

**Speech at the 2nd Asian Consultation on the
prevention of HIV related to drug use
Response Beyond Borders**

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**Century Park Hotel
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“Effective access to health for drug users”

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Good afternoon everyone. I am honoured to have been asked by the organizers to make the closing remarks at this important conference. So, at the outset, let me start by recognizing a number of people who have contributed to making this a success.

- First of all, our brace friends who are living positively.
- Next the honourable members of parliaments and the representatives of the Asian Forum for Parliamentarians on Population and Development (AFPPD)
- Then my distinguished colleagues on the dias – Professor Pinit, and my colleagues and friends whom I have known for many years, Luke Samson and Tariq Zafar
- Representatives of civil society and the community, of donor agencies
- Our friends from the media
- Anf finally, my colleagues from the UN

Introduction

Friends, here is the structure of what I will say during the next 20 minutes.

1. First, as Closing Speaker, I would like to both acknowledge and thank the organizers
2. Then I would like to say a little bit about the mandate which all of us in the UN are working under
3. Next I would like to speak about the gravity of the challenges we face
4. Finally, I would like to say a few words about the role of UNODC in the region

1. Acknowledging the organisers: the Asian Consortium on Drug Use, HIV, AIDS and Poverty

- So please let me begin by thanking the Asian Consortium on Drug Use, HIV, AIDS and Poverty for inviting me to close the 2nd Asian Consultation on the Prevention of HIV Related to Drug Use.
- I am very pleased that the Asian Consortium – supported by the many partners depicted on our banner – has continued its commitment to mobilize civil society and beat the drum on universal rights – particularly the right to health for all drug users – wherever they are.
- In doing so, we are fostering an Asian response to the twin epidemic of HIV and drug use.
- This process started with the 1st Asian Consultation in Goa (India) in January 2008
 - It continued through the three follow-up workshops in East, South and Central Asia,
 - It continued the 9th International Congress on AIDS in Asia and the Pacific (ICAAP),

- and it continues up to now, at this very gathering, which marks a two-year journey of the first community-led movement on harm reduction in the region.
- **I congratulate you on this important achievement.**
- I would also like to take this opportunity to say that although we were not able to launch the Asian Network of People Who Use Drugs (ANPUD) because of technical reasons, we look forward to its being launched in a matter of weeks.
- We do look forward to a steady and fruitful alliance with the Asian Forum for Parliamentarians on Population and Development (AFPPD).
- Both the UNODC Regional Centres in Bangkok and New Delhi are honoured to have been involved in planning this week's conference. I well recall our two offices being fully supportive of the 1st Asian Consultation where we focused on HIV services for prisons, and HIV risks and human rights in respect of compulsory drug treatment centres in our vast region.
- In fact, in 2008, as Representative of our Regional Office in New Delhi, I recall how pleased I was to be invited to open that 1st Consultation. And I recall how happy we were to be able to support a number of community representatives to attend.
- I greatly value this collaboration and I look forward to seeing it mature over time.

2. Our mandate

Please now allow me to use this opportunity of addressing you this morning to share some perspectives on the mandates we, who work in the UN, are obliged to fulfil.

This will – I think – help our friends better understand UNODC's potential to assist in respect of the challenges that we face.

- At root, the mandate of UNODC, as is the case with all other UN agencies, is enshrined in the UN Charter. This commits UN Member States – and the UN Organization – to fundamental freedoms. In the Universal Declaration of Human Rights, Article 25 lists **health** as a basic human right. **And make no mistake – the implementation of the UN Drug Control Conventions must proceed in line with universal rights principles.**
- Let me also add here that, certainly, more needs to be done to make a better connection between international standards and norms and the right of individual countries to decide on how to implement the UN Drug Conventions.
- Nonetheless, practices that are **not** based on evidence or universal rights should be reviewed and reconsidered. I am pleased to learn that in the case of compulsory drug treatment centres, this conference will recommend that the UN accelerate the preparation of minimum standards and good practice guidelines.
- More than this, tried and tested harm reduction services – which are based on evidence of ensuring the right to health – need to be made available in the community. They should be easily accessible. And they should be voluntary.
- Therapeutic approaches administered by health professionals must also be scaled up.

Friends,

- It is well known – but worth repeating – that drug dependence is a chronic, relapsing disorder. And much like any other health disorder, such as diabetes and cancer, it requires evidence-based treatment. Such treatment should be based on informed consent.
- Drug dependence is not and should not be considered as a criminal act that requires punishment.
- Let me repeat – at this point the words of one very prominent Asian, the UN Secretary General, Mr. Ban Ki-moon, recently said: *“let us move away from punitive laws, policies and*

practices that increase stigma and discrimination of drug users, HIV positive people, men that have sex with men and sex workers, and that in fact block effective HIV responses.”

So, at the policy level, what should guide us?

- Let us reinstate public health at the centre drug control in our region – and indeed everywhere else
- Let us stay committed to implementing the WHO and UNODC Principles of Drug Dependence Treatment.
- And let us work relentlessly toward our commitments to achieve universal access enshrined in the 2001 UNGASS Declaration of Commitment on HIV/AIDS.

In UNODC – for our part – we will do our best , within our limited resources, to help you translate these goals into reality.

3. Our challenge

For I fear that our various “wars on drugs” have turned, far too often, into wars on drug users. And this needs to change.

Among the greatest challenges to universal access, today we face:

- Overcrowded prisons - where the risks of HIV, hepatitis and tuberculosis are several times higher than in the community at large;
- We face drug dependence treatment that tends, in our region, to be grounded on compulsory drug treatment centres managed by law enforcement agencies.
- Moreover, those few community-based facilities which do exist also often fall under the jurisdiction of the national drug control agencies.
- The mushrooming of the compulsory drug treatment centres in our region is likely to increase health risks – including HIV. Available information shows a high level of relapse in these centres. Thus the effectiveness of services is called into

question. Questions also arise on the matter of universal rights. And the toll in terms of stigma, and prejudice, against those confined in such centres is significant.

We must provide services that are community-based and evidence-informed. Services that are voluntary and user-friendly. We must do all we can to attract young people to health services that are designed for them. We must do all we can to reach out them - and not scare them away.

4. UNODC Role in the region:

As response to all of this, the strategy of UNODC, as an honest broker, is therefore quite straightforward.

1. First, we are committed to increasing the **coverage** of harm reduction services and evidence-informed, voluntary and community-based drug dependence treatment services for all drug users;
2. Second, we will continue to produce **strategic knowledge** and we will relentlessly advocate for evidence-based programming for HIV and drug dependence treatment options, including support for sound monitoring and independent evaluations;
3. And thirdly, we continue to **mainstream** health approaches across the drug policy spectrum.

Significantly, using our special relationship with law enforcement bodies in the region:

- We will make every effort to **attune law enforcement to the importance of promoting “harm reduction” methods** among drug users.
- We will provide assistance for comprehensive HIV prevention, treatment and care in **prison settings**;

- We we will work toward the implementation of evidence-based, community-based and voluntary-based approaches to drug dependence treatment.
- And last but not least, we will continue our strategic work on all of the above through the UN Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific.

Please allow me to say a few words about two areas which concern us:

Injecting Drug Use (IDU)

- I have resisted the temptation to drown you in a sea of statistics. But what follows is simply too powerful not to mention. We know that there is extremely high HIV prevalence among IDUs throughout our region.
 - in Indonesia (56% of females and 52% of males),
 - Myanmar (43%),
 - Viet Nam (29%),
 - Thailand (28%),
 - Malaysia (10%) and
 - China (7%).
 - In nearby Cambodia, 24% of drug injectors are HIV-infected.
 - Recently, the Philippines and Afghanistan have also reported emerging HIV epidemics among people who inject drugs.
- However, despite such alarming HIV rates, there is extremely scant coverage of the UN-supported comprehensive package for HIV prevention, treatment and care, which – as you know – comprises 9 interventions.
- **Hardly any country has full coverage and to scale.**
- In the South Asia and the East & South East Asia region, coverage of needle and syringe programmes is approximately only 12%. This is up from where we

stood three years ago, but still far below what is necessary.

- And, of the estimated number of people who inject drugs, only some 5% are covered by Methadone Maintenance Therapy and/or buprenorphine.
- In fact, with the exception of China and Malaysia, coverage of people who inject drugs with opioid maintenance therapy is below 5% in most countries of our region.
- Compare this with what we know to be the UA targets.
- We know what to do.
- We need to do it right.
- But we need to do more of it.

Amphetamine-Type Stimulants (ATS)

- Our region accounts for nearly 55% of the world's ATS users. Most of them are young. Most live in cities.
- Currently, five countries in the region – Brunei, Cambodia, Lao PDR, the Philippines and Thailand – report ATS as their primary drug of abuse. It is number two in most of the other countries.
- The abuse of crystalline methamphetamine (or “ice”) – which is **increasingly injected** – has been reported in **almost all countries** of our region.
- This trend towards injecting crystal meth also has severe implications for the spread of Hepatitis C and HIV.
- This upsurge in the consumption of ATS poses a serious threat to regional public health authorities.
- Unfortunately, unlike in the case of opioids, regarding ATS – I am **not** sure that we know clearly what to do in terms of treatment. And I am afraid to say that the UN must take part of the blame for the region's poor

capacity – 15 years after the ATS epidemic struck – for responding.

- But, in our own modest way, my office and the small but dedicated team I am privileged to lead, is doing work in alignment with broad principles I've indicated above – principles such as increased access, improved knowledge, and mainstreaming. They are all outlined in our Regional Programme Framework, and in our projects such as Treatnet II. We have set ourselves performance indicators. We are trying.
- I am also confident that the Regional Strategy of Harm Reduction 2010-2014, which is being developed under the auspices of the UN Regional Task Force – which we co-chair with UNAIDS – will guide countries and all partners to take forward the key outcomes that have emerged from this Consultation.

TO END:

Let me end, then by saying that our goal must be to help protect our communities of drug users. And we must assist in their recovery. Our strategy to do this is through increased access to evidence-informed practices that are voluntary, user-friendly, community-based and administered through public health systems.

Only then, can we hope to achieve our UA goals and – in so doing – contribute to achieving the Millennium Development Goals.

Friends,

If we do this, we shall also fulfil our responsibility to our communities which are looking to us for inspiration and responsible leadership. And to give a voice to those who often

consider themselves to be without voice. I commend – most sincerely – the work of the Response Beyond Borders for doing just this.

Thank you all very much for your kind attention. We look forward to continuing our partnership. And for those of you who have travelled many miles to be with us today, please travel safely as you return home.