

THE LANCET

THE LANCET: Press Conference and Press Release

EMBARGO: 1500H UK time Tuesday 20 July 2010

To launch *The Lancet Series* on HIV in people who use drugs, a press conference will be held at the IAS Conference in Vienna at 1700H Vienna time, in room PC3 Media Centre. (Full address of Conference Centre: Reed Messe Wien GmbH Messeplatz 1, P.O.Box 277, A-1021 Vienna, <http://www.messe.at/en/index.html>)

Prior to the press conference there will be a symposium open to all in Room 5 Conference centre from 14:30-16:00 Vienna time.

The material below is embargoed to 1500H UK time Tuesday 20 July (which is when the symposium ends)

- THE GROWING HIV EPIDEMIC IN PEOPLE WHO USE DRUGS: DISPELLING THE MYTHS AND COMBINING APPROACHES
- 12 MYTHS ABOUT HIV/AIDS AND PEOPLE WHO USE DRUGS
- ALCOHOL: THE FORGOTTEN DRUG IN HIV/AIDS
- HIV IN WOMEN WHO USE DRUGS: DOUBLE NEGLECT, DOUBLE RISK
- INADEQUATE PROVISION OF TREATMENTS, PLUS LAWS PROHIBITING OPIOID SUBSTITUTION, ALL DRIVING DRUG-RELATED HIV EPIDEMICS
- LESS THAN 10% OF INJECTING DRUG USERS COVERED BY EXISTING HIV PREVENTION INTERVENTIONS; HUGE SCALE-UP OF COMBINED APPROACHES NEEDED
- IMPROVED ANTIRETROVIRAL TREATMENT ACCESS REQUIRES DECRIMINALISATION AND END TO PORTRAYAL OF INJECTING DRUG USERS AS 'LESS THAN HUMAN' OR ALREADY DEAD
- HIV-INFECTED DRUG USERS AT GREATER RISK OF HEPATITIS, TUBERCULOSIS, BACTERIAL INFECTIONS AND MENTAL ILLNESS
- INTENSIVE BEHAVIOURAL INTERVENTIONS NEEDED TO REDUCE AMPHETAMINE USE, WHICH IS LINKED TO HIV RISK
- HEALTH OF PEOPLE WITH HIV WHO USE DRUGS CANNOT IMPROVE WITHOUT ACKNOWLEDGING AND RESPECTING THEIR HUMAN RIGHTS

- DRUG USERS MUST BE DECRIMINALISED ALONG WITH SCALE-UP OF COMBINATION TREATMENT AND CHANGES TO DRUG CONTROL AND LAW ENFORCEMENT

THE GROWING HIV EPIDEMIC IN PEOPLE WHO USE DRUGS: DISPELLING THE MYTHS AND COMBINING APPROACHES

Almost three decades after the discovery of HIV, a new *Lancet Series* highlights the threat of a largely unpublicised and growing HIV epidemic—in people who use drugs. While large gains have been made in fighting the epidemic in the general population, socially marginalised populations such as people who use drugs, continue to suffer great stigma and lack of access to treatments that can save both their own lives and prevent HIV transmission to others. “Complacency about the HIV /AIDS epidemic now would be a terrible mistake,” says *Lancet* Editor, Dr Richard Horton.

- There are some 16 million injecting drug users in the world, of which around 3 million are HIV positive. Add to this the uncounted numbers of people with HIV who use other drugs, and it’s clear that the HIV epidemic is still raging in this community.
- *The Lancet’s Series* dispels many of the myths about HIV/AIDs and people using drugs, including that rates of drug use are not higher in minorities in rich countries, and that needle exchanges do not encourage more drug use.
- The double risk of HIV in women who use drugs—through unprotected sex and injecting drugs—is a growing problem in Asia and Eastern Europe, as well as among crack-cocaine users in the USA. A drug that has a massive but hidden effect on HIV transmission is alcohol. Use of alcohol is associated with HIV infection and the behaviours that lead to infection, including unprotected sex, multiple partners, and commercial sex. Drinking venues themselves are associated with risk of HIV infection.
- There is a rapidly growing problem of HIV infection in users of non-injected drugs such as amphetamines. Amphetamine substitution therapies are sorely lacking, since they could help mitigate risk of HIV infection, as could intensive behavioural interventions. A further hidden catastrophe is the group of other diseases that hit people with HIV who use drugs, such as tuberculosis (especially within prisons), hepatitis, and mental illness.
- The interaction of sexual and drug related HIV-infection adds a further impetus to this growing epidemic particularly as new outbreaks of drug use and HIV are emerging in Africa, which the series explores.
- There are no single solutions for people who use drugs. Each country needs a response tailored to its own epidemic. But the *Series* demonstrates that a combination of interventions, including massive, simultaneous scale-up of access to antiretroviral treatment for HIV, opioid substitution therapy, and needle and syringe programmes could contain this epidemic over the next 5 years, since their effects are synergistic. The evidence is already available, and it calls for

IMMEDIATE, combined implementation before new epidemics take hold. This requires concerted action from multinational and governmental agencies and people who use drugs themselves.

- All of these existing interventions, even if scaled-up, will be blunted without a further change in strategy. Traditional biomedical and health solutions are insufficient. An approach that tackles stigma, discrimination, and human rights abuses is essential. The Series concludes that action is needed on all fronts to reverse the HIV epidemic in drug users.

Below is a quote from the final paper in the [Series](#):

“If drug control sectors and law enforcement are not a part of new approaches, then harm-reduction programmes will be closed, substitution clinics will stay sparsely attended, and antiretroviral and preventive interventions will have a low uptake by drug users.”

To interview *Lancet* Editor-in-Chief Dr Richard Horton or Executive Editor Dr Pamela Das, please call +44 (0) 20 7424 4949 E) tony.kirby@lancet.com

12 MYTHS ABOUT HIV/AIDS AND PEOPLE WHO USE DRUGS

In a [Comment](#) which forms part of the Series, 12 myths about HIV/AIDS are debunked. The [Comment](#) is by Dr Steffanie Strathdee, University of California San Diego, CA, USA, and Professor Chris Beyrer, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA (both paper authors in the [Series](#)) and colleagues.

1. Drug users are non-compliant
2. Drug users do not respond as well to antiretrovirals as do non-drug-using patients
3. Drug users are difficult to study and have poor retention rates in cohorts, making prospective research studies with drug users difficult or impossible
4. Drug users are more concerned about getting high than using injecting equipment safely
5. Drug users don't have much sex; their HIV risks are largely or entirely from needle sharing
6. If drug users keep using, it is almost inevitable that they will acquire HIV infection
7. Unlike gay men or sex workers, drug users don't have strong communities, so community interventions are unlikely to work
8. Rates of drug use are higher among minorities in the USA and other industrialised countries
9. Needle exchanges encourage drug use
10. Methadone (or buprenorphine) treatment just exchanges one drug for another
11. People who use stimulants are all heavy, out-of-control users who won't change their risky behaviours
12. Fear is an effective deterrent for drug use

Each of these myths is rebutted in the [Comment](#). For example, there are studies showing that all-cause mortality in HIV patients who had started antiretroviral drugs six years or more ago was similar in both injecting drug users and non-drug users (myth 2). There is also no evidence to show needle exchanges encourage drug use (myth 9), with an Alaskan study showing no difference in drug use between people using a needle exchange and

those buying needles from pharmacies. Stimulant users are not all out of control users incapable of reducing risky behaviours (myth 11), with Muasback and colleagues showing risk reduction is possible in HIV-negative heterosexuals and HIV-positive men who have sex with men, despite both groups using crystal meth.

The authors conclude: "The myths about HIV acquisition and people who use drugs are straightforwardly countered by scientific evidence, but like so many forms of prejudice, they persist despite the evidence. It is past time for these prejudices to change. Providers, decision makers, and all engaged in the global fight against HIV infection have an obligation to examine biases against people who use drugs, learn the facts beyond the myths, and let evidence drive responses."

Professor Chris Beyrer, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA. T) + 1 443 807 0412 E) cbeyrer@jhsph.edu

Dr Steffanie Strathdee, University of California San Diego, CA, USA. T) +1-858-740-4578 E) sstrathdee@ucsd.edu

For full [Comment](http://press.thelancet.com/drugshiv12myths.pdf), see: <http://press.thelancet.com/drugshiv12myths.pdf>

ALCOHOL: THE FORGOTTEN DRUG IN HIV/AIDS

A [Comment](#) highlights the forgotten drug in the HIV/AIDS epidemic: alcohol. The [Comment](#), by Dr Katherine Fritz, International Center for Research on Women, Washington, DC, USA, and colleagues, says that patterns of hazardous alcohol consumption exist in countries with the worst HIV epidemics, most notably Southern and Eastern Africa.

The authors say: "Many studies in southern and eastern Africa have shown that alcohol use is associated with prevalent and incident HIV infection as well as with the behaviours that lead to infection, including unprotected sex, multiple partnering, and commercial sex. Drinking venues themselves are, not surprisingly, associated with risk of HIV infection. The pharmacological properties of alcohol help to explain a portion of the widely observed association between alcohol use and sexual-risk behaviour."

The authors point out that venue-based interventions can be a great driver for behaviour change, such as those implemented in US gay bars throughout the 1990s. They say: "More successful interventions have infused HIV-infection prevention services into high-risk drinking venues, with use of multilevel models that attempt to simultaneously change individual behaviour, shift social norms, and change HIV-infection prevention policies. One example of a multilevel venue-based intervention was tested in the Philippines with sex workers in bars, discos, and night clubs. Peer counselling, focused on condom use and sexual negotiation skills, formed the basis for change in individual and social norms. Changes to the bar environment were achieved by working with bar managers to implement HIV-infection prevention practices."

They also highlight the risk to women who sell and serve alcohol in bars, hotels and other venues who are "at increased risk of drinking alcohol themselves, engaging in unprotected sex with their clients, and HIV infection". They add: "Women's risk of gender-based and

sexual violence is also increased by their partner's alcohol consumption. Without addressing gender, efforts to reduce alcohol-related sexual-risk behaviour might only be partly successful."

They conclude: "More research, by gender and alcohol researchers jointly, is needed to determine methods of integrating gender into programmes that are focused on reducing alcohol-related sexual-risk behaviour, and might offer valuable lessons for the wider field of HIV and substance-use research."

Dr Katherine Fritz, International Center for Research on Women, Washington, DC, USA.
T) +1 202-384-0629 E) kfritz@icrw.org

For full [Comment](#), see: <http://press.thelancet.com/drugshivalcohol.pdf>

HIV IN WOMEN WHO USE DRUGS: DOUBLE NEGLECT, DOUBLE RISK

A [Comment](#) in the [Series](#) says that HIV infections continue to rise in drug-involved women, especially injecting drug users in Asia and eastern Europe, and in crack-cocaine users in the USA and other countries. Women who use drugs are doubly at risk for HIV infection via unprotected sex and unsafe injections. The [Comment](#) is by Dr Nabila El-Bassel, Columbia University School of Social Work, New York, USA, and colleagues.

Many women who use drugs lack the power to negotiate safer sex. Yet, most available HIV-prevention strategies put the onus on women to insist on safe sex, increasing their risk of physical and sexual abuse. The authors say: "Drug-involved women often rely on their partners to procure the drugs that they share, and because women are often injected by their partners, they are 'second on the needle', which increases their risk for infection by HIV and other pathogens. Refusing to share needles and syringes can also increase women's risk of physical and sexual intimate partner violence, further potentiating risks for HIV infection."

The authors propose a number of strategies to prevent HIV infection in women who use drugs:

1. Trauma-informed strategies that concurrently address co-occurring problems of intimate partner violence and drug use.
2. Couple-based HIV prevention, treatment, and care options for drug-involved women and their sex partners that include skills building for safe-sex negotiation within context of ongoing drug use.
3. Empowerment strategies, such as social network, community-based, community mobilisation, and peer-led interventions.
4. Income-generating interventions for women (including job training and microfinance, access to employment).
5. Public policies that: fight discrimination and gender-based violence; stop police mistreatment, arrest, and registration of female drug users; and increase access to drug treatment and care.
6. Increased funding to make drug treatment, harm reduction, and HIV-prevention services more available and friendly to women, by addressing the needs of

pregnant women, mothers, and women with a history of intimate partner violence and trauma; and by protecting human rights of women who use drugs.

7. Increased research funding to improve and support women-specific evidence-based services, and to improve knowledge on global epidemiology of women who use drugs, especially in developing countries. Researchers must make greater attempts to include women, even if they are harder to recruit due to being fewer in number and hidden.

Dr Nabila El-Bassel, Columbia University School of Social Work, New York, USA. T) +1 917 209 0328 E) ne5@columbia.edu

Alternative contact: Jeannie Hii, Director of communications at Columbia University School of Social Work. T) +1 917 445 9557 E) jeanniehii@gmail.com

For full [Comment](http://press.thelancet.com/drugshivwomen.pdf) see: <http://press.thelancet.com/drugshivwomen.pdf>

For all [Comments](http://press.thelancet.com/drugshivcomments.pdf) in the [Series](http://press.thelancet.com/drugshivcomments.pdf), see: <http://press.thelancet.com/drugshivcomments.pdf>

INADEQUATE PROVISION OF TREATMENTS, PLUS LAWS PROHIBITING OPIOID SUBSTITUTION, ALL DRIVING DRUG-RELATED HIV EPIDEMICS

Of the estimated 16 million injecting drug users (IDUs) worldwide, some 3 million are thought to be HIV positive. To curtail the HIV epidemic in IDUs, a combination of interventions are needed specific to the location and population profile. In the first paper in *The Lancet Series* on HIV in People Who Use Drugs, Dr Steffanie Strathdee, University of California San Diego, CA, USA, and colleagues conclude that inadequate provision of opioid substitution (OST), needle and syringe programmes (NSP) and antiretroviral therapy (ART), along with laws preventing OST, are all driving the HIV epidemic in people who use drugs.

Latest estimates of HIV prevalence among IDUs are 20 to 40% in five countries and over 40% in nine. The authors examine case studies in Odessa (Ukraine), Karachi (Pakistan) and Nairobi (Kenya). The authors' first key finding was the evidence backing scaling-up of combination HIV prevention interventions was compelling. Using Odessa as an example, the authors show that if the unmet need of OST, NSP and ART was reduced by 60% over the next 5 years, 41% of incident HIV infections could be prevented. This impact was synergistic—being much more effective when scaled up together as opposed to scaling up OST or NSP alone.

They also found sexual transmission could account for one fifth of new HIV infections in Odessa, but only 5% in Karachi, where the attributable risk (meaning the contribution that a risk factor makes to the overall risk of HIV infection) for use of non-sterile injection equipment was much higher.

The impact of scaling up combination HIV prevention interventions was also compelling. Using Odessa as an example, the authors show that if the unmet need of OST, NSP and ART was reduced by 60% over the next 5 years, 41% of incident HIV infections could be prevented. This impact was synergistic—being much more effective when scaled up together as opposed to scaling up OST or NSP alone.

Inadequate ART access can have a significant impact on some IDU-related epidemics over the next 5 years. The attributable risk due to suboptimal ART access was 38-50% in Odessa and 19-40% in Karachi; thus better ART access would substantially reduce this risk.

In epidemics where the force of infection may be currently be great (meaning the rate at which people are becoming infected is high), such as Nairobi which is experiencing an HIV outbreak among IDUs, simply scaling up coverage of OST and NSP was not enough to significantly curtail the epidemic. For example, scaling up OST and NSP by 80% in Nairobi reduced HIV incidence by 29%. However, if the efficacy of NSP and OST was improved from 50% to 70% in the presence of scaling up these interventions and ART scale up, over 60% of HIV infections could be prevented. Examples of ways to improve efficacy include for OST offering a choice of treatment modalities such as methadone and buprenorphine. For both OST and NSP, providing mobile services; and for NSP, offering 24-hour access, and no limits on the number of syringes exchanged.

The authors also showed that local HIV epidemics are sensitive to different types of structural changes, such as a change in the macro-physical environment. For example, in Karachi there are a large number of heroin smokers—drug market fluctuations such as decreases in heroin availability or drug purity, or increases in price, could lead to an increase in the rate of transition from non-injection to injection drug use. For example, if the proportion of heroin smokers who transitioned to injection increased by 8%, 10% or 12%, the increase in the number of HIV infections could grow by 65%, 82% or 98% over the next 5 years, a situation which is compounded by the fact that OST is virtually absent and thus the number of IDUs who reduce or stop injecting will remain low. Here, scale-up of OST should be an urgent priority. In Odessa, police beatings and other intimidation tactics such as being arrested for carrying needles, whether clean or used, also increase risky behaviour among IDUs. The authors estimate as many as 1 in 5 new HIV infections could be prevented if police beatings ceased through reduction of exposure to contaminated equipment.

In Nairobi, the authors examined the impact of removing the law prohibiting OST from being prescribed to IDUs. If the OST law were to be removed and if both NSP and OST were scaled up to 80% coverage, thereby reducing the frequency of injection and the number of years that people inject drugs, up to 29% of HIV infections could be prevented. Therefore, it is a public health imperative that Kenya make the bold move to follow in the footsteps of 4 of its other African neighbours who have recently endorsed OST.

The authors conclude: “Our modeling scenarios show that HIV epidemics among IDUs can be significantly curtailed ...Adequate coverage of these interventions could not only avert thousands of HIV infections, but also substantially reduce local HIV epidemics through protection of the rights of IDUs to access effective HIV prevention and treatment and services.”

Dr Steffanie Strathdee, University of California San Diego, CA, USA. T) +1-858-740-4578 E) sstrathdee@ucsd.edu

Catherine Hankins, UNAIDS, Geneva, Switzerland. E) hankinsc@unaids.org

For full Series paper 1 see: <http://press.thelancet.com/drugshiv1.pdf>

LESS THAN 10% OF INJECTING DRUG USERS COVERED BY EXISTING HIV PREVENTION INTERVENTIONS; HUGE SCALE-UP OF COMBINED APPROACHES NEEDED

Globally, fewer than 1 in 10 injecting drug users (IDUs) are covered by effective HIV prevention interventions, with just 5% of injections likely covered by a syringe provided from a needle and syringe programme (NSP). Only eight clients receive opioid substitution therapy (OST) for every 100 IDUs, while only 4 of every 100 HIV-positive IDUs receive antiretroviral therapy (ART). While all these interventions can have a stand-alone effect, they must be used together to substantially reduce HIV transmission among IDUs. This is a key message of the second paper in *The Lancet Series* on HIV in People Who Use Drugs, written by Professor Louisa Degenhardt, National Drug and Alcohol Research Centre, University of New South Wales, Sydney, Australia, and colleagues. The paper also shows the need for policy, legal and other structural changes as a core element of HIV prevention for IDUs.

The reviewed evidence in the paper shows the critical importance of scaling-up NSP, OST and ART for IDUs around the world. Individual or group based psychosocial therapy to address risky behaviours can reduce both injection and sexual transmission risk. IDUs themselves have a key role in developing such strategies, including through peer based interventions. The authors emphasise the need to better target HIV prevention strategies for amphetamine and cocaine injectors. They write: "Model projections suggest high coverage of ART, OST and NSP in combination are important for reduction of incidence of HIV infection in IDUs by more than 50%; very high intensity and coverage of single interventions is necessary to achieve similar effects; short-term, small-scale, single interventions are unlikely to be effective."

The authors also stress the importance of structural interventions, ie, those that operate at the population or community level. Strategies such as providing clean needles in prisons can reduce HIV transmission without increasing injection rates. Observational studies suggest providing supervised injecting centres with clean equipment attracts IDUs at greatest risk of HIV, who can also be engaged in health and drug treatment services to further reduce risky behaviours. Peer-based interventions which bring about change at the level of the social network can also reduce needle sharing and risky sexual behaviour. Policy interventions that alter the legal environment are also needed and can have a positive community-level effect. For example, relaxing of legal restrictions on the provision of sterile needles and syringes reduces risky behaviour in IDUs without adverse effects.

Also highlighted in this second paper is that current resources provided for research and implementation of the response to HIV infection in IDUs are insufficient: according to the International Harm Reduction Association, an estimated US\$0.03 are spent per IDU per day, far short of the amount needed. UNAIDS estimated that in 2009, 19% of global resources needed for prevention of HIV infection should be targeted towards IDUs, yet as little as 1% was allocated in this way.

The authors conclude: "Prevention of HIV infection needs high coverage and combined approaches. Single interventions, even at high coverage, are likely to achieve only modest reductions in HIV transmission, particularly in settings with very high levels of HIV risk behaviours. Governments, policy makers, and public-health officials must be engaged and convinced of the importance of scaling up."

Dr Louisa Degenhardt, National Drug and Alcohol Research Centre, University of New South Wales, Sydney, Australia. T) +61 403 373 878 E) l.degenhardt@unsw.edu.au

Alternative contact Marion Downey University of New South Wales Media Relations T) +61 401 713 850 E) m.downey@unsw.edu.au

For full [Series](#) paper 2 see: <http://press.thelancet.com/drugshiv2.pdf>

IMPROVED ANTIRETROVIRAL TREATMENT ACCESS REQUIRES DECRIMINALISATION AND END TO PORTRAYAL OF INJECTING DRUG USERS AS 'LESS THAN HUMAN' OR ALREADY DEAD

The third paper in *The Lancet Series* on HIV in people who use drugs says that in order to improve access to antiretroviral therapy among injecting drug users (IDUs), health providers must focus less on individual patient's ability to adhere to treatment, and more on conditions of health delivery that create treatment interruptions. Among low-income and middle-income countries, almost half of all injecting drug users with HIV are in just five of these countries: China, Vietnam, Russia, Ukraine, and Malaysia. Access to antiretroviral treatment (ART) is disproportionately low in these countries—IDUs make up two thirds of cumulative HIV cases in these countries, but only 25% of patients receiving ART. This third paper is by Daniel Wolfe, Open Society Institute, International Harm Reduction Development Program, New York, USA, and colleagues.

Injecting drug users (IDUs) have successfully started ART in at least 50 countries, with evidence showing clearly that these patients can achieve excellent virological outcomes and with no greater development of drug resistance than other patients. Early adherence to ART is associated with long-term virological response, with behavioural support and provision of opioid substitution treatment (OST) increasing treatment success of ART in IDUs. Preliminary evidence suggests that increased ART provision to IDUs also reduces infectivity and HIV transmission, independent of needle sharing.

Not only is ART vital for saving lives and preventing transmission, but the evidence shows it is cost-effective. Data show clear benefits of targeting of ART to IDUs in areas with concentrated HIV epidemics (such as these five countries). Furthermore, the cost of drug dependence treatment is as little as one seventh that of addressing social and medical costs of untreated drug use.

Systemic barriers to ART and OST provision include stigmatisation of IDUs in health settings, medical treatment separated by specialties, bans on treatment of active IDUs, hidden or collateral fees, and multiple requirements for initiation or modification of treatment for IDUs. In the five countries considered, fewer than 2% of IDUs have access to opiate substitution treatment.

Structural barriers to treatment provision result from wholesale criminalization of drug users. Barriers include sharing the names of IDUs seeking treatment with police, arrest and harassment of IDUs in or around clinical settings, and harassment of physicians who prescribe opioids. Even in Asian countries praised for initiation of OST programs, far greater numbers of IDUs are detained for years in “treatment and rehabilitation” settings that offer no medical evaluation, right of appeal, or evidence-based treatment or rehabilitation. ART and OST in these detention centres are largely unavailable. Incarceration of drug users, and interruption of ART and OST in prison, is also commonplace.

A necessary measure to improve ART coverage for IDUs is improved data collection, including an “equity ratio” to assess whether IDUs are receiving a fair share of antiretroviral treatment. The authors highlight that the Global Fund to Fight AIDS, Tuberculosis and Malaria, which between 2001 and 2008 has awarded about \$180 million for HIV prevention in IDUs, does not ask grantees to detail IDU-related spending, even in countries where most of the HIV-infected population are IDUs. The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), despite legal requirements to collect data about how many IDUs are reached through its programs, also fails to do so.

Other required improvements are integration of ART with OST and treatment for co-infections such as tuberculosis, and greater use of community-based treatment models and peer support.

In view of persistent human-rights violations and negative health effects of policing, detention, and incarceration, law and policy reform is needed to improve ART coverage of IDUs. The authors say that systemic improvements “are unlikely to succeed without action to resolve the fundamental structural tension between public health approaches that treat IDUs as patients and law enforcement approaches that seek to arrest them. Police registries, arbitrary detention, and imprisonment of people who have committed no crime apart from the possession of drugs for personal use are barriers to treatment and care that cannot be overcome by counselling, electronic reminders, or peer support.”

They conclude: “A basic challenge remains in the reversal of social forces, including popular opinion, that portray IDUs as already dead or less than human, and so deserving of less-than-human rights. Resurrection of IDUs from this status is beyond the healing power of ART alone, although reformation of HIV treatment systems can help to emphasise that IDUs, including those actively injecting, are capable of making positive choices to protect their health and that of their communities,” adding that referral to the 1948 Universal Declaration of Human Rights could guide an approach to improve treatment for IDUs and others vulnerable to HIV infection.

Daniel Wolfe, Open Society Institute, International Harm Reduction Development Program, New York, USA. T) +1 917 969 7139 E) dwolfe@sorosny.org

Alternative contact Paul Silva Communications Officer, Public Health. Open Society Foundations T) +1 917-478-8403 E) psilva@sorosny.org

For full *Series* paper 3 see: <http://press.thelancet.com/drugshiv3.pdf>

HIV-infected drug users have increased age-matched morbidity and mortality compared with HIV-infected people who do not use drugs. This includes an increased risk of viral hepatitis, tuberculosis (TB), bacterial infections, and mental illness. In the fourth paper in *The Lancet Series* on HIV in people who use drugs, Professor Frederick L Altice, Yale University, New Haven, CT, USA, and colleagues show that there are evidence based treatments for both HIV and these co-morbidities, and that antiretroviral treatment (ART) for HIV can improve not only the course of HIV infection but also these other conditions.

The authors say: "Evidence-based treatment for substance-use disorders improves the psychological and physiological disruptions that perpetuate the often unstable life of HIV-infected drug-dependent individuals. Treatment of HIV infection, substance-use disorders, and comorbidities in HIV-infected drug users is improved by comprehensive and multidisciplinary management of these disorders."

If appropriately dosed, medication-assisted therapies for opioid and alcohol dependence, such as methadone, buprenorphine and injectable naltrexone, enhance adherence to ART in patients with HIV, as well as treatment for the above mentioned co-morbidities. Furthermore, they improve retention in HIV care and decrease HIV risk behaviours.

The authors note that as and when ART becomes universally available to drug users with HIV, and their health status improves, so their other health problems will take on increased prominence, such as non-AIDS related comorbidities and TB, all of which will come with their own treatment priorities. HIV infected drug users with TB co-infection creates various clinical challenges since TB can be difficult to diagnose in HIV patients due to atypical chest radiographs, high-rates of TB in parts of the body outside the usual setting of the lungs, and the reduced sensitivity of skin tests used to diagnose TB in HIV patients. While people with latent TB but not HIV infection have a roughly 1 in 11 lifetime risk of having their TB develop into full blown disease, it becomes a 1 in 11 annual risk in patients with HIV co-infection. Concentration of people with HIV and substance use disorders behind bars facilitates transmission of TB, including multidrug resistant strains, due to overcrowding and increased numbers of people who are immunosuppressed. Despite available treatments for HIV and substance use disorders, little treatment is available within these settings.

Due to common routes of transmission, between 60% and 90% of HIV infected IDUs have hepatitis C, and few receive treatment for reasons including cost, physician reluctance, concern about poor treatment adherence, and misperception about potential harm of hepatitis C. Though effective treatments are available, treatment resources are limited due to expense and availability; if the person has hepatitis B, however, they can be treated with other oral antiviral agents that are also effective against HIV.

Mental illness and substance-use disorders are closely inter-related with HIV infection and concentrated especially among prison populations. If drug treatments such as antidepressants are warranted, then care must be taken in the selection of the

medication. Some common antidepressants are associated with decreased metabolism of methadone in patients on OST, yet most are safe and effective.

“The concentration of HIV behind bars is a result of society's punitive rather than treatment-oriented approach to drug use,” says Professor Altice*. “Despite society's failed policy of mass incarceration of drug users, many of whom are HIV-infected, these sites may be seminal places for the identification and treatment of HIV, but requires sufficient resources to continue care, not only for HIV but for the myriad of substance use disorders, mental illness and other complications, after release.”

The authors conclude: “HIV-infected drug users have substantial HIV-related and non-HIV-related medical and psychiatric comorbidities. As a result, care is often complicated for the individual and for the health-care system. Several evidence-based interventions are available to improve treatment outcomes for this vulnerable population, but parity in treatment outcomes to reduce morbidity and mortality in HIV-infected drug users will be achieved only with further resources, expertise, political will, and commitment by the health-care establishment.”

Professor Frederick L Altice, Yale University, New Haven, CT, USA. T) +1 203 737 2883
E) frederick.altice@yale.edu

Alternative contact for Prof Altice: Helen Dodson, Media Relations, Yale University. T) +1-203-432-1326 E) Helen.dodson@yale.edu / Karen.peart@yale.edu

Professor Adeeba Kamarulzaman, University of Malaysia, Kuala Lumpur, Malaysia. T) +60 12 3353594 E) adeeba.kamarulzaman@gmail.com

For full [Series](#) paper 4 see: <http://press.thelancet.com/drugshiv4.pdf>

Note to editors: *quote direct from Prof Altice and not in text of [Series](#)

INTENSIVE BEHAVIOURAL INTERVENTIONS NEEDED TO REDUCE AMPHETAMINE USE, WHICH IS LINKED TO HIV RISK

The fifth paper in *The Lancet Series* on HIV in people who use drugs looks at the relationship between amphetamine drug use and HIV. Among the conclusions are that because of the increased HIV risk associated with amphetamine use, amphetamine users should have ready access to HIV prevention interventions, including HIV testing. Furthermore, treatment for amphetamine dependence should be more integrated with HIV prevention and care in populations with high levels of both amphetamine use and HIV, such as men who have sex with men. In this rigorous meta-analysis, the authors found that only intensive, multi-session treatment programmes reduced amphetamine use. This paper is by Dr Grant Colfax, Director of HIV Prevention and Research, San Francisco Department of Public Health, CA, USA, and colleagues.

While there is obviously a relationship, the authors say that the contribution of amphetamine-group substances to the global HIV epidemic cannot be quantified, and the contribution of non-injection use of amphetamine-group substances to the HIV epidemic has been understudied. Improved efforts are needed to quantify and monitor the extent to which amphetamine-group substances are used, and the role of amphetamine-group substances in the HIV/AIDS epidemic, especially in developing countries (most research has been done in rich nations on men who have sex with men).

The authors say: "Greater understanding is needed of the developmental, psychological, social, and environmental factors contributing to amphetamine-group substance use and sexual risks and other harms related to amphetamine-group substances... The prevalence of other drug use among users of amphetamine-group substances needs quantification, and the contribution of specific patterns and combinations of amphetamine-group substance use with other drugs to risk of HIV infection needs to be established."

They highlight that the absence of effective drug treatments for amphetamine-group substance use is a major treatment gap. Scientific research is needed to fully understand the mechanisms of action of amphetamine-group substances, and drug-development efforts should focus on development and testing of compounds which target specific receptors or pathways related to amphetamine-group substance use. They say: "Rigorous trials of behavioural and pharmacological interventions for amphetamine-group substance use are needed with drug-related and HIV-related biological outcomes. The focus must be on scalable and cost-effective interventions. Findings of our meta-analysis showed that as a group, high-intensity interventions reduced use of amphetamine-group substances."

The authors conclude: "In populations using amphetamine-group substances, simple interventions such as testing for HIV and other sexually transmitted infections should be widespread and prioritised, particularly if HIV infection is prevalent and incidence of infection is substantial. Global efforts must be made to integrate, coordinate, and evaluate HIV testing and care strategies with treatment for amphetamine-group substance use."

Dr Grant Colfax, HIV Prevention, San Francisco Department of Public Health, CA, USA.
T) +1 415-265 0261 E) grant.colfax@sfdph.org / grant_colfax@yahoo.com

Alternative contact Eileen Shields, Media Relations. T) +1 415 554-2507 E)
eileen.shields@sfdph.org

For full [Series](#) paper 5, see: <http://press.thelancet.com/drugshiv5.pdf>

HEALTH OF PEOPLE WITH HIV WHO USE DRUGS CANNOT IMPROVE WITHOUT ACKNOWLEDGING AND RESPECTING THEIR HUMAN RIGHTS

The sixth paper in *The Lancet Series* on HIV in people who use drugs says a review of evidence shows that there is widespread abuse of human rights in people who use drugs, which increases risk of HIV infection and adversely affects delivery of HIV programmes.

The paper is by Dr Ralf Jürgens, Consultant on HIV/AIDS, Health, Policy, and Human Rights, Mille-Isles, Quebec, Canada, and colleagues.

The authors say these abuses can take the form of denial of harm-reduction services, discriminatory access to antiretroviral treatment (ART), abusive law enforcement practices, and coercion in the guise of treatment for drug dependence. Women and young people who use drugs face further, additional abuses. They add that the rights of people with HIV, and who use drugs, or are in prison—or any combination of these— must be respected as for any other person, not only because that is their right, but because it is also essential to improve their health. Rights-based responses to HIV and drug use have had good results where they have been implemented. Examples include providing legal services to people who use drugs in Ukraine or meaningfully involving people who use drugs in development, implementation, and monitoring and evaluation of policies and services. The authors call for other countries to try to replicate these successes.

The authors say: “The right to health requires that all countries have an effective, national, comprehensive harm reduction policy and plan, delivering essential services. High-income countries are expected to provide more than the essential services,” adding that “Joining human rights law with public health evidence should help shift global responses to drug control away from the failed emphasis on prohibition to a more rational, health-promotion framework that is both pragmatic and principled.”

The authors point out that reform of international drug policy and policy making processes is needed. They refer to the so called ‘parallel universes’ of United Nations (UN) human rights mechanisms and UN drug control mechanisms, stating that the human rights of people who use drugs do not feature prominently in either. The authors say: “The welcome recognition by UN Special Rapporteurs and the UN High Commissioner for Human Rights of the vulnerability of people who use drugs to a wide range of human rights violations should move debates forward.”

They conclude: “In 2009, the UN Office on Drugs and Crime called for global attention to the right to health of people dependent on drugs and urged that law enforcement should shift its focus from people who use drugs to drug traffickers. If UN Resources were directed to building country capacity for action in these areas, the so-called parallel universes might be nudged to intersect around the human rights of people who use drugs.”

Dr Ralf Jürgens, Consultant on HIV/AIDS, Health, Policy, and Human Rights, Mille-Isles, Quebec, Canada. T) +41 (0)79 279 7514 E) ralf.jurgens@theglobalfund.org / rjurgens@sympatico.ca

For full [Series](#) paper 6 see: <http://press.thelancet.com/drugshiv6.pdf>

DRUG USERS MUST BE DECRIMINALISED ALONG WITH SCALE-UP OF COMBINATION TREATMENT AND CHANGES TO DRUG CONTROL AND LAW ENFORCEMENT

In the seventh and final paper in *The Lancet Series* on HIV in people who use drugs, a call to action is made by experts who say that while scale-up of various interventions outlined in earlier papers are vital, these are not enough. Drug users should be decriminalised,

along with other changes in policy on drug control and law enforcement. The paper is by Professor Chris Beyrer, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA, and colleagues.

The authors highlight that it is possible to control HIV epidemics in people who use drugs with currently available strategies, such as opioid substitution (OST), needle and syringe programmes (NSP), and antiretroviral treatment (ART). The evidence backs a massive scale-up of all three in combination. Now is the time, say the authors, for countries to realise that national harm-reduction policies, programmes and services are desperately needed; failure to act or continuing with inadequate pilot programmes will not prevent the HIV epidemic in drug users advancing.

The authors say: "The dangers of inaction in meeting the needs of people who use drugs include continuing spread of HIV infection in new populations and regions, increased complexity of HIV-1 epidemics at molecular levels, decreased access to opioids for pain management and palliative care, and the human, family, health, and social costs of mass incarceration and detention."

They add: "Expanded action and advocacy by health professionals on behalf of people who use drugs are urgently needed in both health-care and criminal justice sectors. Health professionals should not be complicit in programmes and policies that have no evidence base or that violate human rights. The voice of people who use drugs themselves needs to be heard at all levels, from service delivery to policy decision making."

Highlighting that reform of justice systems is a large part of harm reduction, the authors call for decriminalisation of drug users, along with legal services and access to health services for people who use drugs in all forms of prison and detention. They say: "If drug control sectors and law enforcement are not a part of new approaches, then harm-reduction programmes will be closed, substitution clinics will stay sparsely attended, and ART and preventive interventions will have a low uptake by drug users."

They conclude: "Only around 10% of people who use drugs worldwide are being reached [by current treatment programmes], and far too many are imprisoned for minor offences or detained without trial. To change this situation will take commitment, advocacy, and political courage to advance the action agenda. Failure to do so will exacerbate the spread of HIV infection, undermine treatment programmes, and continue to expand prison populations with patients in need of care."

Professor Chris Beyrer, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA. T) + 1 443 807 0412 E) cbeyrer@jhsph.edu

For full [Series](http://press.thelancet.com/drugshiv7.pdf) paper 7 see: <http://press.thelancet.com/drugshiv7.pdf>