Services for people who inject drugs

Resource kit for high-impact programming

This Guidance Note is part of the resource kit for-high impact programming that provides simple, concise and practical guidance on key areas of the AIDS response. The resource kit is developed by the the Joint United Nations Programme on HIV/AIDS. The resource kit can be accessed at http://www.unaids.org/en/ourwork/programmebranch/countryimpactsustainabilitydepartment/globalfinancingpartnercoordinationdivision/.

For more information, please contact highimpact@unaids.org.

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The development of this Guidance Note was led by the United Nations Office on Drugs and Crime (UNODC) in collaboration with the UNAIDS Secretariat, the World Health Organization (WHO) and the United Nations Development Programme (UNDP). It provides simple, concise and practical guidance on services for people who inject drugs. References and links to full guidance are provided in the last section of this document.

WHAT IS NEW?

- United Nations Office on Drugs and Crime, International Network of People who use drugs, World Health Organization, UN Women. Policy Brief - Women who inject drugs and HIV: Addressing specific needs. Vienna: United Nations Office on Drugs and Crime; 2014 (http://www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf).

- World Health Organization, UNAIDS, United Nations Development Programme, United Nations Population Fund, United Nations Office on Drugs and Crime, Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: World health Organization; 2014 http://www.who.int/hiv/pub/guidelines/keypopulations/en/

- United Nations Office on Drugs and Crime, Training Manual for Law Enforcement Officials on HIV Service Provision for People Who Inject Drugs. Vienna: United Nations Office on Drugs and Crime; 2014. http://www.unodc.org/unodc/en/hiv-aids/new/publications_drugs.html

- World Health Organization, United Nations Office on Drugs and Crime, and Joint United Nations Programme on HIV/AIDS. WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva: World Health Organization; 2012 (http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf?ua=1, accessed 24 July 2014).

- Guidance on prevention of viral hepatitis B and C among people who inject drugs. Geneva: World Health Organization; 2012 (http://apps.who.int/iris/bitstream/10665/75357/1/9789241504041_eng.pdf, accessed 24 July 2014).

- United Nations Office on Drugs and Crime, World Health Organization. Opioid overdose: preventing and reducing opioid overdose mortality. Discussion paper UNODC/WHO 2013. New York: United Nations; 2013 (http://www.unodc.org/docs/treatment/overdose.pdf, accessed 24 July 2014).

Introduction

Ending the AIDS epidemic is impossible without dramatically stronger, more sustained action to address the HIV-related needs of people who inject drugs. Accounting for 0.2–0.5% of the global population, people who inject drugs represent an estimated 5 to 10% of all people living with HIV (UNAIDS publication "UNAIDS by numbers" 2013), with transmission among people who inject drugs driving national epidemics in many parts or the world.[1] Injecting drug use has been documented in 158 countries and territories,[2] and it is estimated that 12,7 million (ranging from 8.9 to 22.4 million) people inject drugs globally.[2] The 2012 UNODC/WHO/UNAIDS/World Bank global estimate of the number of people who inject drugs living with HIV is 1.7 million (range: 0.9 million-4.8 million), corresponding to an average prevalence of HIV among people who inject drugs of 13.1%[2].

Currently, 34% of people living with HIV eligible for treatment (WHO 2013 Guidelines) have access to antiretroviral therapy. In contrast, it was estimated that by 2009, 4% of all HIV-positive people who inject drugs (range 2–18%) worldwide were receiving antiretroviral therapy.3 Given the breadth of injecting drug use and the disproportionate HIV-related risks among people who inject drugs, preventing HIV and other harms among people who inject drugs—and providing them with effective treatment, care and support—are essential components of a sound, effective national response. The active engagement of people who inject drugs in the planning, implementation and monitoring of HIV programmes is critical to success.

1. Key elements

An effective, evidence- and rights-based response for people who inject drugs requires the implementation of a comprehensive package of nine interventions as defined by WHO, UNODC and UNAIDS.[1] These programmes must be of adequate quality and delivered to scale in order to ensure that they have the required impact. Often referred to as harm reduction services for HIV, these nine interventions are:

- needle and syringe programmes (NSPs);
- opioid substitution therapy (OST) and other evidence-based drug dependence treatment programmes;
- HIV testing and counselling (HTC);
- antiretroviral therapy (ART);
- prevention and treatment of sexually transmitted infections (STIs);
- condom programmes for people who inject drugs and their sexual partners;

1 World Health Organization, United Nations Office on Drugs and Crime, and Joint United Nations Programme on HIV/AIDS. WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva: World Health Organization; 2012 (http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf?ua=1, accessed 24 July 2014).

2 World drug report 2014. Vienna: United Nations Office on Drugs and Crime; http://www.unodc.org/wdr2014/

- targeted information, education and communication (IEC) for people who inject drugs and their sexual partners;
- prevention, vaccination, diagnosis and treatment of viral hepatitis;
- prevention, diagnosis and treatment of tuberculosis (TB).

Out of these nine interventions, the first four interventions combined are most effective in preventing HIV among people who inject drugs and keeping people living with HIV alive.

The interventions should be delivered using a range of modalities, including community outreach and peer-to-peer work,[3] and implemented both in community and prison settings.[4] Services for people who inject drugs are best delivered in community-based settings and in close collaboration with civil society. As in other aspects of the response to HIV, services for people who inject drugs should be grounded in a human rights–based and public health approach supported by an enabling legal and policy framework and time-bound, measurable performance indicators and quality assurance mechanisms.

2. Focus populations

The populations of focus for harm reduction activities are:

- people who inject drugs;
- people from key populations who use stimulants;
- the sexual partners of people who inject drugs;
- sex workers who use drugs;
- women who inject drugs;
- people who inject drugs and are living in prisons and other closed settings (including pre-trial detention centres).

3. Data requirements

To respond effectively to HIV, it is vital to "know your epidemic and your response." Countries must tailor their proposed responses within the context of the epidemiological situation and the needs of those individuals at risk. The following data are needed for the development of programmatic strategies, as well as for the establishment of baseline data and targets for monitoring and evaluation.

3 Evidence for action: effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users. Geneva: World Health Organization; 2004 (http://www.who.int/hiv/pub/prev_care/en/evidenceforactionalcommunityfinal.pdf, accessed 24 July 2014).

4 Evidence for action series. In: WHO/Programmes/HIV/AIDS/Publications on injecting drug use [website]. Geneva: World Health Organization; 2014 (http://www.who.int/hiv/pub/idu/evidence_for_action/en/, accessed 24 July 2014).

It is important to stress that the lack of data cannot serve as an excuse for inaction. The nine interventions listed above should be implemented, while simultaneously investing in the necessary research and data collection initiatives required to further develop the evidence base.[5]

Epidemiology

The following data related to the epidemiological context should be collected:

- HIV prevalence in the focus population for the intervention.
- Mapping of problematic drug use in the country, because drug use, particularly opiates, does not distribute evenly across countries or even cities.
- The estimated number of people who are actively injecting drugs, defined as the number of people who injected drugs at any time during the past 12 months. It is recommended that this estimate be further disaggregated according to the following:
  - gender (male, female and transgender);
  - age (<18 years, 18–25 years and ≥ 25 years);
  - the type of drug injected (e.g., opioids, stimulants such as amphetamine-type stimulants and cocaine preparations and other drugs, including benzodiazepines).
- The proportion or number of new HIV infections among the focus population.
- The estimated number of people who inject drugs living with HIV. It is recommended that this estimate be further disaggregated according to the following;
  - gender (male, female and transgender);
  - age (<18 years, 18–25 years and ≥ 25 years);
  - the type of drug injected (e.g., opioids, stimulants such as amphetamine-type stimulants and cocaine preparations and other drugs including benzodiazepines).
- The estimated size of particular populations, including:
  - the estimated number of people living with HIV;
  - the estimated number of people who inject drugs living with HIV;
  - the estimated number of people who inject drugs in prisons and other closed settings;
  - the estimated number of people who inject drugs living with hepatitis C;
  - the estimated number of people who inject drugs living with TB.
- Factors associated with transmission (e.g. structural factors such as societal norms, policies and laws).

5 World Health Organization, United Nations Office on Drugs and Crime, and Joint United Nations Programme on HIV/AIDS. WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva: World Health Organization; 2012 (http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf?ua=1, accessed 24 July 2014).

Programmatic

Data related to specific programmes should also be collected. These can be divided into data related to national targets and the current coverage of national programmes as listed below.

National targets

- Percentage of people who inject drugs regularly reached by NSPs over the last 12 months (recommended coverage of >60%) or the number of syringes distributed per person per year (recommended number >200).
- Percentage of opioid-dependent people on OST (recommended coverage of >40%).
- Percentage of people who inject drugs living with HIV on ART (recommended coverage of >75%).

Current coverage

- Percentage of people who inject drugs who are regularly reached by NSPs over the last 12 months (e.g. low coverage: <20%; mid coverage: 20–60%; high coverage: >60%) or the number of syringes distributed per person per year (coverage of >200).
- Percentage of opioid-dependent people on OST (e.g. low coverage: <20%; mid coverage: 20–40%; high coverage: >40%).
- Percentage of people who inject drugs living with HIV on ART (e.g. low coverage: <25%; mid coverage: 25–75%; high coverage: >75%).

In relation to service providers, the following data should be collected:

- the number and location of sites where needles and syringes, OST and HTC are available;
- the number of clean needles distributed per person who injects drugs;
- the availability of ART for people who inject drugs;
- mapping of ART, HIV testing and counselling and other services that people who inject drugs may be able to access (outside harm reduction service facilities);
- factors associated with barriers to accessing testing and treatment for people who inject drugs living with HIV;
- the co-location of interventions and cross-trainings for providers (for example, the provision of ART in locations where drug treatment services are provided);
- service hours that are routine and dependable and that suit clients' lifestyles;
- the location of services (for example, in settings with high rates of transmission);
- peer-community involvement in the development, promotion, delivery and monitoring and evaluation of services;
- the frequency and quality of training on working with people who inject drugs;
- steps taken (e.g. sensitization and training) to ensure that law enforcement activities do not interfere with clients' access to a particular service.

Financial

Data related to financing include the following:

- the cost of interventions based on the national strategy;
- the funding available and sources of funding including domestic sources.

4. Implementation challenges

People who inject drugs in low- and middle-income countries have limited and inequitable access to HIV prevention and treatment services. It was estimated that by 2009, 4% of all HIV-positive people who inject drugs (range 2–18%) worldwide were receiving ART,[6] despite the disproportionately higher burden of disease this key population carries.

In prisons and other closed settings, access to comprehensive HIV prevention, treatment and care is further limited despite evidence that drug use, high-risk sexual practices and several other HIV risk behaviours are prevalent in these settings.[7] Programmes for people who inject drugs must take into account the considerable access barriers confronting this population, coupling services with focused efforts to encourage utilization and the continuity of services.

In particular, programmes must address the service impediments posed by legal and social factors. People who inject drugs are commonly marginalized, criminalized and subjected to stigma and discrimination. Due to the illegality of drug use, people who inject drugs face legal sanctions that may discourage them from seeking services, including ART, or inhibit some service providers from offering them in the first place. Changes in drug supplies or drug transit patterns can alter injecting practices in ways that affect HIV transmission.

In many countries, legal constraints make it difficult to implement and improve access to relevant health services. Laws and law enforcement practices may inadvertently increase the risk of HIV transmission and impede the delivery and scale-up of HIV prevention services. For example, while NSPs may be officially tolerated or even encouraged, law enforcement and judicial officials who treat possession of drug paraphernalia as evidence of drug use may undermine programmatic efforts. Collaboration between the health, police, other law enforcement agencies and criminal justice sectors is crucial to planning a comprehensive response.

Despite the overwhelming evidence of their effectiveness, opposition to the provision of evidence-based interventions such as OST and NSPs continues. In some cases, opposition may be based on erroneous beliefs that harm reduction programmes encourage drug use. Political leadership, commitment and education are vital to building support for evidence-based HIV

6 Mathers B et al. HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage. Lancet. 2010;375(9719):1014–1028. doi:10.1016/S0140-6736(10)60232-2.

7 Mathers B et al. The global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. Lancet. 2008;372(9651):1733–1745. doi:10.1016/S0140-6736(08)61311-2.

services for people who inject drugs and to address misconceptions regarding harm reduction programmes.

As noted above, many services for people who use drugs are best delivered in community-based settings and by civil society organizations. However, many community groups lack sufficient capacity to play an important role in the HIV response for people who inject drugs. To fully leverage the unique strengths of communities in responding to HIV among people who inject drugs, investments are needed to build the capacity of community-based organisations and to increase the meaningful engagement of people who use drugs in the development, implementation and evaluation of services.

Furthermore, a greater effort is required to properly understand injecting drug use among individuals under the age of 18 and to deliver youth-friendly harm reduction services. Rapid assessments are needed to quickly understand the situation and service needs and to conduct budgetary analyses. At the same time, it is important to carry out population size estimates for individuals under the age of 18 who inject drugs and ensure their appropriate representation in bio-behavioural surveillance.

The international financial crisis, combined with a shift in aid priorities toward low-income countries, pose major threats to the future and sustainability of harm reduction interventions in many countries. Thus far, relatively few national governments have made substantial domestic financial contributions towards the implementation and scale up of HIV and harm reduction interventions.[8]

5. Main activities

Resources should be used to fund evidence-based interventions, including those targeting key populations within the community and in prisons. The development of service delivery models in different settings should be pragmatic and responsive to local conditions.

Countries with concentrated HIV epidemics associated with injecting drug use are strongly encouraged to include harm reduction in their national responses. The same recommendation holds for countries with generalized HIV epidemics and high HIV prevalence among people who inject drugs or in countries where a significant potential for concentrated epidemics to develop exists. In addition, countries are strongly encouraged to include interventions and activities aimed at improving the legal and policy environments to ensure that services are accessible to people who use drugs.

All nine interventions that comprise the harm reduction services for HIV (described in section 1) should be considered for inclusion in national responses. Although the greatest

8 Global report: UNAIDS report on the global AIDS epidemic 2013. Geneva: Joint United Nations Programme on HIV/AIDS; 2013 (http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/, accessed 24 July 2014).

impact will be achieved when all nine interventions are implemented as a complete package, priority should be given to the following:

- NSPs prioritizing the use of low dead-space syringes whenever feasible, possible[9] and acceptable to the injecting community;
- OST and other evidence-based drug dependence treatment programmes;
- the provision of optimized and maximized ART and TB treatment for people who inject drugs.

To enhance service integration and uptake, services should be delivered as part of an integrated programme where feasible.

Viral hepatitis

Interventions related to hepatitis should be designed following the recommendations formulated in the *Guidance on prevention of viral hepatitis B and C among people who inject drugs*, issued by WHO in July 2012. Specific recommendations include the following:

- It is suggested to offer people who inject drugs the rapid hepatitis B vaccination regimen.
- It is suggested to offer people who inject drugs incentives to increase uptake and completion of the hepatitis B vaccine schedule.
- It is suggested that NSPs also provide low dead-space syringes for distribution to people who inject drugs.
- Psychosocial interventions are not suggested for people who inject drugs to reduce the incidence of viral hepatitis.
- It is suggested to offer peer interventions to people who inject drugs to reduce the incidence of viral hepatitis.

9 Low dead-space syringes (LDSS) are designed to reduce the amount of blood remaining in the syringe after completely pushing down the syringe plunger. Studies have shown that this difference in dead space reduces the survival of hepatitis C virus (HCV) and HIV in blood remaining in syringes. Evidence indicates that providing LDSS leads to a reduction in the transmission of HIV and HCV and that NSPs should provide LDSS in addition to other types of syringes appropriate to local needs.

Including hepatitis C treatment in concept notes to the Global Fund

The Technical Review Panel (TRP) of the the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) has previously stated that applications to fund hepatitis C treatment among people living with HIV will be recommended "after close scrutiny of the country context, including well-documented evidence that hepatitis C treatment and funding is available to the general population and that funding from the Global Fund is to fill-in the gap for HIV-infected individuals".[9] The TRP has recommended that Global Fund resources be used to increase evidence on the need for hepatitis treatment, create awareness of the virus, increase prevention efforts and support advocacy for treatment access and affordability.

Please refer to the Global Fund's information note on harm reduction for people who inject drugs for guidance on how to incorporate harm reduction interventions into funding requests to the Global Fund.[10]

As previously noted, multiple delivery modalities should be used, including community outreach and peer-to-peer delivery,[12] and services should be implemented in both community and prison settings.[13] Service provision should be "low threshold," avoiding specific criteria or entry hurdles to access services.

It is strongly recommended that the community of people who inject drugs be included in the project design, programme implementation and oversight. Where necessary, the capacity of people who inject drugs to participate meaningfully should also be strengthened. Involving people who inject drugs in planning and service delivery recognizes and utilizes their unique experiences, knowledge and contacts, and contributes to effectively addressing their needs and ensuring that the proposed services and interventions have the lowest possible thresholds. At the programmatic level, proactive efforts should be undertaken to ensure the engagement and active participation of people who inject drugs in the planning, delivery and monitoring of specific programmes and in the overall response.

Specific complementary strategies should be implemented along with the above-noted service components.

10 Report of the Technical Review Panel and the Secretariat on Round 10 proposals. Twenty-second Board Meeting, Sofia, Bulgaria, 13–15 December 2010. Geneva: The Global Fund to Fight AIDS, Tuberculosis and Malaria; 2010 (http://www.theglobalfund.org/documents/board/22/BM22_13TRPRound10_Report_en/, accessed 24 July 2014).

11 Harm reduction for people who inject drugs: information note. Geneva: The Global Fund to Fight AIDS, Tuberculosis and Malaria; 2014 (http://www.theglobalfund.org/documents/core/infonotes/Core_HarmReduction_InfoNote_en/, accessed 24 July 2014).

12 Evidence for action: effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users. Geneva: World Health Organization; 2004 (http://www.who.int/hiv/pub/prev_care/en/evidenceforactionalcommunityfinal.pdf, accessed 24 July 2014).

13 Evidence for action series. In: WHO/Programmes/HIV/AIDS/Publications on injecting drug use [website]. Geneva: World Health Organization; 2014 (http://www.who.int/hiv/pub/idu/evidence_for_action/en/, accessed 24 July 2014).

Community systems strengthening

To ensure community organizations possess the capacity to participate in the planning, delivery and monitoring of programmes, investments are needed for specific initiatives to build sustainable capacity among community systems. Community systems strengthening provides the resources, skills and expertise needed to ensure that key communities (such as people who use drugs and the clients of harm reduction programmes) have the means to fully participate in the national response.

Prisons and pre-trial detention centres

Imprisonment is a common event for many people who inject drugs.[14] Often, individuals continue using (and injecting) drugs while in prison despite efforts by prison systems to prevent this. It is, therefore, essential to provide harm reduction services in the community as well as in pre-trial detention centres and penal institutions. Prison-based harm reduction programmes must address not only injecting risk, but also sexual and other risks in prison settings. Given the role that prisons play in the spread of HIV and TB (including multidrug-resistant TB), specific efforts are needed to ensure the continuity of ART and TB treatment, effective infection control, NSPs and OST at each and every stage of the law enforcement process—from arrest through pre-trial detention, transfer to prison, during the individual's stay in the prison system and upon release. Throughout the world, a growing number of jurisdictions are finding success with programmes that support evidence-based drug treatment as an alternative to criminal sanctions for people who use drugs.

It is also recommended that legal aid is provided to people in prisons and detention facilities. This will require strong advocacy interventions and the engagement of different governmental departments.

Ensuring supportive legal and policy environments

When NSPs, OST and other services are available, many people who inject drugs have difficulty accessing them due to the lack of supportive social, policy and human rights environments. Critical enablers should be considered in order to ensure access to key interventions, such as:

- advocacy and evidence-building activities to ensure high-level political and professional support for harm reduction;
- the reform of laws, policies and practices related to injecting drug use and HIV to ensure they do not impede service delivery and/or violate human rights;

14 Evidence for action series. In: WHO/Programmes/HIV/AIDS/Publications on injecting drug use [website]. Geneva: World Health Organization; 2014 (http://www.who.int/hiv/pub/idu/evidence_for_action/en/, accessed 24 July 2014).

- legal aid and "know your rights" training for people who use drugs which is ideally integrated into service delivery sites;
- social mobilization and campaigns for people who use drugs to better understand the law and their rights;
- interventions addressing the double stigma and discrimination related to HIV and drug use;
- training and/or sensitization for police, judges and prison staff on evidence- and human rights-based approaches to drug use and HIV;
- improving access to justice by supporting approaches such as street lawyers and legal/human rights trainings for people who use drugs;
- support to ensure that basic needs and underlying psychosocial vulnerabilities are addressed;
- advocacy and evidence-building activities to ensure that funding needed for harm reduction interventions will be increasingly provided, including through domestic sources.

Drug detention centres

In some countries, individuals thought to have used drugs are subject to detention in extra-judicial centres, which have little evidence of effectiveness but are often the site of extensive violations of human rights. The United Nations has repeatedly called for the closure of such centres, coupled with efforts to ensure that those illegally detained receive access to essential health care. Where a state is unable to close the centres rapidly and release all the individuals detained, those who are confined under such circumstances and have a serious health condition such as HIV or TB should be released for treatment. If this is not possible, they should be provided with life-saving services while in detention. These services should include ART, TB screening and treatment and treatment for other opportunistic infections, and should be provided with the informed consent of the individual and preferably by the ministries of health.

Overdose prevention

Although not explicitly mentioned in the comprehensive harm reduction package, overdose prevention is a core component of "targeted information, education and communication" for people who use drugs. Overdose is a major cause of mortality and morbidity among people who use drugs and has a direct impact on the utilization and outcomes of HIV-related harm reduction services. Countries are strongly encouraged to consider interventions such as peer and staff training in overdose prevention. In addition, countries should consider strengthening current overdose responses, including legislative and policy reform where needed and the low-threshold provision of naloxone (a WHO essential medicine that can reverse opioid overdoses) to people who use drugs as well as through harm reduction and emergency health services. These low-cost approaches can empower health-care workers and people who use drugs to save lives.

Countries are advised to make use of technical assistance from partners and the numerous technical guides and support documents available, several of which are listed at the end of this document.

6. Key indicators

Programme indicators, especially outcome and impact indicators, need to be carefully tailored to the country's monitoring and evaluation systems and capacities. When setting targets for service coverage as a percentage, reliable estimates of the population size are essential. To help address the known monitoring and evaluation challenges relating to key populations at higher risk, countries are also encouraged to consider:

- a clearly defined basic (minimum) package of services to be provided to clients based on the information provided in this document;
- improvements to epidemiological surveillance systems where needed and research to further expand knowledge on HIV, injecting drug use, service coverage, impact and need;
- systems to avoid the double counting of individuals in services (such as unique identification codes);
- national legislation specifically supporting the implementation of a comprehensive package of nine essential interventions as defined by WHO, UNODC and UNAIDS.[15]

Programme planners are strongly recommended to establish ambitious targets for service coverage for people who inject drugs. Such ambitious targets might include:

- more than 60% of people who inject drugs regularly reached by NSPs;
- more than 40% of people who inject opiates reached by OST;
- more than 75% of people who inject drugs who do not know their status and who are HIV-positive having received an HIV test in the past 12 months and know their results.

The most essential **impact, outcome and output** indicators include the following:

- HIV incidence among people who inject drugs;
- HIV prevalence among people who inject drugs;
- use of sterile injecting equipment by people who inject drugs;
- frequency of injection;
- awareness of HIV status among people who inject drugs;
- AIDS-related mortality among people who inject drugs;
- incidence of STIs among people who inject drugs;
- use of condoms among people who inject drugs;

15 World Health Organization, United Nations Office on Drugs and Crime, and Joint United Nations Programme on HIV/AIDS. WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva: World Health Organization; 2012 (http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf?ua=1, accessed 24 July 2014).

- number and location of sites where needles and syringes are available;
- quantity of needles and syringes distributed per person who injects drugs;
- OST programme capacity;
- individuals receiving maintenance OST;
- number of services focused on people who inject drugs that provide HTC;
- number and percentage of people who inject drugs receiving ART.

7. Approaches to costing

Countries must know their epidemics and priorities and plan for the resources necessary to implement interventions which have been proven to be most effective. In the same light, the allocation of domestic resources should be prioritized based on the same principles.

Existing information should be leveraged to estimate the unit costs for key interventions. Estimates may draw from existing data on the costs of community-based harm reduction services.

Countries should take into account the additional costs associated with specific strategies that may be proposed for critical enablers or other strategies to enhance the reach and effectiveness of interventions, the reform of laws, policies and practices related to injecting drug use and HIV, legal aid and "know your rights" training for people who use drugs, sensitization training for law enforcement agencies and community systems strengthening.

Responding to individuals' needs demands the full engagement of civil society, including people who use drugs, in the decision-making and implementation processes. It also warrants upholding their human rights, ensuring gender equity and addressing the needs of young people.

8. Addressing gender, human rights and equity issues

Human rights violations directed at people who inject drugs are widespread and serious. They range from compulsory drug testing, forced treatment, arbitrary detention and in some countries even execution. In addition, people who inject drugs are frequently denied basic health care, either as a result of exclusion by health-care workers or because the life-saving, evidence-based interventions that could help them are themselves illegal. It is essential therefore to ensure that law enforcement and criminal justice authorities are included in policy discussions and are aware of the need for a public health approach to people who inject drugs. In addition, health and social care services should be designed and implemented along with people who inject drugs so that their needs are properly reflected.

Addressing gender equity is an important consideration. HIV infection rates among women who inject drugs are significantly higher than among male injecting drug users, and the sexual partners of men who inject drugs also have an elevated risk of acquiring HIV.[16] In addition, pregnant HIV-positive drug users are frequently excluded from prenatal care and consequently have significantly higher rates of mother-to-child transmission than other women.[17] In many countries, women who use drugs have disproportionately poorer access to HIV prevention, treatment and care.[18] Where possible, countries should strive to collect sex-disaggregated data and use this information to identify and rectify service gaps when proposing harm reduction interventions. Examples of gender-sensitive programming for people who use drugs include the following:

- women-specific items included in basic harm reduction kits (women's hygiene materials and female condoms along with syringes, male condoms, wipes and lubricants);
- additional basic services and material assistance for women at harm reduction sites (e.g. pregnancy tests, diapers and other supplies for children, sexual and reproductive health services, participation in support groups and informational materials specific to women);
- providing childcare at drop-in centres;
- gender balance in harm reduction staff, including the active involvement of women drug users in service provision and design;
- secondary syringe exchange programmes focusing on expanding coverage for women;
- supporting access to services to prevent mother-to-child transmission of HIV;
- training OST providers and health professionals specialized in obstetrics and gynecology on drug use and drug treatment during pregnancy;
- providing treatment and care for the mother as well as the newborn;
- providing linkages to services responding to gender-based violence;
- providing linkages between services for people who use drugs and for sex workers including the discreet provision of harm reduction services for sex workers unable to openly visit a harm reduction site.

9. Additional information

Evidence for action: effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users. Geneva, WHO, 2004, http://www.who.int/hiv/pub/prev_care/en/evidenceforactionalcommunityfinal.pdf.

16 Kazatchkine M and McClure C. From evidence to action: reflections on the global politics of harm reduction and HIV. Keynote addresses, IHRA's 20th International Conference, Bangkok. London: Harm Reduction International; 2009 (http://www.ihra.net/files/2010/06/01/FromEvidencetoAction.pdf, accessed 24 July 2014).

17 Eurasian Harm Reduction Network, Open Society Institute. Why overdose matters for HIV. New York: Open Society Institute; 2010 (http://www.opensocietyfoundations.org/sites/default/files/why-overdose-matters-20100715.pdf, accessed 24 July 2014).

18 Joint United Nations Programme on HIV/AIDS, World Health Organization. Guidelines on estimating the size of populations most at risk to HIV. UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance. Geneva: World Health Organization; 2010 (http://www.who.int/hiv/pub/surveillance/final_estimating_populations_en.pdf, accessed 24 July 2014).

From evidence to action: reflections on the global politics of harm reduction and HIV. London, Harm Reduction International, 2009, http://www.ihra.net/files/2010/06/01/FromEvidencetoAction.pdf.

Guidance on prevention of viral hepatitis B and C among people who inject drugs. Geneva, World Health Organization, July 2012, http://apps.who.int/iris/bitstream/10665/75357/1/9789241504041_eng.pdf.

Guidelines on estimating the size of populations most at risk to HIV. Geneva, UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, 2010, http://www.who.int/hiv/pub/surveillance/final_estimating_populations_en.pdf.

Guidelines on surveillance among populations most at risk for HIV. Geneva, UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, 2011, http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2011/20110518_Surveillance_among_most_at_risk.pdf.

HIV/AIDS treatment and care: clinical protocols for the WHO European Region. Geneva, World Health Organization, 2007, http://www.who.int/hiv/topics/idu/care/E90840.pdf.

HIV and drug use: community responses to injecting drug use and HIV. Hove, International HIV/AIDS Alliance, 2010, http://www.k4health.org/sites/default/files/Alliance_DrugUseGuide-BW.pdf.

Information note: community systems strengthening. Geneva, The Global Fund to Fight AIDS, Tuberculosis and Malaria, 2014, http://www.theglobalfund.org/en/fundingmodel/support/infonotes/

Operational guidelines for monitoring and evaluation of HIV programmes for people who inject drugs, UNAIDS, Geneva, 2011 (draft), http://www.cpc.unc.edu/measure/tools/hiv-aids/operational-guidelines-for-m-e-of-hiv-programmes-for-people-who-inject-drugs/operational-guidelines-for-monitoring-and-evaluation-of-hiv-programmes-for-people-who-inject-drugs

Report of the Technical Review Panel and the Secretariat on Round 10 proposals, from the Twenty-second Board Meeting, Sofia, Bulgaria, 13-15 December 2010. Geneva, The Global Fund to Fight AIDS, Tuberculosis and Malaria, 2010, http://www.theglobalfund.org/documents/board/22/BM22_13TRPRound10_Report_en/.

The global state of harm reduction 2012. Towards an integrated response. London, Harm Reduction International, 2012, http://www.ihra.net/files/2012/07/24/GlobalState2012_Web.pdf.

What is harm reduction? A position statement from the International Harm Reduction Association. London, Harm Reduction International, 2010, http://www.ihra.net/files/2010/08/10/Briefing_What_is_HR_English.pdf.

EHRN, OSI. *Why overdose matters for HIV*. New York, Open Society Institute, 2010, http://www.opensocietyfoundations.org/sites/default/files/why-overdose-matters-20100715.pdf.

UNODC and UNAIDS. *Facts about drug use and the spread of HIV*. Vienna, United Nations Office on Drugs and Crime, 2010, www.unodc.org/documents/frontpage/Facts_about_drug_use_and_the_spread_of_HIV.pdf.

UNODC, WHO Opioid overdose: preventing and reducing opioid overdose mortality, UNODC, WHO 2013, http://www.unodc.org/docs/treatment/overdose.pdf

WHO, UNODC and UNAIDS. Evidence for action series, http://www.who.int/hiv/pub/idu/evidence_for_action/en/.

WHO, UNODC and UNAIDS. *WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*. Geneva, World Health Organization, 2012, http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf?ua=1.

Atun R, Kazatchkine M. The Global Fund's leadership on harm reduction: 2002–2009. *International Journal of Drug Policy*, 2010, 21(2):103–106.

Barrett D, Hunt N, Stoicescu C. *Injecting drug use among under-18s. A snapshot of available data*. London, Harm Reduction International, December 2013, http://www.ihra.net/files/2013/12/12/injecting_among_under_18s_snapshot_WEB1.pdf.

Ditmore MH. *When sex work and drug use overlap. Considerations for advocacy and practice*. London, Harm Reduction International, November 2013, http://www.ihra.net/files/2013/11/20/Sex_work_report_%C6%924_WEB.pdf.

Mathers B et al. HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage. *Lancet*, 2010, 375(9719):1014–1028.

Mathers B et al. The global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. *Lancet*, 2008, 372(9651):1733–1745.

UNAIDS / JC2568 (English original, May 2014)

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JC2568/9/E