

Halving HIV transmission among people who inject drugs

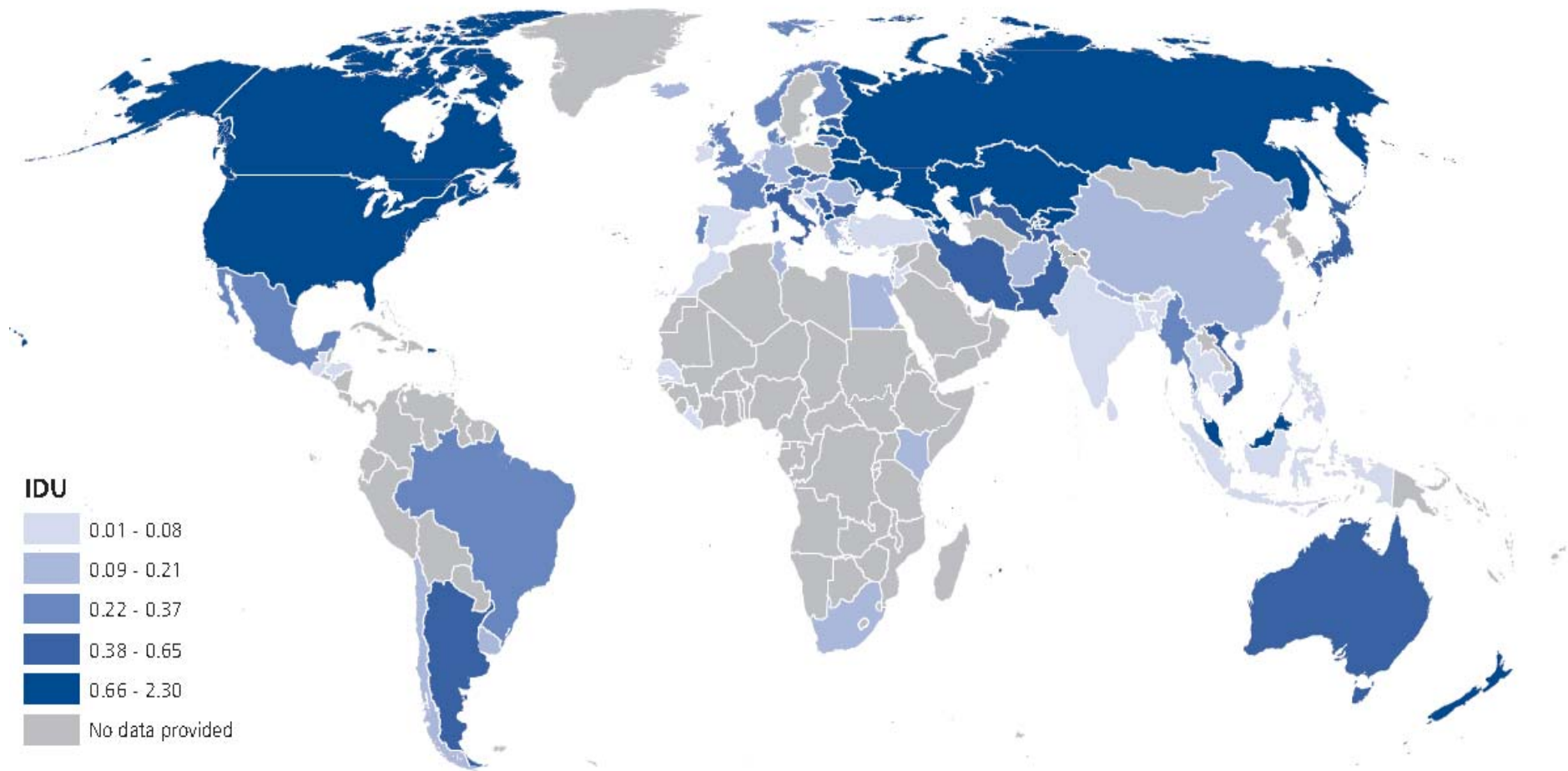


**Setting the scene:
Data, evidence,
barriers and
opportunities**

**Responding to unmet needs
LEAVING NO ONE BEHIND**

Prevalence of people who inject drugs

12.7 million PWID (0.27 %)

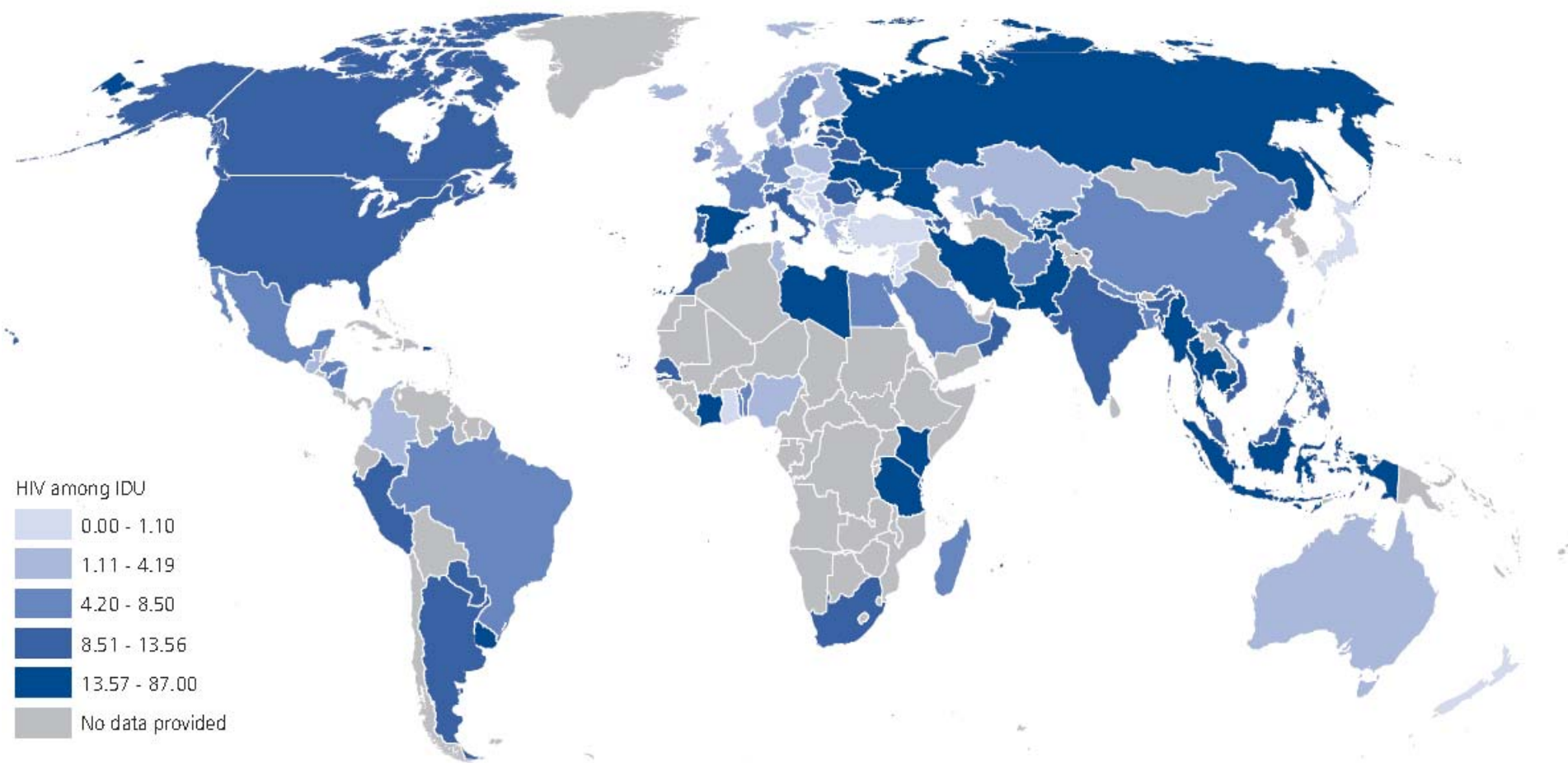


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Source: World Drug report 2014

Prevalence of HIV among people who inject drugs

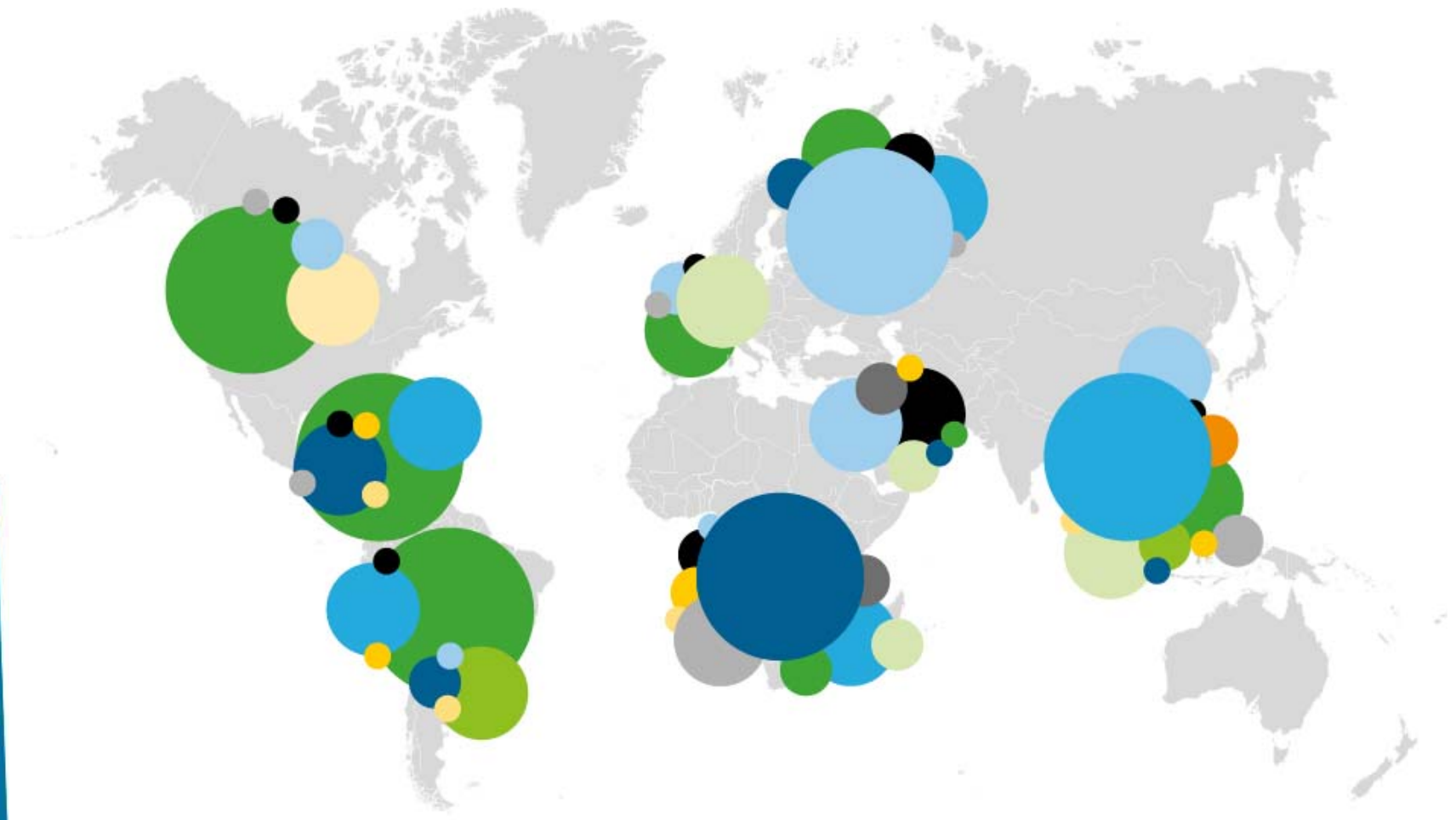
1.7 million PWID living with HIV (13.1% of PWID)



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Source: World Drug report 2014

The importance and location of population



- Young women
- Sex work
- People who inject drugs
- Men who have sex with men
- Transgender
- Migrants
- Prisoners
- Displaced
- Pregnant women
- 50+
- Disabled
- African-American women
- Intimate partners

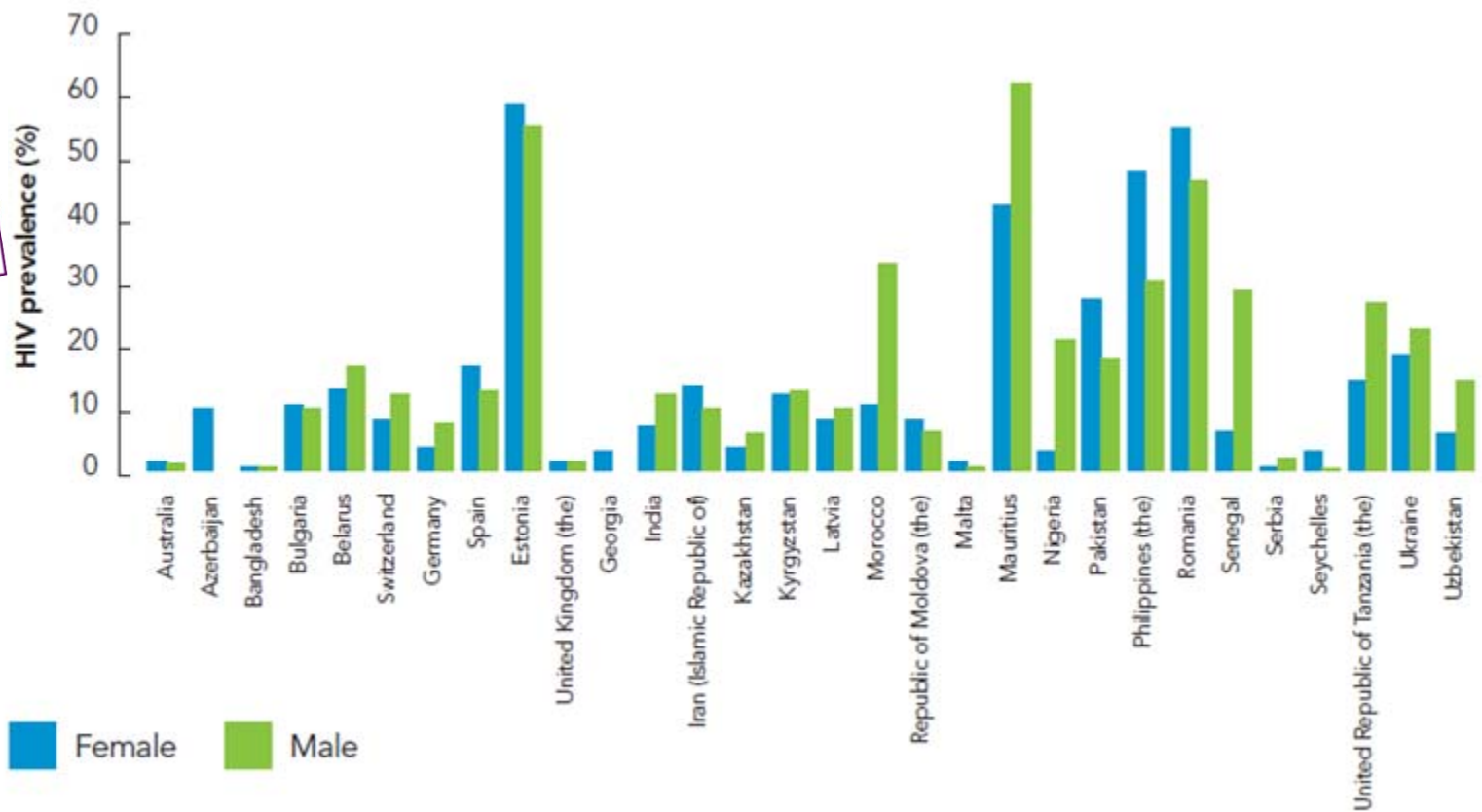
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Source: UNAIDS

Women who inject drugs : HIV prevalence



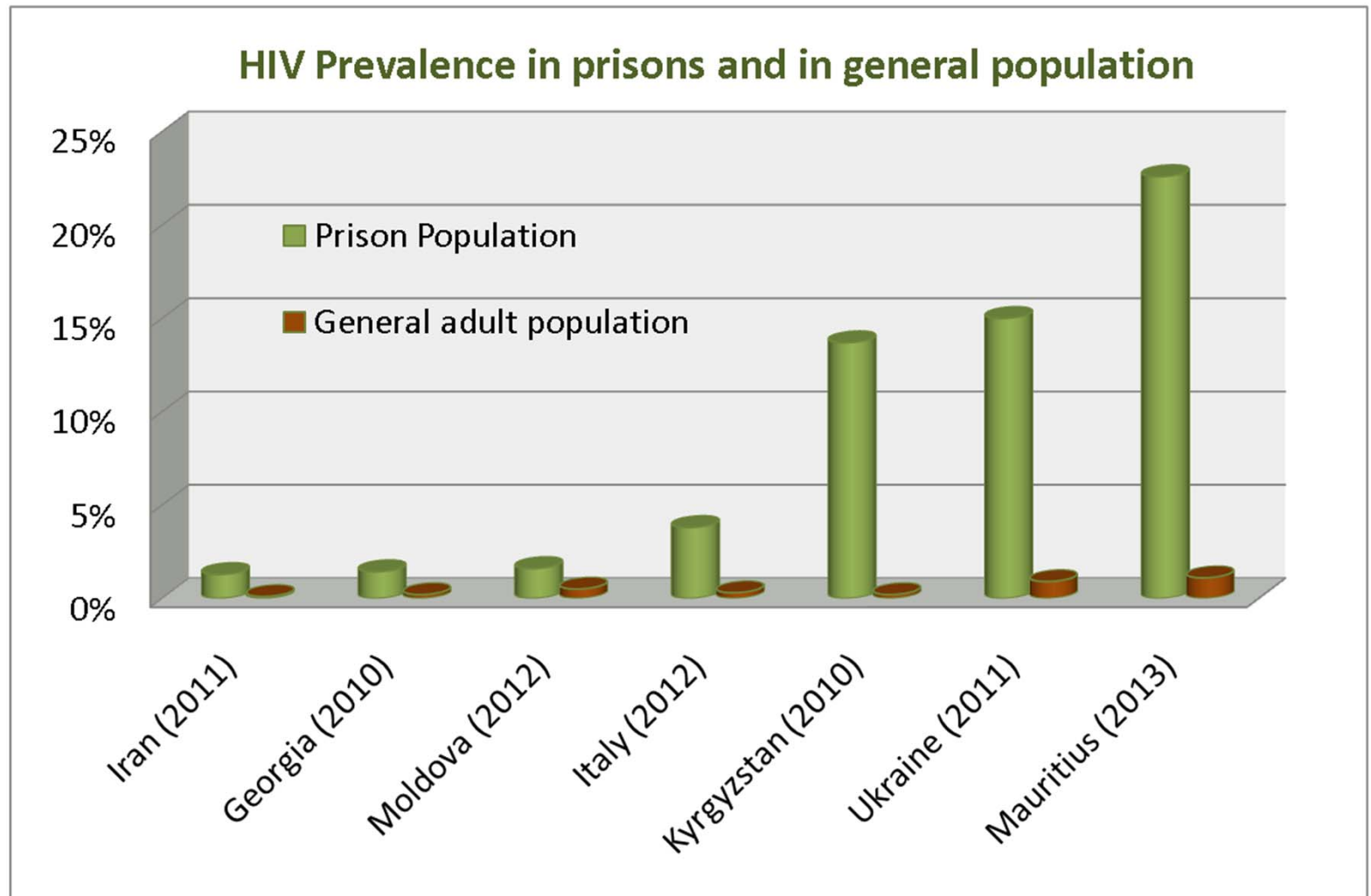
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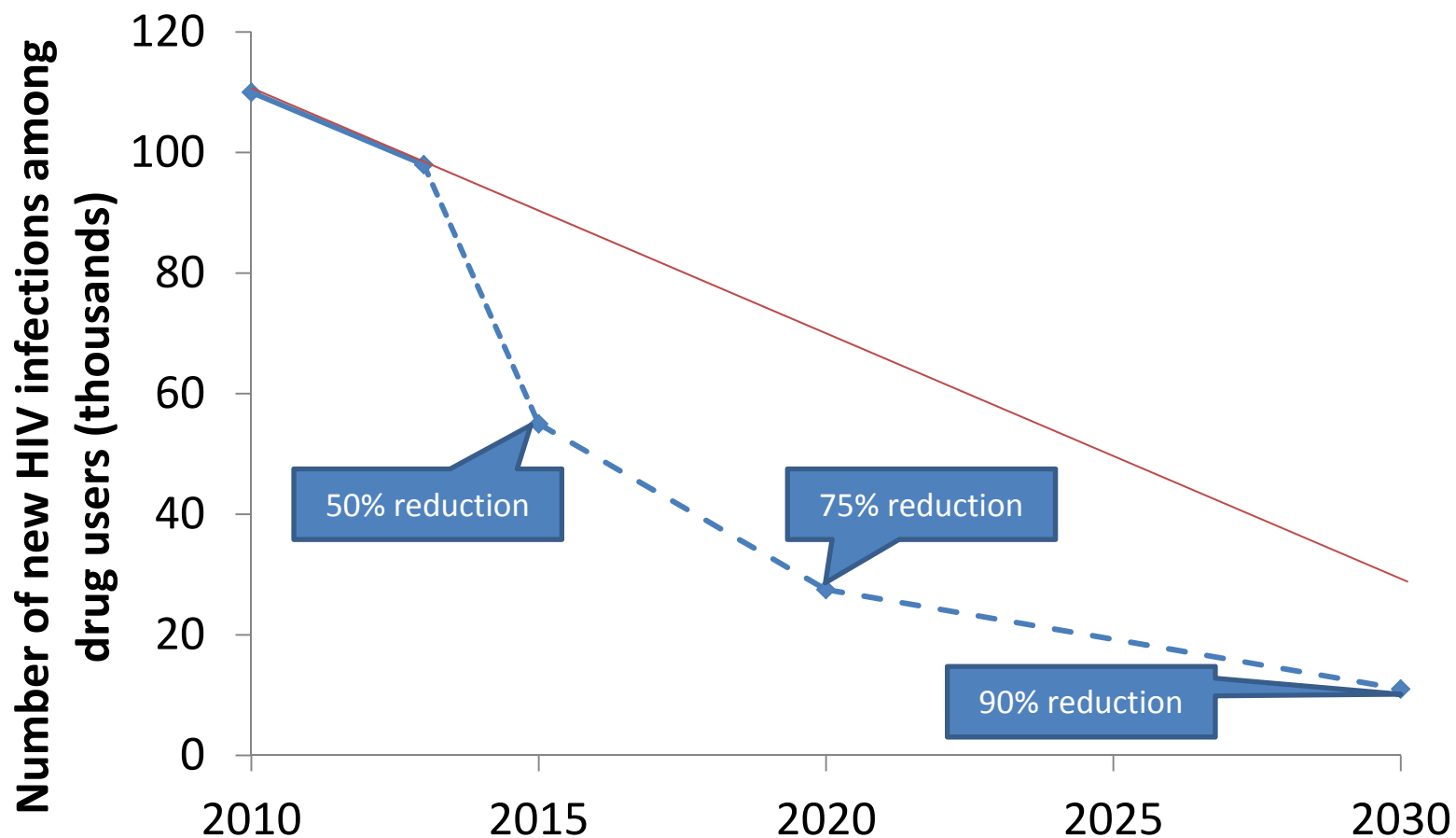
Source: Based on data submitted through GARP reporting submitted since 2011. Geneva, UNAIDS.

HIV AND PEOPLE WHO INJECT DRUGS IN PRISONS

Responding to unmet needs
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Reducing HIV transmission among people who inject drugs



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JOINT UN RECOMMENDED INTERVENTIONS

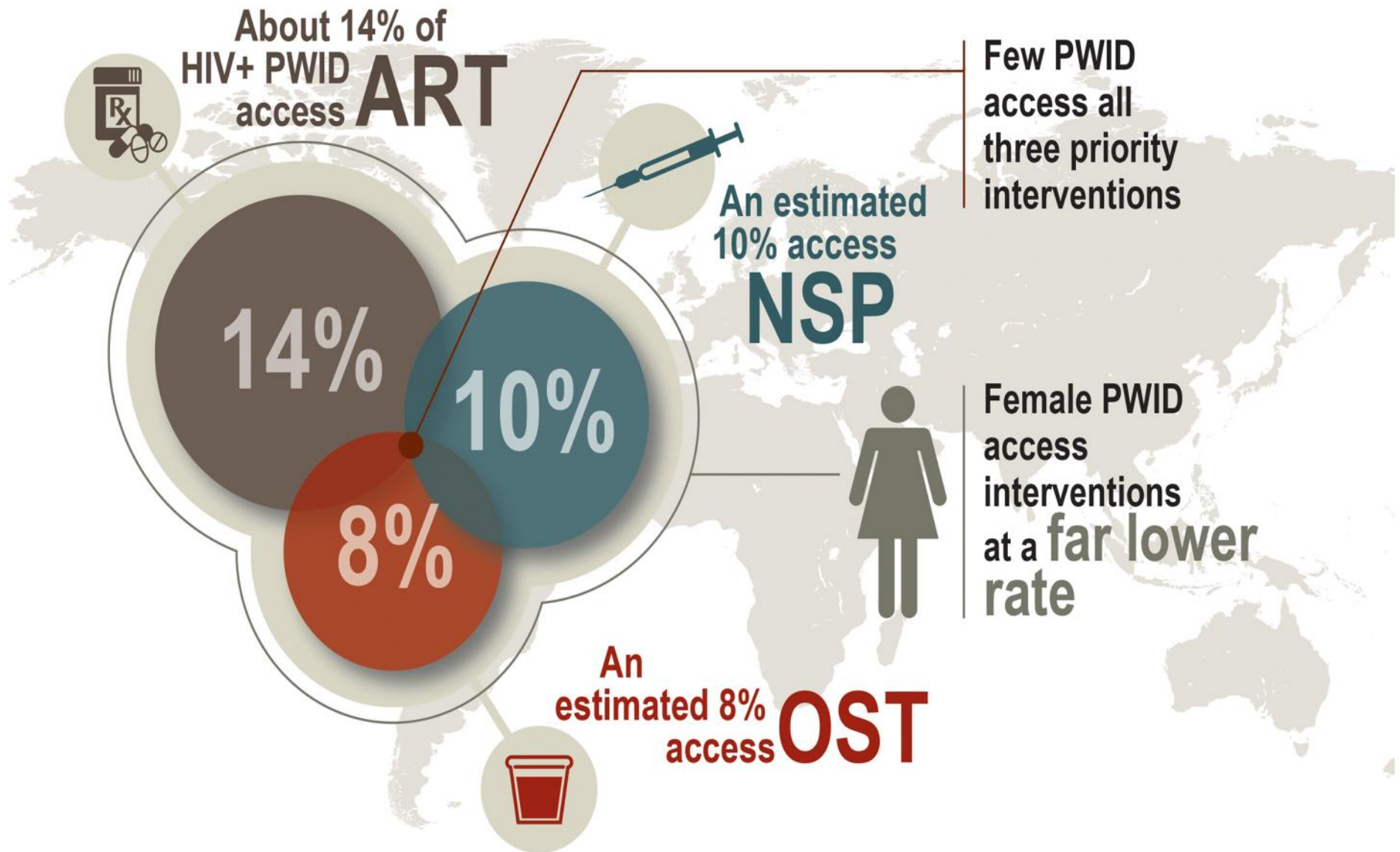
Comprehensive Package of interventions for HIV prevention, treatment and care among people who inject drugs



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
9. Prevention, diagnosis and treatment of tuberculosis (TB).

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What is the global coverage of harm reduction services?



24 HPCs selected for maximum impact on the epidemic

Epidemiological data

Country readiness
(policy, legal framework)

Resources/Capacity

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Regions	Recommended by	Countries	
Asia	1	UNODC & CSO	Indonesia
	2	UNODC & CSO	China
	3	UNODC & CSO	Pakistan
	4	UNODC & CSO	India
	5	UNODC & CSO	Vietnam
	6	UNODC & CSO	Thailand
	7	UNODC	Philippines
	8	UNODC	Myanmar
Eurasia	9	UNODC & CSO	Tajikistan
	10	UNODC & CSO	Belarus
	11	UNODC & CSO	Ukraine
	12	UNODC & CSO	Kyrgyzstan
	13	UNODC & CSO	Moldova
	14	UNODC & CSO	Uzbekistan
	15	UNODC	Kazakhstan
Latin America	16	UNODC & CSO	Brazil
	17	UNODC & CSO	Argentina
MENA	18	UNODC & CSO	Morocco
	19	UNODC & CSO	Egypt
	20	UNODC	Iran
Africa	21	UNODC & CSO	Kenya
	22	UNODC & CSO	South Africa
	23	UNODC & CSO	Nigeria
	24	UNODC	Tanzania, Zanzibar

Bottlenecks

**I am an injecting drug user.
I face these issues.**



UNAIDS



1

Lack of accurate estimates of PWIDs and service coverage

2

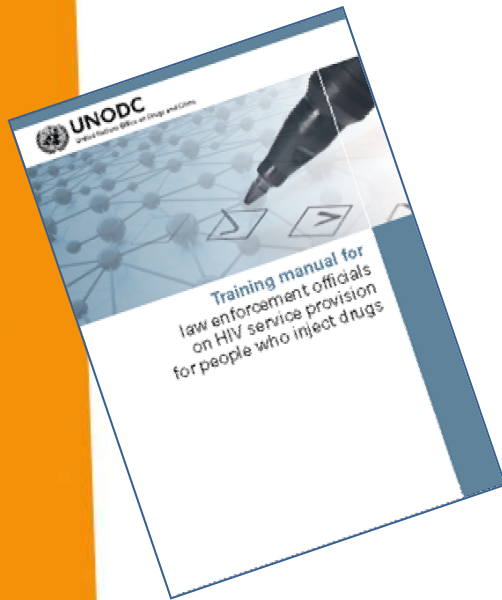
Poor access to and quality of harm reduction services

3

Lack of supporting policy and legislative environments (i.e. repressive law enforcement practices)

4

Lack of financial resources and extremely low (or inexistent) domestic investment in harm reduction service provision threatening sustainability of these programmes



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



The Joint Statement calls for compulsory drug detention and rehabilitation centres be replaced with voluntary, rights-based, evidence-informed programmes in the community.

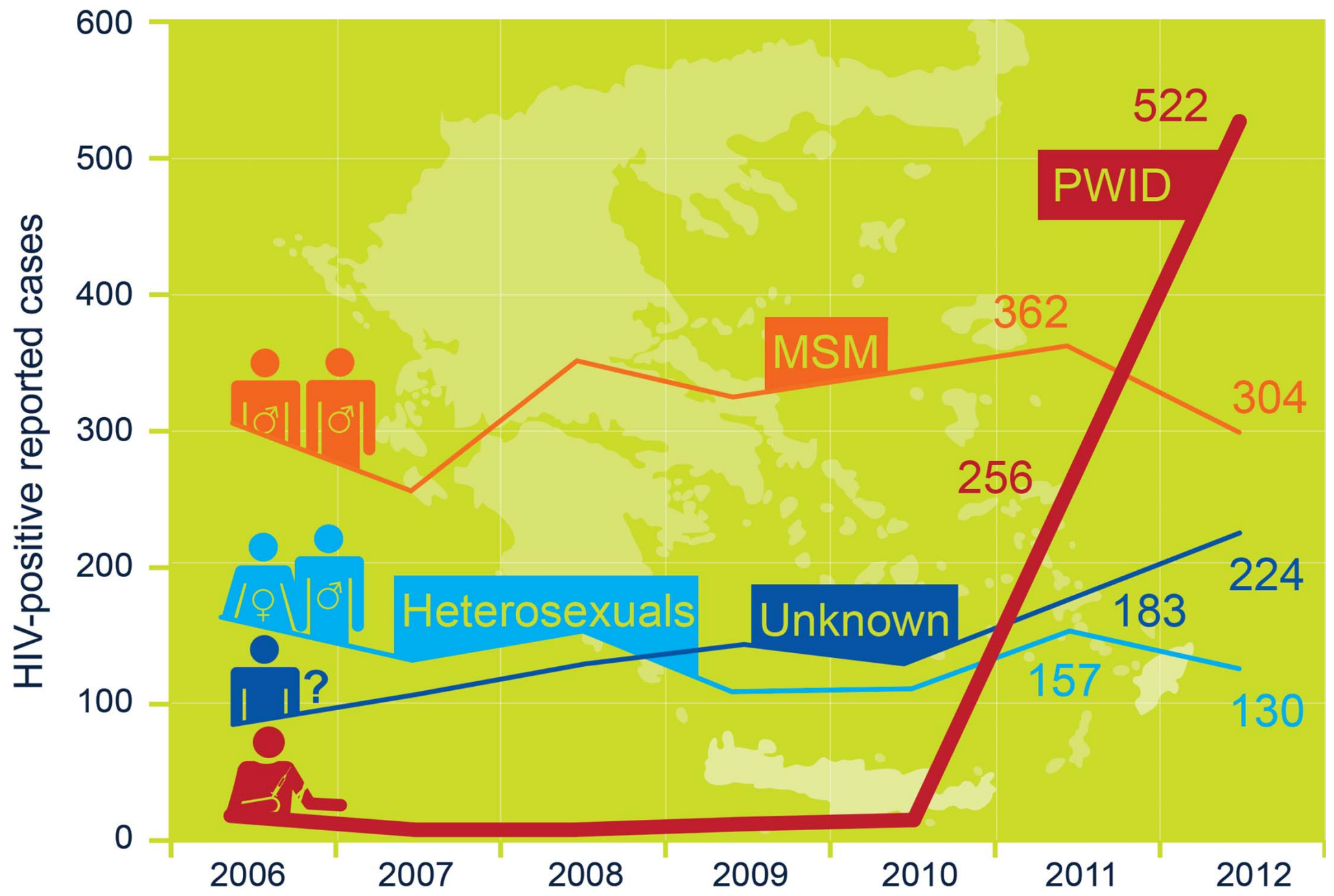
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Appropriate funding

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)



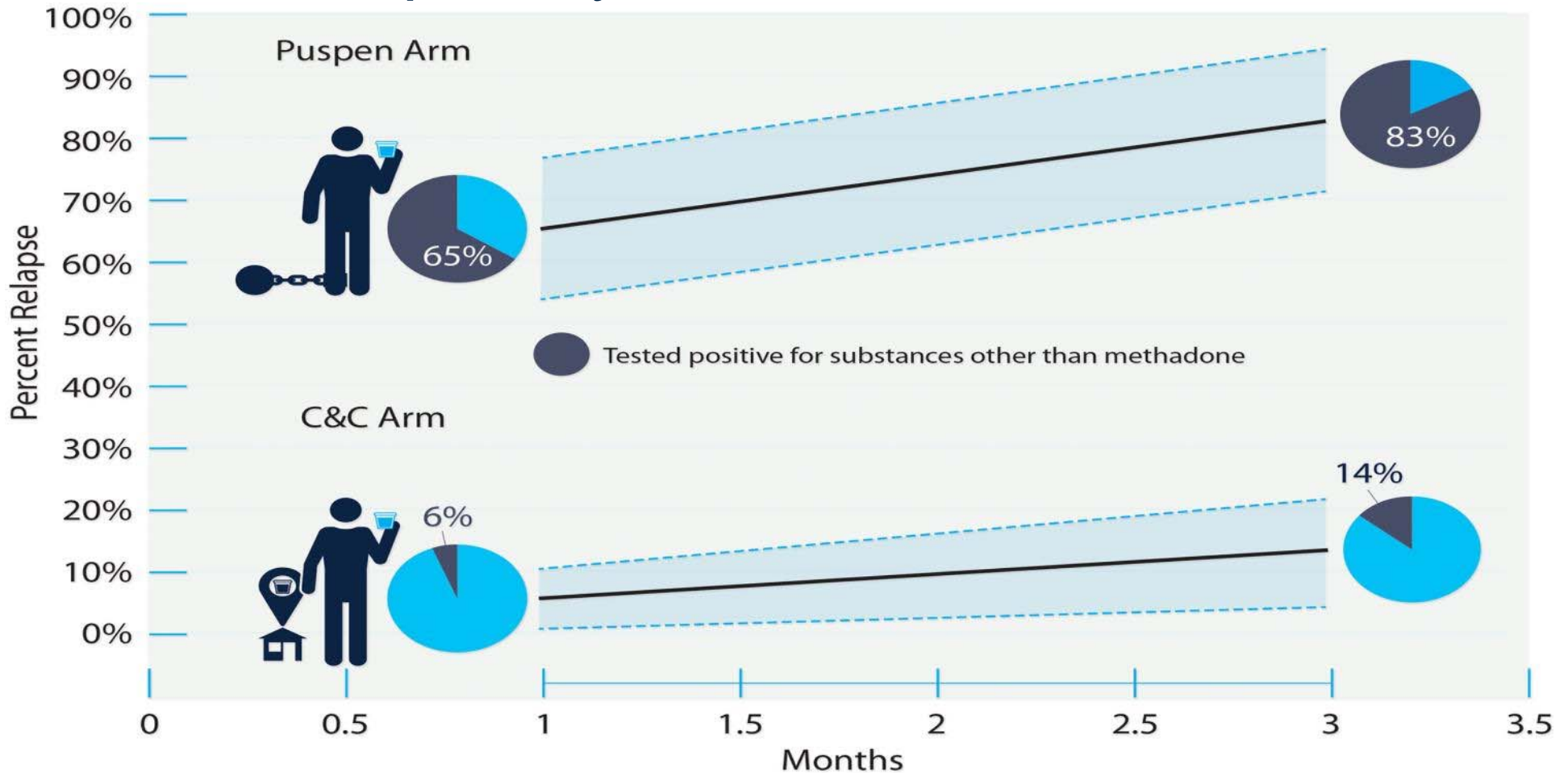
International evidence shows that

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



What are the cost ranges? OST



Few OST cost studies but

consistently
far higher
than NSP



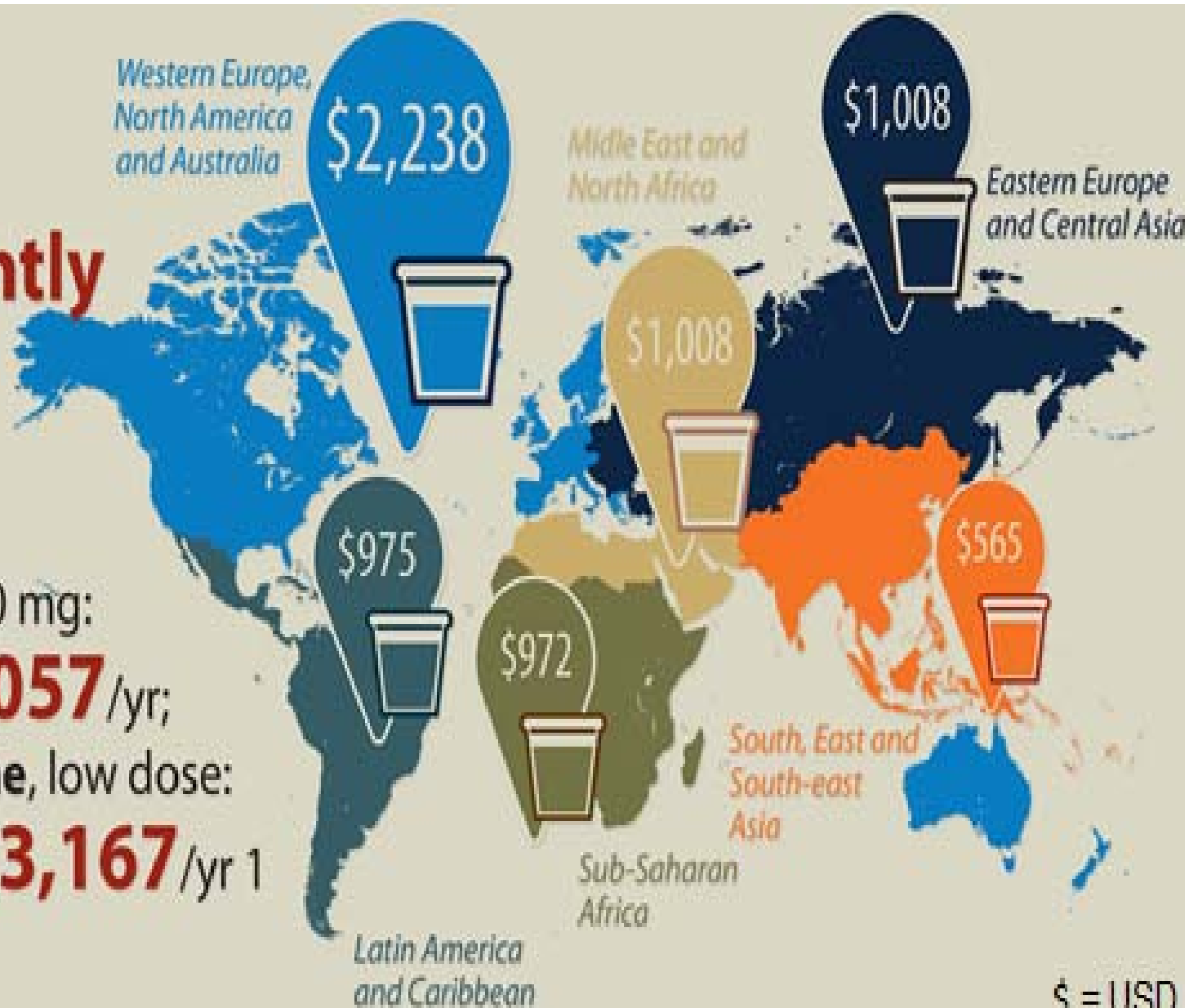
OST cost:

Methadone 80 mg:

\$363 - 1,057/yr;

Buprenorphine, low dose:

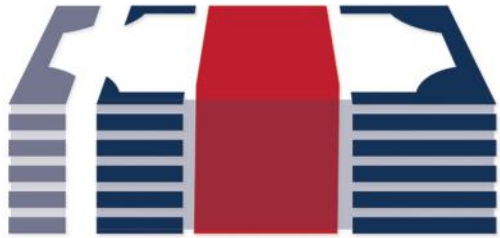
\$1,236 - 3,167/yr¹



\$ = USD

How much is spent on harm reduction?

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



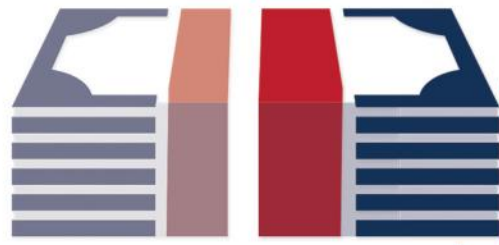
90% from
international donors



= **3 cents** per PWID per day



Global Fund
largest HR funder



Estimated
\$430 million
2002–2009

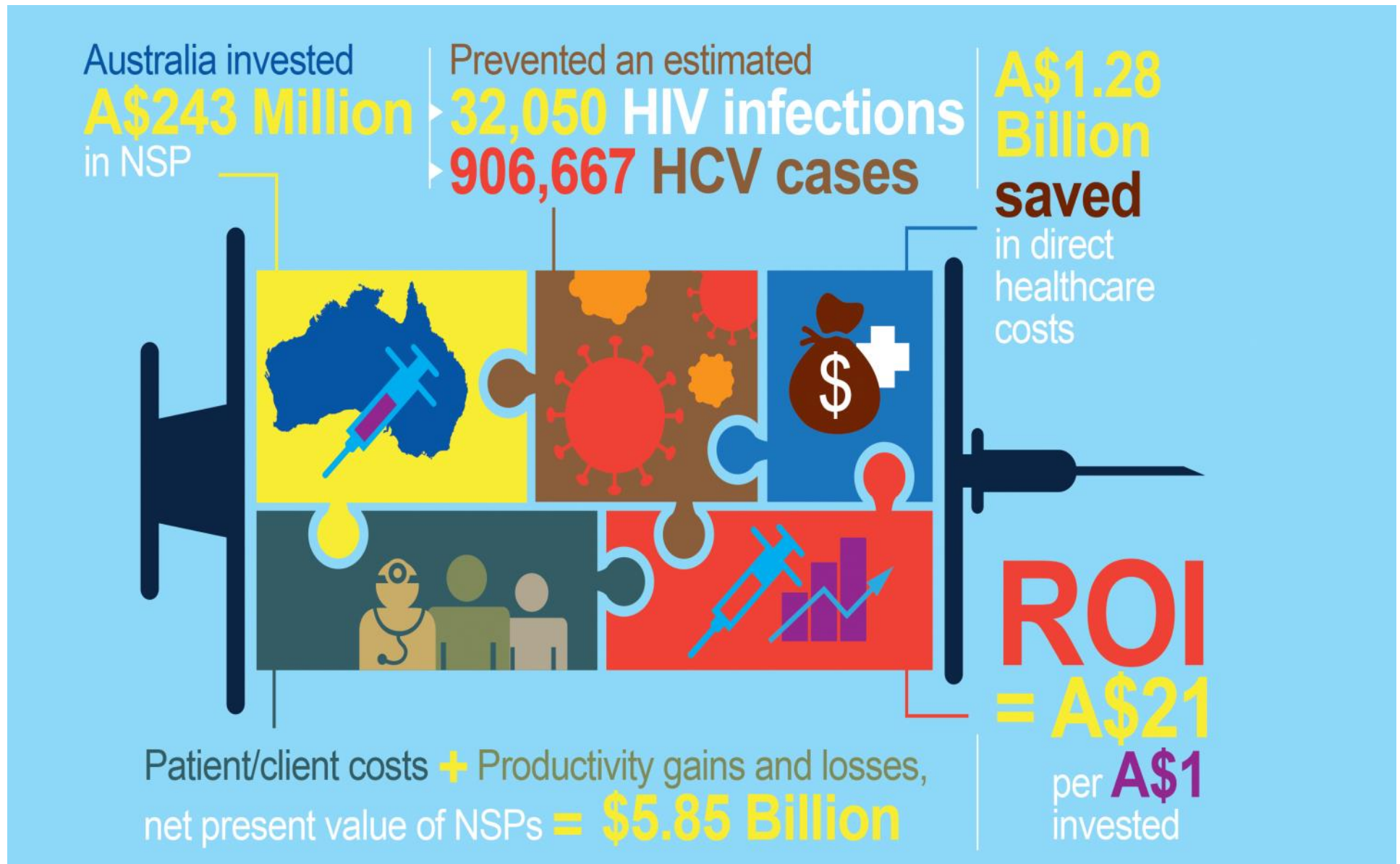


> 50% to Eastern
Europe and **Central Asia**

Estimated scale-up cost of NSP, OST and ART for PWIDs

	Mid target 20% NSP coverage 20% OST coverage 25% ART coverage	High target 60% NSP coverage 40% OST coverage 75% ART coverage
South, East and South East Asia	527M	1.49B
Latin America and Caribbean	625M	1.47B
Middle East and North Africa	26M	55M
W-Europe, N-America and Australasia	17M	1.19M
Eastern Europe and Central Asia	1.04B	2.51B
Sub-Saharan Africa	414M	901M
Total Per year	2.65B	7.62B

Cost-effectiveness of harm reduction: Australia



Conclusion

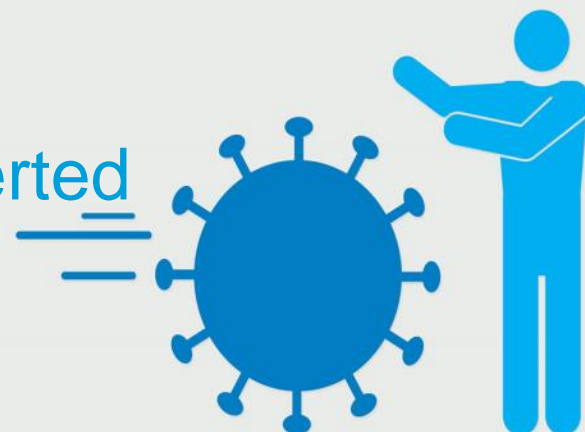
Inaction costly

- **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

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