From Evidence to Action

Reflections on the global politics of harm reduction and HIV

Keynote addresses by

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About the International Harm Reduction Association and HR2

The International Harm Reduction Association (IHRA) is one of the leading international non-governmental organisations promoting policies and practices that reduce the harms from all psychoactive substances, harms which include not only the increased vulnerability to HIV and hepatitis C infection among people who use drugs, but also the negative social, health, economic and criminal impacts of illicit drugs, alcohol and tobacco on individuals, communities and society. A key principle of IHRA's approach is to support the engagement of people and communities affected by drugs and alcohol around the world in policy-making processes, including the voices and perspectives of people who use illicit drugs.

In 2007, IHRA established HR2, the Harm Reduction & Human Rights Programme. HR2 leads the organisation's programme of research and advocacy on the development of harm reduction programmes and human rights protections for people who use drugs in all regions of the world.

IHRA is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations.

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In 2003—2004, McClure played a central role at the World Health Organization headquarters as a member of the coordination team for the development of the '3 by 5' strategy – WHO and UNAIDS initiative to expand antiretroviral treatment access for people living with HIV in resource-limited settings. Prior to working with WHO, McClure worked for the International AIDS Vaccine Initiative, focusing on mobilizing public sector support for vaccine research.

As a founding partner of the consultancy Health Hounds, McClure led a number of HIV policy and programme development projects for intergovernmental, governmental, non-governmental and corporate sector clients during 1997-2000. Prior to 1997, McClure worked for four years for the Canadian AIDS Treatment Information Exchange, a non-governmental organisation focused on HIV treatment information, education and advocacy.

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1. Harm Reduction – From Evidence to Action

2009 Rolleston Oration by Michel Kazatchkine, Executive Director
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I wish to dedicate my remarks today to two heroes of the fight, Amar and Nestor, who died of AIDS in the early '90s 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: the Global Alliance for Vaccines and Immunisation (GAVI) and the World Bank Multi-Country HIV/AIDS Program (MAP) in 2000, the Global Fund and the US President's Emergency Plan for AIDS Relief (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 dollars on treatment in 2001 to around 4 million dollars 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 cent*. 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 antiretrolvirol treatment (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 IHRA points out in its report, the *Global State of Harm Reduction*, since the late 1980s has 'grown in acceptance, popularity, scientific knowledge, advocacy methods and 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.

* Reniers G. et al, AIDS: 20/2/09, Vol 23, Issue 4, p 511-518

Here in Thailand, methadone is now on the Essential Drugs List. Thailand will receive around $6 million 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 realisation 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.

First, as the conference theme recognises, 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 criminalise 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 UN Commission on Narcotic Drugs (CND) is just the latest incarnation of that policy put in place 100 years ago. What upsets so many of 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 legalisation'. 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 the prevention of mother to child transmission, 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 $200 million 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 mobilisation strategy.

My hope is that, working together, we can produce this year a demand mobilisation 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 International Development Law Organization, the Open Society Institute and others to increase access to legal services through Global Fund-supported programs. It should support the efforts of drug users themselves to organise, so that more programmes are designed by them and fewer programmes are imposed on them. It should prompt countries that claim to prioritise injection drug users to actually seek resources for programmes 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 organisations 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.

2. Reflections on the Politics of Harm Reduction and the Global Response to HIV

Address by Craig McClure, Executive Director

International AIDS Society

Five years ago this week I became the Executive Director of the International AIDS Society (IAS).

It was just three months before the International AIDS Conference in Bangkok, and the IAS was about to relocate to Geneva and restructure its operations, staff and strategic vision. Needless to say, things were somewhat of a mess, and believe me, I was terrified, despite having worked in HIV for close to 15 years at the time.

On July 11 2004, the conference opened in Bangkok, the first time the meeting had ever been held in Asia. Close to 30,000 people had registered, and, as the Asian bird flu epidemic had only recently been contained, I sighed with relief that the conference was not cancelled. Though bird flu was under control, the war against drug users in Thailand was not. It was estimated that thousands had been killed as part of then-Prime Minister Thaksin Shinawatra's attempts to rid the country of drugs. The dead were mostly individual drug users and small-time dealers, certainly not the powerful mafia that control the production and distribution of illegal drugs in Thailand. They remained of course untouched.

At the opening session, Prime Minister Thaksin, former UN Secretary-General Kofi Annan, and, who could forget, Miss Universe, made strong commitments to the fight against AIDS. Dignitaries and celebrities were falling over themselves to say how much they cared.

And then it was time for the substantive part of the opening session – a global overview of HIV epidemiology and the current response, and a passionate call for humanity and harm reduction by one of Thailand's bravest and strongest HIV-positive drug user activists, Paisan Suwannawong. Paisan, if you are in the room today, I pay tribute to you. Inexplicably, the dignitaries, led by Prime Minister Thaksin, ceremoniously filed out of the stadium before the substantive discussions began. Paisan was left on the stage with a dwindling audience that, having seen all the dignitaries leave, thought the opening was over, and emptied the hall.

Needless to say, there was an outcry. Behind the scenes over the following days were angry meetings between the IAS and community leaders, and difficult meetings between the IAS and Thai government representatives. I realised that the IAS had made a mistake in allowing Paisan's talk to be scheduled at the end of the programme, even though we did not know that the Prime Minister would leave early. I learned that it was not considered appropriate for a Thai Prime Minister to listen to a drug user. I learned a lot of things that week.

In the end, Paisan was given the opportunity to speak again, this time at the Closing Session, but the damage was done.

One of the many things I learned from that experience, that has been compounded over the past five years in the work I have done related to drug use, harm reduction and HIV, is the enormous fear that underpins the world's approach to drugs, drug use and people who use drugs.

At the end of this year I will be leaving the IAS, after six IAS conferences and some dramatic progress in the response to HIV. I'd like to offer three observations I have made related to the response to HIV as it relates to drug use and harm reduction.

All three are about fear.

The Person Who Uses Drugs as 'Other'

My first observation is how all of us continue to talk about people who use drugs as 'other'. We use terms like 'drug abuser', 'drug user' and even 'person who uses drugs' as if some of us do not use drugs. But which one of us does not use a drug that alters our mood, our consciousness of pain, our physical or emotional state? A joint, a dab of speed, a line of coke, a tab of ecstasy, a shot of heroin. Even the last three Presidents of the United States between them have admitted using some of these. A pint of beer, a glass of wine, a shot of whisky. A cigarette. A cup of coffee or tea. A pain relieving medication, an anti-depressant, a valium, a sleeping pill.

We are all people who use drugs. Our refusal to acknowledge this is all about our fear that 'we' might become, or be seen as, one of 'them'.

Throughout history human beings have been people who use drugs. We will always be people who use drugs. As human beings we strive to develop the knowledge and technologies to control our environment and to manage our circumstances. The drug user, the person who uses drugs, is not the 'other'. She or he is you and me.

It seems to me that what we really need to focus on is the difference between drug use and drug addiction or dependency. Global drug policy continues to focus efforts primarily on the substances alone. This is wrong.

Of course, the harms associated with some drugs are worse than others. Sometimes these are due to the degree of addictiveness of a particular drug. But most of the harms are due to the way that a particular drug is acquired (for example in a dark back alley versus from a pharmacy) the way in which it is used (as a pill, for example, versus smoking, snorting or injecting), and, even more importantly, the way in which society treats people who use drugs. The vast majority of the horrific harms associated with drug use – crime, HIV and other infections, violence, incarceration, death – are clearly fuelled by the drug policies our governments pursue. It doesn't take a rocket scientist to show that criminalising drugs and drug use leads to a dramatic increase in drug-

related crime, and that controlling and regulating the production and distribution of all drugs would go a long way towards reducing that crime.

If we are all people who use drugs then the critical questions seem to me to be:

Why is it that some people who use drugs go on to have problematic drug use?

How we can prevent that from happening?

How we can help those that already have dependence problems?

and

How can we change the social and economic conditions that drive many people into drug dependence?

The reasons for drug use *per se* seem at least fairly well-characterised. We use drugs out of curiosity, to feel good, to feel better, to do better, or to manage physical, emotional or psychological pain. One might add to dance better, to have sex better, to relax more, to switch off, to switch on or to escape from the misery of social and economic deprivation. As to why some people go on to become drug dependent, the answers are less clear. There is some evidence, though still weak, that genetic factors, including the effects of our environment on gene expression and function, may contribute to vulnerability. People with mental health problems are at greater risk for drug dependency. This is not surprising, considering the generally pathetic state of mental health services around the world that drive people to self-medicate, and the neglect of the poor and the marginalised. How and why some people become drug dependent and not others and how we can prevent drug dependency is an area that still requires much research. But no reason should be used to blame or belittle anyone who is drug dependent.

So long as we continue to define the drug user as 'other' and define the drug itself as the problem we will be trapped in our misguided and harm-inducing programmes and policies.

The Wilful Denial of Evidence and the Abuse of Medical Authority

My second observation relates to the wilful denial of evidence by policy makers throughout the world and the abuse of power by some members of the medical profession who support this denial. The most obvious example of wilful denial of evidence is of course the fact that methadone remains illegal in Russia, thereby preventing the introduction of substitution therapy for people dependent on opioid drugs. The International AIDS Society has made the issue of access to methadone in Russia and throughout Eastern Europe and Central Asia a policy priority. Across the region, over 3.7 million people inject drugs, with over two million people injecting in Russia alone, the highest per capita in the

world, with four times the overall global prevalence of injecting drug use. Close to 70% of all HIV infections in Russia are linked to injecting drug use, versus 30% globally outside of sub Saharan Africa.

We all know that there are decades and decades of research showing that opioid substitution therapy is the most effective intervention to reduce injecting and prevent HV infection among people dependent on opioids, particularly if delivered as part of a comprehensive package of harm reduction interventions, including education and counselling, needle and syringe exchange programmes, provision of condoms, HIV diagnosis and treatment and TB and STI diagnosis and treatment.

But in Russia methadone remains illegal, and the Russian government maintains that there is no evidence that it works to prevent HIV infection or reduce the harms associated with injecting opioids. This denial of evidence is so profound that the government even dares to boldly distort the facts in international fora, such as at the high level meeting of the Commission on Narcotic Drugs in Vienna last month.

This kind of blatant and wilful denial of the evidence can only be based on deep-seated fear. Remember, this is a society steeped in denial due to fear. For decades the horrors of Stalin's regime were denied by not only the Russian government but ordinary Russian citizens, until long after the death of Stalin, and despite the disappearance of tens of millions of people.

But this kind of denial of the evidence is by no means limited to Russia. Even in my own home country of Canada, a supposed bastion of democracy and human rights, there is a concerted and organised state-supported campaign to deny evidence related to harm reduction. For a number of years now a number of studies in the Downtown Eastside of Vancouver have struggled against the odds to scientifically determine the impacts of a number of harm reduction interventions, including a supervised injection site and heroin maintenance therapy. These studies have been dogged by government interference since their inception, including unwarranted attempts to shut trials down, spending of public funds on harm reduction-denialist organisations to write negatively about the trials, misrepresentation of the evidence of the studies' results and interference in the peer review process.

Fear drives the global war on drugs. Otherwise how could such clear evidence of the failure of the past ten years' international drug policy be so blatantly denied? How could billions of dollars be wasted on a global anti-drugs programme that fuels violence, harms individuals, families and communities, strengthens organised crime and punishes sick people with prison sentences rather than providing them with the treatment, care and dignity that they need?

Fear also drives the abuse of people who use drugs by doctors and others in the medical system. In particular, I'm referring to the continuing use of forced detention and isolation,

electro-shock therapy, forced participation in medical experiments and other abuses of people who use drugs that many of us might refer to as 'torture'. Doctors who administer these abuses under the guise of 'drug treatment' are not just wilfully denying the evidence, they are violating human rights and the Hippocratic Oath. And make no mistake, as a membership association of health care professionals and researchers working in HIV, the International AIDS Society abhors and condemns these unethical and inhumane practices.

Fear drives the denial of evidence. I have seen it in the denialists who claim that HIV does not cause AIDS and the denial of the evidence that antiretrovirals work to control HIV.

Fear can induce denial of any evidence we throw at it.

The Need for Common Ground between the Harm Reduction and Anti-Drugs Movements

My third and final observation relates to the seemingly vast gulf of irreconcilable differences between those of us advocating for harm reduction approaches to drug use and those in the anti-drugs movement.

Recently I visited the INSITE supervised injecting site in the Downtown Eastside of Vancouver. It was late afternoon, a very busy time at the centre. There was actually a queue of people outside the door over 15 people deep, each waiting impatiently for his or her chance to inject in one of the supervised cubicles inside. I spoke with a few individuals. These were not happy people. They were skinny, undernourished, bruised and cut, in tattered clothing, scared, twitchy and desperate. There was a hint, a glimmer, of hope in the eyes of one or two, but not much. The road ahead for these people looked bleak to me. God knows how it looked to them. Using the supervised injecting site was just one small but significant notch above sharing a needle and syringe in the alley up the road. Homeless and hungry, their lives pretty much devastated by the harms associated with drug use and the failure of the Canadian health and social systems. This is the reality of a supervised injecting site, an entry point to reduce harm amidst a sea of neglect.

To bridge the gap between the harm reduction and anti-drugs movement we harm reduction advocates must not be coy about the horrific problems that can be associated with drug use – their effects on the individual, the family, the community and humanity. Individuals in the anti-drugs movement are motivated too by their experience of the worst harms associated with drug use. Discussing these experiences openly and without prejudice could be the beginning of a common language we share. If we are not able to reach out to these groups and find common

ground then our evidence will never overcome their fear.

Most importantly, our own fear that we might weaken the argument of our evidence that harm reduction works if we acknowledge and talk openly too much about the ugly side of drug dependency must also be overcome. If we let the chasm between us and the anti-drugs movement get too great then we will have to fight this battle far longer than necessary. We are not, after all, 'pro-drug', we are not 'encouraging drug use'. We must reach out for dialogue consistently, with passion and compassion if we are to make further gains.

Conclusion

Next year, in July 2010, the International AIDS Conference will be held in Vienna, Austria. This will not be a repeat of the recent CND meeting in Vienna, whose failure to endorse harm reduction has so angered us all. The conference will have a major focus on injecting drug use and human rights. There will be a special sub-focus on Eastern Europe and Central Asia, using Vienna in its historical role as a bridge between East and West. Let's work together to ensure that Vienna in 2010 helps confront the fear that was rampant at the Commission on Narcotic Drugs in Vienna in 2009.

Fellow people who use drugs, let us all continue to dig deep within ourselves to face our own fears about the drugs we use, how we use them, how we can continue to be curious, to feel good, to feel better and to do better. Let us continue to consider how we can prevent or reduce any harm we might cause ourselves, our families, our communities and society. Let us stop HIV infection in people who use drugs and treat, care and support those that are living with HIV. Let us move towards a unified voice where public health and human rights are two sides of the same coin. Let us fight for a more just and equitable society for all people in all places.

Finally, let us continue to search for common ground with those who are not yet on what Michel Kazatchkine referred to earlier this week as 'the right side of history'. Let us find the passion and compassion to talk to our so-called enemies, show them the way, and help them overcome their fear. Because as Nobel Laureate and human rights warrior Aung San Suu Kyi said:

'Fear is not the natural state of civilized people.'

Thank you.

INTERNATIONAL HARM REDUCTION ASSOCIATION