

## RESPONDENT

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Anindya Chatterjee agreed that injecting drug use was one of the main drivers of HIV/AIDS epidemics, and that provision of harm-reduction services for drug users worldwide was unacceptably low. The real argument was not about the evidence base for the effectiveness of such services, but about ideological and political acceptability.

It was important to be aware of the political and institutional barriers to progress, and particularly the tendency for different policy communities to work disparately. At UN level, there had been challenges in joining up drug and HIV/AIDS policy. An UNGASS report on drug-demand reduction produced in 1998 had not even mentioned HIV/AIDS, referring to the adverse consequences of drug misuse in general terms. There had been significant progress since 1998, but even today, there is not one single UN drug policy document that has been approved by member states (as distinguished from publications of the UN secretariat) which has unambiguously supported harm reduction.

There are formidable obstacles to joining up policy at the national level. Policy on drugs and HIV/AIDS is the concern of three sectors, which are located within different structures and ministries in many countries: the drug control sector, the drug treatment sector and the HIV/AIDS control sector. At UN level, all these policy functions must interact with foreign affairs ministries. In most countries, there are no formal mechanisms to facilitate dialogue between these different agencies. Similarly, many NGOs concerned with drug treatment, harm reduction and HIV/AIDS lack mechanisms for constructive dialogue, both nationally and internationally.

Dr Chatterjee noted Gerry Stimson had spoken of 'bitter policy debates' at the highest level but observed, 'this is only the tip of the iceberg ... it goes down to ground level where even grassroots organisations can be pitted against one another and have different ideologies'. Harm reduction initiatives have always been perfectly acceptable within health policy; it is within the drug policy context that it is controversial. Improved dialogue between these sectors would improve understanding of harm reduction. This will require systematic investment at national level, to create institutions that provide space for productive cross-sectoral dialogue and debate.

Currently, there is a step change on harm-reduction work with drug users in many countries. The Chinese methadone programme is a good example, but this is being rolled out alongside extremely punitive drug policies, including the death penalty and labour camps for drug traffickers. Lack of effective dialogue and of a joined up strategic approach has resulted in the Ministry of the Interior permitting the Ministry of Health to

roll out a methadone maintenance programme, but without any corresponding roll back of China's punitive drug control programme. There have been similar developments in Malaysia.

From the UNAIDS perspective, there is a lot to learn from the messy world of policy implementation at national level, which is not necessarily revealed by more abstract research. Some of the most important lessons concern structural and institutional constraints. It is vital to facilitate dialogue between different ministries and NGOs at national level. Generally, it has been the case that ministries of the interior have much greater power and influence than ministries of health. We need to get a dialogue started, so that they can work more effectively together in pursuit of common policy objectives.

#### KEY POINTS

The evidence for the effectiveness of harm reduction is not contested but the arguments surrounding it are political and ideological.

Law enforcement and health policies are often not joined up. Progressive harm-reduction initiatives may be rolled out alongside punitive drug policies.

Barriers to progress are institutional, as well as ideological.