MAINline

LIGHTING THE SPARK

ANNIVERSARY EDITION
RUSSIA
1997–2010
Mainline goes to Moscow for the first time in 1997 to support an organisation dedicated to preventing HIV infection among people who use drugs (see also page 2). Mainline also works in prisons and trains local organisations to implement harm reduction activities and to publish IEC material in their local setting.

Mainline
SPREADING HARM REDUCTION ACROSS THE WORLD

UKRAINE
1998–2010
Mainline goes to Ukraine to help facilitate access to treatment for people living with HIV who use drugs (see also page 4). Mainline also works in prisons and trains local organisations to implement harm reduction activities and to publish IEC material in their local setting.

BOSNIA
2012
In Bosnia, Mainline helps to strengthen the relationship between local organisations working with people who use drugs and the police. A follow-up visit is organised for 2015.

MOLDOVA
2005–2011
Working with the Bălți branch of the local NGO Youth for the Right to Live, Mainline advocates a broader vision of harm reduction and more rights for people who use drugs. Together they educate people who use drugs and medical personnel involved in the methadone programme.

GEORGIA
2009–2016
From 2009 to 2012, Mainline works with the local organisations Alternative Georgia and Tanadgoma to urge authorities to respect the human rights of people who use drugs. In 2014, Mainline returns to help support ex-prisoners in reintegrating back into mainstream society and to train prison- and probation personnel on harm reduction. From 2014 to 2016, Mainline helps to implement a series of interventions for preventing hepatitis C.

SOUTH AFRICA
2004
In 2011, Mainline and the local NGO Health4Men launch South Africa’s first needle and syringe programme (NSP) aimed at Men who have Sex with Men (MSM) and inject drugs. See page 12 for information on the current project.

INDONESIA
2004–
See page 6

PAKISTAN
2004–
As long time partners, local NGO Nai Zindagi and Mainline jointly created harm reduction activities. Projects currently running include needle and syringe programmes, a successful income-generating project and a facility where people who use drugs receive antiretroviral therapy (ART). In 2015, the country’s first network for people who use drugs is established.

IN DONESIA
2004–
See page 6

Figures: Adapted from the CIA World Factbook 2016.

Mainline
WONDERING WHERE WE PUT THE CONTENTS PAGE?
CHECK THE BACK COVER.

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BOSNIA
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In Serbia, Mainline coaches trainers from the local organisation Veza on the ins and outs of harm reduction.

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Once upon a time, Mainline was merely a Dutch organisation operating within the confines of Amsterdam. Its first venture outside the city was in 1996, to Moscow. This was followed soon after by trips to Odessa, Asia and Africa. Pioneers John-Peter Kools, Jutta Engelhardt and Janine Wildschut remember how it all began.

The scene. It’s the early nineties in Amsterdam and harm reduction has been embraced as a way to prevent the harm caused by drug use. Needle and syringe programmes are up and running, methadone is being distributed among people who use drugs and consumption rooms dot the city. Mainline plays a small but significant role by establishing and maintaining contact with individual users and offering advice on safe use and HIV prevention, thus enabling them to take their fate into their own hands.

“It was the beginning of harm reduction,” says John-Peter Kools, one of the founders of Mainline and now an independent expert on harm reduction. He recalls that they’d initially assumed harm reduction was a typically Dutch approach. “We soon realised there were others with the same idea all over the world.”

However, Mainline’s approach was genuinely innovative in that it supported people who used drugs in practising its measures, adds Jutta Engelhardt, his former colleague who now works for the Swiss Academy for Development. “It was through international conferences that our approach gained visibility, and brought people’s attention to the fact that talking to people who use drugs about how they used them was the key component missing from most other forms of intervention.” Kools: “This was an inspiration to many in similar organisations, so we decided to take our ideas abroad to create ripples in a bigger pond.”

**Mainline starts its overseas activity by supporting Doctors without Borders in Moscow.**

“They were the first harm reduction unit in the city for people who injected drugs,” says Kools. “And it was immediately clear that they were facing the same problems we had in Amsterdam. But as we went on outreach the people who used drugs greeted our ideas with disbelief - HIV was seen as a disease affecting Jews and Americans. Then they began testing. With 700 people testing positive, the Aids epidemic was still relatively small. Unfortunately, the government didn’t realise this was a cause for concern, and I think there are now more than a million people in Russia living with HIV.”

Engelhardt would encounter the same degree of disbelief when she visited Odessa, Ukraine, a few years later.

“Drug use was rife, and drugs were sold in syringes with no way of telling if your syringe had already been used. At the time, the situation in Ukraine was desperate, with the country in full transition from communism to an aggressive form of capitalism. There was so much misery that drugs were all that kept people going. Nobody valued individual lives; neither did they care about this virus from the West, so we had a hard time convincing users to look after themselves.”

**Out in the open**

Such projects were initially funded via small, short-term subsidies, but that changed at the beginning of the new millennium. By 2004, we started a big project in Asia with funding from the Dutch government.”

Mainline started to work with the Asian Harm Reduction Network to support projects in Cambodia, India, Iran, Malaysia, Indonesia, Pakistan and Nepal. “The drug scene was out in the open,” says Wildschut. “In Pakistan they were shooting up in cemeteries. It was like Holland in the eighties, with people shooting up at train stations. But unlike Holland with its needle and syringe programmes and consumption rooms, there were no services at all in these countries. People who used drugs were totally marginalised.”

Reaching out and actually talking to them changed that gradually.

**‘IN PAKISTAN THEY WERE SHOOTING UP IN CEMETERIES’**

“I remember noticing that drug users were starting to see themselves as human beings again,” says Wildschut. “They started to realise they mattered. That was the starting point for change.”

Back to the present day and Wildschut can see that progress has definitely been made, thanks to strong local organisations: “There isn’t a single person using drugs today who doesn’t know about HIV,” says Wildschut. “I recently visited a rubbish tip in Pakistan. Amongst the dirty cows and garbage were lots of people taking drugs. There were no services at all, but they all knew about safe use!”

“Another sign of progress is that governmental bodies now meet with us and ask for training on drug use and harm reduction. The general understanding of HIV, safe use and human dignity has risen considerably.”
Dika (33) has been on methadone since 2003 and is a Health Programme Officer of the Indonesian Drug Users Network (PKNI).

What is your personal dream?
“I am HIV and HCV positive and hope that despite my diagnosis, I can stay healthy, and work and function properly. Unfortunately, I can’t treat my HCV because treatment in Indonesia is too expensive.”

What’s your wish for people who use drugs in Indonesia?
“The Indonesian government has declared the drugs situation an emergency, which is not good for people who use drugs. I wish they would decriminalise drug use some day.”

The facts
Harm reduction is well known in Indonesia, with its population of more than 255 million and over 16,000 islands. With projects in place for over twenty years, even the Indonesian government has become involved and delivers harm reduction services. Unfortunately, the quality of these services is not as high as they ought to be. Furthermore, the mindset is very much about total abstinence. An HIV prevalence of over 36 per cent among the estimated 75,000 people who inject heroin suggests a lot still needs to be done. The five organisations that Mainline supports in Jakarta reach over 8,000 users every year.

What’s happening?
The drug of choice used to be heroin, according to Mainline’s country coordinator Hatun Eksen. “But because the police really started prosecuting people who used heroin, prices rose dramatically. This led to a shift to other, cheaper drugs, like crystal meth, and pushed those who used drugs to the margins to lead hidden lives.”

Those who use crystal meth are still invisible, says Hatun. “We receive signals that there are a lot of them in the major cities. Some are people who used to inject heroin, but there are also sex workers, factory workers and students among them. These people are most at risk because even smokers tend to have risky sexual habits, such as multiple partners and low condom use. But existing harm reduction services only focus on heroin users, and are not available for smokers.”

However, there are also positive developments, says Hatun: “A lot is happening on social media and in regular media, where the community is lobbying to have drug use decriminalised. They are really learning to fight for their rights. It’s empowering and hopeful.”

Dream, dream, dream
“I would love to see the day when everyone who uses drugs in Indonesia feels safe, when their human rights are respected and they have access to the healthcare they need,” says Hatun. “And I hope the Indonesian government finally embraces harm reduction structurally in its policies.”

Safe smoking instead of safe injecting: That is the way harm reduction has worked in Brazil since injecting went out of fashion almost ten years ago.

Brazil is a big country, with a population of 195 million, over 370,000 of whom use crack cocaine. Yet barely any of them inject it. Brazil adopted its harm reduction policy in 2006, when most of those who used drugs were shooting up cocaine because heroin was not available. Education helped in getting them to switch to smoking, and HIV rates went down.

Still, harm reduction has a role to play, says Rafaela de Quadros Ragoni, a Brazilian drugs policy researcher. “HIV rates have gone down from 33 per cent in the eighties, when everybody was injecting, to 5.9 per cent now, with most people smoking.

This is still fourteen times higher than the 0.4 per cent rate in the general population, so these smokers mustn’t be ignored.” Harm reduction has other challenges in daily Brazilian practice: “Nowadays, HIV typically results from unsafe sex practices, with sixty per cent of those who use drugs not using a condom. Furthermore, infectious diseases like TB are a problem, with people living together in huge ‘cracklands’ (open-air crack cocaine markets where people can buy crack, and smoke it in plain sight, day or night - Ed.) or on the streets and sharing dirty self-made pipes.”

She says outreach workers now hand out condoms, talk to people about safe sex, and are very creative in demonstrating how to make proper pipes and use them. “We also have centres for psychosocial help, where people who use drugs can have group discussions about spirituality or medication use. Also, football teams made up of people who use crack routinely sit down after each game to discuss their week and exchange tips with a social worker. In a group-oriented society like Brazil, this works.”

The challenges are still multiple, though: “There is a lot of stigma. Many users are homeless, living in these cracklands with no benefits from the state. Many become drug traffickers, because they see no alternative.”

Much like in other countries, their dream is simply to be accepted in society, she says. “Get homes and jobs again, and to be respected as human beings.”
Lighting the spark

“We what you think? What do you need?”
For 25 years now, Mainline has been asking people who use drugs for their opinion, convinced that each individual is his or her own starting point for change. “It’s about lighting that little spark...”

We’re at Mainline’s head office in Amsterdam on a cold but sunny day, and Machteld Busz, programme manager of Mainline’s work abroad, is talking passionately about the importance of the human approach to harm reduction. She is as ardent an advocate of this approach as they come, and her eyes light up when she talks about reaching out to people who use drugs, touching their hearts and restoring their sense of dignity.

In her opinion, it is one of the most important aspects of harm reduction. “When it comes to harm reduction, the World Health Organization, governments and stakeholders always talk about the three pillars: needle and syringe programmes, opioid substitution and HIV prevention,” she says. “And these are essential for harm reduction. But we believe that the human perspective cannot be neglected in this whole story. Because it’s about people. Always. You can’t teach if you don’t connect.”

The need to listen
“Last year, we asked our partners and people who used drugs around the world to explain what harm reduction meant to them. They all came back with similar answers. People who use drugs want to be seen as complete individuals, not just as people who use drugs,” says Machteld. “Governments should recognise that. Because if you criminalise drug use, you marginalise people. But if you empower them, they will grow and possibly be of value to your society again.”

You need to listen to know what will work
“You need to listen to know what will work,” emphasises Machteld. “Otherwise you may end up setting up a needle and syringe programme in the vicinity of a police station, only to find that no one turns up because they’re afraid of the police. Or you distribute 5 ml syringes when everybody wants 10 ml ones. Furthermore, people who use drugs often stay hidden because of the police and the stigma that society attaches to drug use. So you need to find peers to help you reach out and gain trust within the community. And you need to reach many if you really want to prevent HIV from spreading.”

Just another obsession
Machteld points out that scientific research shows that this human approach is necessary for tackling problematic drug use effectively. “The renowned psychiatrist Zinberg, with his Drugs, Set and Setting theory – and neuroscientist Carl Hart both say the same thing. It’s not so much the drugs, but factors like poverty, stigma and psychological problems that determine whether someone will become a problematic user or not. Meaning their problems are not just caused by drugs, but also by these other factors.”

She pauses a bit, and then says, “If you really want to connect with a person, you have to see these other factors. Only then you can light a spark that might someday fire up an engine. That spark might lead to someone visiting their mother again after a long absence. Which might mean the person is regaining their sense of dignity and social position in their respective countries.”

It’s not so much the drugs that cause the problems
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It’s not so much the drugs that cause the problems
Having operated in the harm reduction field for the past 25 years, the people at Mainline understand that harm reduction is not an easy approach to sell or establish. In 2014, people were injecting drugs in 158 countries around the world, according to the International Drug Policy Consortium IDPC. Needle and syringe programmes were running in 90 countries, and opioid substitution programmes in 80. In 2012, these programmes were running in 86 and 78 countries respectively, which was four and seven more than in 2010. That sounds promising, but the figures don’t reveal if the human rights of those who use drugs were respected, nor does it say anything about their sense of dignity and social position in their respective countries.
CAN YOU RECOGNIZE AN OVERDOSE?

**STIMULANTS (SPEED, COKE, CRYSTAL METH)**
- Seizures
- Chest Pains
- Disorientation
- Severe Headache
- Overheating without sweating
- Agitation and paranoia
- Difficulty breathing
- Panic attacks
- Unconsciousness

**DEPRESSANTS (HEROIN, METHADONE)**
- Shallow or no breathing
- Snoring or gurgling sounds
- Floppy arms and legs
- No response to stimulus
- Blue lips or fingertips
- Disorientation
- Can’t be woken up

**SEEING ANY OF THESE SIGNS, ACT!**
1. Check scene for potential dangers, such as needles or angry bystanders
2. Try to get a response by calling their name and shaking their shoulders
3. If they don’t respond, check their breathing
4. If breathing but unconscious, put in recovery position and keep checking that they’re still breathing.
5. If there’s still no response, seek emergency assistance
6. If breathing fails, use naloxone if available.
7. If there’s no naloxone available, perform rescue breathing

**RESCUE BREATHING:**
1. Lay the person on their back on a hard surface
2. Empty their mouth
3. Place your hands in the middle of the person’s chest, at about the level of the armpits
4. Using your body weight, press straight down on their chest 30 times
5. Pinch the nose shut and lift the chin with two fingers
6. Place your mouth over the person’s mouth
7. Blow in two breaths of air
8. Take your lips off the person’s mouth, and leave their nose free
9. Repeat the 30 compressions and two-breaths procedure until emergency personnel arrives, or until the person wakes up. For a maximum of 10 minutes.
10. Once revived, put them in the recovery position
Victor (43) is a ‘spiker’ (slang for someone who injects drugs - Ed.) and lives on the streets of Pretoria. He takes a while to consider his dream, then his eyes begin to glow. He is now smiling from ear to ear and suddenly looks years younger.

What is your personal dream? “To be clean is my biggest dream, and to see a better future for myself with a job and a place to stay. Now I am here at the traffic lights all day trying to make enough money for my habit. Begging basically... but I want to return to what I did, which was making armoured cars - the ones you see the army in. I can assemble an entire car and have it ready to drive through the bushes and everything. I have two diplomas for this and it is my dream to do that again. I did it for years and it was great!”

What’s your wish for the scene here in Pretoria, South Africa? “I wish the same as I wish for myself: that they can be clean and have a life. Last year we lost 42 of our friends from the street. 42 died, in just one year... this life is hard and I wish everyone a better life.”

The facts
South Africa has a population of almost 55 million and is relatively new to harm reduction. 67,000 of its population inject drugs - typically heroin or crystal meth - and the HIV prevalence among this group is almost twenty per cent. The first needle and syringe programmes began running in three cities in June 2015 and reached 1,600 people in the first seven months. At the moment, those who use drugs in any of the three cities can get tested for HIV at a mobile clinic offering basic services. Methadone is available but expensive, and other services are non-existent.

What’s happening?
More than 25 years after the abolition of the apartheid system, South Africa is still a divided country, says Mainline country coordinator Hatun Eksen. “This creates strange circumstances, one of which is that while harm reduction is actually embedded in the national drugs policy, the situation on the streets is light years behind.” Eksen believes it is harder to make national policy socially acceptable here than in other countries. “There are huge socio-economic differences between the different groups in South Africa, and the challenge is to reach them all, in whichever group they happen to be, whether they’re white, brown or black and use drugs.”

Because harm reduction is a relatively new concept in South Africa, most of those who use drugs are not even aware that such measures exist. “When our partners started the programme last year, many users had tears in their eyes when they were given clean syringes,” says Hatun. “As yet, few, if any, are likely to have heard of methadone, although our partners would love it to be made available.”

According to Hatun, there is still a lot of resistance to harm reduction in South African society: “Like it is in most countries, people think you are promoting drug use when you hand out clean syringes. There is this notion that using drugs is something you simply have to stop doing.”

Consequently, people who use drugs tend to live very marginalised lives. “They end up having little or no self esteem.”

Dream, dream, dream
“I wish harm reduction would be available soon across the whole country, for both injecting and non-injecting users,” says Hatun. “And in every way possible. It is their human right.”
Professor Carl Hart is a scientist at Columbia University, USA. He claims evidence shows that drug use is not a brain disease and is in fact not harmful if you know what you are doing. In the States, he is one of the lead activists pleading for a drug policy that supports rather than punishes those who use drugs. Mainline spoke to him:

**ML: What is the focus of your research?**

“I study the effects of psychoactive drugs on the brain, the body (sleep, food intake) and on social interactions. I also study this the other way around, meaning the effects of environmental factors like poverty on people’s response to drugs.”

**What makes your research different?**

“In our studies, we actually give drugs. Mainline spoke to him:

choose the drugs over money or an incentive.”

**What has been the most striking finding of your research?**

“The large number of positive drug effects. Drugs can enhance cognitive functioning, increase euphoria, and improve social interaction and sexual activity. Of course, if you have no knowledge of the drug you are using, you might be susceptible to negative effects, such as an overdose or HIV infection.”

**In what way can your research help the average person who uses drugs?**

“I hope my research combats the bullshit. There are so many myths around drug use and these are too often accepted as fact. We [society, researchers, common people] reinforce these myths without testing or challenging them. For example, there is a common belief that the majority of drug users are addicted. It is even believed that some drugs are so addictive that only one hit causes addiction. And when new drugs become popular, we always think that ‘this drug is far more dangerous than any other drug.’

Too many people base their opinions (or fears) on extreme situations that cannot be generalised. It would be helpful if more people understood that anecdote is not evidence. Problematic drug use only occurs among an extremely small percentage of all people who use drugs. The vast majority of users control their use and handle their responsibilities, such as employment and family obligations. So, my research attempts to make sure objective information (evidence) is available to the public. Hopefully, this helps to deconstruct some of the myths and false beliefs.”

**Do you think drug use or addiction is a brain disease?**

“There is no evidence to support that. Addiction can be a disease, in the sense that you can continue your use even if you don’t want to anymore. Or in the sense that people spend disproportionate amounts of time seeking their drug, and that they are consumed by their drug behaviour. Some even believe that they have caused irreparable damage to their brain and cognitive functioning. But the vast amount of data collected in human users simply does not support the brain disease hypothesis.”

**Do you have tips and tricks that make it easier to control your drug use?**

“My message to users is simple: educate yourself about your drug of choice. Users should know the positive as well as the potential negative effects. If a specific drug can make you itchy, constipated or anxious, it’s good to know that. This knowledge can help you in your decision to use, not to use or how to use. Users should make informed decisions about their health and recognise early cues of negative effects. For example, stimulant users should know that uppers can disrupt sleep and food intake, and make sure they eat and sleep well before or after using. Perhaps the most important thing to know is the source of your street drug. The cut (adulterants) is often worse than the drug. Knowing everything you can about your drug will prevent a lot of problems and help you avoid surprises.”

**Professor Carl Hart.**
The facts
There are over 50,000 people who inject drugs in this Himalayan country with a population of almost 28 million. Most of them inject a mix of several drugs; usually whatever is available at any given point in time. The estimated HIV prevalence is a little over six per cent, but these numbers are not definite. Nepal has needle, syringe and opioid substitution programmes running in several cities. Mainline supports one organisation in the capital, Kathmandu, that reaches almost 300 people who use drugs per day.

What’s happening?
At the moment, the drug of choice in Kathmandu is a mix of buprenorphine, Advil and Valium, according to Mainline trainer Jos Luteijn, who visited the country in February 2016. “It’s the cheapest thing available. Heroin is much more expensive. It still costs them 8 Euros for a fix, while the average monthly income for a family is 200 Euros.” According to Jos, this creates the main challenge in the Nepalese scene: the sharing of needles. “Because of the price, people chip in to buy one fix. They buy the drugs in three vials, each containing 2 ml. These three vials are divvied up over two 5 ml syringes through a complicated process of dividing and mixing.” It creates a tense situation with everyone craving their share, says Jos, raising his eyebrows as he adds: “And then we come along and start talking about clean syringes.”

Creative harm reduction solutions are needed to combat this situation, says Jos. “S’s wish for 10 ml syringes is one way. It would take away some of the stress. But it doesn’t address the bigger challenge of needing 8 Euros for a fix.”

Dream, dream, dream
Jos would like the stigmatisation of people who use drugs in Nepal to be addressed: “In the future, I would love people who use drugs here to feel safe and to be accepted for who they are.”

S from Kathmandu injects his choice of drug, a mix of buprenorphine, Advil and Valium.

What is your personal dream?
“I want to stop using and create a better life for myself and my family.”

What’s your wish for the scene here in Kathmandu?
“I wish all users could feel safe. Aside from that, I wish we had 10 ml syringes.”

The facts
Kenya has a population of over 44 million, and approximately 18,000 people who inject heroin. The HIV prevalence in this latter group is 18 per cent. At the end of 2014, a methadone programme was introduced in Nairobi, the capital city, and this has since been replicated in three cities, reaching six hundred clients. Mainline supports three partners in two cities along the coast, who together reached 1,200 users in 2015 with services like needle and syringe programmes, drop-in centres and outreach by motorbike.

What’s happening?
It’s been difficult for women to take advantage of the various harm reduction services on offer, because an African mama who uses drugs faces a lot of criticism, says Mainline country coordinator Monica Carriere. “Women are stigmatised for using drugs, for being women, and often for being mothers who engage in sex work. Special hours for women at drop-in centres would help.” Shelters and income generating projects are especially needed now that more people are taking methadone. “Why would anyone come off drugs if they’d only be left hungry and hopeless afterwards?” says Monica.

“People who use drugs are usually rejected by their families, have no home to go to and no job, and often live in drug dens. They might be getting methadone every day, but no one has given any thought to what happens next. Being idle is driving them crazy.”

Dream, dream, dream
“I would love to see people who use drugs in Kenya access services without fear of being stigmatised, beaten or arrested.” Monica recalls what happened after the Kenyan president declared war on drugs in August 2015. “Ever since, users have increasingly been thrown in jail without access to methadone or detoxification services. They are rounded up in drug dens, beaten and sometimes even killed. It violates all human rights.”

Ahmed (42) is a methadone user who lives with his mother and son in Mombasa. He is a peer educator.

What is your personal dream?
“I would love to have a job and support my young son financially. I would like him to go to school and graduate.”

What’s your wish for the scene in Mombasa?
“We need income generating options for people who use drugs so they can provide for themselves and have hope for their future.”

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FROM THE STREETS
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Machteld Busz, 
PROGRAMME COORDINATOR

“I met Jan in Pretoria, South-Africa. He was candid about his drug use as he showed us around the community, He dragged us around all day, showing us the local squats, their homes and their hiding spots from the police. All the while telling us stories, including some from his own life. It had not been easy lately, not since his girlfriend OD’d six months before and he hit rock bottom.

We decided to have lunch at a fast-food joint. Jan hadn’t eaten in a while and wolfed down his meal in no time. Then he shut his eyes and visibly enjoyed the moment. When he opened them, he told us how much he had enjoyed the day. On the way back he told us how he hadn’t thought about dope last week!”

Jos Luteijn, 
TRAINER

“Last February, I was in Kathmandu, Nepal. I was helping outreach workers to distribute syringes when we met these two guys who had just scored. I asked if I could follow them to wherever they were going to shoot up, and they agreed with friendly enthusiasm. So we walked into the woods near Kathmandu, where these two guys of 21 and 23 injected a combination of buprenorphine, Valium and Advil right into the groin.

And there I was, the harm reduction specialist in the woods of Kathmandu, hiding from the police with two guys getting high in the most harmful way you can imagine. It was shocking to see and it made me realise how desperately needed harm reduction is in Nepal. But I’m forever grateful to these two guys. They were willing to show me the reality, without shame. And that just motivates me to really make our voice heard.”

Joost Breuksema, 
RESEARCH OFFICER

A bunch of kids dashes into an alley. The sound of angry, barking dogs rapidly approaches. Members of a militia round a corner and march towards us. They’re clad in dark-green camouflage outfits, long black clubs at the ready, automatic weapons shouldered. The German Shepherds are straining at their leashes.

“It’s the police,” Robbie whispers. Without warning, a rubber whip slices the air and lashes him across the back, hard. “Hey, easy!”, I stammer. “We’re just talking here.”

At the back of my mind is the box of syringes right beside me. In Kenya, people who use drugs are typically arrested just for having a single syringe on them. “Is he with you?”, the officer asks me, pointing at the dreadlocked Kenyan. “I, erm, we, well, you know, help drug users,” I manage to say. He grumbles, frisks Robbie roughly but finds nothing besides a small Stanley knife. He looks disappointed.

“That motherfucker!”, shouts Robbie, after the officers have left. “You know the guy who just beat me? Same guy who sold me left. “You know the guy who just beat me?”

Hatun Eksen, 
COUNTRY COORDINATOR INDONESIA

“I was sheltering from the rain near a methadone clinic in Indonesia, when I was joined by a man and woman with a baby. I had seen them earlier inside the clinic, waiting in line to get their medication. I had assumed the woman was the guy’s social worker, as he looked young and was quite skinny. But as we sheltered together from the rain, I now saw that he was at least 30 years old. We got talking and it turned out they were married and had joined the methadone programme just two days before. “For our baby. We never want to go back to using heroin,” said the woman.

As I drove off, I wondered how long they would manage, having to wait in a room full of people in the middle of the day for two hours every day. With a baby. Access to methadone is one thing, making the system user-friendly something else entirely.”
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