

**1st Asian Consultation on Prevention of HIV Related to Drug Use**  
**28<sup>th</sup> January 2008**  
**Goa, India**

Opening Plenary Speech by **Dr JVR Prasada Rao** - Director of the Regional Support Team of the Joint United Nations programme on HIV/AIDS (UNAIDS).

Ladies and Gentlemen, Colleagues,

It gives me pleasure to address this Consultation for two particular reasons: firstly because it is the first Asia Pacific Consultation on the specific issue of reducing harm related to injecting drug use, including preventing HIV transmission. It is also special as an initiative entirely undertaken by civil society groups and communities and not by formal organizations in the Government or the UN system. I see in this room a dedicated group of individuals who share a common goal of making HIV prevention, treatment and care for drug users a reality. Congratulations to all the sponsoring agencies and individuals.

Today, we have the means needed to make a real difference tackling HIV related to injecting drug use. We have high level commitment to address the epidemic; we have the science, meaning we know what works and we have the resources to scale up interventions.

**Injecting drug use as a catalyst of HIV epidemics and transmission of hepatitis among IDU in Asia**

In the past, HIV responses in the Asia-Pacific region were guided by global strategies on prevention, treatment and care. The global strategies were based on early experiences in high prevalence regions which witnessed extremely high growth rates within a matter of a few years. Only later was there recognition that the risk factors and the underlying social determinants of the epidemic in this region are totally different to those in other parts of the world.

Injecting drug use has acted as a catalyst for HIV epidemics at the onset of the pandemic in many Asian countries. Sharing of injecting equipment is a very efficient way to transmit HIV from one person to the next. Once HIV enters the IDU network, it spreads very rapidly and a drug-use related HIV epidemic kicks off in a country. This is what happened in China, Indonesia, Vietnam and the north east of India, to mention a few of the countries thus affected. Soon after that happens, we start finding HIV among sex workers and sexual partners of drug users, as we saw in Manipur, And within five years of the initial epidemic among people injecting drugs, it had spread to children.

Already, globally, three million injecting drug users are living with HIV. In our region, prevalence of anywhere between 20% and 85% has been reported among injecting drug users in several of the countries, including China, India,

Thailand, Myanmar, Nepal, and Vietnam. And countries, such as the Philippines, which reported no injecting drug use related to HIV transmission before 2005, have since detected HIV among this population.

The good news is that we have the science and we know what we have to do. The first golden rule in preventing a fast spreading HIV epidemic in any country is early intervention to halt transmission. Countries that report injecting drug use need to start prevention before HIV is reported among injecting drug users. I cannot stress this fact enough. Countries that waited and hoped that information, education and communication programmes for the general population would show results did not see them. In these countries, HIV prevalence among injecting drug users sky-rocketed up to 90%. On the other hand, countries, such as Bangladesh, that acted early and implemented focused interventions aimed at preventing transmission among people who inject drugs, have been rewarded with prevalence of around five percent or below, a level comparable level to Australia, Europe and the US.

### **Universal access and barriers to access among drug users**

On the basis of past experience we also have more detailed blueprint for responses to work with. Last year, UNAIDS and its cosponsors endorsed a practical guideline on prevention interventions. It recommends giving priority to interventions reaching people who inject drugs in all countries that report injecting drug use and it provides practical guidance on the core package of interventions for prevention of HIV related to drug use. By a comprehensive package we mean a full range of treatment options and relevant services. These include substitution treatment, needle and syringe programmes, peer education and outreach, voluntary HIV testing and counselling, prevention of sexually transmitted infections, primary health care and anti-retroviral therapy.

On top of this, we have a more supportive political environment. In the political declaration made at the high level meeting of the UN General Assembly in June 2006, countries committed to developing targets for Universal Access, while recognizing that the targets have to be cognizant of the realities at country level. Supporting countries to meet these targets has become a major focus of the international efforts, led by UNAIDS and its cosponsors.

Ladies and gentlemen, with these guidelines and the political commitment we have a strong platform to take action. You might even think we're on course to solve the problem. But let me now give you a brief snapshot of what's actually going on. It's not a comforting picture.

Take the latest data on coverage and access to the essential services by people who inject drugs. It shows that only a tiny proportion of injecting drug users in need of harm reduction programs (3% in South-East Asia and 8% (1 country only, China) in East Asia, actually have access to these services.

Only a few countries provide access to substitution treatment, and where it is available, it is mostly at a pilot stage, for example in Indonesia, Nepal,

Malaysia, and Myanmar. Only one country, China, has demonstrated a significant scale up effort.

Even though it has been quite some time ago that WHO included both Methadone and Buprenorphine to the WHO List of Essential Drugs, yet, as of today, Methadone is legally available in only five countries in Asia (China, Hong Kong, Indonesia, Lao PDR, Myanmar) and Buprenorphine is available in only three: (India, Pakistan and Nepal). Moreover in five countries, namely Bangladesh, Bhutan, Cambodia, Japan and Singapore, both Methadone and Buprenorphine are still illegal.

The priority now is to see that all countries which report injecting drug use make methadone legal, include it in the list of essential drugs and expand access to drug substitution treatment sites on the ground.

However, a comprehensive HIV response also means that drug users have access to needle and syringe exchange and distribution programmes. Scientific evidence shows that easy and consistent access to sterile injecting equipment cuts transmission of HIV and hepatitis. Countries that took the initiative to implement needle and syringe programmes before a drug use related HIV epidemic took off have succeeded to date in averting a generalized epidemic, saving lives and a huge burden of cost.

Yet, only 10 countries in Asia and the Pacific have at least one dedicated needle and syringe exchange programme and only two countries (Malaysia and China) have both NSP and substitution treatment programs in place.

Countries that report injecting drug use need to significantly scale up the number of needle and syringe program sites if they are to attain the goal of Universal Access.

Another issue of concern is equity, or should I say, the lack of equity, in access to HIV treatment by people who inject drugs. Of all injecting drug users receiving treatment globally, an astonishing 90% live in just one country, Brazil (WHO, 2007).

Too often people who use drugs are denied the services that they need and have a right to. We hear that drug users are being told by physicians that "as long as you use drugs you cannot have ART". Similarly, we have heard that drug users on methadone treatment have been denied access to ART.

I find this situation unacceptable. Denial of treatment is a denial of basic human rights. But let us be clear, it is also bad practice. Current or past drug use cannot be used as criteria for deciding who can and cannot access treatment.

To curb and reverse the spread of AIDS, treatment needs to be provided based on clinical criteria, not on moral grounds. Second; health care services need to be comprehensive, with good referral mechanisms between general

medical care, drug dependence treatment, harm reduction services, HIV testing and counselling and psycho-social support.

Delivery of anti retroviral therapy for IDUs through public healthcare services alone will not work. We need to expand access to anti retroviral treatment through community based organizations and experience shows us that the more we can involve people who use drugs in the design and delivery of treatment and care programmes, the more successful those programmes will be. Treatment services also need to reach HIV positive persons in closed settings, such as prisons and drug rehabilitation centres. Lessons learned from prison in Bali, Indonesia, show that it is feasible to make available comprehensive treatment and care services in a closed setting.

Ladies and gentlemen, in 2010 we will take stock of the progress made towards achieving Universal Access. So our main challenge in the next two years is to increase access from 3% to 80% for all injecting drug users in need of these prevention and treatment services. This is a tall order, but unless we have the vision from the beginning, we will not go very far. To be successful, everyone needs to work together to scale up harm reduction programs and make universal access for drug users a reality at country level.

### **Stigma and discrimination, involvement of drug users**

But let us consider some of the obstacles we must tackle to get there. One of the main barriers for access to prevention, treatment and care services by people who inject drugs continues to be the stigma and discrimination associated both with HIV and injecting drug use. The prejudice encountered by people living with HIV is well documented. But people who use drugs also report stigma and discrimination, and being an HIV-positive drug user brings with it a “double-stigma” that makes it all the more difficult to access relevant services.

We also know that in several countries drug users and positive people's networks are still not allowed to organize themselves and that drug users and their networks are excluded from decisions that affect them. This needs to change. The stigma and discrimination associated with drug use and HIV need to go, communities and governments need to embrace the reality of what works in curbing the epidemic.

By treating drug users and their representatives as equals, by including them in consultative processes and the decision-making and policy-making bodies that shape the HIV, drug, and other relevant policies, we are more likely to succeed. We also need to support direct involvement of drug users in provision of services, such as outreach, substitution treatment, needle and syringe programmes, delivery of anti retro viral treatment, and prevention of overdose due to drug use. After all, who understands the health and social needs of drug users better than the drug user?

### **Legislation and policies; Management of national programs**

But the one, overarching bottleneck I hear of whenever I meet and work with colleagues who are dedicated to increasing access to the programmes reducing drug related harm, is how current legislation and policies hamper implementation. There is an urgent need to harmonize drug policies with HIV policies. Criminalization of drug users hampers access to treatment and prevention services.

In most countries, the HIV program is managed by the Ministry of Health while the national narcotics control bodies have been left out of the response and as a result often lack understanding and ownership of the national HIV programs. Ministries responsible for controlling narcotic drugs should come forward to participate in these programmes and work closely with the national AIDS programs. China is a good example of such collaboration.

## **Conclusion**

Despite such challenges, we now have a clear roadmap with which to address this crucial but neglected area of the region's epidemic. The Asia AIDS Commission, recognizing the vital importance of tackling the IDU-related spread of HIV, has given priority to a review of this dimension of the Asian epidemic. Its findings and recommendations will be coming out very soon. I strongly believe that if all of us, the Governments, the parliamentarians, the UN agencies, civil society and drug user organizations implement these recommendations as a matter of urgency we can not only change the current ground reality but alter the course of the epidemic in Asia.

## **Call for Action**

Ladies and Gentlemen, Colleagues,

Let us use this consultation as a platform from which to call on all those who are involved in the response to HIV to move for concerted action on the following agenda:

- To review and revise laws that criminalize drug use
- To tackle the stigma associated with drug use and HIV
- To ensure comprehensive coverage of IDUs with prevention, treatment and care interventions
- To involve networks of drug users and community based organizations in delivery of prevention, treatment, care and support services
- To maximize financial and technical resources for prevention, treatment and care programs for injecting drug users
- And finally to promote and facilitate organizations of people who use drugs.

We have over 20 years of experience at hand, we have the evidence, we have the resources, we have the commitment. So let us just do it. Let's get on and make Universal Access a reality.