Position Statement

Injecting Drug Users and Access to HIV Treatment

The Global Network of People living with HIV/AIDS (GNP +)

and

The International Community of Women Living with HIV and AIDS (ICW)

Amsterdam/London
October 2005

CONTENTS

1. GNP+ and ICW Statement on Harm Reduction

The Global Network of People living with HIV/AIDS (GNP+) and the International Community of Women Living with HIV and AIDS (ICW) express their strong support for harm reduction as the most effective means of preventing HIV and other blood borne infections among injection drug users. Injecting drug use is responsible for HIV infection through the use of contaminated needles and syringes and other drug injecting equipment being used by several people as well as HIV infection through sexual transmission to the partners of injecting drug users and potentially to their children through mother to child transmission.

GNP+ and ICW call upon the United Nations, and particularly UNAIDS and its Cosponsors, to stand against any attempt to deny or limit access to life saving interventions such as needle and syringe exchange and other services for people who inject drugs. At the national level, GNP+ and ICW urge governments, including bi-lateral donor agencies, to adopt and promote harm reduction as best public health practice.

GNP+ and ICW also consider repressive national drug policies to be among the main obstacles to adequate access to effective HIV prevention and treatment programmes for injecting drug users. Consequently, GNP+ and ICW support efforts aimed to pressure governments to repeal drug laws and policies that impede access for injecting drug users to HIV prevention and treatment, and other health services, and commits to establishing better and stronger links between PLHIV, harm reduction and drug users' groups.

In the view of GNP+ and ICW, decades of public health research and international human rights commitments compel support for harm reduction interventions. To limit access to needle and syringe exchange, opioid substitution therapies and related services puts the lives of injecting drug users, their sexual partners and children in danger and exacerbates the HIV pandemic.

2. Background

More than two decades after the AIDS epidemic was first recognized, HIV transmission through injecting drug use is an increasingly serious public health problem in many countries and regions. There are, according to estimates, 13.2 million injecting drug users worldwide, 80% of whom live in developing and transitional countries[1]. In some countries up to 80% of HIV infections are a result of contaminated injecting equipment used during injecting drug use.

During the last decade of the 20th century the number of countries reporting injecting drug use rose from 80 to 134 and the proportion of countries with HIV outbreaks among injecting drug users rose from 65% to 84%[2]. At least 41 countries have HIV prevalence rates above 5% among injecting drug users. HIV prevalence rates above 20% have been recorded at sites in 25 of these countries, and above 50% in 15 of them[3]. In areas of Europe, Asia, the Middle East, the Southern cone of Latin America, and many parts of the United States, the use of contaminated injecting equipment is the primary mode of HIV transmission. This is a public health problem of unprecedented proportions that not only affects people who inject drugs, but also their sexual partners, their children and the wider community.

Recent estimates indicate that at least 10% of all new infections in the world – a figure that rises to 30% when Africa is excluded – can be attributed to injecting drug use[4]. According to the existing epidemiological data, in several countries, HIV epidemics have been driven almost entirely by injecting drug use. These include the states of Central and Eastern Europe of which Estonia, the Russian Federation and Ukraine appear to have the largest and most widespread epidemics. According to the United Nations Office on Drugs and Crime (UNODC), in Eastern Europe, 60% of injecting drug users are under the age of 26.

The recent, dramatic rise in HIV prevalence in South and Southeast Asia is substantially related to injecting drug use[5]. In South and Southeast Asia, the age at which people begin injecting drug use is reducing with young people being especially susceptible. Countries that have been particularly affected include China, Indonesia, Myanmar and Viet Nam. Most countries in region do not make needle and syringe programmes widely available,

---

[1] Carmen Aceijas, Gerry V. Stimson, Matthew Hickman and Tim Rhodes (2005). Global overview of injecting drug use and HIV infection among injecting drug users, *AIDS* 2004, 18:2295–2303.

[2] Needle R et al. (2000). The Global Research Network on HIV Prevention in Drug Using Populations (GRN) 1998–2000: trends in the epidemiology, ethnography, and prevention of HIV/AIDS in injecting drug users. In: *2000 Global Research Network Meeting on HIV Prevention in Drug Using Populations, Third Annual Meeting Report, 5–7 July, Durban, South Africa*. Washington, DC, National Institute on Drug Abuse.

[3] Carmen Aceijas, Gerry V. Stimson, Matthew Hickman and Tim Rhodes (2005). Global overview of injecting drug use and HIV infection among injecting drug users, *AIDS* 2004, 18:2295–2303.

[4] UNAIDS. *Report of the Global HIV/AIDS Epidemic*, Geneva, Switzerland, 2002.

[5] Rhodes T, Ball A, Stimson GV et al. (1999). HIV infection associated with drug injecting in the newly independent states, eastern Europe: the social and economic context of epidemics. *Addiction* 94:1323–1336.

Lai S, Liu W, Chen J, Yang J, et al. (2001). Changes in HIV-1 incidence in heroin users in Guangxi province, China. *Journal of AIDS*, 26:365–370.

Hien NT, Giang LT, Binh PN, et al. (2001). Risk factors of HIV infection and needle sharing among injecting drug users in Ho Chi Minh City, Vietnam. *Journal of Substance Abuse,* 13:45–58.

Panda S, Chatterjee A, Bhattacharya S K, Manna B, Singh, Sarkar S, Naik T N, Chakrabarti S and Detels R (2000).Transmission of HIV from injecting drug users to their wives in India. *International Journal STD AIDS,* 7:468–473.

drug substitution treatment is illegal and law enforcement still represents the main response in dealing with drug use.

Injecting drug use is a global phenomenon including, most recently, Africa, which is also increasingly being used for the trafficking of heroin and cocaine. The joint study between the World Health Organization (WHO), the Nigerian Ministry of Health and the University of Ilorin on drug abuse concluded that injecting drug use with associated health consequences was an emerging problem in Lagos, Nigeria. Injecting drug use has already been described as a major problem in Mauritius. Reports indicate increasing numbers of injecting drug users in Kenya.[6] And there is strong anecdotal evidence from Tanzania of an evolving drug problem.[7] In South Africa, HIV prevalence among injecting drug users was found to be 2.0% in a study conducted in 1991-1992[8].

Explosive growth is one characteristic of injecting drug use-related HIV epidemics. In several well documented instances, HIV seroprevalence among injecting drug users rose from 1%–2% to 60%–70% in a few years[9]. The most obvious explanation is the efficacy of blood-borne transmission through contaminated needles and syringes and other drug injecting equipment being used by several people.

There is great diversity among drug users and HIV/AIDS strategies need to be appropriately adapted for special drug-using populations such as:

- women;
- prisoners;
- young drug users, including children under the age of 15 years old;
- occasional drug users;
- sex workers;
- mobile and displaced populations, such as in conflict areas;
- ethnic and language minorities; and
- urban and rural communities.

A universal characteristic of injecting drug use-related HIV epidemics is that although males constitute the majority of those sero-converting in the early stages, sexual transmission to male and female partners as well as to new-born children through mother-to-child transmission may contribute to HIV transmission to the general population. It should be noted that sex work can act as a bridge between populations through the exchange of sex for drugs or sex work to support drug use

Most injecting drug users are at a high risk of contracting HIV, hepatitis B and C and other infections. They often suffer stigma and discrimination and face high levels of police harassment and incarceration.

---

[6]The prevalence rate of opiate abuse in Kenya is 0.1%, *World Drug Report*, UNODC, 2001, in *Assistance to country responses on HIV/AIDS associated with injecting drug use by the UN and other agencies*, Report for the Interagency Task Team on injecting drug use, 2003.

[7] United Nations Interagency Task Team. *Assistance to country responses on HIV/AIDS associated with injecting drug use by the UN and other agencies, Report for the Interagency Task Team on injecting drug use*, 2003.

[8] Williams PG, Ansell SM, Milne FJ. Illicit intravenous drug use in Johannesburg - medical complications and prevalence of HIV infection, *S Afr Med J* 1997; 87:889–891.

[9] Grassly NC, Lowndes CM, Rhodes T (2003). Modelling emerging HIV epidemics: the role of injection drug use and sexual transmission in the Russian Federation, China, and India. *International Journal of Drug Policy,* 14:25–43.

De la Fuente L, Bravo MJ, Barrio G, Parras F, Suarez M, Rodes A, Noguer I (2003). Lessons from the History of the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome Epidemic among Spanish Drug Injectors. *Clinical Infectious Diseases,* 37(Supplement 5):S410–5.

There are specific issues related to injecting drug use and women, including an increased risk of HIV infection through involvement in forced, dangerous sex work to provide money for drugs, and the female partners of injecting drug users, who suffer from domestic violence are in a more isolated situation than most women suffering from domestic violence.

The health risks related to incarceration or being placed in any closed setting are numerous, including physical and sexual assault, depression and suicide, unsafe injecting drug use and infection with Tuberculosis and blood-borne infections such as Hepatitis B and C, and HIV. In health terms, prison may be the most dangerous environment that most drug users will ever encounter; yet injecting drug users are disproportionately overrepresented in such institutions. In many countries incarceration in some type of closed setting e.g. compulsory detoxification and rehabilitation centres and labour camps is presented as 'treatment' for drug dependence or use. While forcing drug user into compulsory treatment is a clear violation of fundamental human rights; there is no evidence that such approaches are effective in treating drug dependence.

It has to be noted that globally drug users receive little or no sympathy from the general population, and too often the issues of drug use, HIV and harm reduction strategies are entangled in political, religious and moral debates to the detriment of prevention and care efforts. Even within the global movement of people living with HIV/AIDS, based on the human rights of all to life, dignity, access to health care and to treatment, the absence of the voices of drug users speaks to the difficulty of turning community rhetoric into action.

3. Global Commitments

GNP+ and ICW note Goal 6 of the United Nations Millennium Declaration, in which states committed to halting and beginning to reverse the spread of HIV/AIDS by 2015,[10] which by definition includes injecting drug use-related HIV epidemics

GNP+ and ICW further note that in the Declaration of Commitment, unanimously accepted at the 26th United Nations General Assembly Special Session (UNGASS) on HIV/AIDS, New York, United States, June 2001, States made specific commitments relevant to injecting drug users:

- By 2005, ensure that a wide range of prevention programmes which take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including … expanded access to essential commodities, including male and female condoms and sterile injecting equipment.[11]
- By 2003, all States will have eliminated any laws, policies and practices that discriminate against people living with HIV/AIDS and other highly vulnerable groups.[12]
- By 2003...to promote and protect the health of those identifiable groups which currently have high or increasing rates of HIV infection or which public health

[10] Millennium Declaration signed by 189 countries, September 2000. www.un.org/documents/ga/res/55/a55r2002.pdf.
[11] UNGASS, Paragraph 52 http://www.unaids.org/UNGASS/.
[12] UNGASS, Paragraph 58 http://www.unaids.org/UNGASS/.

information indicates are at greatest risk of and most vulnerable to new infection as indicated by such factors as the local history of the epidemic, poverty, sexual practices, drug-using behaviour, livelihood, institutional location, disrupted social structures and population movements, forced or otherwise.[13]

In May 2003 the 56th World Health Assembly endorsed the WHO Global Health Sector Strategy (GHSS) for HIV/AIDS 2003-2007[14]. The Strategy lists the core components of a health sector response to HIV/AIDS, including "promoting harm reduction among injecting drug users, such as wide access to sterile injecting equipment, and drug dependence treatment and outreach services to help reduce frequency of injecting drug use".

At the UNAIDS Programme Coordinating Board, 27-29 June 2005, the UNAIDS Policy Position Paper, *Intensifying HIV Prevention*, was adopted[15], which states:

Essential Programmatic Actions for HIV Prevention

3. Preventing transmission of HIV through injecting drug use—by developing a comprehensive, integrated and effective system of measures that consists of the full range of treatment options, (notably drug substitution treatment) and the implementation of harm reduction measures (through, among others, peer outreach to injecting drug users, and sterile needle and syringe programmes), voluntary confidential HIV counselling and testing, prevention of sexual transmission of HIV among drug users (including condoms and prevention and treatment for sexually transmitted infections), access to primary healthcare, and access to antiretroviral therapy. Such an approach must be based on promoting, protecting and respecting the human rights of drug users.

4. Harm Reduction Programmes

GNP+ and ICW note that in public health harm reduction is used to describe a concept aimed at preventing or reducing negative health consequences associated with certain behaviours. Harm reduction means working with people who use drugs to reduce the health risks and other consequences of drug use, including reducing the risks they face in their day-to-day lives. Specifically, harm reduction programmes include drug substitution treatment, the availability of sterile injecting equipment and its safe disposal (needle syringe programs), peer outreach and factual information about drugs and drug use. Harm reduction must be carried out within a public health framework in which the health, human rights and social needs of drug users and their communities are met.

While recognizing that drug use may have many negative consequences, harm reduction takes a positive stance towards drug users, their right to health and human dignity. Harm Reduction sees drug users as valued members of our communities to be supported and engaged, and marginalization, criminalization and repressive policies that may

[13] UNGASS, Paragraph 64 http://www.unaids.org/UNGASS/.
[14] http://www.who.int/hiv/pub/advocacy/ghss/en/
[15] Agenda Item 3, 8.2. UNAIDS (2005). Intensifying HIV Prevention: UNAIDS Policy Position Paper. http://www.unaids.org/html/pub/governance/pcb04/pcb_17_05_03_en_pdf.htm
The document outlines UNAIDS's policy on HIV prevention and is important for advocacy for harm reduction, including needle and syringe exchange, and drug substitution therapy.

inadvertently increase HIV transmission among injecting drug users and to non/drug users as the main barriers to effective control of HIV and AIDS in this population. Harm reduction focuses on actual harm and assumes that some people will continue to use injecting drugs despite government repression and therefore they should be encouraged to do so in a way that reduces the risks and potential harm to themselves and others.

GNP+ and ICW note that there is overwhelming scientific evidence of the safety and cost effectiveness of harm reduction strategies to reduce the negative health and social consequences of injecting drug use. There is also ample evidence that harm reduction programmes work in both developing and developed countries, and that experience of numerous programmes and projects in all regions of the world indicate that AIDS epidemics among injecting drug users can be prevented, stabilized and even reversed by timely and vigorous harm reduction strategies. It is also clear that harm reduction programmes for HIV prevention for injecting drug users have shown to be most effective when a comprehensive approach is taken, including:

- information, education and communication;
- substitution treatment including methadone, buprenorphine and heroin in any modality agreed by the client and the health professional responsible for the treatment (detoxification, short, medium and maintenance);
- drug detoxification programmes;
- non-pharmacological treatments, including psychological and/or psychiatric interventions;
- complementary services, including social incorporation and vocational training;
- the training of selected injecting drug users to be able to deal with an overdose, including the provision of naloxona;
- needle and syringes exchange programmes, disinfection of needles and syringes, and safe disposal of needles and syringes;
- community outreach;
- peer education;
- risk reduction counselling;
- voluntary counselling and HIV testing; and
- HIV treatment and care.

Although GNP+ and ICW also realize that safe injecting facilities are still a controversial harm reduction intervention, there is little doubt that such direct intervention can save thousands of lives. Safe injecting rooms are in effect safe spaces for injection with medical personal on hand to provide first aid in the event of an overdose or drop.

GNP+ and ICW therefore support efforts made in countries including Australia, Canada and Switzerland to introduce safe injecting spaces and believes that other countries should introduce them.

The main barriers to effectively scaling up harm reduction interventions remain repressive laws and policies that increase HIV transmission among and from injecting drug users. While continued failure to act can no longer be blamed on a lack of information about effective policies, programmes and interventions; in many countries, the implementation of evidence-based strategies is still lacking or too little too late. Increased resources are also required for the scaling up of harm reduction interventions.

GNP+ and ICW urge leaders, policy-makers, opinion leaders and communities to commit themselves to the adoption and implementation of evidence-based policies for

comprehensive harm reduction approaches to HIV prevention, care and treatment for injecting drug users, including the elimination of criminalization, stigmatization and marginalization of drug users and the repeal of legal, regulatory and other obstacles to effective harm reduction policies and programmes, including possession of drug injecting equipment.

5. Needle and Syringe Exchange Programmes

Some countries have passed laws prohibiting people from access to sterile needles to protect people from the harm of injecting drugs. No study has ever shown that these laws are effective in preventing injecting drug use.[16] But these laws have been effective in preventing people who inject drugs from having access to sterile needles. It is a tragic irony that the laws prohibiting access to sterile needles, laws meant to protect people, are now the cause of people dying from AIDS[17].

GNP+ and ICW note with concern the criticism by the United States and Japan of harm reduction and needle exchange at the 48th Session of the Commission on Narcotic Drugs, Vienna, Austria, 7-14 March 2005 and the growing move to restrict needle exchange programmes and other harm reduction measures.

Ensuring the availability of sterile injecting equipment so that each injection can be made free of HIV contamination is a fundamental step in breaking the chain of transmission. Needle and syringe programmes function on the bases of providing sterile needles and syringes accompanied by educational materials, the provision of condoms as well as the collection of used syringes and needles. GNP+ and ICW note that it is important to ensure that used needles and syringes are disposed of safely. In many countries, sharp bins or

---

[16] In previous Annual Reports, the International Narcotics Control Board (INCB) clarified its views on a range of "harm reduction" measures—actions which are taken with the intention of reducing the negative consequences of drug abuse. In its Report for 1993, the INCB already "acknowledged the importance of certain aspects of harm reduction as a tertiary prevention strategy for demand reduction programmes." In its Report for 2000, "the INCB reiterated that harm reduction programmes could play a part in a comprehensive drug demand reduction strategy. The Board drew attention to the fact that harm reduction programmes could not be considered substitutes for demand reduction programmes."

In its current Annual Report, 3 March 2004, the INCB reiterates specific statements and recommendations concerning the following "harm reduction" related measures:

> Needle/syringe exchange or distribution programmes
> "Governments need to adopt measures that may decrease the sharing of hypodermic needles among injecting drug abusers in order to limit the spread of HIV/AIDS. At the same time, the Board has been stressing that any prophylactic measures should not promote and/or facilitate drug abuse."
>
> Substitution and maintenance treatment
> The implementation of substitution and maintenance treatments "does not constitute any breach of treaty provisions, whatever substance may be used for such treatment in line with established national sound medical practice."

http://www.incb.org/e/press/2004/press_release_2004-03-03_4.pdf

The United States argued against needle syringe programmes (NSPs) claiming that they have evidence that needle exchange leads to increased drug use, but this was rejected by 10 countries that spoke in response referring to studies that show the opposite

[17] Day, Dawn, PhD. (Director of the Dogwood Center, United States). *A religious person's view of the moral issues related to the spread of HIV/AIDS among injection drug users,* 1995.
http://www.dogwoodcenter.org/publications/Day96c.html

containers are placed in toilets or other localities out of the view of the general public. The inappropriate disposal of needles and syringes is often cited as a fundamental reason why communities reject needle and syringe exchange programmes.

Some prison programmes have begun to demonstrate the feasibility and efficacy of harm reduction, medical treatment and health promotion efforts in prisons. By December 2000, nineteen prisons in three countries, Germany, Spain and Switzerland, had needle and syringe exchange programmes. All evaluations of these programmes have been favourable and without any reported unintended negative consequences[18]**.** More recently, needle and syringe exchange programmes have been implemented in 53 prisons in 6 countries (Belarus, Germany, Kyrgyzstan, Moldova, Spain and Switzerland,) has been published[19].

GNP+ and ICW therefore support efforts made in countries including Belarus, Germany, Kyrgyzstan, Moldova, Spain and Switzerland to introduce needle and syringe exchange programmes in prisons and believes that other countries should introduce them.

6. Drug Substitution Treatment

GNP+ and ICW acknowledge that drug substitution treatment for opiate use with methadone and buprenorphine, or the prescription of heroin as in Canada, Germany, Netherlands, Spain and Switzerland, provides injecting drug users with access to medication of known quality, purity and potency, obtained from health services or other legal channels, and represents an essential component for retaining opiate-dependent drug users in any kind of treatment and is an essential component of HIV prevention, treatment and care. Furthermore, although opiate substitution is a critical tool for HIV treatment, the absence of available stimulant substitution treatment is not itself a reason to exclude stimulant users from HIV treatment though this does produce its own set of challenges.

In the context of antiretroviral treatment, drug substitution treatment provides additional entry points for scaling up treatment. Drug substitution treatment can also improve adherence and access to care for those who are often marginalized and discriminated against in health care systems. Moreover, drug substitution treatment can contribute to changing negative attitudes towards drugs users, and it reinforce an awareness that drug users are 'normal' members of society who have the same rights as all other members of society. Thus drug substitution treatment contributes to meeting the goal of full, equal and universal access to antiretroviral treatment.

In 2004, the WHO, UNODC and UNAIDS issued a joint position paper, affirming that opiate substitution treatment substantially reduced heroin use, HIV infection, drug overdose deaths and criminal activity by drug users[20].

---

[18] Dolan K, Rutter S, and Wodak AD (2003). Prison based syringe exchange programs: A review of international research and development. *Addiction*, 98: p. 153-158.

[19] Lines R, Jürgens R, Stöver H, Laticevschi D and Nelles J (2004). *Prison Needle Exchange: A Review of International Evidence and Experience*, Canadian HIV//AIDS Legal Network, Montreal. Available at www.aidslaw.ca cited 8 December 2004.

[20] WHO/UNODC/UNAIDS position paper (2004). Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention.
http://www.who.int/substance_abuse/publications/en/PositionPaper_English.pdf

The WHO's essential drugs list includes medicines that are required to meet a minimum standard of health care in all countries. Drugs are only added to the list if a committee of experts concludes they are the most effective drug for a priority health condition. Adding methadone and buprenorphine to the essential drug list emphasize the important roles methadone and buprenorphine play in helping active drug users benefit from HIV treatment and any delay is detrimental to the coverage and quality of treatment for opiate addicted persons, including those living with HIV/AIDS.

Considering the issue from both evidence-based and human-rights approaches GNP+ and ICW see limiting access to drug substitution treatment as putting the lives of injecting drug users in danger, and as a further barrier to securing equal and universal access to antiretroviral treatment. Based on these considerations, GNP+ and ICW strongly support the inclusion of methadone and buprenorphine on the World Health Organization's List of Essential Drugs and opposes restrictions that limit access to drug substitution treatments.

7. Access to Antiretroviral Therapy

At the end of 2004, there were 36 156 former/current injecting drug users with access to antiretroviral therapy in 45 developing and transitional countries, of whom 30 000 were in Brazil. This means that only some 6000 injecting drug users from the other 44 countries are receiving antiretroviral therapy. The coverage of antiretroviral therapy was 13.89% (3 668 389 people in need of ART out of 509 690 people estimated in receipt of antiretroviral therapy) However, in spite of the important contribution to the spread of the epidemic made by unsafe injecting practices (e.g.: 73.95% of HIV cases in Eastern Europe and Central Asia are attributed to injecting drug use), injecting drug users represent 7% of the people on antiretroviral therapy[21].

The available information shows an extremely low rate of access to antiretroviral therapy by injecting drug users among antiretroviral therapy recipients. Furthermore, as many of the injecting drug users with access to antiretroviral therapy are in fact former injecting drug users (at least at the time that they were enrolled in treatment) the access of injecting drug users to antiretroviral therapy is unconscionably low.

As the above illustrates, illicit drug users are at risk of poor access to antiretroviral therapy. This is often a result of misconceptions held by health care providers regarding active drug use and their adherence to drug regimes that result in hesitancy to offer antiretroviral therapy to active drug users. Various international and national bodies have emphasized the complicated nature of social factors that influence treatment compliance and recommend working closely with all patients eligible for therapy, emphasizing that it is impossible to isolate any single social factor which will lead to non-compliance[22].

---

[21] Carmen Aceijas, Edna Oppenheimer, Gerry V. Stimson and Mathew Hickman (Paper in preparation). A*ntiretroviral treatment for injecting drug users in developing and transitional countries before the end of the 3by5.*

[22] International AIDS Society-USA Panel (2000). Updated Recommendations of the International AIDS Society-USA Panel. *Journal of the American Medical Association* 283(1).
British HIV Association (25 April 2001). *Adult Antiretroviral Treatment Guidelines: adherence*. www.aidsmap.com.
Brazilian Ministry of Health (2000). *Recommendations for Antiretroviral Therapy in Adults and Adolescents Infected with HIV 2000.*

Drug users are often poor and marginalized and therefore confront major barriers to medical care[23]. Often, they are less likely to receive antiretroviral therapy, despite having lower CD4 counts and higher viral loads[24]. Yet scientific evidence shows that when properly engaged by an experienced health care provider and adequate support, HIV-positive injecting drug users have clinical outcomes equivalent to those of HIV-positive people who do not use drugs[25]. International organizations, including the World Health Organization and the International AIDS Society as well as national bodies, including the Brazilian Ministry of Health, the British HIV Association, the Spanish AIDS Study and the United States Department of Health and Human Services recommend no physician should refuse effective therapy to a patient who wants it, including active drug users.

Thus GNP+ and ICW believe that being an active drug user is not a valid criterion for denying individual access to treatment and care. Antiretroviral therapy offers an opportunity to improve the prognosis and quality of life of all people living with HIV and AIDS. For HIV-positive injecting drug users, antiretroviral therapy may be also an incentive to take up contact with health care services, facilitating prevention, HIV voluntary counselling and testing as well as AIDS care, support and treatment. It is also an entry point for the treatment of drug use and other co-morbidities such as Tuberculosis, hepatitis B and C.

Spanish AIDS Study group and Secretariat of the Spanish National Plan on AIDS (2000). *Recomendaciones de GESIDA/Plan Nacional Sobre el Sida Repeto al Tratamiento Antoretroviral en Pacientes Adultos Infectadas por el VIH el Año 2000*.

United States Department of Health and Human Services (5 February 2001). *Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents*. Panel on Clinical Practices for Treatment of HIV Infection. www.hivatis.org.

Luber AD, Sherman M, Gotterer H, et al (2000). Community collaborations between physicians and pharmacists improved adherence with HIV Consensus Panel Guidelines and enhances the care of HIV infected individuals. Abstract 800. *40th Interscience Conference o Antimicrobial Agents and Chemotherapy*. Toronto, Canada, 2000.

[23] Celentano DD, Vlahov D, Cohn S, et al. Self-reported antiretroviral therapy in injection drug users. *Journal of the American Medical Association* 1998; 280(6):544-546.

Shapiro MF, Morton SC, McCaffrey DF, et al (1999). Variations in the care of HIV-infected adults in the United States: Results from the HIV Cost and Services Utilization Study. *Journal of the American Medical Association* 281:2305-2315.

Strathdee SA, Palepu A, Comelisse PG, et al (1998). Barriers to use of free antiretroviral therapy in injection drug users. *Journal of the American Medical Association* 280:547-549.

O'Connor PG, Selwyn PA, Schottenfield RS (1994). Medical care for injection-drug users with human immunodeficiency virus infection. *New England Journal of Medicine* 331:450-459.

[24] Mocroft A, Madge S, Johnson AM, et al (1999). A comparison of exposure groups in the EuroSIDA study: starting highly active antiretroviral therapy (HAART), response to HAART, and survival. *Journal of Acquired Immune Deficiency Syndromes* 22(4):369-378.

Junghans C, Low N, Chan P, et al (1999). Uniform risk of clinical progression despite differences in utilization of highly active antiretroviral therapy: Swiss HIV cohort study. *AIDS* 13(18):2547-54.

Bassetti S, Battegay M, Furrer H, et al (1999). Why is highly active antiretroviral therapy (HAART) not prescribed or discontinued? Swiss HIV cohort study. *Journal of Acquired Immune Deficiency Syndromes* 21(2):114-9.

Strathdee SA, Palepu A, Cornelisse PG, et al (1998). Barriers to use of free antiretroviral therapy in injection drug users. *Journal of the American Medical Association* Aug 12;280(6):547-9.

[25] Paredes R, Mocroft A, Ole K, et al (2000). Predictors of virologic success and ensuing failure in HIV-positive patients starting highly active anteretroviral therapy in Europe: Results from the EuroSIDA study. *Archives of Internal Medicine*; 160(8):1123-1132.

8. Drug Policies and Funding

In spite of laws and governmental measures, such as intensive policing, imprisonment and, in some countries, 'war on drugs', illegal drug use is on the increase. This approach, which includes imprisonment and harassment by law enforcement agencies, drive many drug users underground, away from social support services, including health services, making contact, providing HIV education and prevention as well as and health care difficult.

In addition, legalistic approaches and government policies which aim at criminalizing the behaviour of people who use drugs have created and reinforce the stigma and discrimination faced by people who use substances. In some countries, this has been transferred to PLHIV or specifically to PLHIV who use drugs.

The sharing of needle and syringes and other drug injecting equipment is the most important factor fuelling the HIV epidemic among drug users. Drug control laws and policies should aim to reduce, not increase, the HIV risk faced by injecting drug users. Popular strategies of suppression or elimination have not contained the fast growth of HIV epidemics. Experience has shown that HIV epidemics among injecting drug users can be halted, or if injecting drug users are appropriately supported through a comprehensive harm reduction approach at an early stage, epidemics can be minimized or avoided.

Taking into consideration that repressive national drug policies are among the main obstacles for ensuring adequate access to HIV treatment and prevention programmes for injecting drug users, GNP+ and ICW support the urgent need to place and maintain pressure on governments to repeal repressive laws and policies towards injecting drug users.

Given that harm reduction programmes for HIV prevention for injecting drug users have shown to be most effective when a comprehensive approach is implemented; GNP+ and ICW encourage governments and other funding bodies to adequately support financially harm reduction programmes.

Given the link between incarceration of drug users and HIV, Hepatitis and Tuberculosis transmission, GNP+ and ICW believe that there is an urgent need to reduce the incarceration of drug users who have not committed other crimes than drug use, possession or minor trafficking (most incarcerated dealers have trafficked small amounts of drugs, often to support drug addiction).

Linked to the negative impact of incarceration policies are policing measures and policies against drug users in the community, which impede access to prevention measures for HIV, STIs and other infections, health care services and drug treatment as well as being a source of corruption and human rights abuses. GNP+ and ICW believe that policing measures and policies should support harm reduction efforts and respect human rights obligations. Furthermore, GNP+ and ICW believe that drug supply and demand reduction, and drug interdiction efforts are not in conflict with reducing individual criminality and have an important role in up holding the law.

9. Palliative Care and Analgesics

GNP+ and ICW note that additional analgesics may be needed to treat acute or chronic pain in HIV-positive injecting drug users who are on drug substitution therapy. Adequate pain relief is not obtained from the usual daily dose due to the building of tolerance. Many drug user groups complain that when a drug user is in acute pain or has chronic pain, this is ignored, as medical staff believe it to be a ploy to obtain increased doses or other drugs.

GNP+ and ICW believe strongly that pain management generally and palliative care more broadly should be available for injecting drug users as it should be for all people. In no case, should analgesic and palliative care be prescribed and accepted as a substitute to providing antiretroviral therapy to injecting drug users. Furthermore, GNP+ and ICW believe in and supports the training of health care providers on pain management generally and palliative care pharmacology.

10. Research and Drug Users.

GNP+ and ICW support an increased emphasis on epidemiological surveillance among injecting drug users regarding HIV infection and other health issues as well as more transparency in the information available. For example, in no country in North Africa and the Middle East, are injecting drug users included as a study group in the sentinel surveillance systems. This is disastrous in terms of early detection of a HIV epidemic outbreak.

There is a significant gap in the research concerning vulnerable groups such as female injecting drug users, injecting drug users who are also sex workers, young injecting drug users, injecting drug users in prisons, and men who have sex with men (MSM) injecting drug users. In relation to prisons, there virtually exists no information about what is going on in prisons among injecting drug users and HIV prevalence rates[26]. There is also a need for research on adapting interventions to different cultural or national settings, and to develop and evaluate new interventions that may produce greater reductions in sexual risk behaviours. At the same time GNP+ and ICW support the provision of good quality services for injecting drug users.

Despite high HIV prevalence, drug users have largely been excluded from clinical trials. In order to address questions relevant to the clinical care of active drug users, drug users must be properly represented in clinical research.

To date, antiretroviral therapies are marketed without adequate information on potentially life-threatening interactions with commonly used illicit drugs; drug users and their clinicians are often forced to rely on data from studies that did not include drug users or investigate drug-drug interactions. There are many moral, ethical and political questions related to clinical research. GNP+ and ICW urge key stakeholders to include drug users living with

[26] Kate Dolan, Emma Black, Ben Kite, Maria Agaliotis, Margaret MacDonald, Carmen Aceijas, Matthew Hickman and Gema Valencia (2004). *Review of injection drug users and HIV infection in prisons in developing and transitional countries. Summarised version 1*. On behalf of the UN Reference Group on HIV/AIDS Prevention and Care among IDUs in Developing and Transitional Countries.

HIV and their communities to solve these questions. Clinical research should serve the people who suffer the most.

GNP+ and ICW strongly support the European AIDS Treatment Group's (EATG) position on the inclusion of drug users in clinical research, that all governments remove legal barriers for conducting clinical research on interaction between antiretroviral therapies and illicit drugs, and that scientific research be both relevant clinically and to the populations in whom the drugs and/or interventions will be used[27].

11. Sexual Reproductive Rights

HIV-positive women, who are injecting drug users, are often in the "frontline" when it comes to facing stigma and discrimination in regards to founding a family, accessing contraception or abortion, particularly by health care professionals who may have judgmental attitudes about whether HIV-positive women who are injecting drug users or have been are "suitable" mothers or should become mothers at all. For example, HIV positive women injecting drug users may be coerced or forced to have an abortion.

GNP+ and ICW support the right of all people living with HIV, particularly HIV-positive female injecting drug users, to have control over and to exercise informed choices regarding their sexual and reproductive health rights, including founding a family, using of contraception and abortion, and to be able to access treatment, care and support. Furthermore, HIV-positive female injecting drug users, HIV-positive male injecting drug users and their partners must have the access to technologies such as microbicides, assisted conception such as in vitro fertilization and sperm washing, as other people living with HIV.

12. People Living with HIV and AIDS and Drug Users

In addition GNP+ and ICW recognize the discrimination within the PLHIV and larger AIDS advocacy community against such populations as injecting drug users and sex workers. In response, GNP+ and ICW will establish better and stronger linkages between PLHIV and harm reduction and drug users' groups through inclusion in decision-making and the design and implementation of programmes, providing public support and advocacy efforts.

GNP+ and ICW calls on international, regional and national networks and organizations of PLHIV to work with drug user groups and to ensure the full inclusion of HIV-positive injecting drug users in decision-making and the design and implementation of programmes.

[27] European AIDS Treatment Group (EATG) (7 July 2005). Position paper on clinical research and drug users. http://www.eatg.org/download/EATG_PPDU_2005.pdf

13. GNP+ Global Advocacy Agenda

The Global Network of People living with HIV/AIDS (GNP+)[28] is a global network for and by people with HIV/AIDS. This policy position on harm reduction also supports GNP+'s principal goal of working to improve the quality of life of people living with HIV/AIDS. GNP+ works towards this through advocacy, capacity building, and communications programmes that use strategies based on:

- ADVOCATING for Inclusion, Visibility, Access, Rights;
- LINKING by Networking, Mentorship, Dialogue, Education; and
- SHARING of Capacities, Knowledge, Strength, Resources.

This policy position on harm reduction forms part of GNP's Global Advocacy Agenda, which was developed at the 9th International Conference of People Living with HIV/AIDS, Warsaw, Poland, August 1999. There PLHIV activists developed a policy platform, which underpins GNP+'s advocacy work. The policy platform consists of three target areas:

- promoting access to treatment and care for all people living with HIV/AIDS;
- combating stigma and discrimination against people living with HIV/AIDS at all levels; and
- advancing the greater and more meaningful involvement of people living with HIV/AIDS in the decisions that affect their lives and the lives of their communities

14. ICW

The International Community of Women Living with HIV/AIDS (ICW)[29] was established as a response to the desperate lack of support, information and services available to women living with HIV worldwide and the lack of influence and input they had on policy development. ICW is now the only international network of HIV positive women with 3000 members in 134 countries.

ICW's vision is a world where all HIV-positive women:

- have a respected and meaningful involvement at all political levels where decisions that affect our lives are being made;
- have full access to care and treatment; and
- enjoy full rights irrespective of our culture, age, religion, sexuality, social or economic status/class and race.

ICW works in a number of ways to achieve its vision, including:

- advocating at the international level where decisions are made that can significantly impact our sexual and reproductive rights and access to care, treatment and support. For example, ICW is the convening agency for the treatment and care arm of the Global Coalition on Women and AIDS;
- supporting the participation of members at international conferences where we can make a difference, including conferences of People Living with HIV/AIDS and the International AIDS Society;

[28] For more information see http://www.gnpplus.net/
[29] For more information see http://www.icw.org/tiki-view_articles.php

- producing research conducted by women living with HIV/AIDS on the experiences and rights of HIV positive women worldwide;
- developing through our regional staff the solidarity, skills and knowledge of members at a grassroots level; and
- organizing workshops across the world aimed at sharing and developing the activist skills and experiences of members, for example workshops for young women in Africa.

15. Endorsements

GNP+ and ICW endorse:

- The International Federation of the Red Cross and Red Crescent Societies (IFRC). *Spreading the light of science - Guidelines on harm reduction related to injecting drug use*, Geneva, Switzerland, 2003.[30]
- WHO. *Effectiveness of Drug Dependence Treatment in Preventing HIV among Injecting Drug Users*. Evidence for action technical papers. 2005.[31]
- WHO. *Policy and Programming Guide for HIV/AIDS Prevention and Care among Injecting Drug Users*, 2005.[32]
- WHO. *Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS among Injecting Drug Users*. Evidence for action technical papers. 2005.[33]
- WHO. *Evidence for Action on HIV/AIDS and Injecting Drug Use, Reduction of HIV Transmission through Outreach*. 2004.[34]
- WHO. *Evidence for Action on HIV/AIDS and Injecting Drug Use, Provision of Sterile Injecting Equipment to Reduce HIV Transmission*. 2004.[35]
- WHO. *Evidence for Action on HIV/AIDS and Injecting Drug Use, Reduction of HIV Transmission through Drug-Dependence Treatment*. 2004.[36]
- WHO. *Evidence for Action on HIV/AIDS and Injecting Drug Use, Reduction of HIV Transmission in Prisons*. 2004.[37]
- WHO. *Advocacy Guide: HIV/AIDS Prevention among Injecting Drug Users*. 2004.[38]
- WHO. *Effectiveness of Community-Based Outreach in Preventing HIV/AIDS among Injecting Drug Users*. Evidence for action technical papers. 2004.[39]
- WHO. *Training Guide for HIV Prevention Outreach to Injecting Drug Users. Workshop Manual*. 2004.[40]

[30] http://www.ifrc.org/what/health/tools/harm_reduction.asp
[31] http://www.who.int/hiv/pub/idu/en/drugdependencefinaldraft.pdf
[32] http://www.who.int/hiv/pub/prev_care/en/policyprogrammingguide.pdf
[33] http://www.who.int/hiv/pub/prev_care/en/effectivenesssterileneedle.pdf
[34] http://www.who.int/hiv/pub/advocacy/en/throughoutreachen.pdf
[35] http://www.who.int/hiv/pub/advocacy/en/provisionofsterileen.pdf
[36] http://www.who.int/hiv/pub/advocacy/en/drugdependencetreatmenten.pdf
[37] http://www.who.int/hiv/pub/advocacy/en/transmissionprisonen.pdf
[38] http://www.who.int/hiv/pub/advocacy/en/advocacyguideen.pdf
[39] http://www.who.int/hiv/pub/prev_care/en/evidenceforactionreprint2004.pdf
[40] http://www.who.int/hiv/pub/prev_care/en/trainingguideweb.pdf