Annex to the Report of

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PREVENTING THE TRANSMISSION OF HIV AMONG DRUG ABUSERS

A position paper of the United Nations System

Background

1. The aim of this paper is to present a United Nations (UN) system wide position on policy and strategies to prevent the transmission of HIV among drug abusers. Drug abuse and HIV/AIDS issues cut across much of the work of the United Nations family. Both are directly and indirectly associated with many complex public health and social problems. They affect the workplace, undermine social and economic development, and affect the lives and well being of children.

2. This paper is based on the experiences of various UN agencies and programmes in their work to prevent and treat drug abuse and HIV infection as well as on relevant policy principles guiding the work of the United Nations. It draws on research findings to recommend evidence-based practice, to provide general guidance, and to indicate some programming principles for the prevention of drug abuse and HIV/AIDS.

3. Sharing or use of contaminated needles is a very efficient way of spreading HIV. Since injecting drug abusers are often linked in tight networks and commonly share injecting equipment, HIV can spread very rapidly in these populations. Currently, 114 countries have reported HIV infection among drug injectors. Injecting drug abuse is the main or a major mode for transmission of HIV infection in many countries of Asia, Latin America, Europe, and North America.

4. In 1998, 136 countries reported the existence of injecting drug abuse. This is a significant increase as compared to 1992, when 80 countries reported injecting. This illustrates a worrying trend for diffusion of injecting into an increasing number of developing countries and countries in economic transition, where previously the behaviour was often virtually unknown.

5. Numerous studies have also found drug injectors to be disproportionately likely to be involved in the sex industry or to engage in high-risk sexual activities. Drug injecting may also contribute to an increased incidence of HIV infection through HIV transmission to the children of drug injecting mothers, and through sexual contacts between drug injectors and non-injectors.

6. HIV risk among drug abusers does not arise only from injecting. Many types of psychoactive substances, whether injected or not B including alcohol B are risky to the extent that they affect the individual's ability to make decisions about safe sexual behaviour. Studies have associated crack-cocaine use with elevated levels of high-risk

sexual behaviours, for example in the United States, where crack-cocaine abusers account for an increasing proportion of AIDS cases.

7. Deciding on the implementation of the intervention strategies to prevent HIV in injecting drug abusers is one of the most urgent questions facing policy makers. Studies have demonstrated that HIV transmission among injecting drug abusers can be prevented and that the epidemic already has been slowed and even reversed in some cases. HIV prevention activities which have shown impact on HIV prevalence and risk behaviour include AIDS education, access to condoms and clean injecting equipment, counseling and drug abuse treatment.

8. Drug abuse treatment is one approach that may have an impact on preventing HIV infection. Many large-magnitude studies have shown that patients participating in drug substitution treatment such as methadone maintenance, therapeutic communities, and outpatient drug-free programmes decrease their drug consumption significantly. Several longitudinal studies examining changes in HIV risk behaviours for patients currently in treatment have found that longer retention in treatment, as well as completion of treatment, are correlated with reduction in HIV risk behaviours or an increase in protective behaviours. However, studies have found more effectiveness for changing illicit drug use than changing sexual risk behaviour.

9. Drug abuse treatment is not chosen by all drug abusers at risk for HIV infection, or may not be attractive to drug abusers early in their injecting career. In addition, recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment. Relapses to drug abuse and risk behaviour can occur during or after successful treatment episodes. Various outreach activities have been designed to access, motivate and support drug abusers who are not in treatment to change their behaviour. Findings from research indicate that outreach activities that take place outside the conventional health and social care environments reach out-of-treatment drug injectors, increase drug treatment referrals, and may reduce illicit drug use risk behaviours and sexual risk behaviours as well as HIV incidence.

10. Several reviews of the effectiveness of syringe and needle exchange programmes have shown reductions in needle risk behaviours and HIV transmission and no evidence of increase into injecting drug use or other public health dangers in the communities served. Furthermore, such programmes have shown to serve as points of contact between drug abusers and service providers, including drug abuse treatment programmes. The benefits of such programmes increase considerably, if they go beyond syringe exchange alone to include AIDS education, counseling and referral to a variety of treatment options.

United Nations System Policy

11. Several UN documents provide the framework/foundation for the formulation of strategic approaches to preventing the transmission of HIV among injecting drug abusers.

UN Drug Control Conventions and the Declaration on the Guiding Principles of Drug Demand Reduction

12. The policy of permitting the use of narcotic drugs for medical and scientific needs, while preventing their use for non-medical purposes, goes back to the late nineteenth and early twentieth centuries. At that time there was an increasing awareness of the dangers associated with the narcotic drugs that had previously been widely used for pain relief, especially opium-based preparations. Hence, many countries began to restrict the distribution of such drugs, while permitting their use for medical and scientific purposes.

13. This policy is articulated in the preamble to the *1961 Single Convention on Narcotic Drugs*, which reads as follows:

"Recognizing that the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes, *Recognizing* that addiction to narcotic drugs . . . is fraught with social and economic danger to mankind . . ., *Desiring* to conclude a generally acceptable international convention replacing existing treaties on narcotic drugs, limiting such drugs to medical and scientific purposes . . .".

The *Convention* further specifies that the "parties shall give special attention to the provision of facilities for the medical treatment, care and rehabilitation of drug addicts" (Article 38).

14. Also the *1971 Convention on Psychotropic Substances* in its Article 20, paragraph 1 states that parties to the convention shall take all appropriate measures for the prevention of abuse of psychotropic substances and for the early identification, treatment, education, after-care, and rehabilitation and social reintegration of the persons involved.

15. The *1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* in its Article 14, paragraph 4 indicates that parties to the convention shall adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and narcotic substances, with a view to reducing human suffering.

16. In 1998, the UN General Assembly adopted the *Declaration on the Guiding Principles of Drug Demand Reduction*, the first international instrument to deal exclusively with the problem of drug abuse. The *Declaration* emphasises that demand reduction programmes should cover all areas of prevention, from discouraging initial use to reducing the negative health and social consequences of drug abuse for the individual and society as a whole.

UN Human Rights Documents

17. *The Universal Declaration of Human Rights*, which was adopted fifty years ago as a common standard of achievement for all peoples and all nations, states:

"Everyone, as a member of society, has the right to social security and is entitled to realization . . . of the economic, social and cultural rights indispensable for his dignity and the free development of his personality" (Article 22)

"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services. . ." (Article 25).

18. In 1999, the Commission on Human Rights passed a resolution (1999/49) which invited States, United Nations bodies as well as international and non-governmental organizations "to take all necessary steps to ensure the respect, protection and fulfillment of HIV-related rights. . ."

19. In May 2000, the Committee on Economic, Social and Cultural Rights, which is the United Nations human rights monitoring body, adopted a General Comment on the right to health. The Comment proscribes "any discrimination in access to health care and the underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health" (paragraph 18).

UN Health Promotion Policy Documents

20. Respect for human rights and the achievement of public health goals are complementary. Health, as defined in the *Constitution of WHO* (1946), is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The *Constitution* proclaims that "the enjoyment of the highest attainable standard of health" is one of the fundamental human rights of every human being without distinction for race, religion, political belief, economic or social condition.

21. The concept and vision of *Health for All*, which was adopted in 1977 by the Thirtieth World Health Assembly, sets the main social target of governments and WHO as "the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life".

22. The *Ottawa Charter on Health Promotion* (1986) outlines five areas for action: building public health policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services. These areas are all relevant to drug abuse issues and HIV/AIDS.

23. During its session in May 1998, the World Health Assembly endorsed the new World Health Declaration and the new global health policy *Health for All in the 21st Century*. *Health for All in the 21st Century* guides action and policy for health at all levels and identifies global priorities and targets for the first two decades of the 21st century. Key values such as human rights, equity, ethics and gender sensitivity should underpin and be incorporated in all aspects of health policy. A key feature is the strengthening of the participation of people and communities in decision- making and actions for health.

24. Important global "health for all" targets by 2020 include:

". . . the *worldwide burden of disease will be substantially decreased*. This will be achieved by implementation of sound disease-control programmes aimed at reversing the current trend of increased incidence and disability caused by tuberculosis, HIV/AIDS, . . . all countries will have introduced, and be actively managing and monitoring, strategies that s*trengthen health-enhancing lifestyles* and *weaken health-damaging ones*, through a combination of regulatory, economic, educational, organizational and community-based programmes".

Principles and Strategic Approach

25. *Protection of human rights is critical for the success of prevention of HIV/AIDS.* People are more vulnerable to infection when their economic, health, social or cultural rights are not respected. Where civil rights are not respected, it is difficult to respond effectively to the epidemic.

26. *HIV prevention should start as early as possible*. Once HIV has been introduced into a local community of injecting drug abusers, there is the possibility of extremely rapid spread. On the other hand, experience has shown that injecting drug abusers can change their behaviour if they are appropriately supported.

27. *Interventions should be based on a regular assessment of the nature and magnitude of drug abuse as well as trends and patterns of HIV infection*. Interventions need to build on knowledge and expertise acquired from research, including empirical knowledge about the social milieu around which drug taking revolves as well as lessons learned from the implementation of previous projects and interventions.

28. *Comprehensive coverage of the entire targeted populations is essential*. For prevention measures to be effective in changing the course of the epidemic in a country, it is essential that as many individuals in the at-risk populations as possible are reached.

29. *Drug demand reduction and HIV prevention programmes should be integrated into broader social welfare and health promotion policies and preventive education programmes.* Specific interventions for reducing demand for drugs and preventing HIV should be sustained by a supportive environment in which healthy lifestyles are attractive and accessible, including poverty reduction and opportunities for education and employment. It is desirable to include multi disciplinary activities and provide appropriate training and support to facilitate joint working.

30. *Drug abuse problems cannot be solved simply by criminal justice initiatives.* A punitive approach may drive people most in need of prevention and care services underground. Where appropriate, drug abuse treatment should be offered, either as an alternative or in addition to punishment. HIV prevention and drug abuse treatment programmes within criminal justice institutions are also important components in preventing the transmission of HIV.

31. *The ability to halt the epidemic requires a three part strategy*: (i) preventing drug abuse; (ii) facilitating entry into drug abuse treatment; and (iii) establishing effective outreach to engage drug abusers in HIV prevention strategies that protect them and

their partners and families from exposure to HIV, and encourage the uptake of substance abuse treatment and medical care.

32. *Treatment services need to be readily available and flexible.* Treatment applicants can be lost if treatment is not immediately available or readily accessible. Treatment systems need to offer a range of treatment alternatives, including substitution treatment, to respond to the different needs of drug abusers. They also need to provide ongoing assessments of patient's needs, which may change during the course of treatment. Longer retention in treatment, as well as completion of treatment, are correlated with reduction in HIV risk behaviours or an increase in protective behaviours.

33. *Developing effective responses to the problem of HIV among drug abusers is likely to be facilitated by considering the views of drug abusers and the communities they live in.* Programmes need to be reality based and meaningful to the people they are designed to reach. The development of such responses is likely to be facilitated by assuring the active participation of the target group in all phases of programme development and implementation.

34. *Drug abuse treatment programmes should provide assessment for HIV/AIDS and other infectious diseases,* and counseling to help patients change behaviours that place them or others at risk of infection. Attention should be paid to drug abusers' medical care needs, including on-site primary medical care services and organized referrals to medical care institutions.

35. HIV prevention programmes should also focus on sexual risk behaviours among people who inject drugs or use other substances. Epidemiological research findings indicate the increasing significance of sexual HIV transmission among injecting drug abusers as well as among crack-cocaine abusers. Drug abusers perceive sexual risk in the context of a range of other risks and dangers, such as risks associated with overdose or needle sharing, which may be perceived to be more immediate and more important. The sexual transmission of HIV among drug abusers may often be over-looked.

36. *Outreach work and peer education outside the normal service settings, working hours and other conventional work arrangements is needed* to catch those groups that are not effectively contacted by existing services or by traditional health education. It is necessary to have a back up of adequate resources to respond to the increase in client and casework load that is likely to result from outreach work.

37. *A comprehensive package of interventions for HIV prevention among drug abusers could include:* AIDS education, life skills training, condom distribution, voluntary and confidential counselling and HIV testing, access to clean needles and syringes, bleach materials, and referral to a variety of treatment options. This complete package should be implemented along with drug abuse prevention, especially among young people.

38. *Care and support, involving community participation, must be provided to drug abusers living with HIV/AIDS and to their families*, including access to affordable clinical and home-based care, effective HIV prevention interventions, essential legal and social services, psychosocial support and counseling services.