HARM REDUCTION AND THE GLOBAL HIV EPIDEMIC

Interventions to Prevent and Treat HIV Among People Who Inject Drugs

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MAKING AIDS HISTORY
The Foundation for AIDS Research

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EXECUTIVE SUMMARY

Achieving an AIDS-free generation requires that all populations have access to HIV prevention and treatment services. Unfortunately, when it comes to people who inject drugs (PWID), this access is often denied. The result: more people are at risk of contracting HIV and transmitting it to others, increasing the likelihood that the global HIV epidemic will continue to expand.

While the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC), and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have endorsed a comprehensive package of harm reduction services for PWID, few countries are following the evidence. Even though countries that have comprehensive programs have effectively forestalled or significantly diminished existing epidemics among PWID, many governments fail to prioritize or, worse yet, acknowledge the need for such programs. Tragically, the focus is on criminalization of PWID instead of providing access to harm reduction services that potentially ward off HIV infection.

With the governments of many low- and middle-income countries prioritizing general HIV services and prevention of mother-to-child transmission of HIV, work among PWID and other key populations is often primarily supported by international donors. To date, the Global Fund to Fight AIDS, Tuberculosis and Malaria has been the largest funder of harm reduction services in the world. However, recent changes to its approach to funding may disadvantage harm reduction programs in middle-income countries, some of which have HIV epidemics primarily driven by injecting drug use.

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) is the largest supplier of HIV services in the world, but its essential support for harm reduction and PWID services is constrained by the U.S. Congressional ban on the use of PEPFAR resources for the collection and distribution of clean syringes, despite strong evidence supporting the effectiveness of syringe services programs in reducing HIV infection among PWID in a range of settings.[1]**

To better understand the ways countries with different HIV epidemics have—or have not—taken steps to address the HIV epidemic among PWID, amfAR, The Foundation for AIDS Research, undertook case studies in five select countries—Kenya, Kyrgyzstan, Nigeria, Ukraine, and Vietnam—to examine the extent to which: 1) HIV prevention and treatment services are targeted and accessible to PWID; 2) national governments and international donors have shown a commitment to addressing the HIV epidemic among PWID; 3) the needs of PWID and their communities are addressed by civil society; and 4) PWID themselves are involved in HIV program planning, monitoring, and evaluation.

The experience of these countries revealed that the following overarching goals must be met to achieve progress in ending the HIV epidemic by 2030:

- International donors (particularly the Global Fund and PEPFAR) must transparently monitor their portfolios and allocate resources toward implementing the UN comprehensive package of HIV services for PWID, with conditions that help ensure that services reach their intended populations;
- National governments must prioritize and fund harm reduction services in the context of their national HIV plans;
- Laws criminalizing people who use drugs and drug dependence must be reformed in favor of policies that promote public health; and
- The human and civil rights of people who use drugs must be respected and protected.

** For example, the expansion of SEPs in New York City was associated with a substantial decrease in HIV prevalence among PWID in the city, from 54% in 1990 to 13% in 2001. (De Jarlais DC., Perlis T, Arasteh K, Torian LV, Hagan H, Beatrice S, Smith L, Wethers J, Milliken J, Mildvan D, Yancovitz S, Freidman SR. Reductions in hepatitis C virus and HIV infections among injecting drug users in New York City, 1990-2001. AIDS. 2005;19:S20-S25.)

METHODOLOGY

Based on geographic diversity, funder interest, and demographics of local HIV epidemics, amfAR selected five representative countries (Kenya, Kyrgyzstan, Nigeria, Ukraine,* and Vietnam)† for its case studies. In each country, the Foundation solicited referrals for a community-based consultant. Using a standard template, consultants performed literature reviews to understand local HIV epidemiology, particularly among PWID; the legal and social environmental context surrounding drug use and drug users; financing (national, bilateral, multilateral) for HIV prevention and treatment programs, particularly those targeting PWID; PWID prevention and treatment programming; and mechanisms to secure civil society participation in national HIV program planning, implementation, monitoring, and evaluation. Consultants then engaged an array of key informants using a standardized template with open-ended questions. Informants included government officials responsible for HIV programming, implementers supported by the Global Fund and PEPFAR, PEPFAR country staff, UNAIDS country staff, programs targeting PWID, civil society representatives, PWID, and people living with HIV. Consultants collected data between March and June 2014. Findings from all five reports were synthesized and are presented in this report.

PWID: PREVALENCE AND ACCESS TO PREVENTION AND TREATMENT SERVICES

The global AIDS pandemic has slowed considerably, particularly in countries with generalized epidemics. Yet many countries experience concentrated epidemics among key populations, including PWID, and in many of these countries HIV rates continue to rise. Injecting drug use is a significant driver of the HIV epidemic, accounting for up to 40% of new infections in some countries, with PWID accounting for 5–10% of all people living with HIV.[2]

Shifting drug use patterns can accelerate HIV transmission, particularly when injecting drug use increases or emerges in countries where it was not previously established. These situations are often characterized by increased criminalization of drug use and limited, if any, access to harm reduction services, and the consequences can be rapid and grave. In Estonia, HIV was virtually unknown among PWID in the late nineties; ten years later, HIV prevalence reached 72% among one cohort studied.[3] Significant HIV outbreaks recently noted in Greece and Romania were associated with changing injecting patterns, from heroin to cocaine in Greece and amphetamines in Romania, combined with limited availability of harm reduction services.[4] Should injecting drug use become more common in sub-Saharan Africa, where rates are currently relatively modest, but where HIV prevalence among the general population is very high, the impact could be devastating. Recent increases in HIV infection rates among PWID have been seen in Tanzania, Kenya, and Nigeria as injecting drug use has increased, in part as a result of a shift in drug trade routes to Africa.[5]

ESTIMATED HIV PREVALENCE AMONG PWID (SELECT COUNTRIES)

In 74 countries where data are reported, HIV prevalence among PWID is from 1.3 to more than 2,000 times higher than among the rest of the adult population. Globally, in 2012, an estimated 1.7 million PWID (range: 0.9–4.8 million), or 13.1%, were living with HIV. Four countries (China, Pakistan, the Russian Federation, and the United States) account for 62% of total infections among PWID. HIV prevalence among PWID is especially high in Southwest Asia (28%) and Eastern/Southeastern Europe (23%), primarily due to high prevalence in the Russian Federation (18.4–30.7%) and Ukraine (21.5%).[6] And risk begins early—among young injectors (<25 years) in 45 countries HIV prevalence was 5.2%.[7]

> "Oftentimes, as a female you wait for your partner to inject you after he has already fixed himself. So we share needles."
>
> — Female PWID, Nigeria

In some regions, HIV prevalence among PWID is substantially higher among females. In Nigeria, for example, sentinel surveillance studies in 2010 showed HIV prevalence among female PWID (21%) to be seven times higher than among males (3.1%). Identified risk factors included engaging in unprotected sex, sex work, and women being the last on the needle when injecting with their male partners.[8] In Kenya, where male PWID far outnumber females, HIV prevalence among female PWID (44.5%) was almost three times the rate for men (16.0%).[9]

* Data collection in Ukraine coincided with the early stages of political demonstrations in Kiev that ultimately led to President Yanukovych fleeing the country. Following a transition in government, Russian forces forcibly annexed Crimea in March 2014, resulting in the abrupt termination of opioid substitution therapy (OST) services in the region. Ukraine's political crisis has been accompanied by an economic crisis, with a more than 40% decrease in the value of the Ukrainian hryvnia against the dollar. Since March 2015, Ukraine has been racked by protracted civil unrest, and recent reports indicate that availability and accessibility of HIV services generally, and among PWID specifically, may have deteriorated substantially.

† The initial cohort included six countries—Tanzania was removed from the list due to operational challenges.

Table 1: Key HIV Data for Select Countries

	COUNTRY HIV PREVALENCE – ADULTS 15–49	AVERAGE HIV PREVALENCE AMONG PWID	% OF NEW HIV CASES THAT ARE AMONG PWID
KENYA	5.3% (4.7–6.1) (2014) [1]	18.3% (2008/2011) [2]	3.8% (2008) [2]
KYRGYZSTAN	0.3% (0.2–0.3) (2014) [1]	12.4% (2013) [3]	58% (2013) [4]
NIGERIA	3.2% (2.9–3.4) (2014) [1]	4.2% (overall, 2010) [5] 3.1% (male, 2010) [5] 21% (female, 2010) [5]	9% (PWID and their partners, 2012) [6]
UKRAINE	1.2% (1.0–1.3) (2014) [1]	19.7% (2013) [7]	32.7% (2013) [7]
VIETNAM	0.5% (0.4–0.5) (2014) [1]	10.5% (2014) [1]	42% (2013) [10]

1. UNAIDS. AIDSinfo database. Accessed: August 17, 2015.
2. Kenya National AIDS Control Council (2014). Kenya AIDS response progress report 2014: progress towards zero
3. Kyrgyzstan Ministry of Health (2014). Kyrgyzstan country progress report on the implementation of the global response to HIV 2014
4. WHO (2014). HIV/AIDS program in Kyrgyzstan – evaluation report.
5. Nigeria Federal Ministry of Health (2010). HIV integrated biological and behavioral surveillance survey 2010
6. Nigeria National Agency For the Control of AIDS (2012). Global AIDS response country progress report 2012
7. Ukraine Ministry of Health (2014). Ukraine harmonized AIDS response progress report 2014
8. Vietnam National Committee for AIDS, Drugs and Prostitution Prevention and Control (2014). Vietnam AIDS response progress report 2014
9. Vietnam Ministry of Health (2014). Report on review of HIV/AIDS prevention and control program in 2013 and direction for 2014. #6/BC-BYT

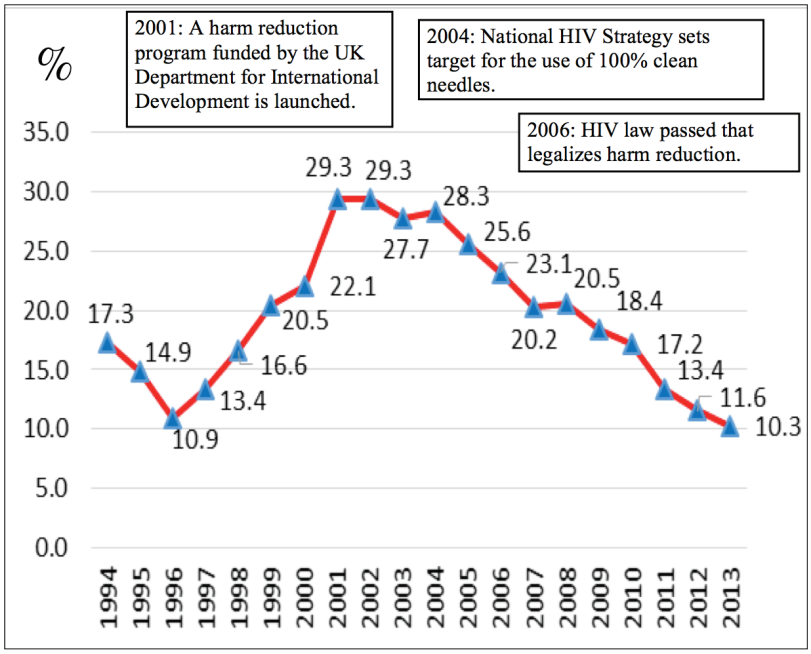
COMPREHENSIVE SERVICES FOR PWID IN CASE STUDY COUNTRIES

In 2009, the WHO, in collaboration with UNAIDS and UNODC, published guidance defining a comprehensive package of HIV prevention, treatment, and care interventions for PWID that has been endorsed by agencies throughout the UN system, the Global Fund, and PEPFAR.[10] The WHO emphasized interventions that have been scientifically proven to be effective in preventing HIV infection and reducing other drug-related harms, when deployed in combination. It urged countries to prioritize the implementation of needle and syringe programs (NSPs) and opioid substitution therapy (OST), both of which specifically target PWID, but also to ensure that drug users have access to other interventions in the package, particularly HIV counseling and testing (HCT) and antiretroviral therapy (ART).

Although there is gradually increasing recognition of the imperative to address the HIV epidemic among PWID, progress is slow. In 2014, 158 countries reported injecting drug use, but only 90 had some form of NSP and only 80 provided OST, though these numbers reflect a slight increase in coverage from 2012.[11]

Countries that have implemented strong harm reduction programs targeting PWID have seen dramatic drops in their HIV epidemics. For example, while it is not possible to demonstrate causation, the Vietnam case study illustrates that the scaling up of harm reduction programs and favorable policy changes coincided with a sharp decline in the annual proportion of newly diagnosed HIV cases among PWID, from 87% in 1993[12] to 42% in 2013.[13] As shown in Figure 1, HIV prevalence among PWID also declined steadily, after a period of increase, from 29.3% in 2001 to 10.3% in 2013.[14]

Figure 1: HIV Prevalence Among Injecting Drug Users in Vietnam, 1994–2013



COMPREHENSIVE PACKAGE OF SERVICES FOR PWID

The WHO, UNODC, and UNAIDS have outlined a Comprehensive Package of Services[15] to assist PWID who have HIV or are at risk of infection.[16] The package has been endorsed by both PEPFAR and the Global Fund. The WHO emphasized that the interventions were recommended based upon scientific evidence of their efficacy in preventing HIV infection and reducing other drug-related harms. The WHO has also noted that the interventions were most effective when deployed in combination. The Comprehensive Package includes:

1. Needle and syringe programs (NSPs)
2. Opioid substitution therapy (OST) and other evidence-based drug dependence treatment
3. HIV testing and counseling (HTC)
4. Antiretroviral therapy (ART)
5. Prevention and treatment of sexually transmitted infections (STIs)
6. Condom distribution 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)

HIV Care and PWID

PWID frequently face discrimination when seeking healthcare and HIV prevention services, and PWID who are HIV positive are far less likely to receive ART than others living with HIV due to beliefs that they are unable to use ART effectively because of their drug use. For those who do receive treatment, maintaining adherence is often impeded by law enforcement or incarceration, reducing treatment effectiveness and compromising viral suppression.

Kenya: Key informants report that PWID who attempt to get assistance from hospitals, health centers, or even members of their communities are often ignored or mistreated. According to a civil society organization (CSO) working in Ukunda, when health centers discover a patient is a drug user they do not even allow the patient in, much less treat him or her. *"I have been to the hospital several times but they refused to treat my wound [abscess], claiming that it is a waste of time. So now I get the wound attended to by outreach workers doing their rounds every morning who look at it and dress it afresh if necessary."* (PWID, Kenya)

> "You have to think about how the person will respond to you. Maybe they will say you are an imbecile because you inject yourselves, or they say 'get out' or 'sit down there.'"
>
> — Male PWID, Nigeria

Kyrgyzstan: Key informants report that doctors initiate ART based on the perceived ability of a person to adhere to treatment. They note that active drug users are often not started on treatment, regardless of their CD4 count, unless they are enrolled in OST programs.[17]

Nigeria: Key informants note that many people who use drugs prefer disclosing their HIV status rather than revealing their drug use to a healthcare provider.

Gender-Sensitive HIV Services for PWID

While in many countries the prevalence of injecting drug use among males far exceeds that among females, the risks and needs of female PWID often differ from those of men—and vary depending on cultural and social context—and their rates of HIV infection are often higher than among their male counterparts. Women who use drugs often suffer discrimination both because of their gender and their drug use, and drug use is often more highly stigmatized among women than among men. Both may impact their ability or willingness to access health services and may increase their risk for HIV.[18]

Female PWID often rely on their regular sexual partners for injections, drugs, and supplies, which may increase their risk of injecting with contaminated equipment. Women who use drugs are more likely than men to provide sex in exchange for housing, sustenance and protection.[19] Violence and the threat of violence in relationships also add to the vulnerability of many female PWID, who may have difficulty insisting that their partners wear condoms.[20] Moreover, counseling related to condom negotiation skills and other reproductive health issues and services is often neglected in harm reduction programs, and gender-specific harm reduction outreach and support groups for women are rare.

Female PWID face many specific challenges related to their reproductive health and childcare.[21] They often lack evidence-based information on drug use and drug dependence treatment during pregnancy. Female PWID are often told that they cannot have healthy babies and are encouraged to have an abortion by medical personnel.[22] Harm reduction and drug treatment services are directed primarily toward men, and most existing drug treatment services do not make any provisions for childcare.[23] Women who leave their children to enter rehabilitation sometimes lose custody, which also stops many women from entering treatment.

Kenya: Key informants reported that due to cultural and traditional beliefs, women often do not disclose their drug use to their families, which can impede their treatment.

Kyrgyzstan: Due to the fact that the vast majority of PWID are men, harm reduction and drug dependence treatment services are largely tailored to male PWID and often lack simple measures that could make these services more attractive to women. A separate room for female PWID in rehabilitation centers would afford them a measure of privacy, for example, and separate hours for women would enable them to freely discuss personal issues.[24]

> "I have worked with several female PWID who have kept their conditions secret from their spouses and families. This has meant that they drop out of treatment from time to time."
>
> – Outreach worker, Kenya

Scarcity of Patient-Competent Services

Beyond stigmatizing attitudes of medical providers toward PWID, systemic barriers such as inconveniently located healthcare facilities, insufficient confidentiality protections, and the need to navigate complicated bureaucratic procedures further diminish the chances of accessing testing and treatment.

Kyrgyzstan: In Kyrgyzstan, long travel times to reach treatment facilities or limited service hours serve as obstacles to care. *"The services exist, but they are not conveniently located—a pregnant woman with kids will not travel from Bishkek to Chuy Oblast TB hospital for TB screening, even if it's free. Meanwhile, HCV diagnosis and treatment are too expensive, and average Kyrgyzstani citizens can't afford them."* (NGO representative, Kyrgyzstan) Moreover, the Kyrgyz Republic has mostly separate, vertical systems for TB, AIDS, and drug treatment—a legacy of the Soviet system. In 2013, with support from the Global Fund and PEPFAR, several "one-stop," integrated TB, HIV, and OST service points were opened to improve adherence to treatment among PWID.

THE IMPORTANCE OF IDENTITY DOCUMENTS

In many countries, lack of identification poses a substantial barrier to obtaining healthcare—in some instances for citizens as well as undocumented persons. In Kyrgyzstan, an identification document—which many PWID lack—is required to access many government services, including, until recently, HIV treatment.[25] The process of obtaining an ID is complex—the application requires the submission of 13 different accompanying documents, each approved by different government authorities. One required document is a residence registration (прописка), which can be difficult to obtain for those who do not own property.

Complicating matters further, when people are arrested their identity documents are confiscated. While they are supposed to be returned upon release, in reality this rarely happens—a vestige of the Soviet system wherein ex-prisoners were given a release certificate in lieu of their identity documents, which helped authorities track them after release and control their employment and benefits. In some instances, people pawn their identity documents to obtain cash.

In June 2013, as a result of persistent advocacy on the part of non-governmental organizations (NGOs), the Kyrgyz Ministry of Health issued a decree permitting homeless persons (and others lacking identity documents) to receive healthcare services with only a certificate from a social service organization (справка), such as a drop-in or rehabilitation center. While this novel approach may reduce the barriers to obtaining HIV prevention and treatment for many PWID who lack identity documents, its implementation has been slow across the country, as officials must be trained on the new procedures.

Nigeria: In communities where both people who use drugs and people living with HIV are severely stigmatized, confidentiality is an important concern. For example, some PWID say they do not trust service providers to keep their HIV status and drug use confidential. While they would prefer attending private clinics, such centers are inaccessible to most PWID due to their high cost.

Ukraine: Even in Ukraine, where OST programs were scaled up in recent years, rigid bureaucratic procedures, lack of incentives for physicians to provide these services, pressure from the police, short operating hours, inability to get take-home naloxone to prevent overdose or methadone by prescription, and the requirement to register as a drug user in order to access OST services are serious barriers to care.

Vietnam: Although Decree 96 (2012) removed many administrative barriers to accessing methadone (such as the requirement for a referral from local authorities), some challenges remain. These include requirements that patients present identification papers, which some drug users don't have, and inform local authorities of their addresses.[26]

NATIONAL GOVERNMENTS' COMMITMENT TO ADDRESS HIV AMONG PWID

The extent to which governments acknowledge, let alone prioritize, the need for harm reduction services among PWID varies greatly around the globe. Moreover, rhetorical promises do not always translate into action—in Ukraine and Kenya, for example, commitment to harm reduction in strategic planning documents has not translated into funding for programs.

Ukraine: HIV prevalence among PWID has declined significantly, and the Ukrainian parliament adopted amendments to its HIV Prevention and Social Protection law in December 2010, committing the state to "reduce HIV transmission through harm reduction, which among other interventions, includes the use of substitution therapy for people with drug dependency and creation of enabling conditions for needle and syringe programs."

Kyrgyzstan: Both the new State Programme on Stabilization of HIV Epidemic in the Kyrgyz Republic and the Public Health Reform Programme Den Sooluk for 2012–2016 view HIV prevention among key populations as a public health priority. The National Anti-Drug Concept of Kyrgyzstan also endorses scientifically proven HIV prevention programs for PWID as a critical part of tackling the HIV epidemic.

> "By definition, as an OST patient, I can't drive. If I weren't on OST, I'd have to get off the registry to get a driver's license. This is one of the reasons why so many drug users don't want to start OST. Because they can't avoid the registry."
>
> – NGO representative, Ukraine

Nigeria: While the HIV/AIDS National Strategic Plan 2010–2015 established a goal of reaching at least 80% of most-at-risk-populations (MARPs), including PWID, with group-specific interventions by 2015, corresponding programmatic objectives focus only on increasing HIV prevention knowledge, correct and consistent condom use, and access to HIV counseling and testing—and omit harm reduction interventions.[27]

Kenya: The government began to take steps to address HIV prevention needs among MARPS, including PWID, with the 2009 Kenyan National AIDS Strategic Plan (KNASP III).[28] In 2011, the National AIDS Control Council (NACC) announced a plan to provide free HIV prevention and treatment for PWID, including previously disallowed harm reduction programs, such as needle and syringe programs.

Vietnam: The National AIDS Program adopted a strategy of providing sterile needles for drug users in its 1996–2000 plan; however, implementation was impeded by drug control policies and the total absence of policies supportive of harm reduction.[29] In 2003, the first National AIDS Strategy framed 100% clean needles and syringes for PWID as one of its objectives, but without the power to counter the Drug Control Law, its effect was also limited.[30] Not until the 2006 HIV/AIDS Law were harm reduction interventions—including needle and syringe distribution and OST—effectively legalized, ushering in a dramatic scale-up of programs targeting PWID.[31] OST programs were piloted in Hai Phong and Ho Chi Minh City in 2008, and more provinces have since joined the program.

HARM REDUCTION FINANCING: RELIANCE ON INTERNATIONAL DONORS

In most low- and middle-income countries, financing for national HIV programs comes from a mix of national and international sources (including multilateral, bilateral, and sometimes private donors). International donors more commonly support services for key populations, including PWID, than national goverments do.

Kenya: The 2009 Kenya National AIDS Strategic Plan (KNASP III) estimated that full funding for HIV programs would require $3.56 billion over a four-year period. Yet, even under the "full-funding" scenario, the plan allocated only $1 million per year for HIV prevention among PWID, and only in 2012–2013, when the total annual HIV budget was estimated to exceed $1 billion—the equivalent of 0.01%.[32]

Kyrgyzstan: In 2013, HIV spending was $17.6 million, with the Global Fund providing 57% of the total (including 55% of funding for HIV prevention among PWID), and the government covering only 23%. The majority of government staff involved in HIV prevention work among PWID is fully funded by international donors, which suggests that increased reliance on national funding may threaten both non-governmental organizations and government-provided prevention programs. Key informants expressed grave doubts that the government would pick up and maintain HIV prevention measures if international donors withdraw, noting that the Ministry of Health underestimates the role of NGOs in the provision of health services for PWID.

Nigeria: In 2010, total HIV spending amounted to $497 million, of which international donors, including PEPFAR, the Global Fund, and the World Bank, provided 75%.[33] Almost none of this amount (only 0.11%) was specifically allocated to programs targeting MARPs.

Ukraine: The PWID effort has been funded almost entirely by international donors. The Global Fund has been the single most significant source of funding for HIV programs for PWID since 2003, and has been instrumental in creating a vibrant network of more than 120 people living with HIV (PLHIV) and PWID-run NGOs that provide nearly all HIV prevention services to PWID in Ukraine.[34] In contrast, the bulk of national funding to date has gone towards supporting the cost of ART.

Vietnam: Like Ukraine, Vietnam's scale-up of harm reduction programs has been financed almost completely by international donors. Between 2008 and 2010, international donors provided 72.5% of a total of $363 million in HIV program funding. Of the total, 32.4% was spent on prevention, and 26.6% of that amount was directed toward MARPs.

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)

PEPFAR's current goals include "expanding its emphasis on HIV prevention and matching interventions and investments with epidemiological trends and needs in order to improve impact." This would be a welcome change if taken to mean the provision of additional resources targeting PWID, which to date have proved disproportionately low. For example, in an analysis of FY2009 PEPFAR funding, of more than $1 billion approved for prevention activities, only $17.9 million (<2%) targeted injecting and non-injecting drug users.

PEPFAR AND NEEDLE AND SYRINGE PROGRAMS (NSPs)

For its first six years, PEPFAR adhered to the Congressional ban on federal funding for NSPs, even though the ban did not include international programs, likely based on concerns that funding needles might harm bipartisan support for PEPFAR and an understanding that Congress has the authority to approve or deny all foreign assistance funds. While the NSP funding ban was temporarily lifted in 2009, PEPFAR did not issue guidelines to support NSP programs in its "Comprehensive Guidance for HIV Prevention for People Who Inject Drugs" until July 2010. The guidance strongly endorsed NSPs and represented a substantial improvement in the federal government's global response to HIV among PWID.[35] After changes in Congressional leadership occurred as a result of the 2010 mid-term election, Congress reinstated the ban, this time explicitly including international programs. Given the well-established scientific support for NSPs, **we urge the leadership at the Office of the U.S. Global AIDS Coordinator (OGAC) to explain how PEPFAR country teams are proactively working with partner governments and civil society to support and advocate for comprehensive programs for PWID.**

‡ China, Georgia, Indonesia, Kazakhstan, the Kyrgyz Republic, Russia, Tajikistan, Ukraine, and Vietnam
§ Cambodia, Kenya, South Africa, and Tanzania

As of FY2009 in Malaysia and 13 PEPFAR countries (nine with concentrated HIV epidemics among PWID‡ and four with heterosexually driven epidemics, but where HIV among PWID has recently been reported§), only an estimated 10% of PWID accessed NSPs, and those who did access them received an average of only 83 needles per year —fewer than half of the 200 needles recommended by the WHO to control HIV infection.[36] Only 3.3% of PWID received OST, and only 4% of HIV-positive PWID received ART. Collectively, these countries are home to an estimated 5.3 million PWID (of whom 60% inject opiates), one-third of the world's total. At least 800,000 are estimated to be living with HIV.[37] By FY2013, of more than $1 billion approved for prevention activities, only $25.7 million (<3%) targeted injecting and non-injecting drug users.[38]

An analysis of PEPFAR Country Operational Plans (COPs) for the two years immediately following reauthorization in 18 PEPFAR countries (representing nearly two-thirds of PEPFAR funding and approximately 60% of the global population of people living with HIV) showed that countries where the epidemic is driven primarily by transmission among men who have sex with men (MSM) or PWID received on average $235 million less in FY2009 and FY2010 than countries with widespread epidemics among the general population.[39] Among case study countries:

Kenya: Kenya's 2013 PEPFAR COP budgeted $275 million ($490 million with pipeline funds**), of which approximately $4.5 million (1.6%) was allocated to prevention among PWID—out of a total prevention budget of $92.9 million. For the first time in Kenya, the 2013 COP proposed providing OST sufficient to reach 15,000 people.

Kyrgyzstan: The 2013 Regional Operational Plan (ROP) for the Central Asia region (CAR) includes Kyrgyzstan, but does not report disaggregated funding by country. Total PEPFAR funding allocated for prevention among PWID in the CAR ROP was $4.16 million, representing 71% of total prevention funding and 30% of total PEPFAR funding. This includes funds to support the region's governments in improving the availability, coverage, and quality of HIV services for PWID and incarcerated populations; mapping HIV health services for PWID; and providing prevention services to PWID and their sexual partners.

Nigeria: In 2013 alone, PEPFAR committed $458.6 million to funding HIV programs in Nigeria, of which $96.7 million was directed to prevention.[40] Of that amount, none was specifically allocated to support PWID activities.[41] The 2013 COP noted that a focus on prevention for MARPs "has begun to result in a full range of program activities, specifically SW [sex workers], MSM, and PWID." When the PEPFAR team was asked during a presentation of its 2014 COP strategy why it would target PWID but fail to provide harm reduction interventions, the response was that PEPFAR only supports programs consistent with the national plan.

Ukraine: PEPFAR is currently supporting two new flagship projects in Ukraine. The first, RESPOND, is aimed at building the capacity of organizations to deliver client-centered case management to improve retention of PWID in OST programs and create an enabling environment for the introduction of OST into primary care clinics. The second five-year project (2013–2018), Health Systems Strengthening for a Sustainable HIV/AIDS Response in Ukraine (HSS SHARE), focuses on transitioning the government from donor funding to greater country ownership by optimizing resource allocation and increasing financing for the national and selected regional HIV/AIDS programs targeting key populations.

Vietnam: PEPFAR support has been instrumental in the country's scaling up of OST programs. The FY2013 PEPFAR COP provided a total of $69.8 million, of which $20 million (28.6%) supported prevention. This included $10.5 million (14.4%) targeting PWID, of which about $4 million supplied patients at various treatment sites with OST.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

Although the Global Fund has maintained unambiguous support for harm reduction programs since it was established, recent changes to its funding approach may uniquely disadvantage additional scale-up of harm reduction programs where they are most needed, and possibly jeopardize existing programs. To date, the Global Fund has been the largest funder of harm reduction services in the world.[42] Between 2002 and 2014 (from its inception until the launch of its New Funding Model), the Global Fund allocated $620 million for services targeting PWID, of which two-thirds was dedicated to the UN comprehensive package of HIV services for PWID.[43]

In 2013, following a record $12 billion in pledges from donor countries, the Global Fund inaugurated its New Funding Model, which allocates funding to countries based on gross domestic product (GDP)—via income categorizations provided by the World Bank—and national

** In some instances, PEPFAR encounters significant challenges, especially in countries with poor infrastructures when funding isn't absorbed as quickly as planned. As a consequence, the program accumulates unspent "pipeline" funds, which are ultimately spent in subsequent years. In mid-2012, total unspent PEPFAR funds exceeded $1.46 billion, including $502 million in Kenya alone. Thus, for any given year, some PEPFAR countries have one amount of funding allocated for that year and a larger amount that is intended to be spent that year (the allocated amount plus accumulated pipeline funds). In some instances, the difference between these two amounts can be substantial. For example, in Kenya in FY2013, PEPFAR allocated $275 million, but also budgeted an additional $215 million in pipeline funds, for a total of $490 million.

disease burden. However, advocates have warned that this approach poses a significant risk to further scaling-up of harm reduction programs. The country-level measurements are blunt instruments that may not account for concentrated epidemics or wealth inequalities within countries, and the ability of a country to pay for services for key populations rarely translates into a willingness to pay for these services from domestic funds. Most PWID—and indeed most low-income people and most people living with HIV—live in middle-income countries. While such countries are presumed to be able to afford additional national investments, it remains highly doubtful that they are politically prepared to replace donor funding for harm reduction with national funding. In addition, several middle-income countries may experience significant shortfalls as Global Fund grants expire in 2015 and 2016, and are not renewed.[44]

In the meantime, the Global Fund's policy commitment to harm reduction remains strong. The New Funding Model requires that 50% and 100% of funding for lower- and middle-income countries, respectively, target underserved and most-at-risk populations. The Global Fund also "strongly recommend[s]" that countries with reported HIV transmissions associated with sharing of injection equipment include harm reduction interventions in their funding proposals, as well as activities that improve the legal and policy environment to ensure that PWID can access Global Fund services. And it "strongly recommend[s]" that the Country Coordinating Mechanisms (CCM) that oversee Global Fund grants include the PWID community in country dialogues, project design, development, and program implementation and oversight.

Kenya: Kenya included harm reduction activities in its Global Fund HIV grants from Round 7 (2007) and Round 10 (2010). The Round 10 grants are worth up to $48.9 million for the Kenyan Red Cross and $363.4 million for the Ministry of Finance—of which an estimated $8.9 million has been budgeted for PWID. The grant, in part, supports the scaling up of Kenya's nascent NSPs, which to date have been funded by the Dutch government and other donors, with the objective of reaching 80% of PWID.

Kyrgyzstan: The country included harm reduction activities in its Round 2 (2003), Round 7 (2007), and Round 10 (2010) Global Fund HIV grants—with an estimated total of $20.3 million invested for PWID. The Round 10 grant (managed by UNDP) is worth a total of up to $29.4 million from 2011 to 2015, and supports the promotion of prevention, treatment, and care services for HIV among "vulnerable populations in the Kyrgyz Republic"—including MSM, female sex workers (FSW), PWID, and prison populations—and establishes OST in prisons for the first time.

Nigeria: Despite being approved for more than $658 million in HIV funding since 2002, the Nigerian CCM has failed to include any core harm reduction services for PWID. The three active Global Fund HIV grants support allocations for MARPs, which technically include PWID, though without specific allocations. For example, of the $46.1 million committed to a Society for Family Health grant, about $11 million is earmarked for MARPS, of which 17% is reported as being spent on HIV prevention—mainly condom distribution and information, education, and communication—among people who use drugs, including both injecting and non-injecting drug users.[45]

Ukraine: The country has by far the largest amount of Global Fund HIV grant funds invested in harm reduction—with an estimated $125 million budgeted through grants in Round 1 (2002), Round 6 (2006), and Round 10 (2010). The three Round 10 grants contained the comprehensive package of services including NSP and OST. Now, with Ukraine classified as an upper-middle-income country under the New Funding Model, the concern is that the country will receive sharply reduced grant awards.[46] The government is expected to assume responsibility for OST in 2015 and for other HIV prevention activities in 2017.[47] Program managers are bracing for a halt in the scale-up of OST, along with other programs targeting PWID, as the government has historically been reluctant to invest in harm reduction programming.[48]

Vietnam: Vietnam has included harm reduction in its Global Fund HIV grants from Round 1 (2002), Round 6 (2006), Round 8 (2008), and Round 9 (2009)—and currently has one active grant for up to $125.6 million from 2011 to 2015. The grant's principal recipient is the Vietnam Administration of HIV/AIDS Control, and it is intended to support the implementation of core priorities, including harm reduction for PWID, condom use promotion for FSW and MSM, and care and support for PLHIV. In previous grants, funding has also gone into compulsory drug detention centers in Vietnam—but following calls from the UN for their closure and a decision by the Global Fund Board to cease all such funding, these investments have since been allocated to evidence-based treatment programs targeting the PWID community.[49] ††

CIVIL SOCIETY REPRESENTATION OF PWID

The participation of civil society in planning, implementation, monitoring, and evaluation has been a hallmark of effective HIV programs since the beginning of the epidemic. Accordingly, many

†† The grant values quoted above refer to the total amount agreed upon between the Global Fund and the principal recipient (PR) at the time of the grant's signing. Total disbursements to date are not included. Only the most recent grants for each country (usually awarded as part of Round 9 or Round 10 proposals) are referenced.

international donors have prioritized civil society participation as a condition of development aid. Nonetheless, the definition of civil society is fluid, and the extent to which PWID are effectively represented within civil society often depends on the country or region. By definition, civil society is not monolithic—often including such disparate partners as academia, business, faith-based organizations, and NGOs—and frequently mirrors tensions evident in society at large. With respect to PWID, the question of civil society representation is paramount—as civil society is often officially charged with representing the needs of PWID and other key populations.

Kenya: Civil society groups representing PWID have emerged, a number of which have outreach workers who are themselves recovering drug users and contribute to the design and implementation of programs. The Kenya National Guidelines for the Comprehensive Management of the Health Risks and Consequences of Drug Use were developed with full participation and input from civil society organizations.

Kyrgyzstan: Kyrgyzstan has a well-developed NGO sector, out of which has emerged a large number of capable and dedicated service providers. There is also a network of NGOs with excellent advocacy and community mobilization skills, and many of these organizations regularly participate in HIV policy and decision making at the national level.

Ukraine: Ukraine has a vibrant civil society sector, with NGOs, PLHIV, and PWID activists broadly involved in the planning, implementation, and monitoring of Global Fund programs and the National AIDS Program. Most AIDS service NGOs include PLHIV, and many are run by former PWID. There is an active Association of Substitution Treatment Advocates of Ukraine (ASTAU) representing the needs of the OST community.

Vietnam: Vietnamese AIDS authorities have never organized consultations with civil society for HIV programming. The situation improved slightly in 2013 with the participation of a civil society representative on the National Committee for AIDS, Drugs and Prostitution, though this committee is oriented more toward policy making than program planning. In the broader civil society context, PWID participation has been stronger. The Vietnam Network of People Who Use Drugs (VNPUD) was officially launched in December 2012 and currently has 57 member groups in 20 provinces.

Civil Society Participation in PEPFAR Program Planning

While in-country PEPFAR administrators are required to solicit civil society input in the development of COPs and to report the input received and its disposition both to OGAC and civil society,[50] experience in the development of 2014 COPs varied considerably from country to country.

Kenya: Key informants reported that in the most recent COP development process, civil society's participation was minimal, as many groups never learned of the process and were not invited to participate.

Kyrgyzstan: PEPFAR conducts semiannual meetings with civil society representatives to discuss plans and share progress. Civil society representatives credited PEPFAR with paying greater attention than other donors to the involvement of national stakeholders in the design of new programs and tailoring them to the needs of local key populations.

Nigeria: Key informants reported that the development of the 2014 COP was almost entirely disengaged and not open to input from community members or primary CSO networks.

CASE STUDY: PEPFAR IN UKRAINE

While the PEPFAR team in Ukraine has more effectively consulted civil society than its colleagues in other countries, key informants offered suggestions for improvement. Some pointed out the tendency on the part of USAID to award large-scale grants to U.S.-based organizations with limited—or no—in-country experience, which was felt to undermine the ultimate goal of building local capacity, as well as impose comparatively greater costs due to large overheads. There was also a sense that many PEPFAR decisions were, in fact, pre-determined. *"When it comes to PEPFAR, you get a request for applications, and the goals and objectives of the project are already defined. But it's not always clear how these goals were defined and who decided that they were a priority for the country. Then they solicit applications and select future implementers."* (Global Fund implementer, Ukraine)

Key informants also suggested that a more systematic process of consulting with PWID communities in the planning stages of PEPFAR-funded programs would be desirable. *"PWID are engaged at the level of project coordination, but I doubt that they are included in project planning."* (PEPFAR implementing partner, Ukraine)

> "I think PEPFAR gets so busy that they often forget to engage with community members. They make their decisions with people they choose to work with and that is all—no broad consultation."
>
> — Program staff member, Nigeria

Ukraine: In developing the 2014 Ukraine COP, the PEPFAR team held a series of meetings with three national NGOs and solicited feedback on challenges and opportunities. Prior to the meeting, PEPFAR disseminated a concept note for discussion. There was also an opportunity to submit recommendations following the meeting, and the PEPFAR team circulated a revised draft requesting additional comments.

Vietnam: PEPFAR has convened only one civil society consultation in Vietnam since its inception, and of all key informants, none were aware of the COP process or had been consulted. Many didn't even know of the COP's existence.

Civil Society Participation in Global Fund Program Planning

While civil society involvement has been a priority for the Global Fund since its inception, the experience varies widely among countries, and the extent to which the Global Fund can mandate effective civil society participation remains an open question.

Kenya: Two elected civil society representatives have seats on the Kenyan Coordinating Mechanism (KCM) and also sit on the National Oversight Committee, which is comprised mainly of government representatives and donors. The primary civil society representative, the Kenya AIDS NGOs Consortium (KANCO), is a national membership network of NGOs, community-based organizations (CBOs), faith-based organizations, private sector actors, and research and learning institutions. However, there are diverging views about the extent to which KANCO effectively represents community stakeholders.

Kyrgyzstan: Civil society comprises 40% of Global Fund CCM members and has been actively involved in the preparation of country proposals, as well as in the implementation, monitoring, and evaluation of Global Fund grants. UNDP, the current Global Fund principal recipient, conducts annual and semiannual meetings with NGO representatives to discuss achievements and opportunities for further improvement. Some key informants felt that using the CCM only to coordinate and monitor Global Fund activities did not fully capitalize on its expertise, and urged that other donor agencies consider engaging the body. At the local level, the picture is different. Many PWID community members don't feel involved in decision making, and a majority of NGOs based outside of population centers (e.g., Bishkek city and Chui oblast) felt the need for better communication among national NGO representatives, including the CCM.

Nigeria: Representation of PWID in Global Fund processes in Nigeria has been poor, partly due to the lack of a viable PWID network, unlike those representing sex workers and MSM. Moreover, there is presently no official MARP representation on the CCM, though at least nine members are drawn from the NGO/CSO sector, and key informants reported that the CCM rarely discusses MARPs or issues affecting them.

Ukraine: The International HIV/AIDS Alliance and the All-Ukrainian Network of People Living with HIV, both Global Fund principal recipients, are key partners in the planning and development of the National AIDS Program. Within the CCM, the NGO sector is represented by the Coalition of HIV Service Organizations. There is currently no official PWID representation on the CCM. At the local level, PWID participate in local coordination councils on HIV/AIDS, but as heads or members of AIDS service or harm reduction NGOs rather than PWID representatives—which is seen as a more strategic way to advance their objectives.

Vietnam: Civil society representation on the CCM has been poor. In the first CCM, key populations were represented by a single PLHIV, who was further disadvantaged by the meeting format. The new CCM, elected in June 2014, includes a significant number (14) of democratically elected representatives of local NGOs, PWID, MSM, sex workers, PLHIV, and TB patients. Vietnam also received technical support from the Global Fund to increase civil society participation in the New Funding Model, and new CCM members were provided with training and opportunities to strategize.

"To be fair, it is very difficult for us to participate. Documents are usually sent right before the meeting or distributed on the spot. There is lots of paper to read in small font, and the language is very difficult to understand sometimes. Many times even I have felt like 'a duck listening to the thunder' [i.e., not understanding what is going on], not to mention a person living with HIV who may not be used to such a setting and language."

— Global Fund CCM member, Vietnam

STIGMA, DISCRIMINATION, AND INCARCERATION

In the global response to drugs, resource allocation may be based upon many factors other than epidemiology. Disparities in resource allocation often reflect a deep, culturally ingrained stigma associated with marginalized populations and drug use. The Global Commission on Drug Policy, which is comprised of international experts including many ex-heads of state, argues that global drug policy fuels the HIV epidemic by: 1) driving at-risk drug users away from public health services, increasing HIV risk behaviors; 2) denying interventions known to be effective through restrictions on the provision of sterile syringes or opioid substitution therapies; 3) increasing risk among entire communities through policies that result in mass incarceration; 4) disrupting or preventing HIV testing and access to ART, resulting in more transmissions; and 5) distorting public policy responses, wasting scarce public resources, and starving public health programs by ignoring evidence-based interventions.[51]

The Criminalization of Drugs and People Who Inject Drugs

The threat of arrest, prosecution, or abusive treatment forces drug users away from health services and into dangerous environments. Criminalization of drug users is widespread, with laws prohibiting possession and/or use of controlled substances and paraphernalia (e.g., syringes, crack pipes, foil for smoking heroin, etc.), which makes drug users an easy target and creates a climate in which aggressive enforcement can lead to human rights abuses. Drug users are often subject to arbitrary detention, unfair trials, torture, or other harassment. The enforcement of paraphernalia laws encourages the use of needle sharing, increasing the risk of blood-borne infections, including not only HIV, but also hepatitis B and hepatitis C.[52] In many cases, laws against the "incitement," "encouragement," or "aiding and abetting" of drug use are used against friends and families of drug users, and sometimes against service providers as well.[53] These laws undermine the WHO's recommendation that "countries should work toward developing policies and laws that decriminalize injection and other use of drugs."[54]

Kenya: The Kenyan Narcotic Drugs and Psychotropic Substances (Control) Act imposes hefty penalties and jail terms for possession of drugs, even for personal use. Police have historically treated drug users harshly and denied them police bail/bond while under arrest and during the pre-trial period. In a study undertaken by UNODC, 31% of PWID respondents from Nairobi and Mombasa reported that police or other authorities had confronted them in the past six months, with some having had their drug equipment confiscated.[55] Workers from a drug treatment center noted that because Kenyan law also criminalizes being found in an area where persons are likely to resort to drug use, even outreach workers and those seeking to offer assistance to drug users risk criminal prosecution. As a result, when health workers go out to provide HIV testing and counseling services, they often avoid areas where drug use is prevalent for fear of being arrested. *"In March 2014, two of our outreach workers were arrested while doing their work on charges of being in an area where persons are likely to resort to drug use. One of the outreach workers spent the night in a police cell and was only released the next morning after the office intervened."* (NGO representative, Kenya) In addition, legal stigmatization of drug users combined with police indifference can encourage so-called 'mob justice.'

"Here in Malindi in December 2013, five PWID were lynched in a span of one week by members of the public who suspected them of petty theft."

— NGO representative, Kenya"

Kyrgyzstan: While drug use has been decriminalized in Kyrgyzstan, possession, storage, production, and transportation of small amounts of drugs are still considered offences, and may lead to payment of a fine or incarceration from five days to four years.[56] "Small amounts" equal an average daily dose of drugs—up to one gram of heroin, three grams of opium, or 20 grams of marijuana.[57] In some instances, local lawyers report that police have

used withdrawal syndrome as torture to compel PWID to confess to crimes they didn't commit.

Nigeria: The Nigeria Drug Law Enforcement Act (NDLEA, 1989)[58] criminalizes the possession and use of illicit drugs, and convicted offenders are subject to imprisonment for 15–25 years. Although people are infrequently sentenced for drug use (as opposed to possession), people who use drugs are routinely arrested, and harassment, extortion, torture, and detention of drug users by law enforcement is common. In some instances, outreach workers reported being arrested alongside PWID during police raids of drug user communities. *"Can you see my hands; can you see the wounds and scars? I was beaten with all manner of things. It is a lie if they say they don't arrest us, or that when they arrest us they just release us."* (Female PWID, Nigeria)

> "The law enforcement agents sometime visit the bunks to harass, arrest, and chase the drug users, or to collect bribes from them, which doesn't help in the provision of services."
>
> — PWID program implementer, Nigeria

Ukraine: Police surveillance of harm reduction NGOs, as well as harassment of OST clients and providers, serves as a disincentive to using harm reduction services.[59] In 2010, the legal threshold for "small," "large," and "extra-large" quantities of drugs was reduced (in the case of acetylated opium, by 20 times to 0.005g), effectively making outreach workers or clients criminally liable for the residue found in a used syringe. Available data indicate that since this policy went into effect, the number of needles collected through needle and syringe programs has gone down, presumably because many programs have stopped collecting used syringes due to fear of criminal prosecution of outreach workers and clients for illegal drug possession.[60]

Vietnam: Since the founding of the Democratic Republic of Vietnam in 1945, the use of opium and later many other drugs has been banned. In the last 15 years, Vietnam has witnessed many changes in the way drug users are treated. By law, drug users are given the opportunity for community-based rehabilitation. In practice, however, many civil sanctions resemble criminal penalties, including detention (see text box, p.14). Although needles are sold widely and inexpensively, in some provinces PWID are discouraged from purchasing them because police wait at pharmacies to arrest them after they make their purchase.

> "In my place, needles are cheap, only 2,000 dongs [10 cents], so the cost is not a problem. The problem is that sometimes police 'ambush' and arrest us at pharmacies."
>
> — Civil society representative, Vietnam

It should be noted that in some countries police have collaborated with PWID to develop approaches that meet the needs of both law enforcement and public health. In Kyrgyzstan, for example, civil society organizations worked with the Ministry of Internal Affairs in 2003 to instruct police to refrain from interfering with harm reduction programs, and civil society organizations and police worked collaboratively to monitor compliance. In 2009, the Police Academy launched a training module on harm reduction, sex work, and HIV that was developed jointly with harm reduction organizations. In 2015, police officers began carrying naloxone, a highly effective antidote to overdoses encountered in the course of their work.[61]

Drug Use, Incarceration, and Increased Risk for HIV

Globally, prisoners are at sharply higher risk for HIV infection than other PWID, owing to higher HIV prevalence in prisons, the dearth of harm reduction services, and the prevalence of risk-taking behaviors (e.g., tattooing, sharing syringes to inject drugs, and unprotected sex). HIV outbreaks in prison settings have been well documented. In 2002, for example, 263 prisoners in Lithuania's Alythus Prison were found to be HIV positive in the space of a few months. Previously, only 18 infections had been identified in the entire prison system and only 300 people nationwide were known to be living with HIV.[62] While WHO, UNODC, and UNAIDS guidelines call for the provision of harm reduction services in prisons,[63] only 10 countries maintain prison-based NSPs, while OST is available in prisons in only 40 countries.[64] Even when implemented, coverage is often extremely limited—as few as 1–14% of eligible prisoners are prescribed OST due to the pilot nature of most programs.[65]

In some countries, predominantly in Southeast Asia, drug "treatment" or "rehabilitation" equates to detention in centers that are indistinguishable from prisons. Such centers frequently employ forced labor and drills in the name of drug treatment, deny essential medicines, lack medical personnel, and impose involuntary HIV testing. In China, for example, individuals suspected of drug use are often committed for up to six years in drug detention centers where they receive no medical care and are confined under horrific conditions and experience abuses that

sometimes result in death.[66] A joint statement by 12 United Nations agencies noted: "There is no evidence that these centres represent a favorable or effective environment for the treatment of drug dependence."[67] In 2014, following a decision made by its Strategy, Investment and Impact Committee (SIIC), the Global Fund decided that it would no longer direct funds to compulsory drug detention centers as a matter of policy, and would instead advocate for the closure of such facilities.[68,69‡‡] Dismal conditions experienced by incarcerated PWID have been documented in case study countries:

VIETNAMESE DRUG DETENTION CENTERS

Until recently, many people who used drugs in Vietnam were subject to compulsory terms in government-run rehabilitation centers, where both adults and children ages 12–18 were held in a locked facility for one to four years.[73] There, they received detoxification followed by a period of highly disciplinary "rehabilitation" activities, often comprising forced labor. Subsequent relapses could result in a prison term of up to five years. By the end of 2012, the country had 107 compulsory centers, with a capacity of 65,000 people, in which 40,000 drug users were typically held at any given time. Even the government has acknowledged that relapse rates following community-based and center-based rehabilitation were as high as 90%.[74] Many drug users have served multiple terms. After pronounced international criticism, a 2012 law required a court decision—which in turn required consultation with a health professional—before drug users could be sent to compulsory drug detention centers. However, the procedure did not take effect until January 2014, and it is reportedly sufficiently complex that there is uncertainty about its effect.

Out of 107 detention centers, ART is available with support from the Global Fund in only 35, housing approximately 900 patients.[75] As of July 2014, the Global Fund discontinued funding ART in the centers following an agreement with the Ministry of Health that patients would continue to be treated with funding from the national program. In other centers, access to treatment depends on the willingness of the local AIDS program and center management.

Kenya: A study undertaken by UNODC found that a large majority (81%) of all PWID had been incarcerated.[70] About 7% had injected drugs in prison, and of those, 61% shared needles or syringes.

Ukraine: In 2012, 18% of the prison population had been convicted of drug crimes. In 2011, more than half of all drug crimes were related to possession for personal use.[71]

Vietnam: Though Vietnam's 2010 UNGASS report estimated HIV prevalence among prisoners at 30%, access to ART in prisons is extremely limited, and the total prison population remains unknown. In 2014, The Global Fund supported treatment in 18 prisons with over 1,100 patients, while PEPFAR was reportedly working with prison authorities to provide ART in five prisons with approximately 600 patients.[72]

Kyrgyzstan: Kyrgyzstan developed and implemented truly low-threshold, prison-based OST programs, with sufficient flexibility to transfer participants to other health institutions in case of sickness, with procedures to rely on relatives for OST dose administration in exceptional situations.

RECOMMENDATIONS

International Donors

- **In countries where international donors provide support, they should help ensure that HIV prevention and treatment services targeting PWID are consistent with scientific-evidence, scaled up, and sustained.**

In 2014, out of a total $20.2 billion in available funding for HIV/AIDS in low- and middle-income countries,[76] international donors provided almost half ($8.64 billion, or 42.8%),[77] of which approximately 65% was contributed by the U.S. through PEPFAR and contributions to the Global Fund.[78] Moreover, international donors provide the majority of support for programs targeting key populations, including PWID. As donors explore transitioning to "country ownership," meaning national governments take greater responsibility for financing and managing HIV programs, they should help ensure that programs serving PWID and other key populations are not compromised. In the context of diminishing resources, it is imperative that international donors collaborate to maximize HIV prevention and treatment programs. In particular, PEPFAR and the Global Fund should do more to prioritize services for key populations, including PWID. Finally, international

‡‡ It should be noted that the SIIC also decided that "the Global Fund may finance scientifically sound medical testing, treatment, treatment services, and treatment monitoring for detainees of such compulsory treatment programs of facilities in exceptional circumstances, such as ensuring access to life-saving treatment to detainees in voluntary, community-based treatment programs located outside of such facilities."

donors should track and report the extent to which their resources are allocated to marginalized populations, including PWID.

- *THE GLOBAL FUND:* **As the largest supporter of harm reduction services in the world, the Global Fund should ensure the sustainability of these critical programs, especially in middle-income countries. The Global Fund also has an obligation to ensure that its mandates for meaningful civil society involvement are effectively operationalized, particularly for marginalized populations, including PWID.**

As many middle-income countries face the prospect of a potential decrease in funding from the Global Fund in the coming years, significant concerns have arisen about whether national governments will sustain harm reduction programs without this support. It is imperative that the Global Fund work to develop a clear and responsible policy for ensuring sustainability and preventing the collapse of these programs as countries transition to greater ownership of their HIV/AIDS programming. Such a policy should emphasize gradual transitions, be mindful of contextual country-specific challenges, and facilitate the increased inclusion of PWID in program planning and monitoring.

- *PEPFAR:* **As the single largest funder of HIV programs in the world, PEPFAR should immediately scale up harm reduction services in proportion to the scope of the epidemic in countries in which it operates. While the program is barred by Congress from purchasing syringes, it should do far more to expand access to the supportive services provided by NSPs, and to coordinate with other donors—such as the Global Fund and other bilateral programs—that can purchase syringes.**

While PEPFAR has been enormously effective and has changed the landscape of the global HIV epidemic, the program cannot achieve its vision until program data demonstrate significantly increased resource allocations to programs that address the HIV epidemic among PWID.

PEPFAR also needs to do more to live up to its commitment to consult with affected communities in the planning of HIV programs, particularly individuals with a history of injecting drug use, and to ensure an enabling environment for a robust civil society. Starting early in the COP process, PEPFAR country teams should allow for a series of meetings with a broad-based coalition of government stakeholders and civil society organizations, including those active at the regional level; develop a system for soliciting input; and provide written feedback on how recommendations were incorporated. PEPFAR implementers should increase their consultation with other major international donors, other in-country programs, and national governments to ensure that programs complement local capacity. Finally, PEPFAR should consider familiarity and experience with local context in selecting grantees to ensure they have adequate capacity and relevant in-country experience to undertake the projects at hand.

Meaningful Civil Society Involvement

- **Countries must provide an enabling environment for civil society participation in HIV program planning, monitoring, and evaluation. In recognition of their unique access to key populations, national governments should partner with and ensure adequate protection for NGOs and their workers in the provision of HIV services. International donors should require and facilitate participation of PWID in civil society mechanisms.**

Laws that impede the non-governmental sector in providing HIV services should be repealed, and mechanisms should be put in place to fund NGOs to provide such services, as appropriate. International donors should actively support capacity building and technical assistance in the NGO sector, take steps to ensure the participation of PWID in program planning, and work to foster the development of PWID networks.

Targeted, Culturally Competent Services

- **Countries should provide PWID with equal access to culturally competent HIV prevention, primary healthcare, and drug treatment services. Additionally, providers throughout the healthcare system should be equipped to meet the needs of all affected populations, including PWID. In countries where they provide funding, international donors should support capacity building to ensure that HIV prevention and treatment services are available and accessible to PWID.**

At a minimum, all PWID should have access to the WHO comprehensive package of interventions for the prevention, treatment, and care of HIV among people who inject drugs, which has been widely endorsed.[§§] The availability of services from which PWID are "not excluded" is insufficient. For PWID, the integration of programs providing ART, TB screening and treatment, and drug dependency treatment is key. Gender-specific programs are needed to address the

[§§] WHO, UNAIDS, UNODC, the UN General Assembly, the Economic and Social Council, the UN Commission on Narcotic Drugs, the UNAIDS Programme Coordinating Board, the Global Fund, and PEPFAR.

systemic disparities and barriers to care experienced by women in many societies.

Addressing Stigma and Discrimination

- **PWID should be protected by law from discrimination, and "official" forms of discrimination and harassment should be eliminated. Onerous registration requirements should be abolished, and essential healthcare services should never be conditioned on such requirements. International donors and national governments should support public education programs that address discrimination by combating perceptions that people who use drugs are criminals, and should ensure that PWID participate in HIV program planning, monitoring, and evaluation.**

Requiring PWID to register with the authorities in order to receive health services, including treatment for drug dependence, diminishes their rights (such as child custody, employment, or drivers licenses) and increases the chances of harassment. Similarly, people who use drugs sometimes have identity documents confiscated or marked, effectively barring them from receiving services. Training is needed for law enforcement to address pervasive harassment of people who use drugs, and to sensitize public safety officials about the needs of people who use drugs and their communities. Programs that help PWID stabilize their life circumstances (e.g., job training, housing, re-entry) are also needed.

Public Health vs. Criminalization

- **Laws that criminalize drug dependence and/or people who use drugs should be repealed in favor of an approach that deploys scientifically proven public health interventions, such as NSPs and OST. Laws that directly impede or criminalize evidence-based harm reduction services, such as laws criminalizing the possession of needles and syringes, should also be repealed or revised. International donors should promote local reforms that reduce stigmatization of and discrimination against PWID and promote policies that favor a public health—as opposed to a criminal justice—approach to drug use.**

People who use drugs are often criminalized and subject to punitive measures, including arrest, fines and civil sanctions, detention, and in some instances, torture and even death. Not only are such policies ineffective in curbing substance abuse, but they exacerbate the HIV epidemic by driving people who use drugs away from the healthcare system. Systemic reforms are needed to ensure that drug abuse is treated as a public health concern.

Detention Centers and Prisons

- **Countries should immediately close centers where people who use drugs are detained without access to due legal process and treatment for drug dependence or HIV, and the United Nations and international donors should provide support for countries to develop alternatives. In instances where people living with HIV are detained in any closed settings, including prisons, countries should provide ART and other needed healthcare services without undue delays.**

Drug detention centers are unethical and have been widely denounced by human rights organizations and the United Nations, and should be closed immediately. In several countries, predominantly in Southeast Asia, people who use drugs are routinely detained, often for periods of years, in settings where they are not only denied effective drug dependence treatment, but subject to forced labor and punishments that constitute torture. People in need of drug dependence treatment should be offered evidence-based interventions, including OST, and should never be punished for their addiction. In countries lacking appropriate drug treatment capacity, international donors should provide capacity building and technical assistance. To the extent that countries lack appropriate alternatives to detention centers, the United Nations and international donors should honor their commitment to "work with countries to find alternatives to compulsory drug detention and rehabilitation centers, including through technical assistance, capacity building, and advocacy."[79]

Research and Data Collection

- **Countries should systematically conduct research, including HIV epidemiology and service utilization, to more effectively and efficiently reach key populations. International donors should monitor and provide data about their funding portfolios for key populations, such as PWID, provide support for strengthening in-country research and data collection capacity to help plan programming, and establish requirements to ensure that such data reflect the unique needs of key populations.**

It is essential to develop models to estimate PWID population sizes, characterize local and regional drug use patterns, estimate HIV incidence and prevalence trends, and assess whether and how successfully PWID access and utilize HIV prevention and treatment services, including the extent to which HIV-positive PWID are treated and achieve viral suppression.

CONCLUSION

HIV transmissions among PWID continue to be a key driver in the global AIDS epidemic. Absent robust harm reduction initiatives, shifting drug use patterns risk dramatically increasing new infections, particularly in countries with generalized epidemics. While effective interventions to prevent HIV transmissions among PWID are well understood, global coverage falls far short of need. This is true even in countries with high concentrations of PWID, where a rationale for such programs has long been clear. Moreover, the international donor community provides a vastly disproportionate share of funding for harm reduction programs, including in countries where they have been significantly scaled up, with many national governments contributing only token amounts. As the global transition to greater country ownership picks up momentum, international donors will need to ensure that PWID—and other vulnerable populations—are not forgotten.

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APPENDIX

Availability of Select Components of the WHO Comprehensive Package of HIV Prevention, Treatment, and Care Interventions for PWID***

(NOTE: YES indicates some, but not uniform coverage)

	Ukraine	Kyrgyzstan	Kenya	Nigeria	Vietnam
Needle and syringe services programs (NSPs)	Yes	Yes	Yes	No	Yes
Notes	As of 2011, there were 1,667 NSP sites across Ukraine, including pharmacies with free distribution of needles and syringes. Sixty-four percent of Ukrainian PWID accessed NSPs in a 12-month period (2010–2011), an increase from 39% in 2008. However, since the 2010 reclassification of small amounts of illicit drugs as illegal (see p. 13), many NSPs have stopped collecting used syringes due to the risk of outreach workers and clients getting detained for drug possession or drug trafficking. According to the International HIV/AIDS Alliance in Ukraine, the reclassification has led to an almost threefold decrease in the percentage of used syringes returned to NSPs—from 27% to 11%.	There are 31 government-based, 15 NGO-based, and eight 24-hour-pharmacy-based NSPs that provide a minimum package of services. However, possession, storage, production, and/or transportation of small amounts of drugs are considered illegal and may lead to a fine or up to four years in prison, which impedes harm reduction efforts.	While the Kenya Round 10 proposal to the Global Fund notes that Kenya has not implemented NSPs to date because "drug use is illegal," the document proposes initiating five pilot NSP sites, one in each grant year. The proposal sets targets for the number of needles to be distributed, increasing from 750,000 in year one to 3.75 million in year five. While the Kenyan government adopted guidelines for NSPs in 2013, it is unclear how many syringes the government intends to distribute each year. Estimates from the Ministry of Health's Standard Operating Procedures for NSPs show that 1.6 million syringes would have been needed to cover just 20% of the PWID population in 2013;[80] however, actual distribution from January 2013 to March 2014 totaled just 135,985 needles in Nairobi and 256,187 in the coast region.	Key informants attribute the lack of harm reduction services in Nigeria to a legal environment that criminalizes drug use and impedes the prioritization of a public health approach. The National Drug Law Enforcement Agency still maintains a strong stance against harm reduction, claiming that NSPs and OST will encourage and increase drug use. In May 2014, a best practice programming workshop organized by the Nigeria Country Coordinating Mechanism Key Affected Populations Engagement Initiative recommended a pilot NSP program in Nigeria, a better and more realistic estimate of the PWID population, and a plan for OST scale-up with coverage at 500, 1,500, and 3,000 PWID in years one, two, and three.	Following the legalization of harm reduction in 2006, HIV prevention services, including peer education, NSPs, and OST, are increasingly available to PWID. By the end of 2013, NSPs had been implemented in all 63 provinces and in 65% of the more than 700 districts in the country. The number of clean needle and syringe packages distributed to PWID increased from two million in 2006 to a peak of 39 million in 2012.[81] During the first nine months of 2013, more than 2,000 peer educators made 3,800,000 contacts with PWID, reportedly distributing more than 14 million clean needles and collecting more than 12 million used ones.
Opioid substitution therapy (OST)	Yes	Yes	No	No	Yes
Notes	As of March 2014, OST was provided in all 27 regions of Ukraine at 171 sites, reaching a total of 8,746 patients, 3,664 of whom were living with HIV. However, in May 2014, Crimea, newly annexed by Russia, dismantled its methadone and buprenorphine programs, causing more than 800 patients to discontinue treatment. Furthermore, in the spring of 2015, OST sites operating in non-government controlled areas of Donetsk and Lugansk oblast ceased operations due to the ongoing military conflict there, leading to a further drop in the number of patients enrolled on OST in the country. OST scale-up is further complicated by rigid bureaucratic procedures, lack of physician incentives to provide these services, pressure from the police, short operating hours at sites, and patients' inability to get take-home doses or methadone by prescription, as well as the requirement to register as a drug user in order to access services.	OST is available at 29 sites, including five in pre-detention centers and the penitentiary system. In 2013, these sites covered 1,434 patients (about 6% of the estimated total number of PWID). Access to governmental drug addiction treatment services, including OST, is possible only upon mandatory registration at narcology centers, which in some cases can lead to loss of employment or parental rights.	While there was no mention of OST in the National AIDS Strategic Plan (KNASP III), the PEPFAR FY2013 Country Operational Plan (COP) for Kenya states that, for the first time, medication assisted therapy would be provided to 15,000 PWID.[82]	See explanation for NSPs.	According to the Vietnam Administration of AIDS Control (VAAC), by the end of 2013, OST had been implemented in 30 provinces, with 80 clinics treating 15,542 patients—an increase of 27% since 2012. The government set a target of enrolling 40,000 OST patients by the end of 2014.

*** Disclaimer – amfAR strives to present the most accurate data and information possible in its reports. The data presented in this report are the most accurate that the authors had at their disposal at the time of writing.

Availability of Select Components of the WHO Comprehensive Package of HIV Prevention, Treatment, and Care Interventions for PWID*** (NOTE: YES indicates some, but not uniform coverage)					
	Ukraine	**Kyrgyzstan**	**Kenya**	**Nigeria**	**Vietnam**
Antiretroviral therapy (ART)	Yes	Yes	No	No	Yes
Notes	ART access in Ukraine has continuously improved in recent years, with 55,784 receiving treatment as of January 1, 2014. However, among 15,287 officially registered PWID living with HIV and eligible for treatment, only 10,834—3,125 of whom are active users—receive ART, comprising only 19.4% of persons on ART, despite the fact that 32.7% of new infections in the country are attributed to injecting drug use.	As of January 1, 2014, there were 2,841 HIV-positive PWID registered at the National AIDS Center, 351 (12.3%) of whom were on ART.	In 2011, the National AIDS Control Council (NACC) announced a plan to provide free HIV prevention and treatment for PWID, but coverage levels are not available.[83]	In theory, PWID are eligible to receive free ART, largely provided in government hospitals. Overall, ART coverage based on the national treatment guideline (CD4 <=350) is estimated at 25.6%, with about 1.4 million people needing treatment but only 359,181 receiving it. There are no available data on ART coverage among PWID in Nigeria.	In theory, PWID have the same access to ART as other PLHIV. A WHO report cites a study that found that 73% of people who received ART in Ho Chi Minh City reported a history of drug use and that their treatment outcomes matched those of non-drug-using populations.[84] But Vietnam continues to detain many PWID in drug "rehabilitation" centers, where ART availability is poor. (In July 2014, the Global Fund discontinued support for ART in detention centers, which it had been providing for approximately 900 patients in 35 of the country's 107 "rehabilitation" centers.)
HIV counseling and testing (HCT) and condom distribution	Yes	Yes	No	No	No
Notes	In 2013, Ukraine reported that 63.3% of PWID were reached by a comprehensive package of HIV prevention services, including HCT and condoms. These services are not uniformly distributed throughout the country, and are particularly absent in rural areas.	In the recent past, of the 300,000 HIV tests conducted annually by AIDS centers, key populations never exceeded 4% of all patients tested. In 2013, NGO-based HCT services were provided to 2,158 PWID. A significantly higher number of PWID then tested positive, suggesting that the pilot HCT program may have increased testing rates among PWID. Thirty-one government-based, 15 NGO-based, and eight 24-hour-pharmacy-based NSPs provide a minimum package of services, including condoms and targeted informational materials distribution. In the first half of 2013, 14,743 PWID accessed a minimum package of services and 10,777 accessed them in the second half of the year (including nearly 1,500 incarcerated PWID).[85]	In 2011, Kenya's NACC announced a plan to provide free HIV prevention and treatment for PWID, which included services such as needle exchange and psychosocial support. Kenya has programs to provide condoms, lubricant, voluntary testing, and counseling for MARPs, which include PWID. However, during an interview for this report, a representative of the NACC stated that there are currently no specific programs for PWID besides NSP.	The National HIV/AIDS Strategic Plan 2010–2015 outlines a goal of at least 80% of all drug-dependent persons, both PWID and non-PWID, having access to quality prevention services, in accordance with national guidelines, by 2015.[86] While PWID are eligible for HCT and condom distribution programs provided by both indigenous and international NGOs, there are very few programs specifically targeting PWID and no data available related to service coverage among PWID.	HCT availability is generally poor in "rehabilitation" centers, and what is available is infrequently voluntary. In July 2014, the Global Fund withdrew the support, including funding for HCT, that it had provided in 35 of the country's 107 "rehabilitation" centers.

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