



HIV and injecting drug use: a global call for action



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When world leaders meet in New York at the UN High-Level Meeting on AIDS (June 8–10, 2011), they will review the past decade's progress and chart the future course of the global HIV response. There are some advances to celebrate, with global HIV incidence falling and access to treatment improving. But there are also unmitigated failures to be addressed moving forward. As a *Lancet* Series emphasised last year, people who inject drugs have been left behind in global efforts to scale up access to HIV prevention, treatment, care, and support. Their needs have been neglected, and their rights have been ignored, and, in many cases, horribly violated as governments have chosen to pursue punitive, disproportionate drug laws instead of evidence-based health strategies to address drug-related harm.

The June meeting represents a unique opportunity to correct these injustices. A new document—the *Beirut Declaration on HIV and Injecting Drug Use: A Global Call for Action*—released at the 22nd International Harm Reduction Conference, Beirut, Lebanon (April 3–7, 2011), sets out how the international community has failed people who inject drugs and the actions now required

by governments. Crucially, evidence-based programmes (needle and syringe exchange programmes, opioid substitution, and antiretroviral treatment) targeting the 16 million people who inject drugs worldwide need to be financed, implemented, and scaled up across all settings to prevent and treat HIV infection. Ineffective drug policies also need to end, funding for harm reduction needs to be vastly increased, and vulnerable groups who inject drugs (including women, young people, and people in prison) need access to integrated health and harm-reduction services. These actions should be explicitly included in the new global declaration on HIV/AIDS that will be drafted at the June meeting with measurable targets to hold governments accountable.

Misplaced moral judgments have underpinned the neglect of people who inject drugs in the global HIV response. Yet it is wholly immoral to let people become infected with HIV or die when evidence-based interventions exist to prevent these outcomes. A bold and humane response is needed from governments at the June meeting and beyond. Millions of lives are at stake. ■ *The Lancet*

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For more on the **UN High-Level Meeting in June** see http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/20110204_HLM_Brochure_en.pdf

For *The Lancet's Series on HIV in people who use drugs* see <http://www.thelancet.com/series/hiv-in-people-who-use-drugs>

For the **Beirut Declaration** see <http://www.ihra.net/declaration>

The **Beirut Declaration** is also available as a webappendix

Rational reform to medical education in India



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In response to *The Lancet's* Commission on education for health professionals, today's Correspondence section and an online Comment discuss the contribution of ethics, social mission, primary care, and local health needs to inform curriculum design. These themes resonate widely, but nowhere are they more relevant than in India. As described in *The Lancet's* Series—India: towards universal health coverage—the country has a health crisis exacerbated by the shortage of doctors and a mismatch between the need for basic medical services in rural areas and the congregation of specialists in urban centres. To improve the density and distribution of doctors, the Medical Council of India proposed wide-ranging reforms to medical education on March 29.

The recommendations, prepared over the past year by academics, will be published in a forthcoming document, *Vision 2015*. The proposals aim to produce an "Indian Medical Graduate" who is reflective, socially responsible, self-directed, and adapts to changing health circumstances in India and around the world. To accomplish this,

education begins with a foundation course that includes communication, ethics, and professionalism, followed by a curriculum that reflects India's particular health burdens. At all levels, an emphasis is placed on clinical skills. National examinations will add transparency and uniformity to medical school admission, licensing, and postgraduate training. More postgraduate paths will be available with entry via a 2 year MMed degree to consolidate clinical experience before specialisation, teaching, community care, or research. And research now becomes mandatory for medical schools and for academic advancement.

The reforms will be a challenge for the country's 314 medical schools and a test of the Medical Council's authority. Despite opposition to change from some doctors, bold changes are necessary to improve India's disappointing health outcomes and to realise the country's research potential. A new curriculum that addresses local health improvement is a welcome start.

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See **Correspondence** pages 1235

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For *The Lancet's Series on India: towards universal health coverage* see <http://www.thelancet.com/series/india-towards-universal-health-coverage>