We can protect drug users from becoming infected with HIV

Joint Action for Results

UNAIDS Outcome Framework:
Business Case 2009–2011

UNAIDS
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Uniting the world against AIDS

UNAIDS Joint Action for Results

In *The Joint Action for Results: UNAIDS Outcome Framework, 2009–2011*, UNAIDS Executive Director, Michel Sidibé, called for a new and more focused commitment to the HIV response. The Outcome Framework committed the UNAIDS Secretariat and cosponsors to leverage their respective organizational mandates and resources to work collectively with national and global partners to deliver results for people at country level. It outlined 10, interconnected priority areas, each representing a pivotal component of the AIDS response. all of which are reflected in the UNAIDS 2010-2011Unified Budget and Workplan. It opened each of the ten areas with an affirmative challenge (see inside back cover).

For each priority area, a business case was developed by a global UNAIDS interagency working group, building upon and complementing action on the ground. Each business case is different, due to differences in the scope, knowledge base and stage of development of the policies and programmes involved. However, each business case succinctly explains the rationale for the priority area and outlines why success in this area will dramatically decrease new HIV infections and improve the lives of people living with and affected by HIV. The business cases delineate what is currently working and what needs to change in order to make headway in the 10 areas. They are intended to guide future investment and to hold UNAIDS accountable for its role in achieving tangible results. Each priority area business case presents three results to be achieved globally by 2011, which mark important progress towards our shared 2015 goals. These business cases informed both the UNAIDS 2011-2015 Strategy and the development of the 2012-2015 Unified Budget, Results and Workplan.

In 2009, UNAIDS' Executive Director asked each country Joint United Nations Team on AIDS, in consultation with their national AIDS programme, to identify three to five of the priority areas for intensified, unified United Nations (UN) support in 2009–2011. The global priority area working groups also proposed strategies to maximize UNAIDS' impact – some focusing on countries with the largest disease burden, and others on phasing waves of research or technical support according to learning opportunities and demand from local stakeholders. The work at country, regional and global levels has strengthened the foundations and baselines for action toward the ten goals of UNAIDS' 2011-2015 Strategy, Getting to Zero.

Focused, concrete and synergistic actions in the ten areas have the potential to change the trajectory of the epidemic. They will help to achieve universal access to HIV prevention, treatment, care and support, and contribute to achieving the Millennium Development Goals. Optimizing partnerships between national governments, communities, the UN, development partners and other stakeholders, the business cases recommend ways forward that build on decades of research and experience, and focus our work, hearts and minds on a unified and strategic vision.


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We can protect drug users from becoming infected with HIV

1. WHY IS THIS A PRIORITY AREA?

Worldwide, nearly 3 million injecting drug users are living with HIV, and 13 million more are at risk of HIV infection. However, HIV service coverage for drug users is well below 10%, making universal access for this population and the related Millennium Development Goals distant targets.

While the largest numbers of HIV-positive people who inject drugs are in eastern Europe, east Asia, South-East Asia and Latin America, new epidemics of injecting drug use are emerging in sub-Saharan Africa. In addition, certain types of drugs that are not injected, such as amphetamine-type stimulants and crack cocaine, have been associated with the sexual transmission of HIV in the Caribbean and South-East Asia.

The need to address these epidemics, regardless of geography, is compelling. HIV infection among people who inject drugs has been reported in 128 of 151(1) countries reporting injecting drug use. Accumulated evidence and experience from the past two decades show that HIV can spread explosively once it enters a drug-injecting population. In some settings, one-year increases in HIV prevalence from 5% to 50% have been observed among people who inject drugs.

Although considerable progress has been made in the global HIV response over the past two decades, the availability and coverage of HIV prevention services for people who inject drugs remain extremely limited in most places, and injecting drug users often do not receive the benefits of improved HIV care and treatment.

Lack of data on population sizes and high levels of stigma around drug use, including among service providers, severely limit delivery and access to essential services, contributing further to rapid growth in the epidemic in these populations. For example, in countries such as the Russian Federation and Ukraine, where adult HIV prevalence is estimated to be between 1% and 2%, prevalence among injecting drug users has been found to be as high as 38% and

50%, respectively. HIV can also spread from people who use drugs to their sexual partners and further to other populations.

Evidence shows that drug users are willing to protect themselves, their sexual partners and their societies. Providing comprehensive services and outreach to people who use drugs—and to their injecting or sexual partners—can effectively prevent HIV transmission. The sooner HIV prevention programmes are implemented, the more effective such responses will be.

Scaling up evidence-informed HIV programmes will ensure that people who use drugs have the same access as others in their communities to voluntary, affordable and high-quality prevention and care without fear of discrimination or punishment. Doing so is consistent with state obligations under the three international drug control conventions (1961 Single Convention on Narcotic Drugs, 1971 Convention on Psychotropic Substances and 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances).

Complicating matters even further, HIV responses in many countries are insufficiently evidence informed, failing to meet state obligations within international law to promote, protect and fulfil human rights. Of the 129 countries submitting reports to UNAIDS, 40% noted the continued presence of laws, regulations or policies that interfered with the accessibility and effectiveness of HIV-related services for people who inject drugs.(2) Drug users living with HIV are thus subjected to a double stigma—they often experience discrimination as drug users, as well as discrimination when they attempt to access HIV prevention services. The care and support services that are available to drug users generally are not tailored to their specific needs, even in situations in which programming and funding for HIV programmes have otherwise expanded considerably.

Other vulnerability factors for this priority area also need to be addressed. These illustrate the strong interconnections among UNAIDS's priority areas, and the potential for synergies when they are addressed together:

- **People who use drugs, especially people who inject drugs, are vulnerable to viral hepatitis and tuberculosis infections, sexually transmitted infections, other bacterial infections and death from overdose, as well as being vulnerable to HIV.** Hepatitis C is more infectious than HIV, and in many countries the prevalence of hepatitis C infection among people who inject drugs has been reported to be greater for hepatitis C than for HIV, sometimes as high as 90%.
- **Many drug users are young people between the ages of 10 and 24 years, and in some countries the majority of people who inject drugs fall within this age group.** The average age for the first use of heroin or other drugs is well below 24 years in most settings, and studies show that the average age for the first use of injection is decreasing. Drug use is also frequently linked to vulnerability factors such as sex work and/or male-to-male sex. In many countries, women and men (especially young women and men) sell sex in order to pay for the drugs used by themselves or their partners—or their parents, particularly in the case of indigenous peoples/ethnic minorities living in a number of countries in Asia.
- **Female drug users and female partners of male drug users can be especially vulnerable.** This is due not only to the intersection between unsafe injecting and unsafe sexual practices, but also to a notable lack of gender responsiveness in policies and services, resulting in a failure to address the specific needs of women.

- **HIV is a serious health problem for incarcerated populations in many countries, and this can contribute significantly to a country's overall HIV epidemic.** The prevalence of HIV infection in prisons is generally higher than in the non-incarcerated population. Many people who use drugs are imprisoned for their drug use. Some non-drug users may be initiated into drug use when incarcerated. Furthermore, some people who were injecting before will continue to inject either occasionally or regularly during detention, often adopting riskier injecting practices in the absence of effective HIV prevention efforts; others will switch from non-injecting to injecting drug use during incarceration. Drug users in prison are also often exposed to other HIV risk practices, such as unprotected male-to-male sex (including sexual violence) and body piercing practices with unsterile equipment.
- **Despite marked increases in funding for the HIV response, a wide gap remains between available resources and the resources needed to achieve universal access to HIV prevention, treatment, care and support services for people who use drugs.** For example, in 2006, less than US$ 100 million was invested in harm reduction out of a total global AIDS response of US$ 8.1 billion. Harm reduction receives less than 1% of global funds for HIV, even though injecting drug use accounts for around 8% of global infections.

Goal and bold results

The goal of this priority area is to **protect all drug users from infection with HIV and ensure that drug users living with HIV have access to HIV treatment and care by 2015, contributing to UNAIDS's overall goal of preventing all new HIV infections among people who use drugs.**

Given the proven efficacy and cost–effectiveness of HIV prevention, treatment and care interventions for people who inject drugs, UNAIDS advocates the following bold results to be met by the end of 2011. In 10 of the 20 countries where the epidemic is driven by unsafe drug use or where unsafe drug use threatens a new wave of HIV infections:

- **Regulations and policies will be implemented to support evidence-based harm reduction and drug dependence treatment services in relation to injecting drug use and non-injecting stimulant use.**
- **Needle and syringe programmes will be extended to regularly reach 40% of people who inject drugs, and opioid substitution therapy will be extended to regularly reach 10% of people who inject opioids.**
- **Uptake of antiretroviral therapy for people who use drugs and are living with HIV will double.**

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2. WHAT NEEDS TO BE DONE?

Globally, key decisions in 2009 by the governing bodies of the UN entities responsible for drug control (Commission on Narcotic Drugs) and HIV (UNAIDS Programme Coordinating Board), by their parent body (UN Economic and Social Council) and by the Human Rights Council demonstrate a shared understanding of what a comprehensive package of HIV services for people who inject drugs should include.

These decisions mirror the commitments made at the General Assembly by all UN Member States in 2001 and 2006, which include explicit support for harm reduction approaches to HIV and drug use. For the first time in history, **the UN system has clearly defined harm reduction in relation to HIV**. The 2009 World Health Organization (WHO), United Nations Office on Drugs and Crime (UNODC) and UNAIDS technical guide for countries outlines **nine interventions**, and their availability, coverage, quality and potential impact, against which countries should set targets for universal access to HIV prevention, treatment and care for people who inject drugs:

- needle and syringe programmes;
- opioid substitution therapy and other drug dependence treatment;
- voluntary HIV testing and counselling;
- antiretroviral therapy;
- prevention and treatment of sexually transmitted infections;
- condom programmes for people who inject drugs and their sexual partners;
- targeted information, education and communication for people who inject drugs and their sexual partners;
- vaccination against, and diagnosis and treatment of, viral hepatitis;
- prevention, diagnosis and treatment of tuberculosis.

Engaging with and providing outreach to drug users is an essential means for delivering these nine services effectively. Therefore, it is important to enhance the capacity of drug users to voice their needs and successfully engage with community and government institutions. The nine interventions should be complemented by other important health and social services, such as overdose prevention and management, the management of abscesses and the provision of food and shelter.

Photo UNAIDS / S.Drakborg

The clandestine nature of drug use and its widespread criminalization make **additional strategies** critically important. These include:

- effective, sensitive outreach to the targeted population;
- advocating for and facilitating policy and legislative reform, with a focus on human rights;
- meaningful involvement of people who use drugs in policy and programme reviews;
- implementation of legal aid for people who use drugs.

Numerous evidence-informed technical papers and reviews have detailed the efficacy and cost–effectiveness of different HIV prevention interventions within this comprehensive package for people who inject drugs.(3) These include needle and syringe programmes, opioid substitution therapy and antiretroviral therapy. Together, these have been shown to be the key strategies to achieve and sustain reductions in HIV epidemics among people who inject drugs.

At the same time, UNAIDS believes that the nine interventions elaborated in the comprehensive package should be periodically reviewed and updated based on the latest evidence in this area. Growing evidence regarding other interventions, such as safer injection facilities and heroin prescription, may require UNAIDS to reconsider these interventions. It is also warranted that an evidence-based comprehensive package of interventions, including drug dependence treatment, is made available to meet the special needs of non-injecting stimulant users.

Ninety-two low- and middle-income countries report the existence of programmes and policies targeted at injecting drug users. Many countries explicitly support harm reduction in national policy documents (71 countries) and/or implement or tolerate harm reduction interventions, such as needle and syringe programmes (77 countries) or opioid substitution therapy (63 countries). UNAIDS (in particular, UNODC, together with WHO) has produced and widely disseminated normative guidelines, policy documents and good practice documents outlining the importance of harm reduction, and has encouraged national partners, including governments and civil society, to expand access to these services for different subgroups of drug users.

Over the years, funding for harm reduction initiatives led by both government and civil society has been increased by the Global Fund to Fight AIDS, Tuberculosis and Malaria. Many nations also support harm reduction through funding and technical support. Strong support in harm reduction advocacy and implementation by other multilateral, bilateral and international donor agencies and national, subnational and international civil society organizations has been crucial.

Organizations of drug users have been another fundamental and successful component of this response. In more than 34 countries across Asia, Eurasia, Latin America, North America, Oceania, sub-Saharan Africa and western Europe, drug user organizations are involved in advocating for an increased harm reduction response and a direct implementation of services.

3. MOVING FORWARD

Drug use and HIV have affected every region of the world to varying degrees. A systematic review by UNAIDS's global expert group identified 20 countries (see the box) where a first wave of intensive and comprehensive support in 2009–2011 can overcome barriers to fullscale implementation of national programmes to achieve the bold results in this priority area.

A clear agenda exists for the expansion of proven, effective harm reduction measures to greatly reduce the level of HIV among drug users. In implementing this scale-up, and in better addressing the needs of drug users, there are key challenges:

- Public health approaches to HIV among drug users are too often disconnected from drug control efforts undertaken by drug control and law enforcement authorities. This sometimes results in contradictory policy and implementation. These efforts need to be brought into a better alignment, based around evidence of effectiveness.
- Alternatives to incarceration, by depenalizing personal use of illicit drugs and police support for health and welfare referral systems for problematic drug use, are approaches that are significantly reducing the social harms around drug use. These approaches need to be systematically implemented and rigorously evaluated.
- Drug detention as a means of forced detoxification of drug users is a central part of many countries' drug control responses, but these programmes are fraught with danger in the form of human rights abuses and have questionable efficacy as a response to drug use, with high recidivism rates. More effective models of community-based care, including access to opioid substitution therapy, need to be considered as an alternative to drug detention.
- The evidence for the effectiveness of educational approaches to deterring drug use, particularly among young people, is equivocal, and shows only limited impact. Better methods of addressing the initiation of drug use and tackling the underlying causes of drug use (social exclusion and economic dislocation) need to be considered.

First -wave countries:

Afghanistan, Bangladesh, Belarus, China, India, Indonesia, Kazakhstan, Kenya, Kyrgyzstan, Lithuania, Mauritius, Myanmar, Nepal, Nigeria, Pakistan, Republic of Moldova, South Africa, Ukraine, United Republic of Tanzania and Viet Nam.

By addressing these challenges, the goal of reducing new HIV infections through universal access to HIV prevention, treatment and care services for people who use drugs is ambitious

but achievable. It requires rights-based and evidence-informed strategies and firm commitments, resulting in alliances and partnerships among national and local governments, bilateral partners, multilateral organizations, foundations, the private sector (employers, donors and drug dependence treatment providers), international and national civil society organizations and community-based organizations (such as the International Network of People who Use Drugs) and harm reduction networks.

The role of UNAIDS

The expertise and mandate of UNAIDS cosponsors and Secretariat, the Joint Programme's political voice and reach, and its presence at the global, regional and national levels enable UNAIDS to make a distinctive contribution towards the global goal and bold results in this priority area. At the country level, UNODC has facilitated the formation of technical working groups comprising various stakeholders, including government ministries, counternarcotics agencies, the national AIDS programme, civil society, drug dependence treatment centres, UN agencies and other multilateral and bilateral agencies in key countries. These active technical and advocacy forums at the national and subnational levels can play an important role in advancing policy and legislation reform and in scaling up the services in each country, in conjunction with, and as a part of, the overall national AIDS strategy.

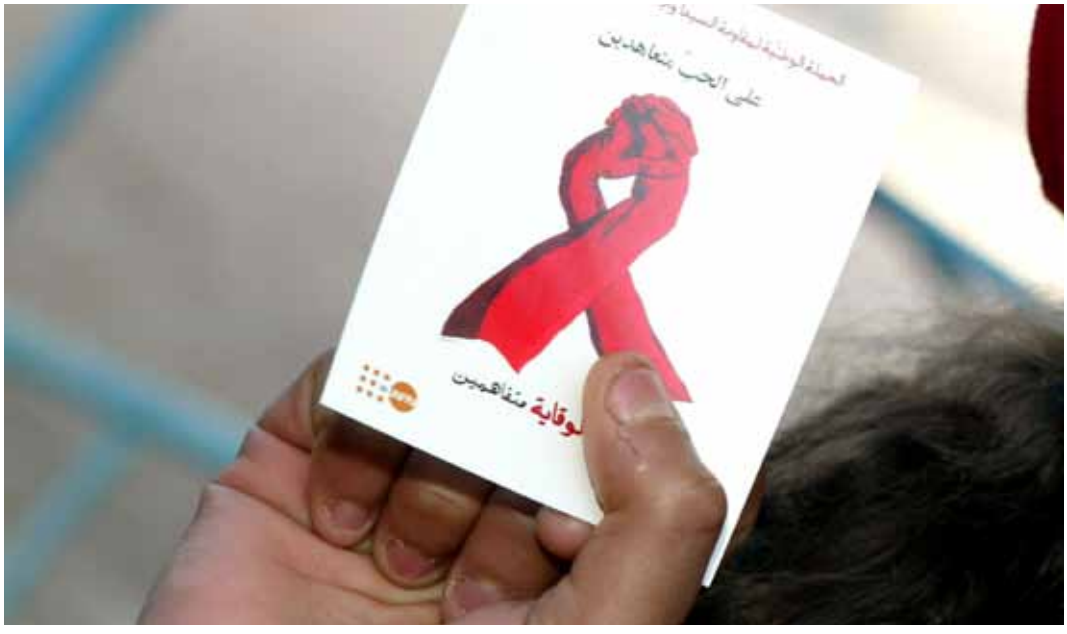
In first-wave countries, UNAIDS will promote and facilitate the meaningful participation of people who use drugs—and inclusion of their prevention, treatment, care and support needs—in the national AIDS response, with a strong emphasis on harm reduction. To this effect, a letter jointly signed by the Deputy Executive Director of UNAIDS and the Global AIDS Coordinator of UNODC went out to all UNAIDS country coordinators and UNODC HIV advisers based in countries on 21 August 2009.

At the international level, UNAIDS—in particular UNODC as the lead agency on HIV and drug use, and WHO and the World Bank in their technical and financing roles—will engage key partners (including the Global Fund, the US President's Emergency Plan for AIDS Relief—PEPFAR, the World Bank, the Open Society Institute and others) to promote the quick and coordinated flow of financial resources to countries and programmes that show commitment to scaling up rights-based and evidence-informed responses. An Informal Working Group on Injecting Drug Use and HIV, a mechanism for resource flow coordination, is already up and running at the global level, involving all major contributors.

All UNAIDS activities will be geared towards strengthening national ownership and building national capacity. Innovative, sustainable financing and delivery mechanisms will ensure that harm reduction services become integral components of national health agendas, including prison health, and social services.

How to ensure accountability and measure progress

To ensure accountability and measure progress, the UN will establish a working group on drug use and HIV, an expanded version of the Steering Committee of the Reference Group on HIV and Injecting Drug Use to the UN. The working group will include representatives from relevant cosponsors and the UNAIDS Secretariat. Convened by UNODC, the working group will coordinate and conduct peer reviews of agency-specific contributions to UNAIDS unified support and will monitor the implementation of activities towards achievement of the bold results. It will lead in the establishment and use of core indicators, including relevant United Nations General Assembly Special Session on HIV/AIDS (UNGASS) and UNODC Annual Reports Questionnaire (ARQ) indicators, and delivery of agency annual progress reports based on the agreed results and indicators.



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UNAIDS
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Joint Action for Results

UNAIDS Outcome Framework:

We can reduce sexual transmission of HIV.

We can prevent mothers from dying and babies from becoming infected with HIV.

We can ensure that people living with HIV receive treatment.

We can prevent people living with HIV from dying of tuberculosis.

We can protect drug users from becoming infected with HIV.

We can meet the HIV needs of women and girls and can stop sexual and gender-based violence.

We can remove punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS.

We can support the ability of men who have sex with men, sex workers and transgender people to protect themselves from HIV infection, achieve full health, and realise their human rights.

We can empower young people to protect themselves from HIV.

We can enhance social protection for people affected by HIV.

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