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Dear Dr. Lee, Dr. Piot, Dr. Feachem and Mr. Costa,

In November 2003, a small group of people living with HIV/AIDS (PLWHAs) met in Geneva with Dr. Jong Wook Lee and Dr. Jim Yong Kim of the World Health Organization. That gathering was the first meeting in the history of the epidemic between a Director General and a delegation of PLWHAs from around the world. One of the priorities for the activists—many of whom were members of populations most vulnerable to HIV transmission, including drug users, women and gay men—was the inclusion of methadone on the WHO's Model List of Essential Drugs and Medicines (EDL).

Shortly after the meeting, in February 2004, hundreds of drug users, PLWHAs and harm reduction advocates from around the globe signed a letter to the agency with the primary objective of urging WHO to champion the rights of HIV-positive injection drug users (IDUs) to equal access to antiretroviral treatment (ART). Furthermore, the letter laid out a strong argument for including methadone and buprenorphine in the WHO EDL by emphasizing the importance of

substitution therapy in providing IDUs with a full range of HIV/AIDS prevention and treatment services.

We are pleased that since then, both methadone and buprenorphine have been included in the WHO list. We hail WHO's decision, which in many parts of the world will undoubtedly lead to the greater availability of these agents to IDUs seeking to manage their drug dependence or HIV disease—or both simultaneously.

Sadly, we know that the listing of methadone and buprenorphine by WHO will not address the plight of the vast majority of millions of HIV-positive IDUs and the thousands more who contract the virus every day. Many governments, especially those in countries with injection drug-driven HIV epidemics, prohibit or severely restrict the implementation of substitution therapy or harm reduction programs. Methadone and other key interventions for IDUs are illegal in several of these nations. Policymakers often remain impervious to exhortations based on safeguarding drug users' human rights and access to public health services.

According to the UN Reference Group on HIV/AIDS Prevention and Care among IDU in Developing and Transitional Countries, at the end of 2004 there were only 36,156 IDUs on ART in the 45 developing and transitional countries where data was collected. We know that there are hundreds of thousands more IDUs in regions including Eastern Europe and South, Southeast and Central Asia and in the Middle East who are in urgent clinical need of antiretroviral drugs. Millions of drug users will die and new infections will continue to rise unabated unless WHO, UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria and UNODC make a concerted effort to ensure that substitution therapy with methadone and buprenorphine, ART and other interventions for drug users are rapidly implemented and scaled up at the country-level. Therefore, we are calling on you to take the following steps to combat this growing global public health disaster.

For WHO:

1. All WHO regional and country offices should immediately announce the decision to list methadone and buprenorphine on the EDL and develop a communications strategy to ensure that this news is widely disseminated to all stakeholders. *Recently, staff at the WHO office in Tajikistan, when asked by a local harm reduction association to host a press conference on the listing of these drugs in the EDL, stated that it was impossible that WHO would list methadone and buprenorphine on the EDL now or in the future. This misinformation needs to be confronted quickly and resolutely.*
2. All WHO country offices should meet with national health officials and other policymakers to explain the decision and to suggest how to remove obstacles and change policies to reflect the global standard of care for the treatment of drug users, which now includes these two substitution therapies.
3. All WHO country offices, in partnership with local NGOs, should approach national institutions responsible for medicines control and regulation and discuss the process for inclusion of these two new medicines into National Essential Drug lists.
4. WHO must clarify what the placement on the complementary EDL means. In particular, it should be clear that this placement does not signify a partial or limited endorsement of

methadone or buprenorphine, but indicates that particular infrastructure and training are important prerequisites for successfully utilizing these two medications.

5. WHO should immediately convene a technical consultation to begin to create the framework for clinical guidelines for countries for the use of methadone and buprenorphine, as the implementation of these programs are of widely differing quality at the current time and a clear description of both best and worst practices needs articulation.
6. This consultation must include drug users themselves as there is significant knowledge within the user community about what constitutes a good program, particularly around dosing, assisted services, etc. and is in line with recommendations of the United Nations System Position Paper on the Prevention of HIV among Drug Abusers. Country-level consultations to create national guidelines should also involve IDUs, and WHO should encourage IDUs' participation and collaboration with national policymakers and local implementing partners and agencies.

For WHO and UNAIDS:

1. WHO and UNAIDS should work together to ensure that methadone is removed from the list of prohibited drugs in Russia. Restrictions are greatest in this country, which not only has the world's largest number of IDUs but also holds great influence with other countries in the region.
2. Working with drug users themselves and allied NGOs, WHO and UNAIDS should make IDUs aware of WHO's decision in simple terms and in local languages, particularly in Eastern Europe, South, Southeast, Central Asia and in the Middle East. Such information could greatly enhance drug users' ability to lobby their national governments for greater access to substitution therapy and ART.

For GFATM:

1. The GFATM must consider methadone and buprenorphine to be an indispensable part of AIDS care and prevention among IDUs. This means that substitution therapy programs must be eligible for GFATM support and applications to the GFATM from countries or organizations where drug use is common must include substitution therapy as a part of a comprehensive HIV prevention and treatment effort. Access to methadone and buprenorphine essential treatment should be considered by the GFATM as one of the critical criteria in judging a country's success in implementing its grant.

For UNODC:

1. Based on a recognition that methadone and buprenorphine are the standard of care for treating opioid dependency and support HIV/AIDS prevention and care for IDUs, UNODC must work to ensure that both agents are reclassified and able to be used without restriction in all countries. This effort will likely require working directly with national law enforcement authorities to assist in identifying and removing policy and other ideologically-based obstacles.

Because of the urgency of these tasks, we are asking to meet with all of you within the next 60 days to discuss your strategies for making methadone and buprenorphine widely available. For millions of people, substitution therapy is the only alternative to illicit opioid use and thus represents a key part of a comprehensive fight against HIV/AIDS.

Please send any correspondence regarding this letter to Gregg Gonsalves at greggg@gmhc.org or by post to Gregg Gonsalves, GMHC, 119 West 24th Street, New York, NY, 10011, USA.

Yours truly,

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