Halving HIV transmission among people who inject drugs

Setting the scene: Data, evidence, barriers and opportunities

Responding to unmet needs
LEAVING NO ONE BEHIND

Geneva, 11 December 2014
Prevalence of people who inject drugs

12.7 million PWID (0.27 %)

Prevalence of HIV among people who inject drugs

1.7 million PWID living with HIV (13.1% of PWID)

The importance and location of population

Source: UNAIDS
Women who inject drugs: HIV prevalence

Source: Based on data submitted through GARPR reporting submitted since 2011. Geneva, UNAIDS.
HIV AND PEOPLE WHO INJECT DRUGS IN PRISONS

HIV Prevalence in prisons and in general population

- Prison Population
- General adult population

Graph showing the prevalence of HIV in prisons and general population across different years and countries.
Reducing HIV transmission among people who inject drugs
JOINT UN RECOMMENDED INTERVENTIONS

Comprehensive Package of interventions for HIV prevention, treatment and care among people who inject drugs

1. Needle and syringe programmes (NSPs)
2. Opioid substitution therapy (OST) and other evidence-based drug dependence treatment
3. HIV testing and counselling (HTC)
4. Antiretroviral therapy (ART)
5. Prevention and treatment of sexually transmitted infections (STIs)
6. Condom programmes for people who inject drugs and their sexual partners
7. Targeted information, education and communication (IEC) for people who inject drugs and their sexual partners
8. Prevention, vaccination, diagnosis and treatment for viral hepatitis
What is the global coverage of harm reduction services?

- About 14% of HIV+ PWID access ART
- 10% access NSP
- An estimated 8% access OST

Few PWID access all three priority interventions
Female PWID access interventions at a far lower rate
24 HPCs selected for maximum impact on the epidemic

### Regions

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<th>Regions</th>
<th>Recommended by</th>
<th>Countries</th>
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<td>UNODC</td>
<td>Tanzania, Zanzibar</td>
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### Epidemiological data

Responding to unmet needs

### Country readiness (policy, legal framework)

### Resources/Capacity
Bottlenecks

1. Lack of accurate estimates of PWIDs and service coverage
2. Poor access to and quality of harm reduction services
3. Lack of supporting policy and legislative environments (i.e., repressive law enforcement practices)
4. Lack of financial resources and extremely low (or nonexistent) domestic investment in harm reduction service provision threatening sustainability of these programmes

Stigma
Critical enablers

- Supportive legal and policy framework
- Supportive law enforcement practices
- Empowerment of people who use drugs
- Closing of compulsory detention centres for rehabilitation of DU
- Alternatives to imprisonment including decriminalisation of drug use

Appropriate funding
The economic case for harm reduction
Surging HIV epidemic among PWID in Greece
Three proven priority Interventions

WHO, UNODC and UNAIDS—three priority interventions plus HCT, condoms, IEC, STI, HCV and TB prevention/treatment
What we know about NSP

HIV prevalence in **99 cities** worldwide
(MacDonald et al, 2003)

- **Down 19%** per year in cities **with NSP**
- **Up 8%** per year in cities **without NSP**

International evidence shows that **NSP is effective**
(Wodak, 2008)
What we know about community OST versus compulsory detention

Community OST 6-fold > effective and 12-fold > cost-effective than detention
What are the cost ranges? NSP

NSP costs $23–$71/yr \(^1\) but higher if all costs included.

NSP costs vary by region and delivery system (pharmacies, specialist program sites, vending machines, vehicles or outreach).

\(^1\) https://www.ncbi.nlm.nih.gov/pubmed/26578748
What are the cost ranges? OST

- Few OST cost studies but consistently far higher than NSP.

OST cost:
- **Methadone** 80 mg: $363 - 1,057/yr;
How much is spent on harm reduction?

Estimated **$160 million** in LMIC in 2007:

- **90% from international donors**
- **3 cents per PWID per day**

Global Fund: largest HR funder

- Estimated **$430 million** 2002–2009
- > **50%** to Eastern Europe and Central Asia
## Estimated scale-up cost of NSP, OST and ART for PWIDs

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<th>Region</th>
<th>Mid target coverage</th>
<th>High target coverage</th>
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<tr>
<td></td>
<td>20% NSP</td>
<td>20% OST</td>
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<td>South, East and South East Asia</td>
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<td>Latin America and Caribbean</td>
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<td>Middle East and North Africa</td>
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<tr>
<td>W-Europe, N-America and Australasia</td>
<td>17M</td>
<td>1.19M</td>
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<tr>
<td>Eastern Europe and Central Asia</td>
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<tr>
<td>Sub-Saharan Africa</td>
<td>414M</td>
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<td><strong>Total Per year</strong></td>
<td><strong>2.65B</strong></td>
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Cost-effectiveness of harm reduction: Australia

Australia invested A$243 Million in NSP

Prevented an estimated:
- 32,050 HIV infections
- 906,667 HCV cases

A$1.28 Billion saved in direct healthcare costs

ROI = A$21 per A$1 invested

Patient/client costs + Productivity gains and losses, net present value of NSPs = $5.85 Billion
Conclusion

Inaction costly

- **NOT** the equivalent of *nothing happening*
- **Hard to reverse epidemic** once established

Whereas *harm reduction* is

- **Effective**—in terms of HIV cases averted
- **Cost-effective**—in terms of healthy years gained and costs

- **Social benefits exceed treatment costs**

And benefits the whole population

- **Benefits more non-drug users**
  than drug users

Global best buy!
Thank you