

THE BECKLEY FOUNDATION
DRUG POLICY PROGRAMME



UNAIDS & THE PREVENTION OF HIV INFECTION THROUGH INJECTING DRUG USE

Mike Trace, Diane Riley, Gerry Stimson.

The Beckley Foundation Drug Policy Programme (BFDPP) is a new initiative dedicated to providing a rigorous independent review of the effectiveness of national and international drug policies. The aim of this programme of research and analysis is to assemble and disseminate material that supports the rational consideration of complex drug policy issues, and leads to more effective management of the widespread use of psychoactive substances in the future.

The International Drug Policy Consortium (IDPC) is a global network of NGOs that specialise in issues related to illegal drug use and government responses to the related problems. The Consortium aims to promote objective debate on the effectiveness, direction and content of drug policies at national and international level.

THE PROBLEM

Since the world community first became aware of the widespread transmission of HIV, the risk of infection through the sharing of syringes by people who inject drugs has been a key concern for policymakers. While the injection of illegal drugs (primarily heroin but also, in many parts of the world, amphetamine and cocaine) is strongly discouraged by drug enforcement and health agencies, it remains a widespread practice – the United Nations estimates that there are currently 13 million regular injectors worldwide (Aceijas et al, 2004). While all continents have recorded populations of injecting drug users, there are concentrations in certain countries and regions – initially in the 1980s in Europe, Australasia and North America, and more recently across Asia, in the former Soviet Union, and Latin America. Nearly 80% of injectors are now to be found in developing and transitional countries. The majority of these individuals will be poor and socially marginalized, with limited access to family support and mainstream health services. Their daily lives

involve a range of hardships and risks arising from their use of illegal drugs, one of which is infection with HIV or other blood borne viruses through using injecting equipment previously used by an individual carrying these viruses. Research indicates that awareness of the risk of infection remains low in many injecting populations. For example, a study of injectors in Iran in 1999 showed that 25% had never heard of HIV/AIDS, and most of those who were aware of the disease had no idea how it was transmitted. (Nissaramanesh et al, 2005). Even where awareness is raised, many injectors continue to share syringes, often through lack of access to alternatives. These are the conditions in which the spread of HIV infection can be rapid (Rhodes et al 1999, Rhodes and Simic, 2005).

As a consequence, this mode of transmission of HIV remains one of the principal challenges facing UNAIDS and its members in their attempts to minimise the spread of the global epidemic. Around 10% of all HIV infections

worldwide – around 4 million – are attributed to injecting drug use. Outside of Africa (where injecting drug use has been limited in the past, but is showing disturbing signs of increasing), the proportion of infections attributed to injecting drug use rises to almost 30%, with rates in different countries ranging from 6% in the UK, to 21% in the USA, and an estimated 50 – 60% in Russia.

It is now clear that the spread of the HIV epidemic in many countries in Central and Eastern Europe, the Middle East, South and South – East Asia and Latin America, is being driven by injecting drug use. As with other routes of transmission, therefore, it is essential that the global community finds effective methods of minimising the transmission of infection through needle sharing, and promotes the implementation of these methods in affected areas.

FINDING A SOLUTION

Fortunately, there is a growing body of evidence that the implementation of a range of public health and treatment measures, targeted at those who inject drugs, can be effective in reducing the number of infections, and in some instances has altered the projected course of an epidemic. This package of measures, which has become known in the public health and drug policy fields as ‘harm reduction’, has three broad components:

- The widespread dissemination of information on the risks of infection, and advice to drug injectors on how they can avoid that risk.
- Accessible provision of clean materials (eg syringes, filters, sterile water) for injection that allows users to avoid re-using infected equipment.
- Easy access for drug injectors to treatment services that help them move away from the most risky behaviour.

Amongst the countries that experienced widespread drug injecting in the 1980s, those that implemented the above activities with sufficient speed and coverage (eg The Netherlands, Australia, Germany and the United Kingdom) have experienced generally low rates of drug related HIV infection, with rates of HIV positivity amongst drug injectors of around 5%. The Netherlands effectively reversed the progress of the epidemic amongst injectors in Amsterdam. Meanwhile, countries who did not take this approach (eg France, Spain, USA) saw their drug-related HIV rates soar. By 1990, for example, Spain had a national HIV positive rate amongst its drug injectors of 39%, with rates as high as 74% in Madrid. The changing proportion of IDU related transmission over time in Europe also indicates that the implementation of harm reduction measures can arrest epidemics – in 1995, 43% of cumulative HIV cases in

Europe were attributed to drug injecting. By 2003, after widespread implementation of harm reduction programmes, the proportion had reduced to 11%. Other countries have faced this challenge more recently, but the overall pattern remains the same – for example, there have been epidemics of drug injection and related HIV infection over the last decade in Russia and the Ukraine. This has been linked with social and environmental factors, as well as a reluctance to endorse public health responses to infection control (Rhodes et al, 1999b). Official figures now show over 300,000 people living with HIV in Russia, an estimated 60% of which are linked to drug injecting, though the true size of the infected population is estimated to be five times greater. Brazil is the country in South America that has been most seriously affected so far, with HIV rates amongst drug injectors rising to as high as 40% in some surveys. In recent years, however, the Brazilian government has made a concerted effort to provide harm reduction services to the drug injecting population, with encouraging results – the latest indications are that the rate of new transmissions, and the proportion of drug injectors carrying the HIV virus, are showing a significant decline.

CONTINUING CONTROVERSY

Despite the clear public health benefits of the main components of a harm reduction approach to drug injection, recorded in a number of academic and policy reviews over the last 10 years, the implementation of these measures has remained the subject of fierce debate at local, national and international levels. There are two broad areas of concern about this approach:

Morality – If the authorities are engaged in a struggle to eradicate, or at least reduce, the use of illegal drugs, then they should not be involved in any activities that acknowledge the continuation of such use, much less facilitate or manage what remains an illegal activity. This has been the initial response of most governments to the problem of injecting drug use, a ‘purist’ position that has been challenged by the reality that, despite all enforcement and education efforts, large numbers of drug users continue to prefer injection as a method of administration. This purist position is therefore challenged by the pragmatic assertion that to do nothing to tackle the harm from continued injecting is, in itself, morally indefensible.

Pragmatism – While there are still people who object to harm reduction on grounds of moral purity, most policy debate now revolves around the pragmatic issue of how best to minimise the number of infections attributed to injecting drug use. Opponents of a harm reduction approach assert that the priority should be to use all available means to reduce the numbers of injectors and that, by providing support services to drug injectors, those

engaged in harm reduction are making the behaviour more attractive to potential injectors, and slowing the rate at which existing injectors give up the practice. As a result, they argue, a higher rate of injecting drug use is maintained, and there is consequently a higher rate of infection. The preferred policy approach of governments that hold these views is to use local enforcement techniques to maximise the inconvenience of a drug injecting lifestyle, and to prioritise treatment services that demand that the user ceases their drug use (what are referred to as abstinence-based treatment services).

The Beckley Foundation Drug Policy Programme is based on the principle that drug policy should seek to minimise the harm that illegal drug use causes to citizens. Therefore, while we consider that governments do not have the luxury of taking a morally purist position on an issue that affects millions of lives, we do think that the debate between these two approaches to minimising drug related infections is a reasonable one, and one that should be resolved by an objective look at the existing evidence. We consider, however, that the global evidence that is currently available on this issue points clearly to support for the harm reduction position:

- As has been mentioned above, there is clear evidence from a large number of studies that the implementation of harm reduction measures (information, needle exchange programmes, and accessible treatment) has effectively reduced rates of HIV transmission amongst drug injectors.
- Many of these studies have specifically examined the proposition that harm reduction measures may actually encourage drug users into injecting behaviour, and delay the processes by which existing injectors cease the practice. They have all found no evidence to support this claim – the reasons why people choose to inject, and to stop injecting, are unrelated to the availability of harm reduction services.
- In countries and areas where abstinence-based treatment is the only option, there has been no significant reduction in injecting use – the behaviour continues, but in more risky conditions.
- All governments are searching for ways to encourage drug injectors to change their behaviour and lifestyles – a difficult task, given that most injectors are socially marginalized and distrustful of the authorities. One of the most effective ways to start the process of change is to provide injectors with services that meet their immediate needs (ie to use safely); then, when trust is established, to encourage cessation of the harmful behaviours.

While it is possible that new evidence may raise questions about our interpretation of the current situation, we consider that the message to policymakers from experience

in this field is clear – that emerging or potential epidemics of HIV infection related to drug injecting should be responded to with the implementation of properly resourced and targeted harm reduction programmes. If this course of action is not pursued, then infection rates will continue to rise, leading to significant future social and health costs. It is a matter of concern therefore that, faced with very real epidemics in many parts of the world, the response of the international agencies over the last 10 years has been inhibited by disagreements between member states regarding the morality and value of harm reduction. As infection rates have spiralled in those countries which lack the resources and expertise to tackle the problem alone, global agencies such as UNAIDS and the UN Office on Drugs and Crime (UNODC) have been slow to mount programmes that provide technical and financial support to develop effective treatment and harm reduction services.

DEBATES AT THE UN – THE SEARCH FOR CONSENSUS

The political and diplomatic sensitivity of the harm reduction issue, with strongly differing views and experiences expressed by different member states, has for many years prevented a clear consensus position (and, consequently, a clear global programme of action) developing through either UNAIDS or the UNODC. These policy differences were brought into focus in late 2004, with the leaking of correspondence between the Executive Director of the UNODC, Antonio Costa, and the US State Department, in which the latter sought and received assurances that the UNODC would not support harm reduction programmes, either in its policy statements or its funding programmes. When this exchange became public, there was an outcry from governments and NGOs who considered that harm reduction measures were the essential component of any response to potential drug injection-related epidemics. In particular, UNODC donor governments that supported harm reduction wanted to know how the agency's policy on the issue seemed to have been changed through private correspondence with a single member state.

There was an attempt to reconcile these differences at the annual meeting of the Commission on Narcotic Drugs, the governing body for the UNODC, in Vienna in March 2005. At this meeting, attended by government representatives from most UN member states, there was a thematic debate on HIV Prevention which highlighted the positive experience of most contributors with the implementation of harm reduction measures, but also showed the continuing ideological and practical concerns held by a small number of member states. The meeting also

WHAT IS UNAIDS?

To address the unique global threat of HIV/AIDS, UN agencies combined forces in 1996 to establish the Joint United Nations Program on HIV/AIDS (UNAIDS).

Cosponsors include:

United Nations Children Fund
 United Nations Development Program
 United Nations High Commission on Refugees
 United Nations Population Fund
 United Nations Office on Drugs and Crime
 UNESCO
 World Health Organization
 World Bank
 World Food Program
 International Labour Organization

UNAIDS' mission is to lead, strengthen and support an expanded response to HIV and AIDS. This includes preventing transmission of HIV, providing care and support to those already living with the virus, reducing the vulnerability of individuals and communities to HIV and alleviating the impact of the epidemic. UNAIDS supports a more effective, comprehensive and coordinated global response to AIDS by providing:

- Leadership and advocacy for effective action on the epidemic
- Strategic information and technical support to guide efforts against AIDS worldwide

- Tracking, monitoring and evaluation of the epidemic and of responses to it
- Civil society engagement and the development of strategic partnerships
- Mobilization of resources to support prevention and care programmes

UNAIDS is served by a Secretariat with headquarters in Geneva and offices in more than 60 countries. The governing body is the Programme Coordinating Board (PCB) which holds a regular session at least once a year. The PCB comprises 22 government representatives, and the UNAIDS Cosponsors. Five non-governmental organisations, one from each region of the world, are included as non-voting members.

All global and regional AIDS activities of the UNAIDS Secretariat and Cosponsors are coordinated every 2 years in a Unified Budget and Workplan which is used as the basis for fundraising and accountability. At country level, UN Theme groups coordinate AIDS-related work by UN agencies. Currently, funding for UNAIDS comes from 32 member states and totals approximately US\$120 million (largest donors are Netherlands, Norway, USA, Sweden, UK and Japan). For the current period, the main focus of UNAIDS is to help countries bring to scale evidence-based action on AIDS.

attempted to agree on a resolution submitted by the Brazilian government, which called for the international community to support robust HIV prevention measures amongst drug injectors in affected countries, including the full range of harm reduction measures. Despite clear support for the draft resolution from both the European and Latin American groupings, the USA delegation effectively vetoed the resolution (resolutions at this meeting are traditionally only passed by consensus), on the grounds that any mention of support for harm reduction as a concept, or needle exchange as a specific measure, was unacceptable to the US government. In the absence of any resolution or policy declaration in support of harm reduction, the UNODC as an agency remains severely limited in the extent to which it can become involved in supporting countries facing injecting related epidemics. A more extensive description of the proceedings in Vienna can be found in TNI Drug Policy Briefing Number 13 – 'The UN and Harm Reduction – Revisited' (Available on the BFDPP Website).

THE UNAIDS PREVENTION STRATEGY – A WAY FORWARD?

Clearly, the differences between governments had not been satisfactorily resolved in Vienna. However, another opportunity to address this problem emerged with the meeting of the Programme Co-ordinating board of UNAIDS in Geneva at the end of June 2005. This is the annual meeting where UNAIDS policy and programming is agreed by member states. At the 2005 meeting, the Board considered a draft strategy for intensifying global HIV Prevention measures. The drafting of this report included a direct focus on the issue of how best to minimise HIV infection amongst drug injectors, and so led to the same disagreements between member states that were experienced in Vienna. The outcome this time has been much more positive, with a clear statement emerging in the UNAIDS Prevention Strategy that harm reduction measures are the most effective response to emerging

epidemics. A brief look at how this conclusion was reached casts light on how the issue has been addressed in recent years:

- From the beginning, it was clear to the officials drafting the document that the harm reduction issue would be diplomatically sensitive. The Executive Director of UNAIDS, Peter Piot, was eager to avoid an impasse that could undermine the production of the entire strategy.
- Early drafts of the paper contained similar non-committal language on harm reduction measures to those produced in Vienna, drawing criticism from NGOs, and several governments. The consultation mechanisms established to enable widespread discussion of the strategy received many responses urging UNAIDS to give greater prominence to one of the few effective prevention measures available to it.
- There followed several weeks, through May and June 2005, of background lobbying of governments and other members of the PCB. NGOs working in this field were urging members to support strong harm reduction and human rights language, while governments were trying to judge the level of support for their own position, whether pro- or anti-harm reduction.
- Meanwhile, the experts working within the UN system (UNAIDS, UNODC, and the World Health Organisation) were attempting to clarify the position of those agencies, issuing a joint statement on the eve of the Board meeting, that was very clear in its assessment of the urgent need for harm reduction measures amongst drug injectors. [See box – key passages from joint statement].
- When members gathered for the Board meeting in Geneva on 27th June, it was clear that the USA delegation still intended to insist on the removal of any language that supported harm reduction. The key question was the extent to which other member states represented on the board would support their position.
- On that first day, an informal drafting meeting was organised with the intention of resolving any differences before the strategy was put to the whole board for final approval. In this meeting, it became apparent that there was a clear majority in favour of strong promotion of harm reduction measures. Those arguing against such measures were asked to produce evidence that they were ineffective or harmful, but were unable to do so.
- Returning to the Board meeting the following day, a new approach to the issue was proposed – that the prevention strategy be approved with harm reduction and needle exchange prominently included, but that a reservation be noted that the US Government was prevented from providing financial or other support to these programmes due to previous decisions by Congress. The US delegation eventually accepted this proposal, so both the official record of the meeting, and

the final version of the prevention strategy (both available on the UNAIDS website), contain those agreements.

- A UNAIDS strategy on intensifying HIV prevention has therefore been approved with the support of all member states and UN Co-sponsoring agencies, that includes a clear call for the urgent expansion of harm reduction measures amongst drug injectors in countries experiencing, or at risk of, HIV epidemics.

*TEXT FROM THE JOINT UNAIDS STATEMENT
ON HIV PREVENTION AND CARE STRATEGIES
FOR DRUG USERS*

HIV transmission and HIV/AIDS impact associated with injecting drug use can best be contained by implementing a core package of interventions, which includes outreach to injecting drug users; sterile needle and syringe access and disposal; drug dependence treatment, particularly substitution treatment; voluntary and confidential HIV testing and counselling; prevention of sexual transmission among drug users, including condoms and prevention and treatment of sexually transmitted infections; HIV/AIDS treatment and care, including antiretroviral therapy for drug users; and primary health care, such as hepatitis B vaccination and vein care.

There is strong and consistent evidence that this package of harm reduction interventions significantly reduces injecting drug use and associated risk behaviours and hence prevents, halts and reverses HIV epidemics associated with injecting drug use. Conversely, there is no convincing evidence of major negative consequences of such interventions, such as initiation of injecting among people who have previously not injected or an increase in the duration of frequency of illicit drug use or drug injection.

WHAT NEXT?

Hopefully, the agreement of the UNAIDS Prevention Strategy, and the publication of the joint position paper by UNAIDS, UNODC and WHO, will bring to an end the period of prevarication by the international community in its response to injecting related epidemics. There is a very real and significant public health threat that can move very rapidly, that requires a broad and well-resourced response from the international agencies and donor governments. A mandate for appropriate action was created at the UNAIDS meeting in Geneva, but the challenge now is to translate those agreements into effective prevention programmes on the ground. Action is now required on three fronts:

- UNAIDS officials should create a detailed plan for preventing injecting related HIV transmission in the countries worst affected. This plan should list the priority countries, assess the current state of the epidemic (and policy and programme responses) in each country, then articulate a proposal for financial and technical support for the authorities in that country.
- Donor governments should bring forward plans to significantly increase their support to HIV prevention work targeted at drug injectors, either through the UN mechanisms, or through bilateral arrangements. As the USA, the main global supporter of HIV programmes, has made it clear that it cannot support harm reduction work, the responsibility falls on other donor governments to agree a package that effectively responds to the needs of affected countries.
- In order to confirm the global acceptance of effective HIV prevention amongst drug injectors, a resolution should be submitted to the 2006 Commission on Narcotic Drugs recognising the language in the UNAIDS Prevention Strategy, and calling on UNODC to support its implementation.

Achieving a global consensus on an issue that can mean life or death to millions of people has been a long time coming. Meanwhile, drug related HIV epidemics have developed largely unchecked in many countries. This public health tragedy will continue if the words agreed in Geneva are not followed up with action from those responsible for the protection of the health of all citizens.

REFERENCES

United Nations Statements on HIV prevention for drug injectors

DECLARATION OF COMMITMENT ON HIV/AIDS. UN GENERAL ASSEMBLY SPECIAL SESSION ON HIV/AIDS, 25-27 JUNE 2001 New York.

PREVENTING THE TRANSMISSION OF HIV AMONG DRUG ABUSERS A position paper of the United Nations System UNAIDS Leadership Statement Injecting Drug Use and HIV/AIDS Bangkok 11-16th July 2004

INTENSIFYING HIV PREVENTION – UNAIDS POLICY POSITION PAPER,. UNAIDS WEBSITE, JULY 2005.

JOINT UNAIDS STATEMENT ON PREVENTION AND CARE STRATEGIES FOR DRUG USERS. UNAIDS WEBSITE, JUNE 2005.

Research on HIV associated with injecting drug use

Aceijas, C., Hickman, M., Stimson, G. and Rhodes, T. (2004) Global overview of HIV among injecting drug users, *AIDS*, 18: 2295-2302.

Rhodes, T. and Simic, M. (2005) Transition and the HIV risk environment, *British Medical Journal*, 331:220-223.

Rhodes, T., Ball, A., Stimson, G. et al. (1999b) HIV infection associated with drug injecting in the Newly Independent States, eastern Europe: the social and economic context of epidemics, *Addiction*, 94: 1323-1336.

Rhodes, T., Stimson G., Crofts, N., Ball, A., Dehne, K. and Khodakevich, L. (1999a) Drug injecting, rapid HIV spread and the 'risk environment', *AIDS*, 13 (supplement A): S259-S269.

Prevention principles

WHO Europe 1998 Principals for Preventing HIV Infection Among Drug Users. WHO Regional Office for Europe: Copenhagen

ODCCP Studies in Drugs and Crime Monographs. UNAIDS Best Practice Collection UNAIDS Drug Abuse and HIV/AIDS: Lessons learned Case Studies Booklet

Central and Eastern Europe and the Central Asian States Vienna and Geneva, April 2001

American Foundation for AIDS Research (2005). The Effectiveness of Harm Reduction in Preventing the Transmission of HIV/AIDS, AmfAR, New York. www.amfar.org/binary-data/AMFAR_PPOLICY_BINARY/binary_file/14.pdf

Needle exchange

WHO, UNAIDS & UNODC. (2004). Policy Brief: Provision of sterile injecting equipment to reduce HIV transmission. <http://www.who.int/hiv/pub/advocacy/idupolicybriefs/en/>

Wodak, A. & Cooney, A. (2004). Evidence for Action Technical Papers: Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS among Injecting Drug Users. Geneva: World Health Organization. <http://www.who.int/hiv/pub/idu/pubidu/en/>

Hurley, S. F., Jolley, D. J. & Kaldor, J. M. (1997). "Effectiveness of needle-exchange programmes for prevention of HIV infection." *The Lancet* 349(9068): 1797-1800.

Outreach

Needle, R. H., Burrows, D., Friedman, S., Dorabjee, J., G, T., Badrieva, L., Grund, J., PC, Suresh Kumar, M., Nigro, L., Manning, G. & Latkin, C. (2004). Evidence for Action: Effectiveness of Community-Based Outreach in preventing HIV/AIDS among Injecting Drug Users. Geneva: World Health Organization. <http://www.who.int/hiv/pub/idu/idu/en/>

Substitution treatment

Gowing, L., Farrell, M., Bornemann, R. & Ali, R. (2004). Substitution treatment of injecting opioid users for prevention of HIV infection (Cochrane review). In: *The Cochrane Library (Issue 4)*. Chichester (UK): John Wiley & Sons, Ltd.

World Health Organization (2004). WHO/UNODC/UNAIDS position paper – Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention. WHO, UNODC, UNAIDS. http://www.who.int/substance_abuse/publications/treatment/en/