

***Controlling HIV among
injecting drug users: current
status of harm reduction***

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Questions:

1. How important globally is HIV among injecting drug users (IDUs)?
2. What can be done to control these HIV infections?
3. What is 'harm reduction'?
4. What is the current status of harm reduction?
5. Are we doing what has to be done?

Questions: 2

6. What stops us doing what has to be done?
7. Next steps?
8. Summary

Global importance?

- **30% global HIV infections now outside Sub Saharan Africa**
- **30% of these infections outside Sub Saharan Africa involve IDUs**
- **IDUs now account for 10% of all new global HIV infections: growing**
- **Generalised epidemics in several countries started among IDUs, often in prisons**

Global importance: 2

- **IDU in 144 countries worldwide, 128 detected HIV among IDU populations**
- **Over 41 countries with HIV prevalence among IDUs > 5%**
- **Increase: global drug production, consumption, number drug types**
- **Global illicit drug turnover \$ US 322 billion/year: profit 26-58% turnover**
- **IDU now started in 10 African countries**

How to control HIV/IDUs?

- **Education IDUs: simple, explicit, peer-based, factual**
- **Needle syringe programmes**
- **Drug treatment, especially substitution Rx e.g. methadone, buprenorphine**
- **Community development of IDUs**
- **This package = 'harm reduction'**
- **Substitution Rx improves adherence ARV**

Harm reduction:

- One of the most effective interventions in HIV/AIDS repertoire
- Needed in community and 'closed settings' i.e. detention, prisons
- Scientific debate now over:
 - effective
 - safe
 - cost-effective
- Evidence: abundant, consistent, compelling

What is 'harm reduction'?

- Means 'reducing harm from drugs even more important than reducing drug consumption'
- More effective: set, achieve realistic, sub-optimal objectives - than set, but fail to reach, utopian goals
- '80% of something > 100% of nothing'

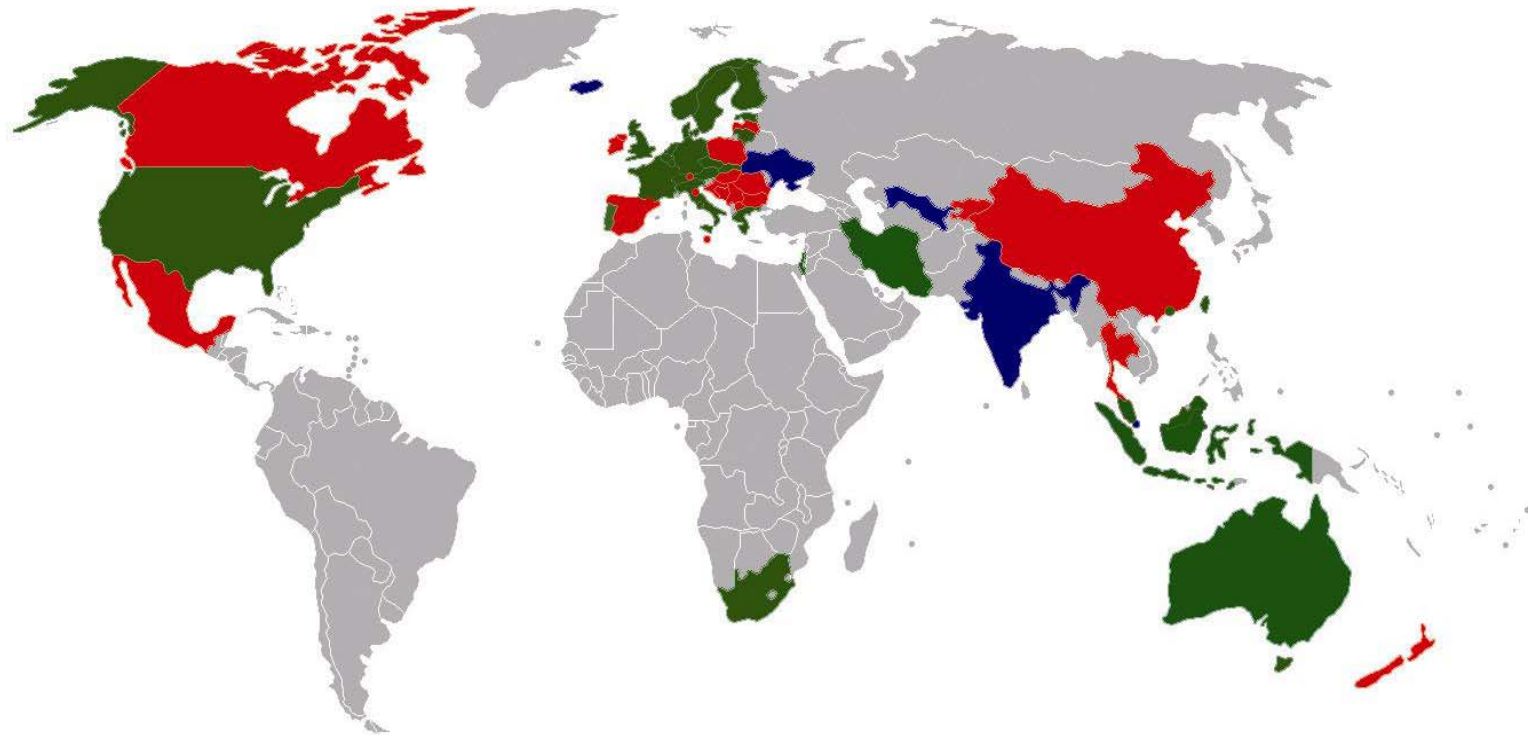
Current status harm reduction?

- Harm reduction now accepted most UN agencies – WHO, UNAIDS, UNODC, UNICEF, World Bank
- Also Red Cross/Red Crescent
- Accepted many countries Europe, Asia, Oceania, Canada, Brazil - growing
- Opposed by INCB, USA, few other countries - shrinking

Current status harm reduction?: 2

- **25/25 EU countries have needle syringe programmes, methadone**
- **25/25 countries, E &C Europe, Central Asia have needle syringe programmes**
- **Asia: China, Vietnam, Malaysia, Indonesia, Burma, Taiwan, India**
- **Every year some new countries adopt**
- **No country started harm reduction, regretted, then stopped**

Global Substitution Treatment 2005



- Methadone & Buprenorphine
- Methadone (48)
- Buprenorphine (34)

Global Needle Syringe Programmes 2003



- At Least 1 Needle Syringe Programme (65)
- No Programme (10)
- Unknown

Are we doing what has to be done?

- **Major increase acceptance harm reduction globally last 5 years**
- **Implementation of programmes now starting many countries**
- **But coverage still very low where most needed: Central & East Europe; Central, South, South East, East Asia**
- **Global coverage prisons extremely poor**

Barriers to implementation?

Excessive reliance drug law enforcement

- 89 large US cities
- Number IDUs per capita
- HIV seroprevalence among IDUs
- Drug arrests per capita
- Police employees per capita
- Corrections expenditures per capita

Friedman et al. AIDS 2006, 20:93–99

Barriers to implementation: 2

- No legal measure associated # IDUs / capita
- All 3 legal measures positively associated HIV prevalence / IDUs
- Conclusions:
 - legal measures little deterrent effect on number of IDUs
 - but may increase HIV
 - consider alternative methods maintaining social order

Barriers to implementation: 3

- **Historical:**

- Eradicating opium smoking elderly men, 10 years replaced heroin IDUs
- ‘pro-heroin effects anti-opium policies’

Westermeyer, 1976, Arch Gen Psych

- **Now:**

‘pro-HIV effects anti-heroin policies’?

Barriers to implementation?: 4

- Stigma of drug use
- Authorities many countries still fighting last war: 'war on drugs'
- *'If demand persists, it's going to find ways to get what it wants. And if it isn't from Colombia, it's going to be from someplace else.'*
Rumsfeld, 2001
- USA leading global opposition to harm reduction: AIDS incidence = 14.7/100,000

Wasteful battles:

- INCB trying since 1995 shift buprenorphine → 1961 drug treaty, constantly undermining harm reduction
- France 2006 trying to re-classify buprenorphine as 'narcotic'
- W Europe, Japan, USA spending \$US 350 billion/year agricultural protection: options drug producers?

Why oppose harm reduction?

- **Conflict between two philosophies**
- **Consequentialists: evaluate interventions by net benefits, costs**
- **Non-consequentialists: evaluate interventions by moral worthiness: 'sending the right message'**
- **Morality consigning future generations
→ endemic HIV?**

Next steps?

- **Recognise drugs primarily health problem; law enforcement secondary support**
- **Raise funding health measures same level law enforcement**
- **More inclusive planning: all major stakeholders involved**
- **Expanding coverage now *the* major priority many countries**
- **Base policy on science, human rights**

Next steps: 2

- **Some countries need advocacy for harm reduction**
- **Prevent HIV among IDUs Middle East - North Africa**
- **Need develop substitution treatment stimulant injectors**

Summary

1. HIV among injecting drug users very important globally
2. Harm reduction: effective, safe, cost-effective
3. Scientific debate now over
4. Acceptance now overwhelming, growing
5. Coverage programs extremely low but improving: now *the* major issue

Summary: 2

6. Coverage even worse prisons
7. Excessive reliance drug law enforcement *the* major barrier
8. Need more balanced approach from drug law enforcement
9. Recognise drugs primarily a health problem
10. Outcomes vs. sending messages?

Because universal access will never be achieved without human rights.

Because proven HIV-prevention and treatment programs are under attack.

Because women face a higher risk of HIV due to gender discrimination.

**Human Rights and
HIV/AIDS:**

Because human rights violations fuel social marginalization and risk of HIV.

Because AIDS activists risk their safety to hold governments to account.

Now More than Ever!

Because increased funding alone will not defeat HIV/AIDS.

Because human rights are good for public health.

Because AIDS is not like other diseases.

Because “rights-based” responses to HIV are practical and effective.

Because human rights rhetoric is not enough.