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**Plenary speech at XVII International
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by

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**From advocacy to implementation:
Challenges and Responses to
Injecting Drug Use and HIV**

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Uniting the world against **AIDS**

His Worship Mayor Sam Sullivan, Dr. Perry Kendal from provincial health office, Senators and other distinguished guests, delegates, Co-chairs of the conference Patricia Spittal, Sue Currie, Prof Gerry Stimson, Ladies and Gentlemen

On behalf of UNAIDS and our Executive Director, Dr. Peter Piot, I am very pleased to address this conference. And I am doubly pleased to do it here, in Vancouver, a city which has demonstrated much innovation and initiative in the field of harm reduction.

My aim today is to provide an overview of the main challenges facing our efforts to implement comprehensive HIV Prevention programmes related to injecting drug use, and to briefly review the effectiveness of our response.

I will focus on the following questions:

- Why, despite two decades of efforts in harm reduction, is the reality still so grim?
- Is HIV among injecting drug users still a gathering storm or is the worst behind us?
- Why are we not intervening adequately when we know what needs to be done?
- And, are we inadvertently undermining our achievements of the last 10 years?

We have come a long way since the first harm reduction conference, held 17 years ago. Four weeks from now, at the United Nations High Level Meeting on AIDS, governments will be setting the agenda to achieve universal access to HIV prevention and treatment. This is a source of great hope not only for injecting drug users themselves, but also for their partners, families and communities.

With this in mind, let us ask ourselves: where do we stand today in terms of actual provision of services to injecting drug users? There are approximately 13.2 million injecting drug users world-wide, and the global HIV infection rate among injecting drug users averages around 16%, with wide variations from 0% to 84%. In the 24 countries with the largest injecting drug user epidemic, representing 9.2 million injecting drug users, fewer than half a million have access to risk reduction messages, less than a quarter of a million have access to syringe exchange programmes, and less than 25 000 have access to drug substitution therapy programmes. Access to antiretroviral treatment continues to remain low.

And, in the majority of countries, drug users are criminalized under domestic laws, creating barriers to accessing services even when they exist.

But grim as these figures are, the HIV epidemic among injecting drug users has not yet reached its peak. It is still, to use Churchill's phrase, a gathering storm. If we do not take notice, the worst is yet to come.

Injecting drug use spread greatly during the 1990s, from 80 countries in 1992 to 136 countries in 1999. It is still spreading, and HIV has followed. The number of countries reporting HIV among injecting drug users doubled from 52 to 114 between 1992 and 2003.

Ten years back, many people doubted that an HIV epidemic among injecting drug users, ran any serious risk of moving into other populations.

Today we know better. Without early and decisive action, an epidemic of HIV among injecting drug users can “kick-start” a rapidly spreading epidemic in other populations, as we have seen in Indonesia and Eastern Europe.

We also know that early prevention can work. In China, it is estimated that one third of new infections in the general population can be prevented by acting now among injecting drug users. That will avert almost 2 million cumulative infections between 2005 and 2015 in the general population, saving lives and billions of dollars.

After almost two decades of research and experience, the core package of interventions we need to initiate is well known: outreach programmes; sterile needle/syringe access, drug dependence programmes, particularly substitution treatment; HIV treatment and care, including antiretroviral therapy; primary health care and comprehensive drug control measures aiming to reduce the number of people using drugs, such as through primary prevention programmes targeting young people.

But such interventions can only be effective if supportive legislation, policies and attitudes are in place to prevent marginalization of drug users, eradicate stigma and discrimination against them, and ensure respect of human rights.

We also know that these interventions are affordable. As shown in a recent estimate, out of the \$11 billion needed for global HIV prevention in the year 2008, less than \$200 million is required for injecting drug users. This compares favourably with the amount of resources needed for HIV prevention among sex workers and their clients.

Yet, although it is probably one of the most cost-effective HIV interventions in terms of public health impact, programming addressing injecting drug users is frankly inadequate. In Asia, one of the most affected regions, only 10% of the resources needed for injecting drug users were available last year.

There are various reasons for this. Some donors cannot fund some of these interventions due to their own internal regulations. At the same time, countries that have serious injecting drug use-related epidemics do not prioritize them for accessing resources from Global Fund and other agencies. In some situations, countries do not even acknowledge injecting drug use as an issue to be addressed in the context of HIV.

HIV prevention among injecting drug users can work when the intervention is introduced early and the coverage is high. For example, when Brazil and Bangladesh introduced HIV prevention among their drug-using populations, overall prevalence among the general population in both countries was lower than 1%. Although one can't prove a negative, it is highly likely that relatively large-scale coverage helped keep the epidemic low in both of these countries.

On the other hand, low coverage and poor quality of intervention definitely do not work. For example, India and Nepal both introduced needle/syringe and substitution programs in 1996. And yet, within two years, both countries experienced epidemics with prevalence of up to 50% among injecting drug users in certain cities and provinces. The experience in Russia and countries of Eastern Europe is similar.

The main reason? Inadequate coverage. Existing prevention programmes achieving less than 10% coverage have little impact on the overall epidemic. This is a hard reality which the country leadership must understand.

Another thing we know is that interventions can be scaled up rapidly if the countries so wish. This is particularly true when police and other public security authorities are involved as active partners.

China had no needle/syringe or methadone programmes until recently. However, once introduced, uptake has been dramatic. Data showing that drug substitution helped to reduce criminal behaviour convinced Chinese security authorities to cooperate with public health institutions, resulting in a rapid rise in needle/syringe and methadone maintenance programmes.

HIV is also a serious problem in prisons around the world, yet only a few years ago, HIV-related interventions among prisoners were politically unimaginable. Today, however, 22 countries are currently implementing prison-based harm-reduction programmes, although many are only pilots.

For example, Iran provides condoms and methadone treatment within prisons, while its neighbour Kyrgyzstan has implemented needle/syringe programming within the prison. We need much, much more of this. Twenty-two countries is only a start.

The major problem is getting the resources—and the political commitment—to work on an adequate scale. As the figures show, HIV prevention coverage for injecting drug users in various regions is well below the level of 80% needed to really control the situation.

Globally, only half of countries reporting injecting drug use offer needle/syringe programmes. Methadone treatment is permitted in only 19 low- and middle-income countries.

Stigma, discrimination and criminalization of injecting drug users continue to bedevil public health efforts. Too often, HIV prevention policies and programmes do not get proper legislative backing or are undermined by other initiatives.

Thailand's "war on drugs" is a case in point. We do not know what actually happened to the drug lords, but we do know that drug users suffered, as the number of people attending methadone clinics dropped by approximately half during this period.

Despite these challenges, the battle can still be won. Here are six major achievements that show that there has been much progress over the past two decades.

First, as regards the UN response, relevant UN agencies working in harm reduction now coordinate their efforts through UNAIDS, with UNODC as the lead agency with WHO as a main partner.

Second, at the 2001 UNGASS, 189 governments supported a *Declaration of Commitment* which confirms harm reduction as an important response to AIDS.

Third, all major donors and governments—admittedly with some funding and internal policy limitations—have endorsed the recent UNAIDS policy paper called *Intensifying HIV prevention*. One of the largest donors, DFID of the United Kingdom, has even issued their own position paper in support of harm reduction.

Fourth, funding has increased substantially. The Global Fund alone has dramatically increased resources for HIV prevention among injecting drug users.

Fifth, WHO has added methadone and buprenorphine to its Essential Drugs List, making it much easier for programmes to obtain them through authorized channels of distribution.

Lastly, partnerships have taken increasingly innovative forms, with UN agencies, governments, donors, networks of positive people and injecting drug users working together in a partnership through interagency forums.

And look at this IHRA conference itself: the quantity and quality of abstracts, and the number of participating countries! It is a testament to the levels of awareness that have been reached, and a major indicator of achievement.

It gives me the confidence to say that Universal Access to all aspects of HIV prevention, treatment and care including in the area of injecting drug use can be a reality, if we follow through with five essential areas of action.

1. We need national legislation to be consistent with public health policies related to HIV and drug use. In most countries, harm reduction has remained in the realm of health policy only, and legal obstacles make it difficult for injecting drug users to access health services. We need very specific country-by-country follow-up on this issue.
2. We need to transform political commitment to implementation with actual accountability. Accountability can be achieved in many forms, and at many levels, through national, regional and global institutions. But whatever form it takes, we need robust indicators and transparent reporting procedures to measure progress.
3. We need stronger partnerships. That doesn't just mean polite meetings and shared recommendations. It means a real flow of resources to drug user networks and to civil society organisations working in this field.
4. We need specific plans to reach injecting drug users with resources and technical assistance. This entails detailed planning with time-bound targets, and human and financial resource plans.
5. We need assured access to commodities including methadone and buprenorphine for substitution treatment, condoms, needles, syringes, antiretroviral medication and medications and diagnostics for control of sexually transmitted infections.

Partnership is the key to success. By this I mean a true, respectful partnership between donors and UN agencies, civil society, the drug user community, and most importantly national governments—including public security authorities. Obviously, some of the partners will need extra support. I am thinking particularly of the need to develop the capacity of injecting drug user community organizations to function as full members of the partnership. Public security authorities will also need to be supported through this process. If we can accomplish that, we will be firmly on the road to success.

Friends, before I conclude I would like to remind you of the words of that great literary figure, Goethe.

“Knowing is not enough; we must apply. Willing is not enough; we must do.”

Time has come to apply our knowledge and move to action.

Thank you.