devoted to direct policy analysis and development by program staff and to a range of communications activities. More attention will also need to be given to maintaining closer contact with the regional Technical Advisers and other institutional and individual providers of technical assistance.

Capacity

These changes in staff function give rise to a range of activities in substantive areas of policy analysis, policy development and policy advocacy. At this stage it is possible to identify need for capacity building in areas such as:

- ✓ Integrating harm reduction and human rights
- ✓ Integrating HIV/AIDS treatment and prevention for drug users
- ✓ Analyzing the public health impacts of drug policies
- ✓ Network and coalition building

Accountability

IHRD's mission and goal, and its emphasis on addressing the rights and needs of its core constituency, has implications for how the program conceives of its accountability to this constituency and its institutional and other stakeholders. During the course of 2003, IHRD will explore ways in which formal mechanisms, such as its Advisory Group, could address these questions of accountability. Other less formal mechanisms for accountability are provided by the program's pool of Technical Advisers, the national consultative groups to be established in each 'focus' country and its relationship with the networks and coalitions with which it works and supports. IHRD will discuss the ways in which it can work with these and other mechanisms to ensure its accountability to the lives of the people for whom it is working.

Annex 1:

List of Stakeholders interviewed

Maureen Aung-Thwin	OSI – Burma Project, USA
Andrew Ball	WHO, Geneva
Joanne Csete	Human Rights Watch, USA
Erica Dailey	OSI – Central Eurasia Project, USA
Gregg Gonsalves	Gay Men’s Health Crisis, USA
Dan van der Gouwe	IHRD Technical Adviser, The Netherlands
Katarina Jiresova	IHRD Technical Adviser, Slovak Republic
Ralf Jurgens	Canadian HIV/AIDS Legal Network, Canada
Ulrich Kohler	DOH, UK
Zahari Nikolov	IHRD Technical Adviser, Bulgaria
Tatiana Rajniakova	OSI National Foundation, Slovak Republic
Balazs Sator	Civil Society Development Foundation, Hungary
Nina Schwalbe	OSI – Public Health Program, USA
Emilis Subata	IHRD Technical Adviser, Lithuania
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Annex 2 List of Advisory Group members

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Annex 3:

Annex 3 List of participants at strategic planning retreat

IHRD staff:

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2. Matthew Curtis
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4. Kasia Malinowska-Sempruch
5. Anna Moshkova
6. Sue Simon
7. Magdalena Sklarski

Consultants and Advisers:

8. Holly Catania
9. Joanne Csete
10. Gregg Gonsalves
11. Alan Greig
12. Andrej Kastelic
13. Alec Khachatryan
14. Mark Jason McLaurin