HIV/AIDS, Injection Drug Use, Harm Reduction and Development

Interagency Coalition on AIDS and Development
Coalition interagence sida et développement

1 Nicholas Street, Suite 726 Ottawa ON K1N 7B7
Telephone: (613) 233-7440 • Fax: (613) 233-7440
E-mail: info@icad-cisd.com • Web: www.icad.cisd.com

Background

Injection drug use (IDU) is responsible for a large percentage of HIV infections. According to UNAIDS, up to 10% of all HIV infections worldwide are contracted from contaminated needles, syringes or other injecting equipment. More than 22% of the world's HIV/AIDS positive population inject drugs.

Governments and NGOs are increasingly using "harm reduction" to guide policy and programming—efforts which, it is hoped, will help prevent further spread of HIV and mitigate the impact of AIDS in communities with high rates of IDU.

HIV/AIDS and Drugs

Worldwide, IDU is second only to heterosexual intercourse as a cause of HIV transmission. In some regions, drug injection accounts for more than 80% of HIV/AIDS cases. Even more significant is the rate at which HIV can spread among injection drug users: In Thailand, where fewer than 1% of users were infected as of January,1988, over 40% were positive by September of the same year.

By 1999, drug injection had been reported in 134 countries worldwide. By the end of May 1999, 114 countries and territories had reported HIV associated with IDU, compared with 52 in 1992. IDU is the major cause of HIV transmission in Central and Eastern Europe, Central Asia, East Asia, North Africa, the Middle East, North America, and parts of South America.

The rapid spread of IDU has major repercussions for global public health. In Southeast Asia, the spread of HIV across borders has been associated with the spread of injecting. Geographical proximity and known migration patterns have been associated with the epidemic spread of HIV—four recent outbreaks of HIV-1 among injection drug users appear linked to trafficking routes. Different subtypes of HIV were followed when mapping the different routes.

During the 1990s, many African states reported an increase in drug-related offenses and in drug injection, raising the prospect of a second wave of HIV infection in Africa.

Many countries of Central and Eastern Europe, especially the Newly Independent States, have the highest rates of spread of HIV in the world—due to the explosive nature of HIV epidemics that are driven by IDU. Although the largest numbers of new infection occur among adolescents in sub-Saharan Africa, the most dramatic increases have been recorded among young drug users in transitional countries—in spite of data which indicates a decrease in IDU in developed countries due, in part, to aging drug users. Evidence also suggests that in Central and Eastern Europe, as in Southeast Asia, drug injection often begins under the age of 20 years.

HIV/AIDS, Injection Drug Use, Development and Transition

Because AIDS kills so many people in the prime of their lives, it poses a serious threat to development. By reducing growth, weakening governance, destroying lives, and eroding productivity, AIDS undermines development.

IDU can produce a number of harms which make it difficult for individuals and communities to reduce poverty and improve living standards. When there is a high prevalence of HIV infection among drug users and their partners, the well-being of the entire country is affected. Combined, HIV and IDU pose a significant challenge to sustainable human development in several regions. Economic, political

and social changes make the situation more difficult and increase vulnerability. Denial and discrimination make HIV prevention among injection drug users a low priority for governments, for the international community, and for donor agencies, thereby increasing the threat to development.

Injection of drugs can be found in most countries, regardless of their level of development. The spread of new modes of drug use has resulted from social, economic and political changes. In some transitional countries, the spread of injecting has occurred primarily since 1990—and the accompanying HIV epidemics have been explosive, with marked effects on economic and social development.

Civil disruption and armed struggle leading to many populations becoming refugees adds to the spread of injecting, the spread of HIV, and the continuation of the vicious cycle of poverty, underdevelopment and vulnerability.

Prevention responses in developing and transitional countries tend to lag several years behind the epidemic primarily because of development issues.

Just as AIDS is both a result of and a cause of poverty, so, too, is IDU. People who live in conditions of poverty, despair and disruption, such as those found in many communities in developing and transitional regions, are at high risk for drug-related harms. Since the harms due to injecting are often related to the use of dirty equipment, and since clean equipment is difficult and expensive to obtain, those in a state of development or disruption are at high risk of injection-related harms such as HIV infection. And there is yet another link between HIV, IDU and development: persons infected with HIV are at risk of becoming injection drug users as a means of coping with their infection and thereby exposing themselves to other strains of HIV and other pathogens.

Harm Reduction and HIV/AIDS

Harm reduction is an approach to the drug issue that focuses on the effects of drug use on the individual, the community and society as a whole. It is concerned with reducing the harmful consequences of drug use rather than targeting those who use drugs. Harm reduction accepts that some people cannot or will not give up drugs, especially in the short term, and looks for ways to keep users and their communities healthy and safe by reducing the harmful consequences of drug use. This does not mean that harm reduction approaches are not compatible with abstinence-based approaches—the two are complementary.

Harm reduction involves setting up a hierarchy of goals, with the more immediate and realistic goals to be achieved in steps on the way to risk-free use or, if appropriate, abstinence. This approach is characterized by pragmatism—because harm reduction can be applied to all drugs, legal and illegal, it is a useful approach in dealing with alcohol, nicotine and prescription drugs as well.

The harm reduction approach attempts to identify, measure and minimize the adverse consequences of drug use at a number of levels: individual, community and societal. One of the main aims of harm reduction is to reduce the spread of HIV and other infections such as hepatitis. This approach has succeeded in many regions where policies including syringe exchange and distribution, prescribing of drugs, safe-injection sites and peer-outreach to users have been introduced. In countries such as the United Kingdom, which adopted comprehensive harm reduction approaches early on, rates of HIV among injection drug users are comparatively low (the national average is 1%).

Although the underlying principle of harm reduction is pragmatism—acceptance that some level of drug use in society is inevitable—it does not rule out abstinence in the longer term. Harm reduction also recognizes the basic rights of everyone—including the dignity and rights of the drug user—and avoids either condemnation or support for use of drugs. The primary focus then becomes identifying the consequences resulting from drug use rather than the drug use itself. This means priority is given to reducing the negative consequences of drug use.

This pragmatic approach means that harm reduction addresses the realistic needs of the community in terms of day-to-day living; the approach can be

readily adapted to fit different cultures and religions. Because it works with a hierarchy of goals, the approach can focus on the most pressing needs of the individual and the community while working towards longer-term solutions—an important concern in areas where resources are scarce. Since the harm-reduction approach is grass-roots and community based, it can be tailored to the needs of a particular community and ensures community involvement from the onset, increasing the likelihood of success.

Harm reduction offers a more humane alternative to traditional approaches which focus on abstinence and punitive measures. Perhaps most importantly for developing and transitional states, harm reduction is cost-effective—it is being used effectively at the local level in developing and transitional countries. Brazil and India are currently implementing harm reduction approaches; Indonesia is also expressing an interest. These countries have been persuaded by the efficacy of the approach.

Case Studies

India

A number of harm reduction programmes have been established successfully in India and on the India-Bangladesh border. Reports of these emphasize the importance of targeting outreach to the larger community before targeting the drug users including political leaders, the police, and members of religious groups. They also point to the need to address the wives and children of users.

In New Delhi, SHARAN, an ASO, offers services to the urban poor, including injection drug users. There is a comprehensive community-based programme for IDUs, with a highly developed prevention component. SHARAN's programme is based on harm reduction and "rehabilitation before detoxification." The SHARAN drop-in centre is located in the poorest part of New Delhi and caters to the most disadvantaged segment of the community. Services include buprenorphine maintenance, a needle-syringe exchange and disposal programme, condom programming, peer education, primary health care, support groups for people living with HIV, referral to detoxification and long-term rehabilitation services, detoxification camps, family support groups, and a crisis support shelter. Despite the severity of the problems related to poverty, caste, religion, and initial local opposition, the project has demonstrated how a comprehensive programme can be established in a developing environment with severely limited resources.

Belarus

In Belarus, an HIV prevention programme for drug users based on harm reduction principles was launched by a community group in Svetlogorsk in 1997. The programme faced considerable local and political opposition but was able to deal with much of this through public education and working toward changes to drug polices and laws.

The programme includes education about safe injecting and safe sex and provides clean syringes and seems to have led to far safer behaviour among drug users. In 1997, before the prevention programme began, 92% of those surveyed said they shared syringes. By 1999, this percentage had dropped to 35%. While some people did continue to reuse syringes, the proportion who cleaned them before using them again rose to 55%, from just 16% before the campaign. The prevention project also included distribution of condoms to help reduce HIV transmission from infected drug users to their sex partners. The users appear to be taking advantage of this: by 1999 nearly two-thirds said they sometimes or always used condoms, twice as many as two years earlier.

The programme, which costs around US$ 0.36 per disposable syringe distributed, is estimated to have prevented over 2000 cases of HIV infection by its second year of operation, at a cost of around US$ 29 per infection prevented—far below the cost of treating a person with AIDS. This programme proves that, despite legal and other barriers, community harm reduction efforts can be effective, even in conditions of extreme disruption.

Bibliography

International Journal on Drug Policy, *Journal of the International Harm Reduction Association*, (n.d.) Elsevier.

Deany, P. (n.d.) *Supporting Responses to HIV/AIDS and Injecting Drug Use in Asia*. Asian Harm Reduction Network.

Deany, P. (n.d.) *HIV and Injecting Drug Use: A New Challenge to Human Sustainable Development*. UNAIDS.

IDU and HIV/AIDS: Report and Background papers (1999). Canadian HIV/AIDS Legal Network.

Riley, D.M. (1993). *The Policy and Practice of Harm Reduction*. Ottawa: CCSA

Fact Sheets and Best Practices on HIV/AIDS. Geneva: UNAIDS.

Newcombe, R., Matthews, A., Buning, E.C., Drucker, E. (eds.) (1992). *The Reduction of Drug-Related Harm*. New York: Routledge.

Heather, N., Wodak, A., Nadelmann, E., O'Hare, P. (eds.) (1993). *Psychoactive Drugs and Harm Reduction: From Faith to Science*. London: Whurr.

Erickson, P.G., Riley, D.M., Cheung, Y.W., O'Hare, P. (eds.) (1997). *Harm Reduction: A New Direction for Drug Policies and Programs*. Toronto: University of Toronto Press.

Web Sites

www.afhrn.org

www.ahrn.net

www.aidslaw.ca

www.ccsa.ca

www.ceehrn.org

www.drugpolicy.org

www.harmreduction.org

www.ihra.net

www.relard.net

www.unaids.org

www.worldbank.org

ICAD's aim is to lessen the impact of HIV/AIDS in resource-poor communities and countries. We are a coalition of Canadian international development organizations, AIDS service organizations and other interested organizations and individuals.

Funding for this publication was provided by Health Canada. The views expressed herein are solely those of the authors and do not necessarily reflect the official policy of the Minister of Health.

Additional copies are available on the ICAD Web site at www.icad-cisd.com

Le feuillet "VIH/sida, injection de drogue, réduction des méfaits et développement" est disponible en français.

November 2001