

Drug use and HIV/AIDS

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The epidemic

AIDS is today a major threat to the world's population — to its overall social, economic and political well-being, as well as to the individual health of hundreds of millions of people. Some 5.8 million people acquired HIV in 1997. There are now over 30 million people worldwide living with HIV or AIDS — more than 90% of them in developing countries — and their numbers continue to rise sharply each year. Around 16 000 people around the world are becoming newly infected with HIV each day.

Injecting drug use

In many parts of the world, injecting drug use is the major mode of HIV transmission. This is the case in a number of Asian countries, including Malaysia, Viet Nam, Yunnan province in China, and the north-eastern states of India; parts of eastern Europe and several of the Newly Independent States; a number of Latin American countries; and some western European countries such as Spain and Italy. In the Russian Federation, more than half of all reported HIV cases to date have been in injecting drug users.

Drug use has an intimate connection with HIV. The connection occurs when drugs are injected using contaminated injecting equipment. Furthermore, it is recognized that some drug use can lead to increased sexual risk behaviour which can also result in HIV transmission.

Of all the different ways that the virus can be passed on, directly injecting a substance contaminated with HIV into the bloodstream is by far the most efficient — much more so, in fact, than through sexual intercourse. Together, therefore, drug injecting and HIV form an explosive combination. And injecting drug use plays a critical role in how and when the HIV epidemic starts in a particular region and how it continues to unfold.

In fact, in some parts of the world, injecting drug use has helped kick-start the HIV epidemic. This was the case in Thailand, where during the first nine months of 1988, HIV prevalence rates among injecting drug users in Bangkok shot up from around zero to almost 40%. Before that, there were few people known to have HIV in Thailand — and afterwards, HIV rates in Thailand rose and rose, through sex mainly. In the ten years since, approximately a million people in Thailand have become infected.

In the world today, there are at least 5.5 million — and possibly up to 10 million — injecting drug users, ranging across 128 countries and territories — up from around 80 six years ago. Some

Reducing the AIDS risk

700 000 people in the United States alone currently inject. In the Russian Federation, there are estimated to be between 350 000 and 700 000 injecting drug users — a figure over 20 times higher than the estimate in 1990.

Given that HIV infection is one of the most serious possible consequences of injecting drugs, our approach must be to reduce the harm to individuals and communities — by advocating for and strengthening effective HIV prevention programmes among drug users. How can this best be done?

Early intervention

First, it is absolutely vital that there should be early implementation of prevention initiatives, while HIV prevalence is still low — and that we shouldn't wait until the epidemic is widespread.

Comprehensive package

Second, there must be a comprehensive package of measures to prevent HIV spread among injectors. Such measures include providing sterile injecting equipment; raising awareness among and educating injectors and their sex partners about HIV risks and safe practices; making available drug treatment programmes; providing access to counselling, to care and support for HIV-infected injectors, and to STD and other health-care services; and providing condoms.

It is important that local communities — including of course the drug user community itself — are mobilized and participate fully for such measures to work. No single element of this package will be effective if practised on its own. But by far the most important element is to provide sterile injecting equipment to injectors.

Outreach and peer education

Third, the most effective way to reach injecting drug users is through outreach work and peer education. Outreach workers are trained people from outside the community of injectors — though they may themselves be former injectors. Peer educators are existing drug injectors who have been trained to work with their community.

Effective interventions

What specific interventions providing sterile needle injecting equipment have proved effective? One that has proved successful is a needle exchange programme, operated in conjunction with other components of the package. In these programmes, a clean needle and syringe are given out in exchange for a used set. The exchange can be effected by a person, or by a dispensing machine. Countries where needle exchange programmes have been successful as part of an integrated HIV prevention programme for drug injectors include Australia and the United Kingdom – and, on a smaller scale, Brazil, Nepal and the Russian Federation. There are also many other needle exchange projects now around the world, and a few of them operate in prisons, where there is often a particularly acute problem of drug injecting.

Many studies have now established that needle exchange programmes, if properly run, reduce the number of new cases of HIV infection – and at the same time do not increase drug use. And we should of course also recognize that strategies for preventing HIV infection in injecting drug users may well also reduce other health risks, including overdoses and the transmission of other bloodborne infections, such as hepatitis B, hepatitis C, syphilis and malaria.

Supportive environment

Beyond these specific essential components, there is still another important requirement. This requirement is to ensure a supportive environment. This means reducing poverty and creating opportunities for education and employment – the lack of which often leads people, out of sheer despair, to inject drugs. And laws and government policies on drugs are important too. We know that in most places drug use is illegal. Without proper policy and legislative support from above – whether at national level or local level – and all the necessary resources, there will be little hope of launching, or of successfully sustaining, comprehensive HIV prevention programmes.

And creating a supportive environment also means continuing to do everything possible to educate and inform people – especially young people – about drugs, and about their implications for health and social well-being, in language that can readily be understood.

Prevention works

Reduction of demand

Along with reducing the harm caused, an important parallel strategy is to reduce the demand for drugs. Our goal must be to stop young people from starting to take drugs in the first place — as well as encouraging existing users of all ages to stop, by participating in treatment programmes.

Partnership

And all these things will only work if in the process partnerships are created, and communities are taken into trust and not confronted. If there is one thing we have learnt it is that AIDS prevention cannot be done *to* people — it can only be done *by* people.

Here are some examples showing that programmes to reduce harm can work.

Nepal

The first is from Kathmandu in Nepal, where the Lifesaving and Lifegiving Society — LALS — has worked with Nepalese injecting drug users since 1991, exchanging sterile injecting equipment in return for contaminated equipment. Injecting drug use in Nepal is a relatively recent phenomenon. And syringes are difficult and expensive for ordinary people to come by.

As part of its comprehensive harm reduction approach, LALS also does outreach work, distributing bleach — for sterilizing needles — and condoms, and providing education, counselling, drug treatment referrals and primary health care for its clients.

After three years of the programme, indicators reflecting unsafe injecting had fallen, while knowledge of HIV risks had risen among those who had been in regular contact with LALS. HIV prevalence had remained low — falling in fact from 1.6% in 1991 to 0% in 1994. All the evidence is that LALS has had a significant effect in promoting safer injecting practices among its clients and in stopping the spread of HIV, and some of this effect will have spread beyond those in immediate contact with LALS.

Australia

The second case is that of Australia. Here, early and vigorous HIV prevention programmes aimed at injecting drug users resulted in stable and low rates of HIV prevalence among drug users and related population groups. It is generally agreed that this prompt – and sustained – action fundamentally altered the course of the country's epidemic. Annually, 10 million sterile needles and syringes are distributed or exchanged in Australia. Among participants in needle exchange programmes in 1996, HIV prevalence was just 3% – a low rate for injecting drug users.

Needle exchange programmes – including bleach distribution, access to methadone maintenance treatment, and comprehensive AIDS education – are at the forefront of harm reduction efforts among injecting drug users in Australia.

Conclusion

We must learn from the growing number of examples of best practice such as these. We need strong political commitment at the highest national level and within the United Nations system to ensure that proper programmes will be put into place and sustained. And we must ensure that adequate resources are provided both locally, and from donors.

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