UNAIDS PROGRAMME COORDINATING BOARD

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THIRTY-FIFTH MEETING

Date: 9-11 December 2014

Venue: Executive Board room, WHO, Geneva

Agenda item 11

Halving HIV transmission among people who inject drugs

Background note

INTRODUCTION

1. The 33rd UNAIDS Programme Coordinating Board (PCB) meeting agreed that the theme for the Thematic Segment of the 35th meeting to be held in December 2014 would be *Halving HIV transmission among people who inject drugs*. The meeting will:

    - Consider the progress made and efforts still needed to reach the commitment *to work towards reducing transmission of HIV among people who inject drugs by 50% by 2015* made by United Nations Member States through the 2011 UN Political Declaration on HIV and AIDS.
    - Provide a forum to inform and prepare participants for the United Nations General Assembly Special Session (UNGASS) on the World Drug Problem that will take place in early 2016, as well as the High Level Meeting on HIV and AIDS planned for 2016, towards helping frame the analysis of drug policy around HIV, public health and human rights based outcomes.
    - Identify and examine potential strategies and actions for change, drawing from good practices from around the world to help articulate measures that should be taken in the context of the HIV retargeting process.

2. At its 34th meeting, the UNAIDS Board, *called for Member States and the UN Joint Programme to pursue, in line with the UNAIDS vision of the three zeros, a clear commitment in the post-2015 development agenda to ending the AIDS epidemic as a public health threat and an obstacle for overall sustainable development by 2030, provisionally defined as the rapid reduction of new HIV infections, stigma and discrimination experienced by people living with HIV and vulnerable populations and key populations, and AIDS-related deaths by 90% of 2010 levels, through evidence based interventions to include universal access to HIV prevention, treatment, care, and support, such that AIDS no longer represents a major threat to any population or country*[1]. A process of establishing new targets for 2020 and 2030 is underway, within which targets and commitments on reducing HIV transmission among people who inject drugs will be considered.

3. There is now three decades of available scientific research data assessing the evidence regarding the effectiveness and cost effectiveness of harm reduction services and the right to health for people who inject drugs. This data shows that evidence-based harm reduction interventions such as Needle and Syringe Programmes (NSP) and Opioid Substitution Therapy (OST) are effective, pragmatic and cost effective—provided they are delivered in a way which is accessible and acceptable to people who inject drugs, for example at sufficient scale. Nevertheless, in many countries this evidence has not been translated into programmes of sufficient size or reach.

[1] Decisions from the UNAIDS 34th PCB meeting, decision 5.5. Joint United Nations Programme on HIV/AIDS.2014(http://www.unaids.org/en/media/unaids/contentassets/documents/pcb/2014/pcb34/20140703_Decisions_Recommendations_Conclusions_34PCB_meeting_EN.pdf, accessed 14 November 2014).

CURRENT SITUATION

People who inject drugs and HIV transmission: by the numbers

4. Currently it is estimated by UNODC WHO, UNAIDS and the World Bank that worldwide there are some 12.7 million[2] people who inject drugs with around 1.7 million (13%)[3] also estimated to be living with HIV.[4] It is estimated that injecting drug use accounts for around 5-10 % of new HIV infections globally, a figure which rises to around 30% outside sub-Saharan Africa. People who inject drugs have higher rates of hepatitis C (HCV) and tuberculosis (TB), with a possible 10 million having HCV, surpassing HIV infection rates.[5] An estimated 1.6 (IQR: 700,000-4.5million) people are co-infected with HIV and HCV.[6]

5. New infections among people who inject drugs has declined slightly in recent years from around 110,000 (97,000 – 123,000) in 2010 to 98,000 (85,000 – 111, 000) in 2013 a reduction of about 10%[7]. Hence while some progress has been made, the target endorsed through the 2011 Political Declaration to reduce HIV among people who inject drugs by 2015 by half will be missed without urgent and significant investment to scale up coverage of the core interventions that are known to reduce transmission among this group, such as OST and NSP.

6. The Russian Federation has the largest HIV epidemic among people who inject drugs with more than 30,000 HIV infections in 2013[8]. Some other countries with a large number of estimated new infections among people who inject drugs (between 2,000 and 4,000 in 2013) include Vietnam, Indonesia, India and Iran in Asia, South Africa and Nigeria [9] in Africa and the United States of America.[10]

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[2] United Nations Office on Drugs and Crime (UNODC). World Drug Report 2014. United Nations; June 2014; p 5, Range 8.9 - 22.4 million (http://www.unodc.org/documents/wdr2014/World_Drug_Report_2014_web.pdf, accessed 17 November 2014).
[3] *Ibid* p 16. (Range 0.9 - 4.8 million)
[4] Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key populations. Geneva, World Health Organization (WHO); July 2014; p6 (http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1, accessed 17 November 2014).
[5] The Global State of Harm Reduction 2012: Towards an Integrated Response. Harm Reduction International; 2012 http://www.ihra.net/files/2012/07/24/GlobalState2012_Web.pdf, accessed 17 November 2014).
[6] UNAIDS, WHO, unpublished data, 2014.
[7] UNAIDS, unpublished model, 2014. Estimates are based on different methods including HIV epidemic models, modes-of transmission studies and reported national estimates. The margin of error is wide, but these are the best estimates available
[8] ВИЧ-ИНФЕКЦИЯ: Информационный бюллетень № 38.
[9] Modified from UNAIDS New HIV Infections by mode of transmission in West Africa: A Multi-Country Analysis, Geneva, UNAIDS; 2006. (http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/countryreport/2010/201003_MOT_West_Africa_en.pdf, accessed 17 November 2014).
[10] Centers for Disease Control and Prevention. HIV Surveillance Report 2012; vol. 24. http://www.cdc.gov/hiv/library/reports/surveillance/. Published November 2014. Accessed 14 November 2014

7. Several countries including Thailand, Vietnam and Ukraine[11] reported a significant decline in new HIV infections among people who inject drugs since 2010 while in others, including Pakistan[12] [13] and some European countries including Romania and Greece[14], there have been recent outbreaks.

8. HIV prevalence among people who inject drugs appears to be rising in some countries and geographical areas of Asia and the Pacific and in Eastern Europe and Central Asia, where HIV prevalence among people who inject drugs ranges from 18% to 31%.[15] In such cases, national HIV epidemics are typically driven by the use of contaminated injecting equipment and then multiplied by further transmission to the sexual partners of people who inject drugs. Increased injecting drug use and HIV prevalence among people who inject drugs has also been reported in a number of high prevalence countries such as Kenya.[16]

9. Injecting drug use can emerge in any country or region within a country, for example where an injectable drug like heroin (as well as other possible injectable drugs like cocaine, amphetamine-type stimulants [ATS] and prescription painkillers) becomes less available and/or the cost increases such that the user will seek the most cost effective method of use— injection. Although the specific link between ATS use and HIV risk has not been unequivocally identified, a proportion of ATS users do inject, with attendant potential HIV transmission risk. ATS use has also been associated with sexual risk taking and this is an additional risk factor for HIV. [17]

10. While HIV prevalence is estimated to be 12 times higher among sex workers and 19 times higher among men who have sex with men than among the rest of the adult population, it is 28 times higher among people who inject drugs. The risk of contracting HIV for people who inject drugs often begins at a relatively young age and in the early stages of their injecting drug use. In 45 countries reporting youth data since 2009, HIV prevalence among young people under 25 years old who inject drugs was 5.2%.[18] While there is no global population size estimate for people who inject drugs aged 19 or under, a number of cases suggest early age of initiating

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[11] Abdul-Quader A, Dumchev K, Kruglov Y, Rutherford G, Salyuk T, Vitek C. Ukraine HIV Data Synthesis Project: Final Report. University of California, San Francisco/University of Zagreb, 2012 (http://s116768.gridserver.com/sites/default/files/content/pphg/triangulation/ukraine-triangulation.pdf , accessed 14 November 2014).
[12] Drug Use in Pakistan 2013. UNODC; 2013 (http://www.unodc.org/documents/pakistan//Survey_Report_Final_2013.pdf. Accessed 14 November 2014).
[13] Reza T, Melesse DY, Shafer LA, *et al*. Patterns and trends in Pakistan's heterogeneous HIV epidemic. Sex Transm Infect. 2013 Sep;89 Suppl 2:ii4-10.
[14] Outbreaks of HIV among IDUs in Greece and Romania. In European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) http://www.emcdda.europa.eu. 2012 (http://www.emcdda.europa.eu/news/2012/HIV-outbreaks, accessed 14 November 2014).
[15] The GAP Report. Geneva: Joint United Nations Programme on HIV/AIDS; 2014; chapter 05 – People who Inject Drugs (http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf, accessed 17 November 2014).
[16] UNODC. World Drug Report 2013. United Nations; 2013; p. 3 (http://www.unodc.org/unodc/secured/wdr/wdr2013/World_Drug_Report_2013.pdf, accessed 17 November 2014)
[17] Allsop S, Fischer A, Carruthers S.J, Power R and Degenhardt L. , The link between amphetamine-type stimulant use and the transmission of HIV and other blood-borne viruses in the Southeast Asia region. Australian National Council on Drugs; 2012; ANCD Research Paper 25 (http://apddic.ancd.org.au/images/PDFs/Projects_and_initiatives/rp25-amphetamine-type-stimulants.pdf, accessed 17 November 2014).
[18] UNAIDS, The Gap Report, *op. cit*; p127.

injecting. For example, in Indonesia in 2007 and 2009 48% of 2,085 people who injected drugs reported initiating at or under the age of 19.[19]

11. The majority of people who inject drugs are men, with data on women who inject drugs being particularly sparse. However the pooled HIV prevalence rates from 30 countries showed women who inject drugs at 13% prevalence compared with 9% for men from the same countries. Surveys from several countries found high rates of sex work among injecting respondents and high rates of injecting drug use among sex-worker respondents.[20] Women who inject drugs are an often hard-to-reach and highly vulnerable population with specific challenges and needs that may go unrecognized or unmet in gender-neutral or male-focused harm reduction policies and programmes.[21]

Box 1: Ukraine stresses the need for gender integration

An evaluation of gender sensitivity related to harm reduction services in Ukraine has led to the provision of ongoing assistance to local NGO partners to increase service utilization by female injecting drug users regarding specific gender-sensitive approaches and actions: structured training for female harm reduction staff; creating an emotionally and physically safe environment; changing policies and procedures for service delivery; gender sensitive indicators; secondary NSP; women-focused outreach; short-term childcare; case management for female injecting drug users; and addressing violence against females.

Source: WHO and the International HIV/AIDS Alliance Ukraine case study submission

12. Prison settings are particularly significant for the issue of HIV and drug use. In some settings, the HIV prevalence among prisoners can reach 50 times higher than in the general population and it has been estimated that between 56 and 90% of people who inject drugs will be incarcerated at some stage in their life.[22] Many will continue to use drugs inside prison sharing injecting equipment where there is no or inadequate access to sterile equipment, resulting in increased risk of HIV infection and transmission. In the process some people who have not injected drugs previously may be initiated into injecting for the first time. All prisoners may be at risk of sexual violence within the prison setting. Apart from the risk of HIV transmission, more than half of people who inject drugs are estimated to be living with HCV[23] and many contract TB while incarcerated.

[19] D Barrett, N Hunt, C Stoicescu, Injecting Drug Use Among Under-18s: A Snapshot of Available Data, Harm Reduction International. 2013; p16 (http://www.ihra.net/files/2014/08/06/injecting_among_under_18s_snapshot_WEB.pdf, accessed 17 November 2014).
[20] UNAIDS, The Gap Report, *op. cit* ; p175.
[21] Policy Brief: Women who inject drugs and HIV Addressing specific needs. UNODC, UN Women, WHO,INPUD; 2014 (http://www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf, accessed 17 November 2014)..
[22] UNAIDS, The Gap Report, *op. cit*; p149.
[23] UNODC, World Drug Report 2014, *op. cit.*; pp ix

Evidence and technical guidance on effective strategies and programmes

13. Building on and responding to the large body of evidence on the efficacy and efficiency of harm reduction interventions, significant normative and policy guidance on HIV and injecting drug use has been developed.

14. The WHO/UNAIDS/UNODC Technical Guide[24] to reduce HIV infection among people who inject drugs sets out nine interventions that have proven effective in reducing HIV transmission among this population. Universal access to the comprehensive package of nine interventions is a priority. Of these nine, the first four have been identified as the most effective in reducing the spread of HIV[25] :

    a. Needle and syringe programmes (NSPs)
    b. Opioid substitution therapy (OST) and other drug dependence treatment
    c. HIV testing and counselling
    d. Antiretroviral therapy (ART)
    e. Prevention and treatment of sexually transmitted infections (STIs)
    f. Condom programmes for injecting drug users and their sexual partners
    g. Targeted information, education and communication for injecting drug users and their sexual partners
    h. Vaccination, diagnosis and treatment of viral hepatitis
    i. Prevention, diagnosis and treatment of tuberculosis

15. While this list of nine interventions is sometimes referred to as the 'comprehensive harm reduction package', it does not include a focus on promotion of a wider range of 'low-threshold' evidence-based interventions such as supervised drug consumption facilities[26], and of peer led services such as naloxone distribution[27] and peer to peer outreach, access to legal support. Neither does it include focus on advocacy for structural changes such as drug policy reform and provision of social services like shelter, food and educational/employment opportunities. These additional interventions have proven to increase programme efficiency and impact and are considered critical considerations for most effective harm reduction responses.

16. Greater emphasis on these additional low threshold interventions—complementing the nine interventions for a comprehensive package—is included in the 2014 WHO *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations*.[28] As countries move towards the implementation of these guidelines it is important to note a new core intervention is recommended on community

[24] WHO, UNODC, UNAIDS Technical Guide for countries to set universal access to HIV prevention, treatment and care for injecting drug users. WHO, UNODC, UNAIDS; 2012 (http://www.unodc.org/documents/hiv-aids/publications/People_who_use_drugs/Target_setting_guide2012_eng.pdf, accessed 17 November 2014).
[25] UNODC, World Drug Report 2014, *op. cit.*; p. x.
[26] Health Evidence Network report. Copenhagen, WHO Regional Office for Europe.(http://www.euro.who.int/document/E86159.pdf, accessed November 17).
[27] Community Management of Opioid Overdose. WHO; 2014 (http://apps.who.int/iris/bitstream/10665/137462/1/9789241548816_eng.pdf?ua=1, accessed 17 November 2014).
[28] WHO, Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations, *op. cit.*; p40.

distribution of naloxone plus instruction on its administration to people who are closest to people who inject drugs, such as friends, family and peers, who might witness an opioid overdose. The prevention and management of overdose is an essential life-saving service targeted at people who inject drugs.[29]

Box 2: Value for money; value for health

"Not only is there an ethical imperative to make harm reduction programmes universally available, but in stark contrast to compulsory detention, these approaches are globally effective, represent good value for money and are often cost-saving, indicating their value to improving the health outcomes for people who inject drugs and the broader population."

Source: World Bank case study submission

17. Since 2013, UNODC, in collaboration with partners, has selected 24 'high-priority countries' where it has focused its efforts for a greater impact on the epidemic. These countries were selected following an analysis of the epidemiological data on injecting drug use and HIV burden, including in prisons, the resource environment and the country readiness regarding the policy and legislative environment allowing essential services such as needle and syringe programmes, opioid substitution therapy, voluntary testing and counselling and antiretroviral therapy.

Response and coverage

18. In several European countries, scaling-up of the provision of harm reduction services has resulted in the decline in newly diagnosed HIV cases and AIDS-related deaths among people who inject drugs (*see Box 3*). However, despite this, and other, unequivocal evidence, many countries with HIV epidemics among people who inject drugs are yet to scale up these lifesaving interventions.

19. High coverage of NSP is mostly limited to Western Europe, Australia and Bangladesh with greater than 200 needles/syringes per person who injects drugs per year. Globally NSP coverage is less than 20% in all regions with a global average of less than two clean needles/syringes distributed per person who injects drugs[30].

[29] *Ibid.*
[30] The Global State of Harm Reduction. Harm Reduction International; 2010 (http://www.ihra.net/files/2010/06/29/GlobalState2010_Web.pdf, accessed 17 November 2014).

Box 3: Impact of scaled-up harm reduction services on HIV

In several European countries with a high incidence of HIV among people who inject drugs newly diagnosed cases (incidence) of HIV among people who inject drugs, there was a noticeable peak in the number of new cases between 1999 and 2003, indicating that the epidemic in the region was greatest in those years and subsequently declined. That development is visible also in the sharp decline in the number of deaths from AIDS attributed to unsafe injecting drug use that occurred in later years in the western part of the WHO European region, with the number of deaths declining from 1,358 in 2006 to 179 in 2012. During that time period, the contribution of unsafe injecting drug use to total AIDS related deaths in that region declined from 43 per cent to 25 per cent. The decline in newly diagnosed HIV cases and AIDS-related deaths among people who inject drugs are consistent with the scaling-up of the provision of harm reduction services.

Source: UNODC World Drug Report 2014

20. Only 79 of 192 countries report that they offer OST and of them only 33% report high coverage, with 35% reporting low coverage and 31% medium[31], meaning that only some 26 countries globally provide opioid substitution to the extent that it will have an impact on HIV transmission among people who inject drugs.

21. Only 74 countries report that people who inject drugs and are living with HIV have access to antiretroviral treatment, and only 25 countries report high coverage.[32] A World Bank analysis estimates that about one in ten people who are living with HIV and inject drugs are receiving antiretroviral treatment.[33]

22. Kazakhstan has been relatively successful in mitigating the impact of HIV among people who inject drugs. As of January 2013 there were 19,748 registered HIV cases.[34] The epidemic has been primarily concentrated among people who inject drugs and sex workers. Clear evidence exists for the positive impact of NSP and the benefits of harm reduction approaches, In Kazakhstan over a ten year period assessed that there had been between 2,205 and 2,720 new HIV cases and between 20,941 and 24, 715 new cases of HCV averted resulting in an economic saving of 11,200,000 quality-adjusted life years and between $3.82 and $5.04m lifetime health cost savings[35].

23. A review looked at what has been achieved between 2010 and 2012 in HIV prevention, treatment and care for people who inject drugs in the six highest burden countries that account for half of the global population of people who inject drugs: China, Malaysia, Russia, Ukraine, Vietnam and the United States of America. While policy shifts had led to promising developments such as an increase in OST in

[31] UNODC, World Drug Report 2014, *op. cit.*; p.11
[32] *Ibid*; p.11
[33] UNAIDS, The GAP Report, *op. cit.*; p.11
[34] Harm Reduction Works. Joint United Nations Programme on HIV/AIDS; 2014 (http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/JC2613_HarmReduction_en.pdf, accessed 17 November 2014).
[35] Wilson D, Zhang Z, Kerr C, Uuskla A, Kwon J, Hoare A *et al*.The Cost Effectiveness of NSP in Kazakhstan from 2000-2010. University of New South Wales and Government of Australia; 2012.

China, Vietnam and Ukraine and a move away from a punitive law enforcement approach to evidence-based treatment in Malaysia, the policies of the United States of America remain largely unchanged. The Russian Federation[36] reported having invested close to $800million in the AIDS response, however less than one percent of this amount was targeted towards people who inject drugs. According to the 2014 UNAIDS Gap Report, one in a hundred Russian adults are estimated to be infected with HIV as a result of lack of evidence-informed HIV prevention services for people who inject drugs, particularly NSP and OST.[37]

Box 4: China's rapid MMT scale-up

Since 2004 the rapid nationwide scale-up of the Methadone Maintenance Treatment (MMT) program has been the cornerstone of the Chinese government's response to the HIV epidemic among injecting drug users. Currently 765 MMT clinics, including 29 MMT vans, have been established in 28 provinces, autonomous regions and municipalities. The program follows an outpatient model with clients attending clinics daily to obtain their methadone dose (charged a maximum of approximately $1.5 per day irrespective of dose) with no option for take-home doses, nor any legal way to obtain methadone outside the clinics. Among newly diagnosed HIV cases, the proportion of HIV infections due to injecting drug use has decreased from 43.9% in 2003 to 7.7% in 2013 and the national average HIV prevalence among drug users in sentinel surveillance declined by 50%, from 7.5% in 2005 to 3.6% in 2013. However, despite these successes and having the largest MMT program in the world, many challenges remain for China such as low overall program coverage, low retention rates, uneven service quality and need for improved staff capacity.

Source: National Center for AIDS/STD Control and Prevention case study submission.

24. UNAIDS issued a joint statement with the Office of the High Commissioner for Human Rights (OHCHR) in 2012 calling for the immediate closure of compulsory detention centers for people who use drugs.[38] While modest progress has been reported in some countries such as Malaysia, others have continued to support such institutions and in some countries they have even been expanded.[39]

25. In many low- and middle-income countries policy may provide for NSP and OST but coverage can be minimal and/or of poor quality due to shortage of funding, insufficient political will and other factors. Pakistan, for example, has a large

[36] UNAIDS World AIDS Day Report 2011. Joint United Nations Programme on HIV/AIDS; 2011 (http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2216_WorldAIDSday_report_2011_en.pdf, accessed 17 November 2014).
[37] UNAIDS, The Gap Report, *op. cit*.
[38] JOINT STATEMENT: Compulsory drug detention and rehabilitation centres ILO, UNHRCR, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, UN Women, WFP, WHO, UNAIDS; 2012 (http://www.unaids.org/sites/default/files/sub_landing/files/JC2310_Joint%20Statement6March12FINAL_en.pdf, accessed 17 November 2014).
[39] Amon J, Pearshouse R, Cohen J, Schleifer R. Compulsory drug detention in East and Southeast Asia: Evolving government, UN and donor responses.International Journal of Drug Policy; 2014; pp.13 – 20.

population of people who inject drugs and a supportive national policy on NSP yet access levels are low (*see Box 5*)

Box 5: Challenges of transforming supportive policy into accessible services

In Pakistan there is explicit supportive reference to harm reduction in national policy documents and NSPs are operational. However, challenges remain in ensuring harm reduction services are accessible to people who inject drugs. A recent study estimates there are around 420,000 people who use drugs representing 0.4%of the population - a higher number than previously reported – with almost 75% of opiate-using people who inject drugs sharing and/or reusing injecting equipment. Only 13% knew about the various modes of transmission of HIV (1). Among regular opiate users who injected drugs, 73% reported sharing syringes either before or after someone else. When asked why they shared, most reported it was because there was only one needle available. While 73 % of people who inject drugs reported sharing a syringe, only 2.5 % had accessed an NSP. Almost half of all people who inject drugs reported high-risk injecting behaviours yet only 11 % had accessed a drop-in centre or other form of low-threshold service providing prevention, treatment, care, and support for HIV. Among people who inject drugs who tested for HIV in Pakistan, UNAIDS reports the HIV prevalence is 27.2 % (2).

Sources:

(1) UNODC and Ministry of Narcotics Control and Pakistan Bureau of Statistics, Government of Pakistan, 2014, *Drug Use in Pakistan 2013: Technical Summary Report*

(2) http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_PK_Narrative_Report[1].pdf, accessed 17 November 2014.

BARRIERS TO REDUCING HIV TRANSMISSION AMONG PEOPLE WHO INJECT DRUGS

26. A wide range of complex challenges needs to be overcome to reduce HIV transmission among people who inject drugs at greater speed and scale.. Harm reduction interventions have a strong evidence base yet there is a dissonance between the theory and practice on the ground. The main factors that contribute to preventing the development, implementation, availability and sustainability of accessible quality services include punitive legal and policy environments, a severe lack of funding (particularly domestic funding for services) and poor-quality service provision.

27. There is also a need to consider the many daily challenges and personal factors faced by people who inject drugs and how these might affect access to HIV prevention services, for example: poverty; lack of suitable housing; lack of supportive family/friend relationships; stigma and social isolation/exclusion; lack of employment or other income generation opportunities. Without harm reduction service providers and other agencies addressing these factors, some people who inject drugs may not be able to access harm reduction services.

Policy and legislative environment

28. Globally, drug policies have been framed within a prohibitionist stance on drugs, drug use and drug users. The majority of national drug control policies focus on supply reduction and law enforcement against drug use resulting in a wide range of repressive policing and over-criminalization practices, including involuntary drug testing, imprisonment ,compulsory detention, and the imposition of harsh and excessive punishments— the death penalty in some settings.[40]

29. Criminalization of drug use and possession has been found to lead to an increased risk of illness among people who use drugs.[41] Higher rates of legal repression have been associated with higher HIV prevalence among people who use injecting drugs, without a decrease in prevalence of injecting drug use. This is a likely result of individuals' adopting riskier injection practices such as sharing of needles and syringes and other injection equipment, hurried injecting, or use of drugs in unsafe places for fear of arrest or punishment.

30. Although the first two preambular paragraphs of the Single Convention on Narcotic Drugs 1961, which is still the international treaty that guides drug control, state that Member States are "Concerned with the health and welfare of mankind" and "that the medical use of narcotic drugs continues to be the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes", the third and fourth paragraphs describe drug addiction as a "serious evil" and commits to countering such "evil". Many countries have focused on countering the "evil" and have developed drug control policies that focus not on the drugs themselves, but on those who use drugs.

31. Policies and legislation based on prohibition, criminalization and punishment have not been found to achieve their aims in reduction of drug use. At a time where a number of countries are implementing strong anti-drugs policies, an estimated 183,000 drug related deaths nevertheless occurred in 2012.[42] ' People undertaking 'High- risk' drug use[43] were estimated at about 27 million, roughly 0.6 per cent of the world's adult population, or 1 in every 200 people.[44] It has also been estimated that profits derived from illicit drug trafficking worldwide are around US$600 billion, or 7.6% of global trade, with up to US$1.5 trillion in drug money laundered through legal enterprises, accounting for 5% of global GDP.[45]

32. Stating that the 'War on Drugs' has failed, the Global Commission on Drug Policy emphasizes alternative approaches to drug policies that work including: putting people's health and safety first; ensuring access to essential medicines and pain control; ending the criminalization and incarceration of people who use drugs; and targeted prevention, harm reduction and treatment strategies for dependent users.

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[40] UNAIDS, The Gap Report, *op. cit.*;p176.
[41] Degenhardt L, Hall W. Extent of illicit drug use and dependence, and their contribution to the global burden of disease. The Lancet; 2012; 379, 2012.
[42] UNODC, World Drug Report 2014, *op. cit.*; p.3
[43] 'High-risk drug use'. EMCDDA. http://www.emcdda.europa.eu/activities/hrdu.
[44] UNODC, World Drug Report 2014, *op. cit.*;p. 1.
[45] UNODC. World Drug Report 2010. United Nations; 2010 (http://www.unodc.org/documents/wdr/WDR_2010/World_Drug_Report_2010_lo-res.pdf, accessed 17 November 2014).

As the Commission point out "there is growing support for more flexible interpretations and reform of the international drug control conventions aligned with human rights and harm reduction principles."[46]

33. At the national level, positive policy changes are necessary to reduce the multitude of harms associated with criminalization of drug use. Development of national harm reduction strategies and guidelines to provide policy support for the successful development and implementation of harm reduction services are also needed. The quality of harm reduction services should be identified by the extent to which they comply with approved harm reduction and human rights standards/guidelines as well as by the level of clients' perceived need, preference and satisfaction.

34. It is a reality that in a number of countries there are disconnects between the existence of harm reduction laws and policies and their enforcement at the community level. Recognition should be given to the influence that the police and other law enforcement agencies can have on the successful implementation of harm reduction policy and programmes, and action taken to engage with them to ensure that they can be a part of the solution.

35. Despite evidence that where good quality services are delivered the wider community also benefits through safer and healthier environments, some local communities may resist the introduction of harm reduction programmes, seeing them - often contrary to available evidence - as likely to lead to deterioration of public order.

Stigma and discrimination

36. Experience over decades of the AIDS response shows that the most successful HIV approaches are those based on human rights to ensure that the response is universal, equitable, inclusive, and fosters participation, informed consent and accountability. However, in many countries the political environment is not favorable to supporting marginalized and criminalized groups, especially during times of constrained national spending and competing public service needs. Globally, funding for human rights programmes and the organizations that run them is decreasing with less than 1% of the $18.9 billion spent on the overall HIV response in 2012 going toward the human rights response to HIV.

37. Changing political environments can strongly influence policy and capacity to deliver services even if a particular country subscribes to harm reduction. Marginalized groups such as people who inject drugs are often focused upon in crime-reduction strategies towards political ends. In these instances, evidence based approaches can be replaced by interventions that focus on abstinence and other actions that are not compatible with evidence, human rights and public health measures.

38. Stigma and discrimination towards people who inject drugs and people living with HIV remain high in most countries and access to justice in the context of HIV is very low resulting in many people's inability to access HIV prevention and treatment

[46] Taking Control: Pathways to Drug Policies that Work. Global Commission on Drug Policy; 2014;p6 (http://static.squarespace.com/static/53ecb452e4b02047c0779e59/t/540da6ebe4b068678cd46df9/1410180843424/global_commission_EN.pdf, accessed 17 November 2014).

services or participate in national AIDS responses. People who inject drugs are criminalized and often face punitive legal environments that can result in detention, involuntary drug testing, compulsory treatment, long prison sentences and the death penalty for some drug-related crimes. In Bangkok, Thailand, for example, 25% of respondents in a national survey reported they were avoiding health care out of fear of being referred to compulsory treatment.[47] In several countries the possession of clean syringes or other injecting equipment can be used as evidence to prosecute people who inject drugs or provide grounds for police harassment, thereby deterring safe injecting practices.

39. Estimates[48] suggest that 56–90% of people who inject drugs will be incarcerated at some stage during their life. Criminalization fuels stigma. It perpetuates and even validates discrimination, increases contact with law enforcement which can increase incarceration, negatively affects employment and education and can perpetuate and exacerbate poverty.

40. Universally recognized human rights standards should guide national and international policymakers in formulating the direction and content of HIV-related policy for people who inject drugs and form an integral part of all aspects of national and local responses to HIV.[49] Harm reduction services for people who inject drugs need to be recognized as part of the human rights obligations of states and need to be included as an essential element of human-rights based HIV responses and programming. In her statement to the high level segment of the Commission of Narcotic Drugs 2014, Ms Navi Pillay, High Commissioner for Human Rights said "Regrettably human rights violations continue to occur in the implementation of drug control policies by States. Violations of the right to life, the right to health, the prohibition of torture and other forms of ill treatment, the prohibition of arbitrary detention, the right to equality and non-discrimination, the rights of indigenous peoples and the rights of children are all sources of serious concern."

41. People who inject drugs often face stigma, discrimination and negative attitudes related to their drug injecting by their families, communities and health workers. Such stigma is common in many health facilities and law enforcement services and may be exacerbated by insufficient national laws and policies against discrimination and harsh sentences for drug-related offences. The effects of such stigma and discrimination, as with other key populations, can be poor uptake of harm reduction services, delayed HIV testing and concealment of HIV positive status.[50]

42. Stigma and discrimination in health- and social-care settings can exclude people who inject drugs or lead to poor or no provision of general medical care and treatment. Even within specialist harm reduction services discriminatory and judgmental personal attitudes of project staff can also negatively impact on communication with

[47] Kerr T, Hayashi K, Ti L, Kaplan K, Suwannawong P, Wood E, The impact of compulsory drug detention exposure on the avoidance of healthcare among injection drug users in Thailand. International Journal of Drug Policy; 2014; 25(10).
[48] UNAIDS, The Gap Report, *op. cit.;* p.176.
[49] International Guidelines on HIV/AIDS and Human Rights: 2006 Consolidated Version. OHCHR, UNAIDS;2006, ; p79 (http://www.ohchr.org/Documents/Issues/HIV/ConsolidatedGuidelinesHIV.pdf, accessed 17 November 2014).
[50] WHO, Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations, op. cit.; p96.

clients who inject drugs. At the same time NSP, OST, outreach, counselling and drop-in centre services and their staff may be negatively perceived by local communities and/or the general population and face resistance from authorities and law enforcement.

43. It is recognized that key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses should be part of every country's response to HIV. Such key programmes need: HIV-related legal services; monitoring and reforming laws, regulations and policies relating to drug use and HIV that hamper access to HIV services; literacy such as 'know your rights' campaigns; sensitization of law-makers and law enforcement agents to criminalized and socially excluded populations such as people who inject drugs; training for health care providers on human rights and medical ethics related to drug use and HIV; reducing discrimination, violence and harmful laws against women.[51]

44. A joint UNAIDS statement issued in June 2005 emphasizing that prevention of HIV transmission among people who inject drugs can best be achieved by implementing the comprehensive package of interventions also stated that effective implementation is "only achievable if supportive legislation, regulations, policies and attitudes are in place to prevent the marginalization, discrimination and stigmatization of drug users and ensure respect of human rights. The active participation and support of communities in the response is critical to its success."[52]

The funding crisis

45. Despite the large and growing body of evidence to support the effectiveness and cost effectiveness of harm reduction interventions there is a serious lack of financial support with little sign of improvement in the near future.

46. It has been estimated that in 2013 global HIV-related harm reduction expenditure equated to US$8.50 for each person injecting drugs in low- and middle-income countries, or just US$ 0.02 per person injecting drugs per day based on the reported spending of US$34.5 million divided by an estimated 4.05 million people who inject in low and middle income countries which expenditure submitted reports for 2013[53].This figure is consistent with that estimated by other studies as of three cents per injector in 2007.[54]

47. UNAIDS estimates, as part of the Fast Track approach, that in 2015 the annual investments required to fund HIV prevention among people who inject drugs in low- and middle-income countries[55] –scaling up from current coverage levels towards reaching 85% coverage in 2020 in outreach including needle and syringes exchange

[51] Guidance note: Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses. Joint United Nations Programme on HIV/AIDS; 2012 (http://www.unaids.org/sites/default/files/media_asset/Key_Human_Rights_Programmes_en_May2012_0.pdf, accessed 17 November 2014).
[52] Joint UNAIDS statement on HIV Prevention and Care Strategies for Drug Users. Joint United Nations Programme on HIV/AIDS; 2005 (http://data.unaids.org/UNA-docs/cco_idupolicy_en.pdf, accessed 17 November).
[53] Global AIDS Response Progress Reporting (GARPR). 2014, UNAIDS
[54] IHRA, 2010, Three cents a day is not enough: Resourcing HIV-related Harm Reduction on a Global Basis, p5.
[55] The Russian Federation was classified in August 2013 as a high income country.

programs, peer education, and 40% for Opium Substitution Therapy (OST) - is estimated to be US$ 1.8 billion and US$2.6 billion in 2030 for 90% and 60% coverage respectively. Other estimates are higher with an estimated US$2.3 billion needed.[56] As per the latest available data in 2013, US$ 22.7 million (out of the total $34 million) has been invested by international donors – approximately 8%% of the need. As a result, coverage of essential HIV and harm reduction programmes targeting people who inject drugs, especially NSP and OST, continues to be very low and insufficient to respond effectively to HIV prevention in this community.

48. UNAIDS estimates that among low- and middle-income countries, NSP costs vary by region and delivery system. Estimates suggest unit costs ranging from a regional low of US$31 in Sub-Saharan Africa to a high of US$113 in Latin America with a mean global unit cost of US$60 per year. Although there are fewer OST cost studies they consistently show considerably higher regional average unit costs than NSP, ranging from US$265 in Sub-Saharan Africa to US$4300 in Eastern Europe and Central Asia[57].

49. International donor policy and practice is changing with funds increasingly directed towards low-income countries with a high disease burden and related HIV treatment services. As more countries move to middle-income status, eligibility for development support is decreased, regardless of epidemiological need or if transition planning has been put into place to ensure national governments will cover the remaining funding gaps. This is despite the fact that a majority of people who inject drugs live in these countries.[58]

50. Historically, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) has been the largest harm reduction funder with an estimated US$430 million between 2002 and 2009.[59] From 2012 onwards, the Global Fund requires all supported countries to make a minimum domestic government co-funding contribution to the HIV programme relative to the Global Fund's budget for the HIV programme, of a proportion increasing with country income (5% for low-income countries; 35% for lower-middle-income countries, and 65% for upper-middle-income countries).[60] Given these changes within the New Funding Model provision of resources to a number of middle income countries is therefore reduced, including a number of countries that had previously provided harm reduction services. In the US, previous legislation permitting federal funding for needle and syringe programmes has been changed meaning such funding is no longer possible.[61]

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[56] HRI, 2014, The funding crisis for harm reduction: Donor retreat, government neglect and the way forward.
[57] Estimates obtained for the estimation of the Global Price Tag by validation in 36 low- and middle-income countries. (UNAIDS unpublished document).
[58] HRI, IDCP, Int. AIDS Alliance, *op.cit*; p2.
[59] Wilson D, Fraser N, *op. cit.*,
[60] Galárraga O, Wirtz V, Santa-Ana-Tellez Y, Korenromp E. Financing HIV Programming: How Much Should Low- And Middle-Income Countries and their Donors Pay? PLoS; 2013 (http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0067565, accessed 17 November 2014).
[61] Federal Funding Ban on Needle Exchange Programs. In: http://www.whitehouse.gov; 2012 (http://www.whitehouse.gov/blog/2012/01/05/federal-funding-ban-needle-exchange-programs, accessed 17 November 2014).

51. While funding for harm reduction is decreasing in these ways, in a number of countries investments are increasing in punitive law enforcement and interdiction regarding injecting drug use, as well as compulsory drug treatment programmes. It has been estimated that global drug enforcement easily exceeds US$ 100 billion annually. On the other hand a mere 3% of the total estimated resources invested for global drug enforcement would cover the totality of resource needs for per year and it would be consistent with the suggested co-financing of these services from HIV earmarked funds but increasingly from other sectors.

52. Funding for the vast majority of harm reduction programmes outside of Western Europe and Australia comes from non-domestic sources, either through the Global Fund[62] or other donors, or arises from outside of specific HIV-earmarked budgets. In this way scale up and sustainability of programmes is challenging. Most of the countries reporting high programme coverage are high-income countries. The vast majority of low- and middle-income countries are not adequately meeting their programmatic responsibilities to address HIV prevention among people who inject drugs.[63]

53. It is clear that if sustainable, effective programming is to become a reality for harm reduction a strong case for the cost effectiveness of such interventions has to be made that will persuade national governments to invest in it.

54. Increasing focus on strategic 'investment approaches' to AIDS spending—as supported by UNAIDS and other stakeholders—encourages greater efficiency and value for money through prioritization of evidence and rights-based HIV programming.[64] Economic modelling has illustrated that implementation of such an investment framework for the HIV response would cover the full range of HIV interventions including harm reduction programmes. It is also calculated to avert an estimated 12.2 million new infections and 7.4 million AIDS-related deaths between 2011 and 2020.[65]

55. Funding required for the prevention, treatment and care of HIV among people who inject drugs is substantial. It has been estimated that the annual cost of scale-up of prevention and harm reduction, including NSP and OST would be US$1.8 billion in 2015 reaching US$4.3 billion in 2020 when the coverage of these preventive measures would be 85% of outreach for PWID (NSP, Prevention services) and 40% for OST as estimated by UNAIDS for low- and middle-income countries.

56. The social, health and community costs of inaction are significant. Harm reduction services need to be funded and implemented now to avoid much greater financial and societal costs in the future. In the context of limited resources, the need to provide low-threshold community-based services for people who inject drugs is

[62] Middle-income countries such as Ukraine and Vietnam with high concentrations of people who inject drugs are not included in the new Global Fund funding model.
[63] UNAIDS, The Gap Report, *op. cit*.; p181.
[64] SMART Investments. Joint United Nations Programme on HIV/AIDS. 2013 (http://www.unaids.org/sites/default/files/media_asset/20131130_smart-investments_en_1.pdf, accessed 17 November 2014).
[65] Guidance: Investing for results. Results for people. Joint United Nations Programme on HIV/AIDS. 2012 (http://www.unaids.org/sites/default/files/media_asset/JC2359_investing-for-results_en_1.pdf, accessed 17 November 2014).

fundamental. Low-threshold services for people who use drugs can be defined as those which offer services to drug users; do not impose abstinence from drug use as a condition of service access; and endeavor to reduce other documented barriers to service access

Poor service delivery

57. As is the case with policy development, harm reduction interventions and programmes are often planned and delivered without engagement of the community of people who use drugs. Consequently, services are often inaccessible and/or unacceptable to the community.

58. In some countries, service provision is fragmented, requiring people to travel long distances and in many cases wait long hours in multiple sites to access their basic health and social care. Despite the evidence of efficacy and impact of low-threshold, community-based harm reduction interventions necessary to provide accessible and user-friendly services for people who inject drugs, many countries still prioritize high threshold interventions within programming.

59. Improvement of quality services is hampered by the lack of regular and thorough monitoring and evaluation, with the result that positive and negative lessons learned have not always been documented. Even where monitoring and evaluation of services has been a regular requirement, as with the Global Fund, turning recommendations into service quality improvements remains a challenge.

60. Perceptions of harm reduction services by injecting drug users provide important data for the further development of such services. The OST service in Moldova was evaluated in 2012 which was widely welcomed by many and signified bold political will on the part of the government. However the service was still perceived by many people who use drugs as difficult to use because the image of OST was negative among most people who inject drugs. Patients reported that the main barrier to their entering OST was that their 'association' to the treatment site prevented them being perceived as having a normal life.[66]

61. In some middle and low income countries there is a particular risk that poor quality injecting equipment and condoms will be provided to people who inject drugs or only a limited choice will be given, for example in size of needle and/or syringe. Full ranges of quality injecting equipment, such as needles, syringes, skin cleaners, sterile water, mixing pans/cookers and filters, are often not offered.[67]

KEY CONSIDERATIONS FOR THE FUTURE

62. Much can be done at the international, regional, national and local levels to accelerate the HIV response for people who inject drugs. No 'one' response will fit every country, or different localities within a country but a comprehensive national

[66] E Subata. Evaluation of Opioid Substitution Therapy in the Republic of Moldova Vilnius University. 2012 (http://aids.md/aids/files/1429/FINAL%20(ENGL)%20MD%20REPORT_FINAL_2012_12_31.pdf, accessed 17 November 2014).
[67] WHO, UNODC, UNAIDS Target Setting Guide to reduce transmission among People who Inject Drugs, *op. cit*.

response where government agencies and civil society, including drug users, collaborate in the development and coordination of harm reduction services is needed to ensure effective measures. Low threshold community based services led by people who inject drugs themselves as well as a strong advocacy movement are a critical part of the solution.

63. The 2016 UNGASS on the World Drug Problem will be an opportunity to incorporate lessons learned in the AIDS response into the analysis of the response to the global drug problem and to ensure ending AIDS is well reflected in any resulting UNGASS goals and targets. This is predicated on a comprehensive and critical review of current international drug conventions based on prohibition and the criminalization of drug use and drug users. In this regard it is notable that the WHO's 2013 Consolidated Guidelines recommends the review of laws, policies and practices including current criminalization of injecting and other use of drugs, citing the example of Portugal where decriminalization has led to an increase in people accessing treatment, a fall in HIV cases among people who inject drugs, reductions in drug use and less overcrowding within the criminal justice system.[68]

Box 6: Enabling legislation improves harm reduction programmes in Iran programmes in Iran

The Iranian national programme, funded mainly by government, was geared up after issuance of a directive by the Head of Judiciary in 2005 to support harm reduction activities. As a result, judges and the police were obliged to cooperate with all harm reduction centres. The harm reduction programme was developed and implemented through collaboration of various organizations including Ministry of Health, the State Welfare Organization, Drug Control Headquarters, Medical universities and civil society organizations that have been successful in advocacy with local mosques, local councils and communities. The 3rd National Strategic Plan (2010-14) developed to respond to the HIV epidemic was the result of close, multi-sectoral collaboration between all the relevant stakeholder institutions and organizations with harm reduction targeted at people who inject drugs one of the most important strategies under the Plan. By the end of 2013 this resulted in the establishment of 238 drop-in-centres and 400 outreach teams providing harm reduction services to almost 200,000 clients.

Source: Ministry of Health, Tehran, case study submission

64. It is important to also note that there are often several crosscutting issues relating to drug use where people who inject drugs merge with other key populations such as sex workers, transgender people, men who have sex with men, migrants, women, indigenous people, incarcerated people and youth. Joined-up responses therefore need to be considered.

65. The effectiveness of harm reduction service provision can depend on its ability to address immediate and fundamental human needs. For example, a client may suffer from malnutrition, have primary health problems, or lack of financial resources for

[68] WHO, Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations, *op. cit.*; p92.

transport – as well as fear of arrest - which can make it difficult to access available harm reduction services, such as NSP or OST, even if they are motivated to change behaviour. For these reasons, services need to be comprehensive in scope and reach.

66. Recognition that people who inject drugs have different needs depending on their individual circumstances and that harm reduction services should be comprehensive and flexible enough to provide for these needs is necessary to improve the quality and coverage of services.

67. If the international community is to succeed in achieving the agreed reduction in HIV transmission among people who inject drugs, the challenges listed above must be comprehensively addressed through a number of actions including:

Increased political commitment, policy reform and advocacy

68. In order to respond to a policy and legislative environment that stigmatizes and discriminates against injecting drug users there needs to be increased political commitment to the establishment of evidence based harm reduction programmes. In particular advocacy is essential to ensure necessary policy and legal changes as well as to empower and mobilize the community.[69]

69. A systematic approach that can be replicated and adapted to different cultural, economic and political circumstances is needed.[70] This includes general principles of advocacy for HIV prevention, treatment and care for people who inject drugs, a step-by-step process of establishing advocacy groups with specific goals and strategy development including analysis of stakeholder and advocacy audiences.

70. Advocacy needs to be conducted at many levels, including with the community in the immediate neighbourhood of harm reduction services, through formal and informal meetings, public information campaigns, involvement by programme managers in multi-sector AIDS and drugs committees and, in most cases, by carefully building relationships with community leaders and selected representatives from the mass media.

[69] Advocacy Guide: HIV and AIDS Prevention among Injecting Drug Users. Geneva. World Health Organization 2004; pp84-89 (http://www.who.int/hiv/pub/advocacy/en/advocacyguideen.pdf, accessed 17 November 2014).
[70] *Ibid*; p1.

Box 7: Seeking proven alternatives to criminalization in Puerto Rico

The NGO Intercambios founded the Puerto Rican Harm Reduction Coalition in 2012 and has developed harm reduction services and initiated a drug policy change programme "Descriminalizacion.org". This latter is a technology-enabled campaign seeking proven alternatives to the criminalization of drugs and drug users in Puerto Rico. It currently has a growing social media reach of over 60,000 with over 29,000 Facebook followers. The campaign seeks to promote a national discussion on alternative drug policy models and create public awareness about the negative consequences of the "war on drugs" which has driven the incarceration of drug users and increased the social drivers of HIV transmission among injecting drug users by alienating them, criminalizing their behaviour and preventing them from accessing clean injecting equipment and adequate care. The campaign has been involved in over 20 radio interviews and 10 TV shows, over 30 news articles and has been invited to over 15 panel presentations in academic forums on drug issues which have been covered by local and international news media. Intercambios has also participated in drafting a joint resolution of government institutions, professional health associations and community-based organizations supporting drug policy reform efforts in Puerto Rico.

Source: Intercambios Puerto Rico case study submission

71. Building political and community support is essential and should actively involve people who inject drugs at each stage. Sustainability is most likely in sites where political commitment exists.

72. In particular it is essential to provide information to agencies such as the police, to families/co-dependents and community/religious leaders in areas where harm reduction services may be located to reassure them that harm reduction can provide benefits, not only for the individual drug user, but also for families and the community.

73. The role of law enforcement services is crucial for success where addressing HIV prevention, treatment and care among people who inject drugs is carried out within a context of criminalization of drug use and drug users.

74. The experience from a five year harm reduction programme for HIV prevention in Central Asia shows that while law enforcement services do not have to support every initiative, if they allow programmes to operate without hindrance and build flexible and trust-based working relationships with programme staff, then mutual benefit can result.[71] Capacity building and training for police officers may be necessary, as illustrated by the programme in the Kyrgyz Republic (*see Box 9*) to provide a continuous consistent system for instructing police officers on harm reduction interventions and the role of policemen in HIV prevention.

75. Harm reduction programmes should operate where drug users are located, including in detention, since a majority of people who inject drugs are incarcerated at some point. Focus on low threshold initiatives with people who inject drugs and dealers

[71] Developing and implementing harm reduction programmes for HIV and AIDS prevention in Central Asia: the CARHAP experience. GRM International.2012.

who are street based, to ensure the maximum participation of people who inject drugs. Outreach workers carrying new and used needles and syringes and other injecting equipment should be able to work without supplies being confiscated. Clients need to be able to attend NSP sites, and OST or HIV treatment clinics without fear of arrest or harassment from police.

Box 8: Relation building with police in Kyrgyz Republic

In the capacity building programme conducted with police officers in the Kyrgyz Republic, key elements included:

- Creating a team of friendly policemen in five regions of the Kyrgyz Republic appointed by the Ministry of Internal Affairs (MIA) to be focal points for NGOs experiencing problems with police relationships
- Participation by police in a thorough training on HIV and the official Guidelines on HIV prevention among vulnerable groups and police officers approved by government in 2008
- Seminars in project sites for police officers, mostly district police officers, including HIV/AIDS facts, cooperation with AIDS-service NGOs, and detailed information about the Guidelines; introduction of HIV/AIDS and harm reduction problems/issues to the curricula of the local MIA Academy
- Regular round tables linking up MIA officials with community leaders to discuss further cooperation between police officers and AIDS-service NGOs

Need for better data and monitoring and evaluation (M&E)

76. Increased quantity and quality of data on injecting drugs use and HIV and HCV is needed for resource allocation, programme prioritization, planning and evaluation and advocacy.[72]

77. Greater involvement of people who inject drugs, transparency and increased peer review, expanded reporting systems and harmonization of data from different data collection methods is critical.

[72] Harm Reduction Advisory No. 1: Concerns regarding new estimates on HIV, hepatitis C and injecting drug use. HRI.2013.

Box 9: Community-led evidence: the case of the Indonesian Drug Users Network

People who use drugs in Indonesia remain largely excluded from local programming and high-level policy making, but in 2012 the Indonesian Drug Users Network [*Persaudaraan Korban Napza Indonesia (PKNI)* in Bahasa*]*, advocated for a systematic evaluation of existing services with a central role for the drug user community. As a result collaboration between PKNI, Indonesia's National AIDS Commission, and the Directorate-General of Prisons established a systematic evaluation of the quality of harm reduction services in prisons and in the community. PKNI took responsibility for assessing the quality of services within the community from the beneficiary perspective, with PKNI community members trained to conduct key informant interviews and focus group discussions with people who had used harm reduction services in target areas. A total of 270 people provided comprehensive information on their experience of service quality. The success of the project demonstrated that genuine collaboration between policy makers and the drug user community is not only possible, but is necessary for the delivery of effective, evidence based harm reduction services that accommodate the needs and concerns of the drug injecting community.

Source: Indonesian Drug Users Network/ Persaudaraan Korban Napza Indonesia (PKNI)

78. Within harm reduction data collection, greater focus is needed on population size estimates for people who inject drugs, ensuring consistency in data on service quality as well as instances of scale-down of services.

79. Comprehensive monitoring and evaluation should be a systematic and integrated element of effective programme management to assess whether all activities are being implemented as planned and the programme is delivering the expected outputs and impact in terms of HIV-prevention behaviours, in particular safer injection practices.

Box 10: Central Asia: Quality Management Tool promotes service monitoring and evaluation

The QMT (Quality Management Tool) has been pioneered among harm reduction service organizations in Central Asia. The tool enables organizations to regularly assess their own capacity as well as the quality of their service, make evidence-informed management and programmatic decisions and make timely adjustments to services when needed. In general, most harm reduction service organizations focus M&E activities on collecting basic data for the purpose of reporting to development partners. The QMT helps to integrate strengthening of service quality and organizational capacity as key components of harm reduction service organizations' internal standard management practice. Questions posed by the tool focus on whether all activities are being implemented as planned, is the programme delivering the expected outputs, and does the programme lead to meaningful results in terms of HIV-prevention behaviours, in particular safer injection practice? The first version of the QMT concentrated on assessing the quality of NSP but was revised to include a separate tool for assessing organizational capacity and a range of tools to assess the quality of different harm-reduction services beyond NSP. The revised QMT toolkit comprises a step-by-step guide and a range of Excel-based assessment tools and its modular character allows maximum flexibility for harm reduction service organizations to use the tool according to their specific needs and priorities.

Source: Developing and implementing harm reduction programmes for HIV and AIDS prevention in Central Asia: the CARHAP experience. GRM International. September 2012

Service delivery: safety, supervision and support

80. Outreach can deliver cost effective, accessible and acceptable HIV prevention interventions such as NSP, condom programmes and targeted communication, and serve as a useful access point for referral to OST, testing and counselling, antiretroviral treatment, drug dependency treatment and other healthcare and social services.[73] OST itself, although not usually an outreach service, can also be based on a low threshold model with policies and practices that can achieve the goals of reducing barriers to admission and improving retention in treatment.[74]

81. Outreach services often rely on people who currently or formerly injected drugs to make contact with people who inject drugs who are not in treatment, living where services are not available or accessible, or who choose or are not able to use available services. In order to develop effective, realistic and achievable programmes it is important for people who inject drugs to be involved in planning, influencing and delivering services.

82. Peer-driven interventions, based on peer-to-peer principles and mobilization of peer networks, facilitate a wider involvement of people who inject drugs into harm reduction and HIV prevention programmes compared to more traditional outreach

[73] WHO, Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations, *op. cit*.; p29.
[74] Strike C, Millson M, Hopkins S, Smith C. What is low threshold methadone maintenance treatment? International Journal of Drug Policy. 2013; 24; pp51–56 (http://www.ijdp.org/article/S0955-3959(13)00079-0/fulltext, accessed 17 November 2014).

methods. Unlike the traditional outreach work model, peer-driven intervention is entirely reliant on active drug users who implement the activities usually carried out by outreach workers.

Box 11: New York State's low-threshold programmes based on community needs

In New York State NSPs are designed to be accessible to people who inject drugs through low threshold programmes where no names or addresses are required or collected for enrolment, instead replaced with participant specific unique identifiers and NSP identification cards for clients. Various models of NSP are developed based on the needs of people who inject drugs in different communities, including storefront office sites, mobile van, street side, 'walkabout', single room occupancy hotels, peer-delivered syringe exchange and special arrangements in areas where distance and lack of public transportation act as barriers to service acquisition. The relative importance of each model type varies according to geo-spatial, political, and social considerations as well as community support or concerns. Due to such interventions, since the early 1990s the HIV rate among injection drug users in New York State has fallen from 54% to less than 4% as of December 2012 with injection related HIV transmission continuing to decline

Source: New York State, Department of Health case study submission

83. Peer-driven interventions distribute harm reduction materials to peers such as condoms, safer injecting equipment (secondary exchange), sharps boxes and informational brochures. They can also recruit peers to prevention services where they are offered free HIV testing and counselling, health/risk assessments, NSP, and further prevention education. Implementation of peer-driven interventions needs to take into account the local environment, any potential conflicts with law enforcement agencies and fraud related to incentives for people who use drugs. To minimize the risk of fraud, non-cash incentives such as food packages can be provided to each newly recruited and educated peer worker.

84. In outreach community settings, work with people who use drugs is often challenging and can sometimes be risky and even dangerous. The safety and security of both workers and clients is of primary concern. Outreach workers, as well as people who inject drugs, can face particular problems such as harassment, verbal abuse and violent treatment by police or other authority figures. Without proper management, support and supervision (as well as a living wage to help them carry out their work) outreach workers can become isolated, disempowered and frustrated in their work, putting them at risk of leaving their job. Staff in static harm reduction services can also experience similar problems and programmes therefore need to be developed that take these factors into consideration.

Box 12: Contributing factor of salary levels

In the Central Asian Region low salary levels have been the most significant contributing factor in the high turnover of outreach workers, also due to lack of long term comprehensive training and continuing support and supervision. While a certain degree of turnover in outreach workers is normal, turnover due to low salaries is not cost effective and defeats the purpose of funding outreach and other harm reduction services. Defining career paths in service organizations is a useful way to reduce staff turnover. This way outreach workers have a clearly marked-out career path where each step has its own set of responsibilities and requirements and is linked to regular salary increments. Where harm reduction service organizations develop clear and transparent mechanisms for promotion outreach workers are motivated to enhance their performance, skills and knowledge. Serious consideration should be given to salary levels of outreach workers, particularly if they are stable ex-drug users or co-dependents. Paying small salaries that do not constitute a living wage increases the risk of the outreach worker leaving the post and/or finding other means to supplement their income, including the sale of injecting equipment and/or drugs. One solution is to introduce a system of incrementally increased wages based on performance indicators such as client satisfaction, fulfilled caseloads, showing initiative, attendance at training and complying with M&E. This provides an incentive to stay in post and reward those doing the hard work of frontline harm reduction service provision.

Source: Developing and implementing harm reduction programmes for HIV and AIDS prevention in Central Asia: the CARHAP experience. GRM International. September 2012.

Need for capacity building, staff development and community mobilization

85. The success of harm reduction programmes depends heavily on the availability of trained, technically competent staff, particularly those in the field, such as outreach, healthcare and social workers directly providing services to people who inject drugs. Developing an internal staff capacity building system/plan becomes essential if staff are to be retained. A trained worker will feel more motivated, confident and able to do the job, will provide a better standard/quality of service to the client and be less likely to leave their job.

86. Community mobilization is recognized as a cornerstone of HIV and harm reduction programmes because it leads to improved uptake of services and promotes local-level advocacy, transparency and accountability. The key role played by the community of people who inject drugs and affiliated organizations to reach hard to reach groups is essential especially in settings where health and/or judiciary systems and services are not trusted, and stigma and discrimination are strong. At the same time many people who inject drugs may be ‘hard to reach’ precisely because services are inappropriate or unwelcoming and staff display stigmatizing attitudes to clients.

87. Community mobilization and people who inject drugs are an integral component of the HIV response. For example the UNODC HIV/AIDS Section has developed a positive engagement with drugs civil society (including global and regional networks

of people who inject drugs) over the last two years establishing a joint work plan and an annual consultation process with drugs civil society alongside the Commission on Narcotic Drugs. This can serve as a positive model for other organizations and governments about to engage with the people who inject drugs community. Such engagement is critical given the slow progress in addressing the HIV epidemic among people who inject drugs and the challenges of overcoming the legal and financial barriers to taking to scale globally endorsed harm reduction models. This type of civil society engagement should also extend to all areas of UNODC's work given the relationship between the HIV response, criminalization and the legal environment.

RECOMMENDATIONS

88. Given the strength of evidence of how to reduce HIV transmission among people who inject drugs and the imperative to address the serious dearth of quality harm reduction services globally for this vulnerable population, concerted efforts should include:

    a. Wherever possible, services for people who inject drugs should be low threshold and efforts made to ensure that such services are accessible and acceptable to the population.

    b. Programmes for people who inject drugs should always contain an element for community empowerment building and strengthening advocacy with people who inject drugs participating actively at all stages of the design, planning and implementation of services

89. All efforts should be made to implement the recommendations contained within the WHO/UNODC/UNAIDS Target Setting Guide for reducing HIV Transmission among people who inject drugs (2012) as well as the WHO et al Consolidated Guidelines for Key Populations 2014.

90. The Joint Programme will continue to provide strategic policy and technical guidance, promoting evidence and rights-based approaches. This will include active participation and support to the preparation of UNGASS on Drugs in 2016 to contribute all available evidence on the impact of drug control systems, in particular the criminalization of people who use drugs, in order to ensure a thorough, well informed analysis of the current situation and how it could be improved.

91. The Joint Programme and partners will work closely to advocate that reducing HIV transmission be an explicit high-level objective of the international drug control system, reflected in the High Level Political Declaration that will accompany the 2016 UNGASS on Drugs. Outcomes of the UNGASS should be used to inform the 2016 High-Level Meeting on AIDS and any resulting political declaration.

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