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Speech

CHECK AGAINST DELIVERY

Plenary speech at XVIII International Harm Reduction Conference:

Winning on Policy, faltering on implementation

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Speech by
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Excellencies, Distinguished Delegates, Ladies and Gentlemen,

On behalf of UNAIDS and its Executive Director, Dr. Peter Piot, I am very pleased to address this conference on a subject relegated to a low priority for a long time in the debates on, and responses to, HIV epidemic. I congratulate the organizers for holding it in Eastern Europe to highlight the significance of drug related HIV epidemic in this part of the world. And I welcome the opportunity it affords us to really step up our fight against what has become, helped by past neglect, a key driver of the HIV epidemic in many parts of the world

There have also been significant developments on the global scene with regard to HIV and injecting drug use since we met in Vancouver last year. My aim today is to take stock of the achievements dealing with HIV related to injecting drug users and to look at what we can do better to bring it under control.

To do this, I'd like to focus attention on five issues:

First, it is essential to look at what makes HIV among Injecting Drug Users an issue for urgent action, namely that it is the fastest growing component of the epidemic in many parts of the world ;

Second, more positively, we need to consider the major global initiatives that are under way and provide a policy platform for action;

Third, we can already see how these initiatives are producing perceptible change in the way countries and regions are addressing the issue of harm reduction;

But, fourth, the level of services still falls far short of what it could, and needs, to be;

And finally, we need to consider the challenges and possible responses to enhance services and service delivery;

Coming back to the context: injecting drug use spread rapidly during the 1990s, from 80 countries in 1992 to 134 countries till now. It is still spreading, and HIV is spreading in its wake. The number of countries reporting HIV among injecting drug users more than doubled from 52 to 114 during this time.

If we look at this global AIDS map, we see the heaviest burden of the disease is in sub-Saharan Africa, where so far it is attributed to heterosexual epidemic. But in recent years the disease has spread fastest in Eastern Europe, and there more than 70% of the infections are due to injecting drug use. In fact, injecting drug use has become the single most important factor in the spread of the epidemic in many parts of the world.

Out of the global estimate of 13 million IDUs, 80% are in developing countries and three million are already infected. That means one in every four injecting drug users already has HIV. But the most disturbing news is that sub-Saharan Africa today is experiencing a new wave of the epidemic among IDUs. In such countries as Kenya and South Africa, some preliminary studies show that the prevalence of HIV among IDUs has reached levels ranging from 19 to 50%.

Ladies and gentlemen, there is some good news too.

The year since Vancouver has seen some major global initiatives to control the epidemic. The most significant is the High-Level Meeting on Universal Access at the UN in June 2006. Governments at that meeting, set the agenda to achieve universal access to HIV prevention and treatment. UNAIDS on this occasion advocated for raising resources to reach 80% coverage by effective prevention services of key population groups like IDUs and 80%

coverage by ART of all those who are eligible. The new UN Secretary General, early this year, in one of his first report to the General Assembly highlighted stigmatization of the drug users in the context of universal access.

This is a victory for all those who advocated for harm reduction strategies around the world. It's also a testament to the commitment and relentless advocacy of the drug user community, who had the courage to set up services under very difficult conditions all over the world, once again proving that activism saves lives.

Last year, I reported on the UNAIDS governing body's approval of a core package of harm reduction measures as part of the policy of prevention. This year all UN agencies and major stakeholders endorsed the practical guidelines on prevention. These not only recommend making IDU intervention a priority for practically all countries outside sub-Saharan Africa, they also advocate for a single, comprehensive package of measures.

The message is strong and emphatic.

All drug users must have access to both needle-syringe supplies **and** drug substitution programmes. To make harm reduction effective, practitioners, governments, and providers cannot deliver piecemeal services in an ad hoc manner, a practice we still see in many parts of the world, including some large countries like India, China and Russia where drug users can get access mainly to either needle-syringe or substitution drugs like methadone or buprenorphine. Drug users need both.

Secondly, in line with the Global Task Team's recommendations on harmonisation, the UN system has adopted a division of labour to avoid duplication by UN agencies. This lays down clear lines of responsibility for delivery of services. As the lead agency for injecting drug use, UNODC has produced in collaboration with WHO the framework for HIV prevention in close settings, supported 25 countries in 2006 in this area. UNICEF has supported an international task force for young people and harm reduction and has prioritised young IDUs within its global HIV programme for young people .

However, , such interventions can only be effective if supportive legislation, policies and practices are in place to prevent marginalization of drug users, eradicate stigma and discrimination against them, and create respect for human rights. That is why the involvement of drug users in peer outreach programmes is seen as an essential part of the package.

There is also encouraging news to report on the resource front. We often lose sight of the fact that resources for combating HIV have dramatically increased in the last few years. Investment in the global fight against AIDS has increased more than 25 times, in the space of less than a decade. In 1996 investment amounted to less than $300 million. Last year, it reached a new high of almost $9 billion.

For IDU programmes, the Global Fund alone has allocated almost 60 million US dollar a year. The World Bank has prioritised IDU intervention in all of its earlier investments in Asia and Latin American countries like Brazil. Private foundations like Bill and Melinda Gates have come forward with large grants with no restrictions on spending these resources either on Needle and syringe or drug substitution programmes. Only a few years ago, nothing like this was in sight.

The new emphasis on prevention and the declaration of commitment to Universal Access is already producing a perceptible shift in the approach of many countries to the provision of services to injecting drug user population.

A few developing and middle income countries, for example Brazil, China, Iran and Malaysia, have attempted nation wide programme of harm reduction. Support for the harm reduction program in Malaysia has come from the Prime Minister himself.

And this deserves our recognition. For many countries, introducing a needle syringe or methadone programme without requiring IDU's to register with law enforcement agencies is a sea change in policy. Take the case of Vietnam where, the government and the ruling Communist Party have recently endorsed harm reduction after many years of prosecuting drug use as a 'social evil,' In spite of these difficulties more and more countries are adopting the harm reduction services.

These maps clearly illustrate the growing number of countries that have adopted methadone and Needle and Syringe programs (NS). Just a few years back the number of countries endorsing NS and substitution programmes was 39 and 43 respectively. In less than 10 years that has gone up to nearly 67 and 53 respectively.

Special mention should be made here of the example set by countries in this part of the world. Three Baltic countries have not only started harm reduction program, they have also pioneered programmes inside prisons with support from UNODC. At the same time, countries in Central Asia, have introduced large scale programs on all fronts --, outreach, needle syringe, substitution and antiretroviral treatment.

At the regional level, AusAid has offered a grant of approximately 50 million US dollars exclusively for harm reduction programs in Asia and the Pacific. Partnership between NGOs, governments, civil society, the UN and academics working through the Regional Task Force on Drugs and HIV in Asia and Middle Eastern Countries have become a norm.

Regional Initiatives by harm reduction net work and financial support from DFID have made significant progress on advocacy and program response in Eastern Europe.

However, Ladies and Gentlemen, the hard fact remains that all these policy achievements and resources have yet to make an impact on the people for whom they are intended, the people who matter. That is the drug users who want to live a life ***with care and support, treatment and dignity***. And little change has occurred in the lives of partners and families of drug users who do not want to suffer from the anguish of seeing their loved ones and families criminalised.

The figures shown here reveal a distressing state of affairs in services for the IDU population. Today, a mere one in eight IDUs have access to risk reduction messages, and only one in 33 to needle/syringe programmes. A recent study of coverage found that in 24 developing countries with a total of about 9.2 million IDUs, only 33,000 had access to drug substitution programs. In ART services accurate figures for IDUs are not known, it appears that we have not been able to reach even 10% coverage despite several global initiatives.

And in spite of progressive examples of collaborative work between law enforcement and health agencies in Moldova, Romania Indonesia and Middle East country like Iran, criminalisation of drug use continues in many settings, which poses problem for service provision as well as contributes to social marginalisation and increased vulnerability of drug users.

The resource picture also leaves us no room for complacency. Out of the $11 billion estimated to be required for global HIV prevention in 2008, a conservative estimate of less than $200 million is required for IDUs. To me, this appears an underestimate because the per capita cost of programmes like buprenorphine substitution are quite high. Yet the

resources available today don't match even this conservative estimate, amounting to less than 100 million US dollars a year.

Some donors still continue NOT to fund some of these interventions because of their internal regulations and in countries with adequate resources, few give priority to drug use intervention in their national strategic plans. Even in Thailand, one of the few countries in the world with significant resources, less than 10 percent are spent on prevention and very little is invested on IDU programmes although 30 percent of annual new infections are attributed to injecting drug use.

And, equally alarming, country after country is running its IDU programmes on external resources. In many countries today, 95 to 99% of IDU programme resources are external. If these countries do not mainstream IDU support in their social, health and medical services, these programmes will be at risk of collapsing once external resources are withdrawn.

Ladies and gentlemen,

Countries face a formidable array of challenges to get services in place in a very short time: poor resources, vacillating political commitment, lack of services, failure to integrate programmes within existing services, putting the burden of service delivery on civil society groups without providing adequate resources, lack of synchronization between law and health agencies, the absence of any procurement agency to supply substitution drugs at an affordable price and extraordinary dependence on external funding.

All these factors stand between the 80% coverage that we are targeting and the utterly inadequate level of services that most countries currently deliver.

Ladies and Gentlemen, I would like to conclude by saying that HIV today is not a short term problem that will disappear in 5 to 10 years. Even if the dream of halting or reversing it globally is fulfilled the world will still have a large infected population needing care, treatment and attention. The need of the hour, then, is to sensitize national governments to the imperative of investing more indigenous resources into AIDS programmes to ensure they become sustainable in the long term.

There is a growing realization in the world today that global warming and AIDS are the two most important global challenges that will have the most serious impact on the lives of people in the years to come.

We are already witnessing the results of decades of neglect which is warming up the globe. We should not wait for the day when AIDS will also assume such menacing proportions.