Your Excellency the Governor of Bangkok:

Executive Director of the IHRA, Dear Gerry:

Dear Friends and colleagues in the fight against AIDS and fellow harm reduction advocates:

Sawadee kap:
Bonjour:
Good morning:

Let me first extend my very warm thanks to Gerry and the organizers for the honour of inviting me to the opening of this conference.

It is always a pleasure to be among so many friends in the harm reduction community and so many people who are doing such tremendously important work.

I wish to dedicate my remarks today to two heroes of the fight, Amar and Nestor, who died of AIDS in the early '90's before triple-combination therapy became available. They taught me so much about harm reduction, about life and death, patient and doctor, and about what courage really means.

In preparing my remarks for today I was fascinated to learn of the legacy of Sir Humphrey Rolleston.

Many of you will know, as I did not, that as President of the Royal College of Physicians in 1926, he chaired the British government committee which determined that it was legitimate medical practice to prescribe heroin or morphine to people addicted to those drugs.

More than 80 years later, it is still worth returning to the language of his committee’s report. It said that the indefinite administration of morphine or heroin would be permitted for those who are “capable of leading a fairly normal and useful life so long as they take a certain quantity, usually small, of their drug of addiction but not otherwise”.

What is striking about this language is both its pragmatism and its compassion. Rolleston was clearly concerned about people, and about helping people with drug dependence to lead normal lives, useful lives.

Today we would call this an approach grounded not only in sound public health rationale, but in human rights.
And that is why we are all here, to affirm our commitment to the human rights of all people, in particular, the rights of people who use drugs; to affirm our commitment to evidence-based approaches to HIV prevention and treatment. And to ensure that the compassionate and common-sense principles enunciated by Rolleston more than 80 years ago are sustained.

My remarks this morning will focus on some of the key challenges that we face as a movement. Of course, on human rights. On the political and ideological obstacles that still sadden and frustrate so many of us. On financing, including the role of the Global Fund in supporting harm reduction interventions.

But, as we struggle in this fight every day, it is perhaps easy for us to lose a sense of the progress that has been made in recent years.

Firstly, in the fight against AIDS.

As Italy is hosting the G8 this year, I have been thinking back to the last G8 meeting hosted by Italy, in Genova, in 2001. This was a very important G8 for global health, and for the Global Fund, because it was the meeting at which major donors made the first pledges to the Fund.

At Genova, eight years ago, we saw an extraordinary example of what the world can do when it comes together with a common purpose.

And since 2001, we’ve seen sustained increases in annual resources for health, notably for AIDS, which exceeded $14 billion last year.

With new resources in the last decade have come new bilateral and multilateral instruments in global health: GAVI and the World Bank MAP in 2000, the Global Fund and PEPFAR in 2003, to name a few.

We have also seen significant innovation in health financing. For example, with the establishment of Unitaid in 2005, and new approaches such as (Product) Red and Debt2Health that help to finance the Global Fund.

Progress in expanding access to antiretroviral drugs in developing countries in the last few years has been dramatic, increasing from a couple of hundred thousand on treatment in 2001 to around 4 million today.

The result is that we are seeing impressive declines in HIV-related mortality at a population level, such as in Addis Ababa, where a recent study in AIDS estimates that the reduction in AIDS deaths in 2007 was around 60 per cent¹. In Botswana, where HIV prevalence has reached 30 per cent, the mortality trend is now declining in the age groups most affected by AIDS.

A person who begins ART at age 20 in the UK can now expect to live another 40 years, and another 25 years in developing countries.

These extraordinary gains are the results of the hard work of many people, including many of you here.

If we step back and look at progress over the last ten to fifteen years, we have made progress in harm reduction, too. Indeed, as the IHRA points out in its global report, harm reduction since the late 1980s has “grown in acceptance, popularity, scientific knowledge, advocacy methods and

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evidence base. The scientific debate has been won, and only ideological or moralistic criticisms remain.”

Only five years ago, very few donors were supporting harm reduction interventions in developing countries. Since then, resources have steadily increased - in large part through the Global Fund - and countries that had long denied the existence of injecting drug use have significantly scaled up interventions, including China, Indonesia, Vietnam, Taiwan and Morocco.

Here in Thailand, methadone is now on the Essential Drugs List. Thailand will receive around $6 million dollars from the Global Fund in Round 8 to scale up needle and syringe programs through NGOs at drop-in centres and street outreach in 17 provinces. The Department of Corrections will provide methadone to IDUs in closed settings, and pharmacies in major cities will provide more sterile needles and syringes. Policy reforms are also planned.

The Malaysian Minister of Health recently informed me that Malaysia will come to the Global Fund in Round 9 with a significant request for funding for NGOs to undertake harm reduction.

These are very encouraging new developments for this region.

Last month I was in Tehran. The needle exchange and methadone programs that I saw in Keraj Prison outside Tehran, and in a neighbourhood of Shiraz, were not just impressive, but moving, in their truly humane approaches and the deep commitment of those providing services.

Our movement has some true heroes that we should pause to acknowledge and celebrate. Here I wish to particularly acknowledge my many friends in Russia. Sasha Tsekhanovitch and his colleagues at the Bodkin Clinic in St Petersburg, are just some of the many people in Russia providing compassionate and comprehensive services to drug users in a hostile political, societal, and legal environment.

Civil society groups, in Russia and around the world, have every reason to be proud of their role, as advocates, policy-makers and implementers of harm reduction programs. In this of all areas in global health, civil society has come to be seen as the repository of expertise, and harm reduction networks are increasingly vocal, respected and resourced.

On the policy front, there is increased attention to tuberculosis in injection drug users, and a slow but growing realization that ways must be found to tackle hepatitis C at the same time as we deal with HIV.

And finally, the prospect that the United States could re-engage in harm reduction is tremendously encouraging, and necessary. Our call from this conference is for the US to firmly and emphatically do so.

All of these developments, all the contributions you are making, are for me a great source of hope. I really believe that with the successes we’ve achieved, the evidence we’ve gathered, and the growing commitment of countries, that we are in a moment of new opportunity.

To consolidate these gains, and build on these opportunities, let me highlight what as I see as four key priorities: human rights; evidence; a more comprehensive understanding of drug users’ vulnerability, and financing.

Firstly: as the conference theme recognizes, human rights must continue to be at the forefront of everything we do.
It should not be necessary for us to say that human rights are drug users’ rights, as well. But we must say it loudly and clearly at every opportunity, because in too many countries, in too many police cells, in too many prisons, and in too many health services, drug users are still treated as less than human.

Unless they begin with a firm commitment to human rights, efforts to reduce the harms associated with drug use are doomed to fail.

Here I mean the right to health and decent care. But also the right to freedom from discrimination. The right to equality before the law. The right to privacy. The right to work, and to education. The right to share in the advances of science.

These are universal rights. And no matter where they are, whether it’s Moscow, Melbourne, Bangkok or Baku, these are drug users’ universal rights.

Second: we must continue to promote the evidence. We must continue to show why drug use is most effectively addressed as a public health challenge, and why punitive approaches that criminalize users, drain the resources of law enforcement agencies and overburden judicial and penal systems, are futile and counter-productive.

Alex Wodak has reminded me that the harm reduction community recently observed a rather inauspicious anniversary. February 2009 marked the centenary of the first meeting of 13 nations in Shanghai, known as The First Opium Commission, which eventually led to the international system of global drug prohibition that we know today.

The outcome of the recent meeting in Vienna of the Commission on Narcotic Drugs is just the latest incarnation of that policy put in place 100 years ago. What upsets so many us in the harm reduction movement is the CND’s abject failure to appreciate how times have changed; how global drug prohibition has made controlling HIV among injecting drug users so much harder, and that proven approaches to HIV prevention, such as harm reduction, are so important to mitigating the public health impact of drug use.

We can take small comfort from some of the coded language in the CND political declaration and plan of action, such as the timid commitment to “reduce discrimination that may be associated with drug use” and its call to “deliver prevention programs based on scientific evidence”. What we cannot accept is an overall framework that focuses exclusively on reduction of demand and supply when, as the political declaration itself acknowledges, these approaches have to date had such limited success.

My fundamental difference with the approach endorsed by the CND in Vienna is that, as a physician, I subscribe to Hippocrates: “First, do no harm”. Unlike the CND, we should never shy away from this as our first priority, or from using language that speaks unequivocally of reducing harm.

We must continue to reject the myth implicit in the CND outcome, that harm reduction promotes addiction. And we must expose the false statements of governments, such as those of Russian officials in Vienna that the US still “prohibits substitution therapy” and that compared substitution therapy to “drug legalization”. We must demand, at a minimum, that serious countries tell the truth when discussing serious matters of policy.

Let us nevertheless thank and support the 26 countries that explicitly supported harm reduction in Vienna. They have helped to show that the consensus that has driven global drug prohibition for 100 years has actually fractured. They give hope that we may eventually have a more nuanced policy in the coming years, in which countries are given the flexibility to implement a
drug policy that best fits their needs, rather than be constrained by the stifling “one size fits all” approach that has served us so poorly, for so long.

And let us strongly encourage and support those countries that have traditionally employed a law enforcement approach to drug control but who are now moving, in some cases cautiously, to a public health approach, including countries here in Asia. Let us say, to China, to Malaysia, to Vietnam: keep up the good work. By embracing harm reduction, you are on the right side of history.

Unfortunately, there are still countries that seem determined to swim against the tide with their willful blindness to the evidence.

It is easy to feel that we are getting nowhere with Russia on methadone, or with some countries in the region that seem unable to scale up services. And there are those countries that still seem determined to wage the senseless War on Drugs.

But we have no choice but to continue our advocacy, maintain the moral and political pressure, and, above all, promote the evidence.

We need look no further than my own country, France - where for years now, less than 2 per cent of new HIV infections have been among drug users - to know what works; to know that, as with PMTCT, we can come close to resolving drug use as a means of HIV transmission. Not by picking and choosing one intervention or another, but by a comprehensive package of needle syringe exchange, substitution therapy, and overdose prevention.

Of course, alarming evidence is also a powerful tool. I referred earlier to data from Egger and colleagues showing that life expectancy for someone beginning antiretroviral treatment today can extend from 20 to 40 years, depending on the setting. That is good news, but it refers to non-IDUs. In sharp contrast, the study also shows that life expectancy for an injection drug user beginning ART today is on average 12 years less than for a non-IDU. This speaks more powerfully than any evidence I’ve seen lately about the scandalous lack of attention to providing effective and comprehensive health care for injecting drug users who are living with HIV.

My third message is that we need, in our policy settings, interventions and discussions, a more nuanced understanding of the factors that make drug users vulnerable in the first place. Too often in UN documents on AIDS, we see long lists of so-called “vulnerable populations”: men who have sex with men, sex workers, prisoners, with injecting drug users often near the end, as though drug use alone is the source of vulnerability. In reality these categories frequently overlap, and such lists fail to convey the many social and economic factors that contribute to drug use, drug dependence, poverty, crime and incarceration. We need to find better language that describes drug users as people and their vulnerability as multi-dimensional.

Finally: on the key issue of financing. We are all only too aware that resources for prevention of HIV transmission among injecting drugs users are far from commensurate with need, at perhaps $200m to $300 million per year, perhaps 1 or 2 per cent of all available resources for AIDS.

I am always proud to say that the Global Fund is the largest donor globally for harm reduction. Close to $1-billion has now been invested by the Fund in HIV grants that have a harm reduction component. In large parts of Eastern Europe and central Asia, it is virtually the only donor for harm reduction. But I am less satisfied by an analysis undertaken in the Global Fund Secretariat that estimates the quantity of these resources specifically devoted to needle syringe exchange, substitution therapy and related education at around $250-million since the Fund began. It is not enough.
That’s why I have proposed to the Global Fund Board that it consider as a matter of some urgency the need to have a strategic discussion about increasing demand for resources for harm reduction from the Global Fund. My colleagues have also spoken with some of you about working together on a demand mobilization strategy.

My hope is that, working together, we can produce this year a demand mobilization strategy to address injecting drug use that is not a top-down product of the Global Fund Secretariat, but something by and for Global Fund stakeholders, using all the advantages of the Global Fund’s inclusive model and flexible opportunities to strengthen community systems.

The strategy should link with the work of the IDLO, OSI and others to increase access to legal services through Global Fund-supported programs. It should support the efforts of drug users themselves to organize, so that more programs are designed by them and fewer programs are imposed on them. It should prompt countries that claim to prioritize injection drug users to actually seek resources for programs that serve them. And it should not neglect Africa, where the rapidly expanding availability of illicit drugs is of growing concern and where early intervention could have a major impact.

My final word on financing concerns eligibility for Global Fund resources.

Many of you are rightly concerned about the future of harm reduction programs in Russia. I have repeatedly made clear my view that if eligibility for Global Fund resources is based primarily on GDP, then it is not in fact a Global Fund to fight epidemics. Although eligibility is ultimately a matter for the Global Fund Board to determine, I will continue to strongly advocate for a Global Fund in which the primary eligibility criterion is epidemiology, and not GDP.

Let me conclude then, with a simple word of thanks, to all of you.

Your work is among the most important, and sometimes the most difficult, in global health.

But together, all of you and the organizations you represent, have saved many thousands of lives.

Together, you are bringing hope to millions more.

So for every step back, as in Vienna, let’s take two steps forward.

No matter how often the evidence is denied. No matter that we are told it’s too difficult, that it won’t work, that it’s forbidden.

We must continue, to maintain the hope, and keep up the fight.

Thank you very much.