A Situational Assessment of Responses to HIV and drug use from a Harm Reduction and Rights-Based Perspective in Santo Domingo, Dominican Republic, Kingston, Jamaica, and Port of Spain, Trinidad

The Caribbean Vulnerabilised Groups Project is a five-year regional project which responds to HIV and AIDS among Caribbean sex workers, men who have sex with men, socially excluded youth, and people who use drugs.

The Caribbean Vulnerable Communities Coalition (CVC) and El Centro de Orientación e Investigación Integral (COIN) have come together to implement the project as sub-recipients of a Pan Caribbean Partnership against HIV and AIDS (PANCAP) Grant provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

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Preface

The Vulnerabilised Groups Project (VGP) is a five-year regional project which responds to HIV and AIDS among Caribbean sex workers, men who have sex with men, socially excluded youth, and people who use drugs. The Caribbean Vulnerable Communities Coalition (CVC) and El Centro de Orientación e Investigación Integral (COIN) have come together to implement this project as sub-recipients of a Pan Caribbean Partnership against HIV and AIDS (PANCAP) Grant provided by the Global Fund to Fight Malaria, Tuberculosis and Malaria. In Phase I, the project works in three pilot countries, the Dominican Republic, Jamaica and Trinidad.

This report encompasses three components. It consists of:

1. A regional assessment of issues related to drug use and the overlap with HIV infection
2. National assessments of existing harm reduction interventions targeting people who use drugs in the Dominican Republic, Jamaica and Trinidad

This assessment report, the reports from the various national community consultations, the one day regional consultation, street-based research, and priority framework for people who use drugs will inform a community grants scheme that will endeavour to:

Support a cost effective and peer driven “continuum of care” with particular emphasis on low threshold street and community-based interventions programmes by:

- Expanding the reach of existing services
- Establishing new services in other locations
- Focusing on institutional capacity building
- Training staff
- Upgrading the physical structures of existing centres

A key positive outcome of the VGP project will be the expansion and increased visibility of model harm reduction interventions in the 3 pilot countries.

On a national level, CSOs in the project countries will be encouraged to organise into national coalitions of service providers. The objectives of that being to:
• Advocate for the needs of people who use drugs to the appropriate departments of governments
• Provide peer input, review and evaluation of programmes that address the needs of drug users
• To identify training needs
• To provide a unified voice to speak to government

In addition objectives include focus on the following programming areas:

**Community Based Intervention**
Expand and implement low threshold street based intervention programmes based on the principals of harm reduction.

**Women**
Address the special needs of substance using woman especially those who are homeless and those with children who are homeless

**Economic and Social Re-integration of Drug Users**
• Assist in the establishment of skills training programmes based on the adolescent development programme (ADP) model developed and used by the well established Trinidian community based organisation called “SERVOL”
• Assist in the establishment of half way houses
• Assist in the establishment of drop-in centres that will work with drug users, providing services

**Research and Evaluation**
Promote a culture of self-evaluation within the NGO service providers

**Introduction**
Harms associated with the illegality of drugs far outweigh any of the medical harms associated with drug use. Many of the harms commonly cited when discussing drug related harm, drug use and the necessity of keeping non-prescription drugs illegal, may be caused by the prohibitive laws rather than the substance. Crime, governmental corruption, sex work, HIV and drug related violence are outcomes often significantly related to the criminalisation of and subsequent war on drugs. In countries that approach drug use as a public health issue, much of these aforementioned problems are greatly minimised. For example, the prevalence of cannabis use in Amsterdam, where it is decriminalised, is less than any major European city. In terms of the reduction in prison populations, the Netherlands, because it no longer criminalises drug use, has closed 8 prisons because without drug offenders there are not enough inmates to fill the cells. Conversely, in the Caribbean where 60 – 70 % of incarcerated populations are interned for crimes motivated by drugs and drug use, prisons are overcrowded. In a Caribbean context where punishment rather than rehabilitation is the accepted societal norm, there is

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1 Latin American Commission on Drugs and Democracy, Drugs and Democracy: Towards a Paradigm Shift
http://www.drugsanddemocracy.org/
2 http://vorige.nrc.nl/international/article2246821.ece/Netherlands_to_close_prisons_for_lack_of_criminals
3 John Rogier, Outgoing president of the Association of Caribbean Heads of Corrections and Prison Services, opening address at the 2012 Annual Conference. Private notations of the author who attended the opening.
continuing public pressure to increase prison capacity rather then look for alternatives to custodial sentencing.4

Throughout the Caribbean, governments rely on criminal justice sanctions as their primary response to illicit drug use. Health care and health services are difficult to provide to drug users in many places due to restrictive laws that prevent proper care and the resulting social stigma attached to drug use. The result is poor health outcomes. Promotion of rights-based approaches is an essential pre-condition to improving the health of individual drug users and improving the public health of the community.5

A Brookings Institute study in 2008 concluded that intense interdiction and eradication efforts have failed to decrease the global supply of drugs and that punitive methods have had no success in lowering drug use. This sentiment has been echoed by a Commission which met in Mexico6 headed by Fernando Henrique Cardoso, former president of Brazil, Ernesto Zedillo, former President of Mexico, and Cesar Gaviria, former President of Columbia. They concluded that, “The war on drugs is a failed war,” that Latin American Governments as well as the US must break what they say is a policy taboo, and that there is need for the new US administration to re-examine its anti-drugs efforts.

Developments in harm reduction implementation

There are few harm reduction services in the Caribbean region7. The programmes operated by the Caribbean Harm Reduction Coalition are based in Saint Lucia and offer shelter and other services for homeless crack users living with HIV. As well as providing adherence support for residents receiving antiretroviral therapy (ART), the shelter advocates for the therapeutic use of cannabis (though does not distribute or provide cannabis) for residents for its therapeutic value. Cannabis has been shown to inhibit HIV progression in PLHIV, is effective in addressing the nausea which is often a side effect of (ART), and has been shown as a possible substitute in addressing crack cocaine dependency. At present in the Caribbean there are no estimates of the numbers of people who inject or otherwise use drugs and also receiving ART.

Universal access reports from Caribbean governments indicate progress towards targets in some areas of the response, however, no Caribbean countries or territories reported on the availability and coverage of harm reduction programmes for people who inject drugs in any UNGASS report.10

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4 Ibid
6 February 2009
7 The only drop in centres are in Santo Domingo, Dominican Republic, Port of Spain, Trinidad and Kingston, Jamaica and Saint Lucia
Drugs and HIV in the Caribbean

The Caribbean region has the second highest prevalence of HIV/AIDS in the world after Sub-Saharan Africa. Injecting drug use is rare in the English speaking Caribbean and it is the use of crack cocaine that is common and most problematic in relation to HIV infections. The role of crack cocaine in the Caribbean HIV and AIDS epidemic is not widely documented and this knowledge gap was identified as a priority area in both the past and present Caribbean Regional Strategic Framework for HIV/AIDS.

In the Caribbean, the virus is predominantly sexually transmitted and injecting drug use remains rare in much of the region, with the exception of Puerto Rico and some parts of the Dominican Republic. In 2008, a systematic review by the Reference Group to the UN on HIV and Injecting Drug Use (IDU) found very limited data on the numbers of people who inject drugs and the prevalence of HIV among injecting populations in the Caribbean. For instance, the drugs use statistics among students in Jamaica and Trinidad and Tobago (two of the selected countries of this study) indicated a lifetime and past year prevalence that were the highest in all Caribbean in some substances as inhalants. The use of marijuana and cocaine was also high among these countries, but there were no report of heroin use. In Dominican Republic (the third selected country) the same type of survey was conducted in 2008 and the report among Dominican students of heroin use was 0.2% higher than the 0.06% obtained in 2004.

It is entirely possible however, that injecting drug use does occur in the English speaking Caribbean. For example, Hepatitis C Virus has been reported in the blood supplies of Guyana and Trinidad and Tobago and there are anecdotal reports of injecting drug use among the high socio-economic population of those countries, indicating that injecting may be occurring but at present there is no reliable data to confirm these reports. The Caribbean Harm Reduction Coalition regularly polls drug treatment programme managers from the English-speaking Caribbean regarding clients presenting for treatment who are injectors or opiate users. To date there have been none reported.

Despite the lack of evidence of injecting behaviours, researchers in the Caribbean have found a link between non-injecting drug use and sexual HIV transmission in several Caribbean countries, with HIV prevalence estimates among crack cocaine smoking populations reaching those found among injecting

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populations elsewhere.\textsuperscript{19} The Caribbean is located between the major cocaine transhipment routes in the south and the consumers to the north and east. Due to this strategic location, huge quantities of cocaine transit the region. The customary method of paying for the facilitation of transhipment is with ‘product’; in this case payment is made with 95 percent pure cocaine. That residual product that stays behind to finance the transhipment is sold on the local market and is widely available at prices well below the destination countries. Cocaine use is reported to be ‘extensive.’\textsuperscript{20}

Harm reduction interventions targeting drug related harms are very limited in the region. The predominant drug demand reduction treatment responses in the region are characterised by abstinence-based, high threshold services for people who want to stop using drugs. There are few programmes designed for people who, for whatever reason, continue to use drugs.

The use of illicit drugs is highly criminalised in the region with tough sentencing regimes, resulting in a high rate of incarceration of people who use drugs. Despite the evidence that drug use is playing a role in HIV epidemics in the Caribbean, national drug and HIV policies remain largely unlinked.

Jamaica remains the exception and as a result of the research conducted by Dr Peter Figueroa (2007) at the National AIDS Programme and Dr Winston De La Haye at the University Hospital (2009) the Jamaican National Council on Drug Abuse addresses the HIV and other socio-medical needs of street engaged people who use drugs. Much of the early sensitisation of Jamaican service providers on HIV and drugs came from the Caribbean Harm Reduction Coalition (CHRC).

The Government of the Dominican Republic is undergoing increased pressure to support harm reduction interventions. Much of the early advocacy work was undertaken by Meson d’Dios, a member of CHRC since 2001. In 2004, with the formation of the Caribbean Vulnerable Communities Coalition, COIN and CHRC became collaborators and COIN has carried on with a human rights based advocacy programme and is developing a service model for people who use drugs in the Dominican Republic. The Dominican national drug authorities are heavily invested in an abstinence model and find it a challenge to embrace a harm reduction philosophy because of existing laws. The current Dominican national drugs strategy has no harm reduction approach at all.\textsuperscript{21} Trinidad has benefited from harm reduction training and support and the Organization of American States (OAS)/CICAD, drop-in centre is a service model that can be replicated anywhere in the region. While the National Drug Council has harm reduction in their national drugs strategy\textsuperscript{22}, the government does not operate harm reduction services nor does the National AIDS programme name people who use drugs as a population to work with in addressing elevated HIV prevalence.

The approval of The VGP, which includes programming for drug users, finally gave important recognition of the value of a harm reduction approach to drugs in a Caribbean context.

\textbf{Civil society and advocacy developments for harm reduction}

\textsuperscript{22} National Strategy to eliminate illicit drugs. 2008-2012. Trinidad and Tobago.
The acceptability of harm reduction in the region remains an issue, but it is an approach that has gained recognition in selected countries. In February 2009, the Caribbean Community (CARICOM) Secretariat held a two day workshop on harm reduction in Jamaica. Significantly, this event marked the first of its kind organised by this regional body, indicating an open acknowledgement of the need for harm reduction interventions in the region. NGOs were engaged in the event and facilitators included the chairman of the CHRC.

**Laws that criminalise drugs**

The Single Convention on Narcotic Drugs of 1961 is an international treaty to prohibit production and supply of specific (nominally narcotic) drugs and of drugs with similar effects except under licence for specific purposes, such as medical treatment and research.

Since the Single Convention is not self-executing, parties must pass laws to carry out its provisions. The United Nations Office on Drugs and Crime works with legislatures to ensure compliance. As a result, most of the national drug statutes share a high degree of conformity with the Single Convention and its supplementary treaties, the 1971 Convention on Psychotropic Substances, and the 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

Article 36 of the Single Convention requires Parties to ‘criminalize’ "cultivation, production, manufacture, extraction, preparation, possession, offering, offering for sale, distribution, purchase, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation and exportation of drugs contrary to the provisions of this Convention.” It further requires Parties to ‘criminalize’ "intentional participation in, conspiracy to commit and attempts to commit, any of such offences, and preparatory acts and financial operations in connexion with the offences referred to in this article”.

People who use illicit drugs are criminalized as a result of a range of offences, including possession of drugs, self-administration of drugs and possession of equipment for drug use such as crack pipes. All countries of the region criminalise supply of illicit drugs. Most also criminalise possession and use of illicit drugs. The penalties for possession can vary but it is not uncommon to read accounts of individuals being sentenced to 3 months in prison for possession of small amounts of cannabis. In Dominican Republic, Law 50-88 on Drugs and Controlled Substances is a very strict regulatory framework. For example, Article 7 of the Law provides that any person found with any quantity of LSD or other hallucinogenic substances, such as opium and its derivatives (including heroine) is arrested and classified as a trafficker. There is no distinction between use and dealing in law and no distinction in sentencing.

**Law enforcement practices**

Relationships between health services and law enforcement agencies are sometimes undermined by police crackdowns on people who use illicit drugs. In those cases, police crackdowns impact the capacity of harm reduction services to maintain continuity of services and retain clients.

Criminal laws, disproportionate penalties, and punitive law enforcement practices result in negative health outcomes. At a recent meeting of the heads of Caribbean prisons it was agreed by the participants that between 60% -70% of the prison populations of the Caribbean are drug users, creating a massive problem of over-crowding in prison. In a study in Dominican Republic, it was observed that
drugs users in prisons were more likely drug dealers too and that being in jail increased their drugs consumption.\textsuperscript{23} Some drug control efforts have resulted in human rights abuses, police mistreatment, arbitrary detention and extra judicial killings.\textsuperscript{24}

Regional drug control policies remain heavily influenced by ‘war on drugs’ policy imperatives. The Barbados Plan of Action\textsuperscript{25} (1996) had been endorsed by all CARICOM countries with a target of a “drug free Caribbean”.

\textbf{Law Enforcement or Public Health}

Harm reduction services have difficulty even starting up when drug use is heavily penalized and subject to harsh law enforcement. Because of the intense stigma associated with being a crack cocaine user, partially as a result of anti-drug messages that demonise and dehumanise drug users, organisations are reluctant to start programmes to address the needs of people who use drugs. Drug users also may not access services because of fear of arrest or other negative consequences that can follow from identification as a drug user, such as harassment and violence or dismissal from employment. Many do not seek treatment or attend harm reduction services for fear of stigma and discrimination.

There is a challenge of how the various organs of the State interpret outreach work. Is it a public health initiative as the National AIDS Programme interprets or is it a criminal undertaking that promotes illegal behaviours, in this case, drug use? Laws that create criminal penalties for incitement to use drugs, or aiding and abetting drug use, may be used to criminalize outreach workers.

\textbf{Sexual transmission of HIV among crack cocaine smokers}

Among Caribbean vulnerabilised groups are non injecting drug (crack-cocaine) users. Lewis and Hospedales (1988) reporting on research of crack cocaine users and HIV in the West Indian Medical Journal stated that “despite the absence of IV drug use in Trinidad and Tobago, drug users may be significant in the transmission of the HIV virus to and within the heterosexual population”.\textsuperscript{26} So as early as 1991 research was published revealing a higher rate of HIV among this sub-group of drug users compared to the general population despite the absence of IV drug use.

This is supported by studies in the US that have shown that crack smokers have infection rates of HIV similar in magnitude to injection drug users.\textsuperscript{27} US based researchers hypothesize that this association occurs through the mechanism of increased unsafe sexual practices precipitated by the use of crack.\textsuperscript{28}

\begin{flushright}
\textsuperscript{25} http://www.caricom.org/jsp/community_organ/cohsod_youth/regional_drug_control_activities.jsp
\end{flushright}
In Trinidad and Tobago, survey data has shown high HIV prevalence among crack users, and a study in sexually transmitted infection clinics found that the strongest predictor for HIV infection was crack cocaine use. In Antenatal clinics on the island of New Providence (Nassau and environs) there was a significant association between HIV infection and crack cocaine use in Bahamian women. A further association between crack use and HIV has also been established in the Bahamas, where cocaine use among patients with an STD was significantly associated with HIV infection. Crack cocaine use and risky sexual behaviours, both associated with increased risk of medical and psychiatric complications, have been described as common behaviours among the homeless in Trinidad.

As early as 2000, Persaud noted an overlap between crack cocaine use and HIV infection in Guyana citing that it was not just risky sexual behaviour that was the issue but sex work driven by drug addiction. Qualitative research conducted in a drug treatment programme in Trinidad found that high levels of sex exchanges for drugs were common. In 2007 a behavioural and sero-prevalence study (BSS) of poor and indigent crack users was conducted in Saint Lucia that found a 6.8% HIV rate among crack using men and an 11% among crack using women (with a small sample of 22 women). Significant was that a control group of poor and indigent non-crack smokers were also tested and no HIV was found in that population.

The evidence above and the advocacy of the Caribbean Harm Reduction Coalition resulted in the CARICOM Secretariat including a small harm reduction component in the 9th EDF project under Caribbean Regional Indicative Programme. This was followed by PANCAP’s inclusion of harm reduction

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References:

28 Castilla, J et al, Drug and alcohol consumption and sexual risk behaviour among young adults: results from a national survey, Drug and Alcohol Dependence Volume 56, Issue 1, 2 August 1999, Pages 47–53
in the 9th Round Global Fund Project, officially acknowledging that people who use crack cocaine are a population that requires targeted interventions. As Caribbean nations revise their national strategic plans it is an advocacy opportunity to ensure the inclusion of people who use drugs in the national AIDS strategic plans and harm reduction in the national drug plans.

The disregard of people who use crack cocaine as a population at higher risk for HIV is primarily attributed to the fact that Caribbean HIV strategies have been ‘donor driven’. The Caribbean has consistently provided the research to show that HIV infections were 5 to 10 times higher than the general population yet donors have consistently stated that due to the lack of injecting drug use in the Caribbean, Caribbean drug users are not at risk. This is even apparent in the UNGASS indicators that ignore any substance use except injecting. This has frustrated efforts to intervene as no funds were made available for non-injecting crack users. This speaks loudly of the disconnect between evidence-based research and policy formation.

Legal responses that protect and empower

Supportive police attitudes are critical to the success of harm reduction programmes. Partnerships between police and public health services can occur where police use a community policing approach, with referral systems to health and welfare services, and training for police on HIV and human rights-based approaches. Law reform options include decriminalisation of drug use, and the use of drug courts that divert drug offenders from the prison system into community-based treatment. These types of programmes have worked well in Europe and Canada and make better models to follow.

Drug traffic in selected countries

The Dominican Republic, Jamaica and Trinidad and Tobago are located between the producers of cocaine and heroin in South America and the main consumers of the drug in North America and Europe. In the past three decades these countries have been used for the transhipment of cocaine bound for both North American and European markets. Heroin produced in Columbia largely transits the Dominican Republic on its way to America37. The available statistics in Dominican Republic showed that in 2011 42,010.4 grams and 38,718.8 grams in 2012 of heroin were seized by the authorities. Marijuana, which is also in produced in Jamaica is used both locally and exported regionally and beyond. Though most drug-related youth cultures started in North America, one well-known exception is the Jamaican Rastafarian movement. The Rasta culture, associated with reggae music and the use of cannabis, spread from Jamaica to many other countries in the 1980s38.

South American drugs move through these countries and persons involved in the traffic receive cocaine or heroin as a ‘payment in kind’ for the facilitation of the transit. In order to convert this ‘product’ into cash, the drugs are sold on the local market at a price well below that of the destination countries thus making cocaine and heroin easily affordable to the local population. Many urban garrison or ghetto communities have a strong crack cocaine sub-culture with well established distribution networks39. In the Dominican Republic this is also true of heroin.

37 Europe receives its heroin from Afghanistan and SE Asia
39 Figueira, D. Cocaine and Heroin Trafficking in the Caribbean: The Case of Trinidad and Tobago, Jamaica and Guyana, 2004, iUniverse.
Drug trafficking in these countries and indeed throughout the Caribbean has in recent years led to increasing local use. In the same studies cited above, conducted in secondary schools by the OAS, half of the sampled population said that they knew of a drug user or dealer (this does not include alcohol or nicotine users)\(^\text{40}\).

**Other Socio-economic impact of drug use in a prohibitionist environment**

In addition to, and compounding the direct public health risks of substance use, is the poverty and criminality associated with substance use in a context where use and possession are highly criminalised behaviours and almost always punished by incarceration.

The high profits associated with the distribution and sale of illicit drugs in communities leads to corruption of the organs of government and social dislocation due to the violent culture of both state sanctioned drug suppression and the intra-community turf wars based on fear of reprisal and gang-membership\(^\text{41}\).

Other than a few rapid assessments undertaken ‘on the street’ in selected communities in the region, there is little information about demographics or behaviour of this ‘hidden population’ of users and the extent and nature of their substance use\(^\text{42}\). While street engaged drug using populations may be more visible and a bit more easily counted, the vast majority of “middle class” substance users remain out of the public eye and hidden from interventions. Raising the question of whether drug related HIV risk is the same for the various categories of people who use drugs. At a recent meeting of global experts on non-injecting stimulant use and HIV overlap,\(^\text{43}\) it was agreed that not all stimulant user were vulnerable to HIV infection. In relation to crack cocaine users, it was agreed that indigent, homeless, crack cocaine smokers were the population that required HIV prevention interventions and that “middle class, recreational users” did not share the same HIV risks.

**Extent of drug use in the assessed countries**

The injecting phenomenon found in Santo Domingo is quite different from that of Jamaica or Trinidad. There is a widely held view by health and drug treatment professionals that “West Indians” have a needle aversion that inhibits their adoption of injection drug use and that therefore injection drug use is unlikely to become common. This remains embedded in the belief system of people involved in treatment.

However the injection drug use in Santo Domingo and Santiago (second city of the country) the influx of people from the Dominican Republic relocating to the CARICOM Caribbean creates an exposure opportunity that should motivate CARICOM countries to develop harm reduction protocols to address injecting drug use behaviours should it spread to territories where it was previously undetected.


\(^{42}\) Day. M., A review of HIV and the overlap with drug use in the Caribbean.

\(^{43}\) Convened by the UNODC in San Paulo, Brazil in January 2012
Existing responses to drug use in countries assessed

At the regional level there are several mentions of drug use in HIV strategy documents, but as yet there has been little translation of this at the national level in either policies or programmes. There has been no official movement within national HIV policies in relation to harm reduction since 2008. While there is clearly strong commitment from policy makers in the region to respond to Caribbean HIV epidemics, as articulated in national policy and strategy documents, these have not yet included harm reduction. Similarly, national policies and strategies on drugs are in place for all Caribbean countries and territories, but neither do these include a harm reduction approach. The exception to this is the National Anti-Drug Plan of The Republic of Trinidad and Tobago 2008-2012, which explicitly includes harm reduction as a key part of the national response to drugs.

Harm Reduction acceptance is in flux in the region. The HIV programmes basically embrace harm reduction with people who use drugs, to the degree that they treat with any vulnerable population. Drug use when adopted by any of the other vulnerabised populations increases their HIV risk and creates a stigma that extends into their own communities. Throughout the Caribbean sex workers who use crack cocaine are shunned by non drug using sex workers especially when drug using sex workers sell their services below the market value. This also applies to MSM populations who use drugs. Based on the level of drug use and surrounding chaos of the drug use, drug using MSM have difficult times integrating into the social context of well groomed, employed MSM.

With the appointment of former CARICOM Assistant Secretary General Dr Edward Green as UN Special Envoy for HIV in the Caribbean, harm reduction is ensured an active supporter at the highest levels of Governments. This is based on public statements by Dr Edward Greene, Assistant Secretary-General, Directorate of Human and Social Development, Caribbean Community (CARICOM) Secretariat has made in the past. In his opening remarks at the Lugo Summit, Dr Green indicts “prohibitionist” framework and states that it’s a time to change our strategy. He goes on to state that we need to look at issues of “Harm reduction and human rights” and “that the same old prohibitionist approach leads to the infringement of human rights.” He says, “Intense interdictions have failed to decrease the supply of drugs and that punitive measures have had no success on lowering drug use.”

Scope and extent of services for people who use drugs (PWUD)

The Public Sector

The public sector approach to drug use in the project countries primarily focuses on one aspect of the continuum of care for people who use drugs, the provision of high threshold drug treatment and rehabilitation services. These services use the traditional psychiatric hospital based methodology and have a strong medical bias and a focus on detoxification. A number of issues including clients who are ...

46 The National Anti-Drug Plan (2008-2012) for Trinidad and Tobago.
47 CICAD Twin Cities meeting in Lugo Spain 20-23 April 2010
not ready or able to stop using drugs, high levels of co-occurring psychiatric illness and the social stigma attached to residency in psychiatric facilities, the public sector facilities are under-utilised\textsuperscript{49} resulting in the provision of treatment services that are cost ineffective. Furthermore, many of the patients who attend these facilities are alcohol dependent. The majority of street engaged drug users are men. In reviews of all literature cited in this paper, the author found no reference placing women drug users at more than 25-30\% of the street engaged drug using population.

There is a lack of gender appropriate services for drug users. Trinidad and Tobago has the only treatment facility\textsuperscript{50} solely for drug or alcohol dependent women. Drugs, harm reduction, and drug treatment services are notoriously heteronormative and masculine. Women, gay men, sex workers, transgendered are not really made to feel safe and comfortable in these spaces and there are no services directly related to them.

After-care, when available at all, is limited to former clients voluntarily revisiting the treatment facilities for after-care services. In conversations the author has had with treatment professionals throughout the Caribbean, it was often cited that clients who come from lower socio-economic backgrounds were hindered from returning for outpatient treatment due to both travelling costs and time off required from employment in order to participate in aftercare. Further compounding the issue of after care and also cited by treatment professionals is the stigma attached to the treatment centres themselves (especially those located either in psychiatric facilities or nearby). This deters users who are in the beginnings of their drug using away from seeking assistance.

The exception to this is the National Council of Drug Abuse, which, despite the stigmatising connotations of the word “abuse”, runs a low threshold, mobile harm reduction programme in Kingston and St Andrew, Jamaica. An in-depth look at this programme may be found below in the section entitled “Available resources identified”.

It is also important to mention that Jamaica and Dominican Republic are ready or getting ready for drugs courts where persons of determinate characteristics and drugs user may be able to access to free treatment instead of jail. Jamaica was the first to get involved in this model with the support from the Organization of American States.

\textbf{Civil Society}

Within the project countries, there are few community run low threshold interventions for people who use drugs. The projects in Port of Spain, Oasis and the COIN operated outreach service in the Capotillo community in Santo Domingo funded through a grant from the US Centre for Disease Control are highlighted in the country reports appended at the end of this assessment.

There are a variety of abstinent based drug treatment and rehabilitation services, ranging from therapeutic communities with international partners to grass roots programmes initiated by former drug users or what is commonly referred to as ‘recovering addicts’. However, at present most of these services reach only a small section of the population in numerical terms. Their philosophy and approach tends to be conservative and restricted to an abstinence approach through 12-step and/or therapeutic


\textsuperscript{50} Serenity Place, Pt Fortin, Trinidad is a female only treatment programme operated by a civil society organisation.
programme, much of it influenced by the Hazelton model.\(^{51}\) Many of these programmes appear to have limited success and are under-utilised for a variety of reasons including commitment, community\(^ {52}\) and cost. Their approach, which requires a high commitment from clients prior to engaging in treatment, means that pre-contemplation or contemplative\(^ {53}\) clients just do not enter the services.

**Community Partners identified**

Expertise and project methodologies have been identified which should be supported and assisted to expand. Each of these three countries has a unique intervention that could be transferred successfully to other agencies both nationally and throughout the region. This could be a central part of an expanded programme not only in terms of cost-effectiveness but also in terms of being contextually appropriate. The resources/expertise identified are as follows:

Community based treatment and rehabilitation centres such as Rebirth House, Trinidad have good user-friendly approaches. The work creates a community spirit among clients, which lasts beyond the inpatient period. Rebirth House includes a farm, entirely run by the clients. The Oasis drop-in centre on Duncan Street operates under Rebirth House and remains the only truly low threshold service in urban Port of Spain or throughout the twin island republic.

The National Council on Drug Abuse (NCDA) operates a mobile outreach programme called “Tek It to Dem”. This is the only government sponsored harm reduction outreach in the CARICOM Caribbean. The project provides services to assess rehabilitation and to reintegrate the homeless population of Kingston and St. Andrew into independent, productive members of the society. This is achieved though assessment, stabilisation and treatment of substance use, HIV, psychiatric and medical issues. They also conduct a social assessment and evaluation. The overall goal of the programme is the rehabilitation and reintegration through skills training, independent living, job placement and family reunification. The “Tek it to dem” project understands that not all individuals they work with will become rehabilitated and reintegrated. Providing services for the sake of services with no expectations of ‘recovery’ is the guiding principal of this programme.

The COIN outreach project works with drug using populations including people who inject drugs (PWID) in a CDC funded outreach project that focuses on HIV prevention. The COIN outreach team is unable to use CDC project funds to purchase and distribute certain commodities (i.e. syringes) due to a US Federal Government ban on using federal funding for syringe distribution programmes. The advantage of meshing the existing programmes is that the funds available from the Global Fund may be used to purchase commodities not covered in the CDC grant. This means that the CDC outreach team can teach safe injecting and distribute safe injecting kits (minus syringes) while clean syringes and sharps bins are left at the shooting galleries. The focus of the outreach is on homeless street engaged crack cocaine users.

**Other community partners that may be drawn upon**

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51 http://www.hazelden.org/
52 Community can refer to the community based service providers who often require near religious transformation to be successful
The Centre for the Socially Displaced Persons (CSDP), Port of Spain, Trinidad and Tobago is a community based intervention project with the homeless and urban poor (drug users). This project, funded by the Government of Trinidad and Tobago (GoTT), through the Social Displacement Unit of the Ministry of the People and implemented by the Saint Vincent De Paul Society successfully provides support to homeless people including many drug users. The intervention uses a community-based approach.

School and vocational education programmes developed using the SERVOL (Trinidad) method. SERVOL provides services for vulnerable young people from economically disadvantaged and underserved communities with considerable success. They have a consistent record of placing over 80% of individuals who completed their two-year programme.

Richmond Fellowship Jamaica’s (RFJ) Patricia House, Kingston, Jamaica is a drug treatment centre run on the principles of an abstinence model. The manager Howard Gough has a master’s degree in addiction studies and a regional reputation as an expert in the field. The Centre has well-established guidelines, protocol and procedures that are transferable to other programmes in the region. Over the past 12 years, Howard Gough has been a champion of the harm reduction approach as a critical intervention on the continuum of care.

**Major gaps in current responses**

*Lack of LGBT friendly interventions for drug-users*

There is a major gap in HIV prevention services for ‘street engaged’ people who use drugs. This population is very diverse. Subsets of the group ‘street engaged people who use drugs’ include psychiatric patients with co-occurring psychiatric issues and vulnerable youth and men, women and transgendered populations who sell sex. The drug treatment and harm reduction culture is very heteronormative and any person biological male that does not conform to society’s concept of what a “man” should be, including gay men, men who have sex with men, bi-sexual men and male to female transgendered persons are not encouraged or welcome. All of these sub-populations are neither serviced as drug users nor do they receive attention from the community service organisations that target psychiatric patients, youth, sex workers or MSM. There is both the need for LGBTI-sensitive treatment services in the Caribbean and for helping those involved in the treatment process to become more aware of LGBTI issues, both drug treatment issues and wider health issues that compound drug use challenges. Drug use among these sub-populations results in their exclusion from both services targeting them and from drug services.

There is also important public health functions related to treatment issues for LGBTI persons. For example, the convergence of HIV, hepatitis, and substance abuse is a major concern that has not been adequately addressed in LGBTI communities, especially regarding the availability of vaccines for hepatitis A and hepatitis B. Educating LGBTQI people about these vaccines, the importance of vaccination, and strategies for preventing hepatitis C infection is a responsibility not only for drug treatment professionals but for all health care providers.

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54 Clearly there is a major lacking of any services for street engaged populations in the Caribbean. Most of the contact with this population is through criminal justice system.

Often when an MSM presents for an HIV test, the counsellor will focus on his sexual risk behaviours and may not think to enquire of drug use history or the combination of drug use and sexual behaviours especially if the person who presents is well-presented. As stated above much of drug use is in the form of self medication for co-occurring psychiatric issues. Given the trauma associated with being a LBGTI person in the Caribbean, there is a measure of untreated substance use issues and a lack of skilled services to address the issue.

**Strategic Priorities** The following have been identified as the major gaps in service and training at present:

1. **Low threshold services:** There is little access in the Caribbean to services other than high-threshold residential services e.g. to social rehabilitation prior to detoxification or basic harm reduction interventions. There is little support for drug users to explore other options for improving his/her quality of life.

2. **Gender perspective:** The limitations in treatment and rehabilitation facilities are apparent for women who are drug-dependent. A 2001 CARICOM sponsored needs assessment of drug demand reduction activities identified only one treatment and rehabilitation facility dedicated to the provision of service for women who are drug-dependent. In 2012 there is still only that one centre located in rural south of Trinidad. There are no specific harm reduction programmes that target women. There also are a limited range of gender responsive services targeting women’s or LBGTI needs within the generic gender services on offer.

3. **Half-way houses:** Halfway-house facilities, which could enable the client to make the transition from the street or prison and a more “home” like environment in a supportive manner, are virtually non-existent. People engaged in offering services to street engaged persons region continue to stress the need for the establishment of these facilities as an important step in the path to the social and economic re-integration. Halfway-houses, like all harm reduction services must be low threshold, community based, located in areas where appropriate, close to the client’s urban environment rather than isolated in rural areas.

4. **Training:** There are substantial training gaps which need to be addressed in order to support the upgrading of expertise and services in the region. These are especially present in the areas of:
   - Community based interventions including drop in centres
   - Street based peer programmes
   - Half-way house establishment and operations
   - Appropriate prevention and treatment methodologies including medical assisted therapies for opiate dependence
   - Monitoring, planning and evaluation
   - Financial administration
   - Clinical Supervision
   - User friendly/needs based approaches to treatment
   - Economic re-integration
   - Research and evaluation which focuses on the improvement of service delivery and to inform the development of information, education and communications materials
 Networking: As a result of the Caribbean Vulnerable Communities, the Caribbean Harm Reduction Coalition (CHRC) has been able to develop a link between their members and CHRC members. There has been a greater level of communications and sharing of information between different CSO providing HIV services in the region. Effective networking is vital for advocating for the development of a Regional approach and strategy to address the needs of people who use drugs. Effective networking will add an element of sustainability, confirm the success of interventions and provide a forum for NGO service providers to keep the needs of NGOs on the regional policy formulation agenda.

Dominican Republic Specific Assessment

Background
The researcher conducted a group interview with 3 participants who injected drugs at Capotillo with help of an outreach team. The participants were involuntary returnees (2 injectors, 1 internal user). Based on the data gathered during the focus group, the researcher assembled a structured instrument to measure various behaviours (health seeking, sexual, drug use, and criminality). The interviews were held at the home of one of the volunteer outreach workers and the others were in an “abandoned” house that served as a “shooting gallery”.

The prevalence of injecting, the use of heroin alone, the mixing of heroin and cocaine (called speedball) and all the health and social issues associated with opiate use and injecting make the drug use context of Santo Domingo very different from the situation in Trinidad and Jamaica, where at the street level, injecting drug use and opiate use are unknown.

Finding
There is no opiate substitution therapy (OST), (methadone and / or buprenorphine) available in the Dominican Republic for the use of people who inject drugs. The majority of the persons interviewed who were opiate users (injection or intranasal) thought the provision of OST was needed and stated that if available they would welcome the availability of methadone maintenance (Note: there was no knowledge of buprenorphine as an OST as this treatment was unknown in the USA when the participants lived there.

Recommendation
COIN should develop an advocacy programme targeting the appropriate government departments and calling for the provision of OST as critical for stabilising opiate users and ending unsafe injecting behaviours and the accompanying transmission of HIV and other blood borne virus (BBV).

Syringe use and re-use
Respondents reported re-using discarded syringes they found on the ground. There was some recognition that flushing out the used syringe with water was “better than nothing”. There was no use of bleach or disinfectant reported, (not that cleaning syringes with bleach is particularly effective or recommended as an intervention.)

Improper disposal of used syringes
There was no mechanism reported for the safe disposal of used syringes. Syringe reuse was common.

Syringe sharing
There were high levels of syringe sharing reported. Some individuals reported just sharing in among their “network” of close friends while others shared syringes with anyone.

**Other unsanitary/ non-sterile harmful personal injecting behaviours**
- No alcohol or other mechanisms were used to clean injecting sites prior to injecting
- Little use of clean water used to dilute the shot – respondents reported the use of water obtained from bottle, bag, bucket or gutter was used.
- Dirty Bottle caps used to dilute the shot
- No reported washing of hands or injection site prior to injecting
- Even when syringes are not shared they are often reused by the same individual, resulting in vein damage.
- Used cigarette butts from the ground are used to filter the “shot” as it is drawn up into the syringe
- No use of any “acid” to dissolve the heroin, just water and at room temperature
- No report of “cooking” the shot

**Results**
- High level of transmission of HIV and other blood born viruses (BBV)
- Abscess wounds from unsanitary/ sterile injecting habits
- Vein damage from syringe reuse

**Recommendations**
- Training outreach team on the proper techniques required for safe injecting that they may pass this information on to PWID.
- Develop IEC materials for PWID on safe injecting and health issues related to injecting.
- Installation of “sharp” bins in the shooting galleries
- Distribute safe injecting kits
- Contents of a safe injecting kit
- Sterile water to mix the drug with
- Clean container or bottle cap for mixing water with the drug before it’s drawn up into the syringe
- Cotton balls to trap dirt and debris as the drug, mixed in water, is pulled into the syringe
- Alcohol swabs to clean the injection site before insertion
- Step-by-step injection instructions that come in English and Spanish
- Tourniquet to “tie off” above the injection site
- Kits (without syringes) may be given out by outreach workers while syringes are distributed by the shooting gallery, which appear to be safe from law enforcement scrutiny.
- Sharps bins installed at shooting galleries and regular pick up and exchange of bins by outreach staff.

**Reported Opiate Overdose episodes**
Focus group and study participants reported no knowledge of Naloxone, an opioid antagonist specifically used to counteract life-threatening depression of the central nervous system and respiratory system by countering the effects of opiate overdose

**Opiate withdrawal**
The persons interviewed who had resided in the US and who had experienced medicated assisted opiate withdrawal complained of the lack of knowledge by physicians, health care providers and
treatment centre professionals concerning opiate dependency and accompanying issues around withdrawal.

**Recommendation**

- Train physicians, health care providers and treatment centre professionals on issues related to opiate dependency and medicated assisted opiate withdrawal.
- Train about opiate withdrawals and the use of Naloxone for overdose treatment for A&E physicians
- Train PWID on use of naloxone for overdoes and provide naloxone kits.

**General findings related to the profile of street drug users**

**Co-occurring psychiatric illness:** There was a high level of reported co-occurring psychiatric issues. The majority of the people interviewed spoke of their heroin use in terms of taking their “medication”. Most users referred to using as “getting straight” as using stabilised them rather then got them “high”

**Jamaica Specific Recommendations**

**Background**

As mentioned, the National Council on Drug Abuse (NCDA) conducts a mobile outreach programme called “Tek It to Dem”. The focus of the outreach is on homeless street engaged crack cocaine users. By definition the Government of Jamaica through the Board of Supervision considers a person *homeless* if they reside:

- In places not meant for human habitation such as cars, parks, sidewalks, abandoned buildings, gullies and on the Street
- In transitional and supportive homes for homeless persons for less than 30 days.

When proposing the services the NCDA cited the high HIV prevalence among the homeless substance users in the Kingston environs with one study showing an 82% positive prevalence of a small sample (9 of 11) tested at a location tested in 2009.

It was also recognised that the homeless were not interested in being institutionalised for treatment and that if services were to be rendered to the population it would have to be taken to them. Thus the name “Tek it to Dem” which is designed to take practical care/service to the Clients and to provide referrals where needed.

The NCDA target populations are

- Homeless Persons
- Substance Users
- Sex Workers – Female & Male
- MSM
- Street Youths

In the first year the project reached 289 males and 44 female. In the second year 206 males and 40 females were provided with services. In addition to HIV testing, the van tests for substance use using an oral swab. The percent of individuals testing positive for at least one substance in the first year was 58% of males and 64% of females. In the second year it was 80% of males and 74% of females. While
less than 20% of the males or females tested negative for any substance, 60% of the female and 40+% of the males tested positive for crack cocaine.

Average age at first drug (not otherwise specified or NOS) use for males was 16 and for females slightly older at 22. The average age of the participants was determined to be 45 for males and 42 for females.

The table below shows the number of referrals made during year one and year two. In this context referrals mean that the client was referred to and taken to the service named.

<table>
<thead>
<tr>
<th>Referrals</th>
<th>YEAR 1</th>
<th>YEAR 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Health Clinic</td>
<td>25</td>
<td>19</td>
</tr>
<tr>
<td>Kingston Public Hospital</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Food for the Poor Clinic</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>SHARES (HIV Clinic)</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Tek It To Dem Doctor</td>
<td>0</td>
<td>182</td>
</tr>
<tr>
<td>Placed in Open Arms Drop-in-Centre</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Sheltered in JASL (now back home)</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Placed at Missionaries of the Poor</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Marie Night Shelter</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

In addition 7,585 condoms were distributed in year one and a 3 fold increase in year two of 22,033 condoms distributed.

1,713 meals were served in year one and 3,884 in year two.

7 HIV+ cases were managed over the past 2 years, 4 females and 3 males. Of the positive persons, all 4 females and 2 of the 3 males reported to engage in sex work. All reported using substances and all the males, and 2 of the females reported having been previously incarcerated. Age of sexual debut for the PWHIV was in the range of 9 (a male who also reported being a sex worker) to 17, a female also engaged in sex work.

The NCDA has established excellent linkages with community based organisations and the private sector providing food and meals, the provision of medical care and medication, the provision of shelter and alternative housing and other services.

The project provides services to assess rehabilitate and reintegrate the homeless population of Kingston and St. Andrew into independent, productive members of the society. This is achieved through an assessment, stabilisation and treatment of substance use, HIV, psychiatric and medical issues, and a social assessment and evaluation. The overall goal of the programme is the rehabilitation and reintegration through skills training, independent living, job placement and family reunification.
The “Tek it to dem” project understands that not all individuals they work with will become rehabilitated and reintegrated. Providing services for the sake of services with no expectations of “recovery” is the guiding principal of this programme.

The NCDA reported the following challenges for providing treatment to the population:

- Unable to locate the HIV+ persons for follow-up referral appointments as they are nomadic or have to “hustle” to exist.
- The provision of comprehensive sexual and reproductive health education services (including VCT) to clients is difficult due psychiatric condition.
- Condom access limited unless provided free of cost on a consistent basis and when provided it is often sold.
- The project has an inconsistent supply of HIV Test Kits.
- Untreated STIs and other illnesses and high susceptibility to HIV re-infection including a reluctance of the State to provide ARVs because of perceived adherence issues. This is further compounded by poor nutrition that makes taking medication problematic.
- There is no shelter for the homeless HIV substance users, especially the female clients. What services are available in Kingston and St Andrew are a maximum capacity, and are unable to accept new clients. Clients also claim that some shelters are too restrictive; or they are concerned about physical and sexual abuse.
- Challenges to reintegrate and re-socialize the homeless with insufficient community based services and resources such as low threshold drop-in-centres, rehab centres and facilities for skills training.

Barriers to care

- Poor health seeking behaviours of the client base: without the project many of the clients would forgo treatment all together as it takes too long to access care at the public clinics and hospitals
- Structural barriers such as a lack of a national identification also keeps people from accessing services that require ID
- Low literacy of target population
- Poor coping skills especially among the population identified as those with co-occurring psychiatric illness

General Recommendations

- Develop a holistic and comprehensive package of services for homeless persons especially for those who are HIV positive and substance users which should include access to HIV services
- Establish a dedicated hostel for homeless substance users who are HIV+
- Increase the available low-threshold drop-in shelters that offer:
  - General medical services
  - Access to ART
  - Consistent nutritional support
  - Peer support groups to provide psychosocial support to clients and families as part of reintegration process
  - Consistent supply of condoms for free distribution

Specific Recommendations related to this project
• The effectiveness of the NCDA mobile outreach would be enhanced with the recruitment and training of peer workers from the street to assist with client engagement
• Recruitment, training and hiring of known persons from the street to work as peers
• “Piece work” payments based on delivery of a set task within a set time frame
• Bounce and draw payments in cash at each contact
• The conversion of 4 - 40 ft containers into a drop in centre (place in a U shape and cover centre with a roof 1280 sq ft of lockable secure space in containers and an open floor plan of 1600 sq ft)
• Develop IEC materials for PWUD on safer drug use and health issues related to drug use

General findings related to the profile of street drug users

Co-occurring psychiatric illness. There was a high level of reported co-occurring psychiatric issues.

Trinidad Specific Recommendations

Background

In Trinidad civil society in the drug treatment sector is lively, sustained by a network of faith-based charities reflecting the religious diversity of the island. There are NGO operated drop in shelters, rehabilitation centres, and therapeutic communities. There are night shelters, hostels, and services dedicated to women only. The government has supported these efforts and channelled funds into NGO run services. NGOs and state agencies, including the police and the correctional services are coordinating their efforts to provide referrals and a continuum of care. Jamaica has taken the road of state sector provision of service while Trinidad, a nation of 40% the population of Jamaica has both state and civil society provided services in the marketplace.

Trinidad has a dynamic and diverse service sector that responds to a drug environment that is exacerbated by virtue of its geographic location, the southern tip of the island being 9 miles from Venezuela, which facilitates fast transit of cocaine by go-fast boats. Cocaine prices are lower here than anywhere else in the islands of the Caribbean.

The researcher visited and interviewed representatives and key informants involved in working with drug users in Port of Spain.

Specific Recommendations related to this project.

• Extend the services to where Joe MeHarris runs his senior home and extend the services to the youth and street engaged persons in the neighbourhood.
• The effectiveness of any outreach would be enhanced with the recruitment and training of peer workers from the street to assist with client engagement
• “Piece work” payments based on delivery of a set task within a set time frame
• Develop IEC materials for PWUD on safer drug use and health issues related to drug use

General findings related to the profile of street drug users

Co-occurring psychiatric illness. There was a high level of reported co-occurring psychiatric issues.
Findings
The Oasis Drop In Centre on Duncan Street operates under Rebirth House and remains the only truly low threshold service in urban Port of Spain or thought the twin island republic. It is managed by Joseph “Joe” Meharris. Joe was one of the two individuals who participated in the September 2001 SERVOL ADP instructors programme and still works with Rebirth House 11 years later.

In The Servol ADP Programme and the ADP training, teenagers explore their insecurities, complexes and prejudices in a warm and family like atmosphere. They are taught how to handle anger, boredom and loneliness. They discuss different kinds of love, from love of the family and friendship to the meaning and responsibility of sexual love. Group therapy and peer counselling deal with many emotional problems that surface. ADP is like a treatment, trainees come here scarred and wounded and leave with much more discipline and self-awareness.

The Servol ADP programme is an experiential programme that changes the attitude of the individual and makes them more excepting of the flaws of their fellow man, a quality seen as desirable in an individual who works with drug users and street based users. The Servol model also contains skills training and a self-sufficiency component that allows for skills training centres to provide services to the community and thus generate revenue that assists with offsetting the cost of operations.

The Instructors course is a 90 days programme designed to train individuals in the skills necessary to run an ADP. The Instructors programme mirrors the trainee programme and instils in the adult the information, qualities and attributes necessary to be an ADP instructor. Adults are first taught how to “actively” listen to young people in order to understand what they are going through.

Recommendations
- Support the training of additional staff at the ADP Instructors Course
- Support communicating with Joe MeHarris about duplicating OASIS out in the Arima area where he manages a community home for seniors

Funding for the Trinidad component of the project will be channelled through Rebirth House of the registered CSO that operates the Seniors Home.

Barriers to Care
- Poor health seeking behaviours of the client base – without the project many of the clients would forgo treatment all together as it takes too long to access care at the public clinics and hospitals
- Structural barriers such as a lack of a national ID also keeps people from accessing services that require ID
- Low literacy of target population

56 The Servol Mission statement - “Servol is an organization of weak, frail, ordinary, imperfect yet hope filled and committed people seeking to help weak, frail, ordinary, imperfect, hope drained people to become agents of attitudinal and social change in a journey which leads to total human development. It does so through respectful intervention in the lives of others and seeks to empower individuals and communities to develop as role models for the nation.”
• Poor coping skills especially among the population identified as those with co-occurring psychiatric illness

**General Recommendations**

• Develop a holistic and comprehensive package of services for homeless persons especially for those who are HIV positive and substance users which should include access to HIV services
• Establish a dedicated safe zone for sleeping without harassment
• Increase the availability of low-threshold drop-in shelters that offer
  - General medical services
  - access to ART
  - consistent nutritional support
  - peer support groups to provide psychosocial support to clients and families as part of reintegration process
  - Consistent supply of condoms for free distribution

**Conclusion**

The capital cities of these three nations, Santo Domingo In the Dominican Republic, Port of Spain in Trinidad and Kingston in Jamaica display some of the general symptoms of the twin processes of uneven development and urban decay. Each city has pockets of opulence with facilities equal to those of NY or London sharing the same urban space where homeless people take shelter, making a living on the margins of the informal economy. – they live off charity, odd jobs, petty crime, and have created a manic underground economy in which drugs are a standard of exchange. This study was conducted to look at the impact of drug availability and service provision in the three most developed nations in the Caribbean, Jamaica and Trinidad, the industrial and agricultural foundation of CARICOM and CARIFORUM and the Dominican Republic the non-CARICOM, CARIFORUM leader in industrial and agricultural production. Each island having (i) a street culture, (ii) open street drug markets and (iii) a sizeable population of the socially excluded. The data presented is a brief assessment of the few harm reduction services available to people who use drugs. It also highlighted the very different policy approaches, and social responses these countries have had on addressing substance use in a low threshold, scientifically substantiated harm reduction programmes and accompanying access to prevention care and treatment of HIV and other primary health care.

The research is clear, HIV and other health issues are compromised in an environment of prohibition, be it drug prohibition, buggery and homophobia or stringent “anti-prostitution”. Legislative prohibitions create an environment of vulnerable.

Laws that restrict minors from accessing sexual and reproductive health services with out parental consent, “buggery” laws that seek to legislate private adult consensual sex prostitution laws that criminalise a financial transaction between a willing buyer and a willing seller and the challenge of providing services to people who use drugs, drug prevention programmes that do not include harm reduction programmes for people who use drugs.

The vulnerability of these individuals is further compounded when social factors, including poor housing, poverty, and inadequate education are present. The needs of vulnerable populations are likely to be unmet, growing serious, often debilitating or life-threatening, and require extensive and intensive medical and nonmedical services. Current financing and service delivery arrangements are not meeting these needs.
The “STATE” as the enactor of legislation and policies has the power to reduce or increase vulnerability through laws that address the protection of basic human rights.

People who engage in behaviours or activities that are criminalised are less likely to present for care. When their health issue is an infectious disease, this then has a negative effect on the overall public health.

Action required including putting in place measures to promote and protect the human rights of all populations including vulnerable populations and insuring the availability of low threshold harm reduction services.

A case study of heroin use in Capotillo, Santo Domingo, Dominican Republic

This section explores and assesses substance use, HIV status, and access to primary healthcare among a sample of the urban street drug using populations in Capotillo, Santo Domingo, Dominican Republic. The data presented here is a quick snapshot of what one researcher found. What was discovered requires further investigation and programmes to mitigate the harms associated with the lack of services.

Methods, Sampling and Setting

El Capotillo, a barrio of 100,000 people, is considered by many to be one of the most dangerous and impoverished areas of Santo Domingo. The focus group reported that there was a “shooting gallery” located nearby and used by both heroin users and crack smokers. They also reported that the shooting gallery was not only used by residents but that people travelled from other areas of the city and surrounding areas to Capotillo to purchase heroin and use the shooting gallery to inject.

From the information derived from the group interview held in Capotillo, a structured instrument was used to tease out data that could then be used as a basis for larger more structured studies. A questionnaire was assembled. It was based on two CDARI, IRB approved questionnaires, one designed to be used to conduct street assessments of crack users in the CARICOM Caribbean and the other, a questionnaire that was approved to administer if a person in a crack study reported injecting behaviours. The final version of the questionnaire and the protocol was emailed to the Chair of the CDARI IRB for expedited approval, and after some clarification, approval was granted.

Recruitment was the responsibility of an outreach harm reduction worker and the founder of the Dominican Harm Reduction Association. The outreach worker who used to use drugs in the neighbourhood being investigated, works in the area regularly conducting a harm reduction group session every Saturday.

A pre-screening checklist was administered to all individuals who volunteered for participation. Respondents were asked four questions that probed drug use and homelessness.

To qualify to participate in the study, respondents needed answer positively to the following 4 questions:

- Spend most of their time on the street – ie: street engaged
- They needed to be patrons of the shooting gallery in Capotillo
• Be an involuntary returnee
• Be an injector

The participant profile that was given to recruiters was to recruit
• street engaged heroin users
• “involuntary returnees”
• English speaking

Street engaged heroin users who claimed to not be involuntary returnees presented and requested to participate. It was determined that some individuals who when confronted with deportation from the USA selected to leave voluntarily and therefore did not consider themselves “deported”. At that point we broadened the target to street engaged heroin users irrespective of immigration status.

The other variation of the target came when a few individuals who had only a history of crack cocaine smoking were included in the sample. 36 individuals were ultimately sampled. Of that 36, 26 individuals (including 3 of the 6 females sampled) reported life time injecting. Of the 26, 22 individuals reported injecting heroin in the past month. Of the 10 individuals reporting never having injected 8 were also returnees. Only 3 individuals reported never using heroin and were strictly crack cocaine smokers. All 3 were involuntary returnees, female, and who sold sex. On that basis they were interviewed. They were the last 3 interviews to be conducted as it was the close of the second day of field work and the recruiters reported that there were no more heroin users available to be interviewed at that time.

The researchers were careful to fully explain the purpose of the study and to obtain informed consent from each respondent. All participants were informed of their right to refuse participation, though none declined. Strict anonymity was assured, so codes were used to replace the names of individuals. The technique of a modified targeted sampling, in which geographical areas with specific populations of individuals that are familiar to the researcher is identified and from which respondents are recruited, was followed throughout the data collection phase (Watters and Biernacki, 1989).

The researcher early in the process noted the difficulty of finding women who met the interview criteria. It was decided to implement a form of respondent-driven sampling (Heckathorn, 1997). Male respondents were asked to bring in a female heroin user to be interviewed. Despite this, the recruiters were unable to recruit more than 6 women, three of whom only smoked crack. The men who indicated a stable relationship noted that their women were not users. It begs investigation into social networks with male drug users and non-drug using females.

The structured instrument was used to conduct anonymous and confidential interviews.

**The participants**

The researcher interviewed 36 persons, 30 of whom were men and 6 women. 26 reported injecting sometime in their life with 22 reporting having injected in the past 30 days. The average age of the respondents was 42. The predominant response for ethnicity included mixed race (52.8%), Afro-Caribbean (27.8%), and Indo-Caribbean (16.7%) with less than 3% reporting “white” as their race. The majority (61.1%) self-identify as homeless, and 63.9% report having been deported, all from the United States.
None of the respondents had formal employment or a steady job, instead they obtained money through casual wages in the informal economy, begging, crime, family and partner support, sex work, and drug dealing. When asked which drugs they had used in the past month, the majority (42.3%) reported using heroin, followed by 23.9% who reported using cocaine. 54% (12 of 22) of the injectors reported injecting a combination of cocaine and heroin called a speedball. The survey oversampled for injection drug users on purpose, resulting in 81.5% reporting having injected drugs in the past month. Most (60%) began injecting drugs while living in the United States.

Smoking crack is fairly common in the sample with 58.1% responding in the affirmative. Though only 13 people responded to the follow-up questions, most of those who responded received their first crack rock from friends (7) or sex partners (5) and most did not have to pay for it (10). Comorbidities are fairly common among the sample population. 8 report having been diagnosed with depression by a doctor and 5 with anxiety. Seven of the respondents have been hospitalized for treatment for a mental illness.

Risk Factors

Slightly fewer than half (47.6%) of the IDUs report that they do not use a clean, new syringe each time they inject. 43.5% report sharing syringes with others, and 42.1% report using syringes they found on the ground.

![Frequency of Reusing Syringes](image)

Many (64.7%) report having exchanged drugs or money for sex. Though less pervasive in the sample population, many (25.7%) have made the reverse exchange, trading sex for drugs or money. During the last exchange of sex and drugs or money, 14.8% did not use a condom. In general, condom use is inconsistent in this sample population. Though the majority report “always using a condom”, almost 35% reported that they “used condoms only sometimes”.
Access to Services

Nearly all (90%) of the IDUs interviewed have attended a residential treatment centre. Infection is relatively common in this population. Nearly half (42.3%) were diagnosed with an infection in the past year including syphilis (1), gonorrhea (5), and Herpes (1). Most do not know their Hepatitis B or C status and few have been vaccinated against Hepatitis B. Of those who know their hepatitis C status, two are positive. Almost all the respondents have been tested for HIV (94.3%), and two report being HIV positive.

Few think the health services available are sufficient. Most (86.1%) do not think there are enough health services for drug users in the area, and 81.8% say the services are not meeting their health care and other related needs. Half of the respondents are reluctant to use health services. The following reasons were listed:

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not welcoming or friendly</td>
<td>16</td>
</tr>
<tr>
<td>There is too much of a focus on abstaining</td>
<td>11</td>
</tr>
<tr>
<td>Do not trust services</td>
<td>10</td>
</tr>
<tr>
<td>Limited time to talk about problems</td>
<td>9</td>
</tr>
<tr>
<td>Treated differently because of drug use</td>
<td>9</td>
</tr>
<tr>
<td>Waiting time is too long</td>
<td>8</td>
</tr>
<tr>
<td>Felt discriminated against</td>
<td>8</td>
</tr>
<tr>
<td>Reception was unhelpful/unfriendly</td>
<td>7</td>
</tr>
<tr>
<td>Drug users are not understood</td>
<td>6</td>
</tr>
<tr>
<td>Atmosphere was too chaotic</td>
<td>4</td>
</tr>
<tr>
<td>Services were too costly</td>
<td>4</td>
</tr>
<tr>
<td>Services could not help you</td>
<td>4</td>
</tr>
<tr>
<td>Staff lacked the skills</td>
<td>3</td>
</tr>
<tr>
<td>Service was not flexible</td>
<td>2</td>
</tr>
<tr>
<td>Restrictive hours</td>
<td>1</td>
</tr>
<tr>
<td>Travel problems</td>
<td>1</td>
</tr>
<tr>
<td>Cultural barriers</td>
<td>1</td>
</tr>
</tbody>
</table>
The respondents made recommendations for improving medical and drug-dependence services. Nearly all respondents (96.8%) recommended more peer worker programs and outreach services. Most (29 of 34) would like to have access to an opiate substitution service such as methadone, and 80.6% refute the idea that having clean syringes available encourages injection. Other suggestions for improving rehabilitation services are included in the graph below.

![Recommendations for helping Drug Users Achieve long-term Rehabilitation](image)

When asked what they think are the most important/major issues that need to be considered when setting up a specialized health or health related service for drug users, the most frequent answer was counselling (28.8%), followed by friendly staff (16.9%) and free meals (16.9%). Job placement (13.6%) and confidentiality (13.3%) were also listed as important.

(Data analysis was provided by Rose Calnin) of Pangaea Global AIDS Foundation
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## ANNEXES

### Programme Priorities for People who Use Drugs from a rights-based perspective

<table>
<thead>
<tr>
<th>Human Rights of people who use drugs</th>
<th>Examples of types of interventions that can be supported</th>
</tr>
</thead>
</table>
| Right to Equality and non-discrimination | - Support low threshold services that are safe for and friendly towards people who use drugs  
- Support training of services providers on the human rights of people who use drugs including drug using LGBT, women sex workers, and youth  
- Invest in community-based Halfway-house facilities, as an important step for drug users in the path to the social and economic re-integration.  
- Support peer programmes that target LGBT and sex worker drug users with harm reduction interventions |
| Right to healthcare | - Support scientifically proven approaches for reducing HIV transmission in HIV users, including needle exchange programmes, opioid substitution therapy, condom distribution, access to medical services, access to ART  
- Support programmes which provide community based mental health services and psycho-social support for drug users and their families  
- Invest in peer education and community outreach programmes  
- Support advocacy for removing structural barriers to accessing healthcare, for example, requirements regarding possession of identification cards  
- Support development of low literacy IEC materials for people who use drugs |
| Right to protection from medical abuses | - Support advocacy against policies which promote voluntary HIV testing of PWUD  
- Support training of physicians, health care providers and treatment centre professionals on issues related to the special treatment needs of PWUD including but not limited to opiate dependency and medicated assisted opiate withdrawal. |
| Right to housing | - Invest in the establishment of appropriate housing for homeless people who use drugs who are HIV positive |
| Right to be free from inhumane or degrading treatment | - Support training of police on HIV and human rights based approaches to policing drug use (promote community policing)  
- Support advocacy that promotes law reform options include decriminalisation of drug use, and the use of drug courts that divert drug offenders from the prison system into community-based treatment. |
Yes - from the perspective of the CDARI IRB, you have approval to go forward with this assessment survey in Capotillo.
Stephan

Hi S
Please look at this questionnaire. I found this problem with injecting drug use here in SDQ while I was doing a focus group.
I will use it in Capotillo, Santo Domingo tomorrow and Friday to interview heroin injectors. As an incentive I will pay 200 Dominican pesos for an interview, maybe 7.00 USD. There are no project funds for this but I feel the importance of the data is worth the expense. I do not envisage it costing more than $1000. US

So would you be so kind and review the attached. I am requesting an expedited review based on the non-intrusive nature of the study. No bio-samples are being taken.
Look forward to hearing back from you by tomorrow early morning, so I may proceed.
Regards
Marcus
Informed Consent form used

What is the purpose of the study?
In this research study we wish to know what your drug using behaviours are to see if your drug using methods increases the risk of infection with HIV and other blood borne viruses.

Who may enroll?
Individuals who belong to the following groups may enroll:

- Persons who inject drugs and / use cocaine or crack cocaine

By being here we have determined that you are eligible to participate in this study.

What does your participation involve?
If you choose to participate in this study, you will be here with us for 20 minutes. We will conduct an interview in which we will ask you questions about your lifestyle including questions about your drug and alcohol use, your sexual habits, your experience with the criminal justice system and with the health care system.

Are there any risks in this study?
The risks of this study are minimal. Your records are identified only by a personal identification number. No one outside of the project staff will have access to the information you provide to us, or know your identity.

What benefit will come from participating in this study?
It is not known whether you will benefit from participation. This study may provide important information about the risk of HIV infection in persons who use inject drugs.

Compensation: You will be paid a stipend of $200 Dominican pesos to compensate for your time.

Confidentiality: An assurance of confidentiality form will be signed by all persons involved in this research project. All information obtained from you will be coded with an identification number to protect your privacy. Only the study staff will have access to your name which will be kept separate from your study ID. Only authorized personnel will have access to study data.

Whom to Contact: If you have any questions or any problems during the study you may contact the person listed below. Dr. Marcus Day, DSc, Investigator, (office-day) 1758-458-2795
PARTICIPANT’S STATEMENT:
I have read this consent form and have discussed with Dr. Day or his representative the procedures described above. I have been given the opportunity to ask questions which have been answered to my satisfaction. I understand that any questions I might have asked will be answered verbally or, if I prefer, with a written statement.

I understand that my participation in this study is voluntary. I understand that I may refuse to participate in this study. I also understand that if, for any reason, I wish to discontinue my participation in this study at any time, I will be free to do so, and that my decision not to participate will have no effect on my future care or treatment.

If I have any questions concerning my rights as a research participant in this study, I may contact the CDARI Institutional Review Board at the CDARI Office in Saint Lucia at 758-458-2795.

I have been fully informed of the above-described study with its risks and benefits, and I hereby consent to the procedures described above. I will receive a signed copy of this consent form.

I understand that as a participant in this study my identity and my medical records and data relating to this research study will be kept confidential.

_________________________                                           ______________________________
Date                                                                  Participant’s Signature

I have fully explained to ______________________________________ the nature and purpose of this above described study and the risks that are involved in its performance. I have answered all questions to the best of my ability.

_________________________                                           ______________________________
Date                                                                  Principal Investigator/Representative’s Signature