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Implementation of the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem: follow-up to the high-level review by the Commission on Narcotic Drugs, in view of the special session of the General Assembly on the world drug problem to be held in 2016

Responding to the prevalence of HIV/AIDS and other blood-borne diseases among drug users

Report of the Executive Director

Summary

The present report has been prepared pursuant to Commission on Narcotic Drugs resolution 49/4, entitled “Responding to the prevalence of HIV/AIDS and other blood-borne diseases among drug users”. It provides an overview of the UNODC response to the spread of HIV/AIDS and other blood-borne diseases among people who use drugs, including a summary of activities implemented by UNODC in 2012 and 2013. It contains recommendations and indicates gaps and remaining challenges in responding to HIV/AIDS and other blood-borne diseases among people who use drugs.

UNODC delivers technical assistance in full compliance with the relevant declarations, resolutions and decisions of United Nations bodies and assists Member States, civil society organizations and other partners in developing, adopting and implementing strategies and programmes on HIV/AIDS related to drug use, particularly for people who inject drugs, and policies and programmes for HIV/AIDS prevention, treatment, care and support in prisons and other closed settings.

* E/CN.7/2014/1.



I. Introduction

1. The present report has been prepared pursuant to Commission on Narcotic Drugs resolution 49/4, entitled “Responding to the prevalence of HIV/AIDS and other blood-borne diseases among drug users”, in which the Commission invited Member States, in accordance with their national legislation:

(a) To give the utmost consideration to the development of demand reduction actions based on studies and research that demonstrated the efficacy and efficiency of drug-related treatment and prevention;

(b) To adopt drug-related health policies that facilitate prevention of drug abuse and access by drug users to different types of prevention, treatment and care for drug dependency, drug-related HIV/AIDS, hepatitis and other blood-borne diseases;

(c) To enhance efforts to promote access to health and social care for drug users and their families without discrimination of any kind and, where appropriate, to cooperate with relevant non-governmental organizations;

(d) To provide access, as appropriate and in the framework of the pertinent national policies, to medications, vaccines and other measures that are consistent with international drug control treaties and have been shown to be effective in reducing the risk of HIV/AIDS, hepatitis and other blood-borne diseases among injecting drug users, under the supervision of competent authorities or institutions.

2. Also in its resolution 49/4, the Commission endorsed the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors, as well as related decisions of the Programme Coordinating Board of the Joint United Nations Programme on HIV/AIDS (UNAIDS). The Commission also requested the United Nations Office on Drugs and Crime (UNODC), in conformity with the *UNAIDS Technical Support Division of Labour* document,¹ to provide technical assistance, upon request and subject to the availability of extrabudgetary resources, to Member States to develop comprehensive demand reduction strategies and measures, including HIV/AIDS prevention and care in the context of drug abuse, that are consistent with the international drug control treaties. The Commission further requested the Executive Director of UNODC to report to it biennially, starting at its fifty-first session, on the implementation of the resolution.

II. Epidemiological situation and required responses

3. At the end of 2012, an estimated 35.3 million people (a range of 32.2 million-38.8 million) were living with HIV worldwide. That represents an increase from previous years, as more people are receiving the life-saving antiretroviral therapy. There were 2.3 million new HIV infections globally (a range of 1.9 million-2.7 million), showing a 33 per cent decline in the number of new

¹ Joint United Nations Programme on HIV/AIDS, “UNAIDS technical support division of labour: summary and rationale” (Geneva, August 2005); see also *UNAIDS Division of Labour 2010: Consolidated Guidance Note* (Geneva, Joint United Nations Programme on HIV/AIDS, 2011).

infections from 3.4 million (a range of 3.1-3.7 million) in 2001. The reductions in new infections among adults since 2001 are due primarily to a reduction in the sexual transmission of HIV.²

4. Worryingly, the global community is seriously lagging behind in achieving the target of halving the transmission of HIV among people who inject drugs by 2015.³ Injecting drug use continues to drive the expansion of the HIV epidemic in many countries around the world. In 2013, UNODC estimated that there were 14.0 million (a range of 11.2 million-22.0 million) people who inject drugs worldwide, and of those, 1.6 million (a range of 1.2 million-3.9 million) were living with HIV, representing a global prevalence of HIV of 11.5 per cent among people who inject drugs.

5. There is a very high prevalence of injecting drug use in Eastern and South-Eastern Europe and in Central Asia: 1.3 per cent of the population aged 15-64 (i.e., four times the global average). In addition, there are elevated rates of HIV infection among people who inject drugs in Eastern Europe and Central Asia, as well as in East and South-East Asia. While in sub-Saharan Africa HIV is transmitted mainly via heterosexual contact, HIV transmission through injecting drug use has emerged as a major concern in East Africa and is reported in several other African countries.⁴

6. The past 10 years have seen the implementation of a rapidly increasing number of integrated biological and behavioural surveys for key populations, which have contributed to an improved understanding of the dynamics and risks of HIV infection in a particular country or context and provided critical data for programme planning and implementation, as well as for the monitoring and evaluation of HIV/AIDS interventions for people who inject drugs. While the exact number of integrated biological and behavioural surveys carried out to date is not known, it has been estimated that between 125 and 200 behavioural surveillance surveys⁵ and integrated biological and behavioural surveys have been carried out in over 50 countries.⁶ The changes in estimates related to injecting drug use and HIV among people who inject drugs are due to the improved data in combination with other factors, including methodological differences; therefore, the new estimates cannot be compared with previous estimates to reliably assess a global change or trend in the epidemic.

7. The use of amphetamine-type stimulants (ATS) and “ecstasy” remains widespread globally, with over 53 million people having used those substances in the past 12 months in 2011. The most common HIV risk faced by people who use ATS and/or “ecstasy” and people who use “crack” cocaine involves unprotected sexual behaviour with partners from groups with high rates of prevalence and incidence of HIV. People who inject stimulant drugs (such as ATS and cocaine) and

² *Global Report: UNAIDS Report on the Global AIDS Epidemic 2013* (Geneva, Joint United Nations Programme on HIV/AIDS, 2013).

³ See the Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS (General Assembly resolution 65/277, annex).

⁴ *World Drug Report 2013* (United Nations publication, Sales No. E.13.XI.6).

⁵ Behavioural surveillance surveys do not include the HIV testing component included in integrated biological and behavioural surveys.

⁶ E. de Buhr, “Assessment of integrated biological and behavioral surveys (IBBS) for key populations”, draft report dated 28 October 2013.

do not use a sterile needle/syringe for every injection face levels of risk of HIV transmission similar to those faced by people who inject opiates using non-sterile injection equipment.

8. Hepatitis C, also transmitted by means of contaminated injection equipment, represents another major health challenge for people who inject drugs. Globally, approximately 150 million people are infected with hepatitis C.⁷ UNODC estimated that in 2011, half (51 per cent) of all people who injected drugs were living with hepatitis C. As with HIV, the transmission of hepatitis C is further fuelled by incarceration.

9. Globally, each year at least 30 million men, women and children go through prison systems, where high-risk behaviours and HIV transmission are highly prevalent. The prevalence of HIV, sexually transmitted infections, hepatitis B and C and tuberculosis is from 2 to 20 times higher (and in some cases up to 50 times) among prison populations than among the general population. The proportion of people who use and inject drugs in prisons can be as high as half the incarcerated population, especially among women in closed settings. In some countries, up to 50 per cent of people who inject drugs go through prison and pretrial detention once or several times in their lifetime, and a large proportion of the people who inject drugs and are living with HIV are found in prisons and other closed settings.^{8, 9}

10. The absence of an enabling environment and supporting regulatory framework has hampered effective implementation of HIV prevention, treatment and care programmes, and the provision of evidence-based HIV interventions for people who inject drugs remains very limited. According to UNAIDS, with few exceptions, only in high-income countries is the number of syringes distributed annually per person who injects drugs approaching the global recommendation of 200.¹⁰

11. In many countries, where people who inject drugs make up a sizable component of national epidemics and account for up to over 40 per cent of all new HIV infections, there is a lack of strong political and programmatic commitment to reducing HIV transmission among people who inject drugs. At the global policy level, the decisions adopted by the Commission on Narcotic Drugs, the Programme Coordinating Board of UNAIDS and the Economic and Social Council in 2009 reflect the common understanding within the United Nations about required responses to the HIV epidemic among people who inject drugs. The comprehensive package of HIV prevention, treatment and care services for people who inject drugs contains the following:¹¹

- (a) Needle and syringe programmes;

⁷ World Health Organization, "Fact sheet No. 164: hepatitis C" (rev. July 2013).

⁸ See the UNODC/ILO/UNDP/WHO/UNAIDS policy brief on "HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions" (2013) (available from www.unodc.org).

⁹ UNODC, "Drug dependence treatment: interventions for drug users in prisons" (available from www.unodc.org/docs/treatment/111_PRISON.pdf).

¹⁰ *Global Report: UNAIDS Report on the Global AIDS Epidemic 2013*.

¹¹ *WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users* (Geneva, World Health Organization, 2009).

- (b) Opioid substitution therapy and other evidence-based drug dependence treatment;
- (c) HIV testing and counselling;
- (d) Antiretroviral therapy;
- (e) Prevention and treatment of sexually transmitted infections;
- (f) Condom programmes for people who inject drugs and their sexual partners;
- (g) Targeted information, education and communication for people who inject drugs and their sexual partners;
- (h) Prevention, vaccination, diagnosis and treatment for viral hepatitis;
- (i) Prevention, diagnosis and treatment of tuberculosis.

12. In its resolution 56/6, the Commission requested UNODC, as the convening agency of UNAIDS for reducing HIV transmission among people who use drugs, in particular people who inject drugs, including those in prisons, to work with the other co-sponsors of UNAIDS, especially the World Health Organization (WHO) and the UNAIDS secretariat, to implement, as appropriate, the *WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users: 2012 Revision*.

13. In its resolution 56/6, the Commission also requested UNODC to significantly expand its work with relevant civil society groups in order to address the gap in access to services for people living with or affected by HIV, including people who use drugs, in particular people who inject drugs, to tackle the issues of stigmatization and discrimination and to support increased capacity and resources for the provision of comprehensive prevention programmes and treatment, care and related support services, including for co-occurring common mental health disorders, in full compliance with the international drug control conventions and in accordance with national legislation, taking into account all relevant General Assembly resolutions.

III. Technical assistance provided by the United Nations Office on Drugs and Crime with regard to HIV/AIDS in 2012 and 2013

14. UNODC provides technical assistance to Member States in the area of HIV/AIDS in full compliance with the relevant declarations, resolutions and decisions adopted by the General Assembly, the Economic and Social Council, the Commission on Narcotic Drugs, the Commission on Crime Prevention and Criminal Justice and the UNAIDS Programme Coordinating Board. The work of UNODC on HIV/AIDS is guided by the UNAIDS Strategy 2011-2015, which is aimed at advancing global progress in achieving country-set targets for universal access to HIV prevention, treatment, care and support and at halting and reversing the spread of HIV, thus contributing to the achievement of the targets set in the 2011 Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS

(General Assembly resolution 65/277, annex) and the achievement of the Millennium Development Goals by 2015.

15. UNODC, a co-sponsor of UNAIDS, is the convening agency of the UNAIDS family for protecting drug users from becoming infected with HIV and ensuring access to comprehensive HIV services for people in prisons and other closed settings, in accordance with the *UNAIDS Division of Labour 2010: Consolidated Guidance Note*. The division of labour makes use of the comparative advantages of UNAIDS with respect to leveraging respective organizational mandates and resources to work collectively to deliver results, including strengthening joint work and maximizing partnerships. UNODC is also promoting an evidence-informed, public health-focused and human rights-based United Nations response to human trafficking as it relates to HIV and AIDS.

16. UNODC has reviewed its capacity to help countries to rapidly scale up delivery of harm reduction services in the context of HIV, including advocacy, technical assistance and capacity-building, and in consultation with national stakeholders including civil society organizations, identified key strategic areas where the Office has the comparative advantage of being able to contribute most to achieving the target set in the Political Declaration on HIV and AIDS of reducing HIV transmission among people who inject drugs by 50 per cent by 2015.

17. UNODC has identified, together with global and regional civil society organization partners, 24 high-priority countries in the area of injecting drug use and HIV, in which the Office is concentrating its efforts and resources in the period 2013-2015 in the area of addressing the HIV epidemic.¹² The countries were selected following an analysis of (a) epidemiological data on injecting drug use and HIV burden, including in prisons, and (b) country readiness regarding the policy and legislative environment allowing essential services such as needle and syringe programmes, opioid substitution therapy, condom programmes and antiretroviral therapy and regarding the resource environment, including international and domestic funding and human resources.

A. HIV/AIDS policy and programme development

18. UNODC has advocated and provided training and technical assistance for the development of AIDS policies and programmes, which are evidence-informed and human rights-focused and support public health approaches for HIV prevention, treatment and care for people who use drugs and those living in prisons and other closed settings.

19. At the meeting of the inter-agency working group on drug use and HIV and on prisons and HIV, chaired by UNODC, held in Vienna in October 2012 and attended by the International Labour Organization (ILO), UNAIDS, the United Nations Children's Fund, the United Nations Development Programme (UNDP) and the

¹² The UNODC high-priority countries in the area of injecting drug use and HIV (2013-2015) are Argentina, Belarus, Brazil, China, Egypt, India, Indonesia, Iran (Islamic Republic of), Kazakhstan, Kenya, Kyrgyzstan, Morocco, Myanmar, Nigeria, Pakistan, the Philippines, the Republic of Moldova, South Africa, Tajikistan, Thailand, Ukraine, Uzbekistan, Viet Nam and the United Republic of Tanzania.

United Nations Population Fund, reviewed the contributions by United Nations entities in the areas of drug use and HIV and prisons and HIV. In the meetings, challenges in implementing key activities were identified, and new opportunities to intensify inter-agency collaboration and improve implementation modalities at the global, regional and country levels were explored.

20. At the global technical meeting on stimulant drug use and HIV, held in São Paulo, Brazil, in January 2012, organized by UNODC with the Government of Brazil, leading researchers and technical experts from countries affected by stimulant use and HIV and representatives of civil society, UNAIDS and UNDP recommended a targeted approach to address the unique needs of certain sub-groups of stimulant drug users, especially those who also belong to other key population groups such as sex workers and men who have sex with men, due to their increased risk of contracting HIV through high-risk sexual practices.

21. The results of UNODC-supported studies and assessments have helped in advocating for and developing evidence-informed policies and prioritized and costed programmes in several countries. Support provided by UNODC includes the mapping of key constituencies working on the issue of drug use and HIV in South Africa, and a rapid assessment of HIV prevalence and HIV-related risks among people who inject drugs in three provinces of South Africa; an epidemiological study to assess HIV prevalence in prisons in Nepal; a national study of drugs and HIV in prisons in Bangladesh; a study on the adequacy of health services and accessibility of health and social protection services for people who use drugs in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan; a joint study conducted with the University of Yale, United States of America, on substance use, HIV, hepatitis C, tuberculosis and access to health services in prisons in Azerbaijan, Kyrgyzstan and Tajikistan.

22. In South Asia, UNODC and UNAIDS have developed and launched, through a consultative process with Member States, a regional strategy for the period 2012-2015 to address the interrelated issues of drug use and sexual transmission of HIV, including in prisons and other closed settings. UNODC has provided technical assistance and strengthened national capacity to review and implement operational plans in Bangladesh, Bhutan, India, Maldives, Nepal and Sri Lanka. In India, with support provided by UNODC, standard operating procedures for HIV prevention, treatment and care for people who inject drugs to improve the quality of harm reduction service provision have been developed, and several studies on harm reduction, including on barriers to and opportunities for HIV testing and counselling and the uptake of antiretroviral therapy among people who inject drugs, have been conducted.

23. With regard to prisons, UNODC has developed a regional monitoring and evaluation framework for countries of sub-Saharan Africa to provide guidance to national prison authorities for planning, implementation, monitoring and evaluation of HIV services and activities and interventions for other communicable diseases in prison settings. UNODC has also provided technical assistance for the incorporation of a component on prisons and HIV into national HIV strategic plans in several countries in South Asia.

24. UNODC has advocated for increased HIV policies and programmes for women who use drugs and the removal of barriers to access to comprehensive services

through the implementation of needs assessments with respect to gender-responsive services for women who inject drugs and for female sexual partners of men who inject drugs. A policy paper and a practical guide on gender-responsive HIV services for women who use drugs have been developed to strengthen gender-responsive HIV services. The first protocol on HIV and tuberculosis in prisons developed by UNODC was piloted by the Iranian Prisons Organization, which published a training package on the prevention of HIV/AIDS and sexually transmitted infections among women prisoners.

25. In the Middle East and North Africa, advocacy efforts and technical support provided by UNODC to national AIDS programmes have helped to establish priorities with respect to prisons and other closed settings, to set targets and align national policies and operational plans addressing illicit drugs and prison settings within national HIV strategic frameworks (for example, in Egypt and Morocco). In Egypt, UNODC is conducting a study to explore the feasibility of establishing an opioid substitution therapy programme in Egypt, with the purpose of informing the national decision-making process and advocating for opioid substitution therapy, and identifying the operational model for the delivery of opioid substitution therapy best suited to the Egyptian context.

26. In 2012, UNODC together with other United Nations entities, issued a joint statement on compulsory drug detention and rehabilitation centres, in which those entities called on States to close compulsory drug detention and rehabilitation centres and implement voluntary, evidence-informed and rights-based health and social services in the community.¹³ UNODC and UNAIDS have involved civil society organizations and networks, donor partners, other United Nations agencies and technical experts in an in-depth international debate and efforts to inform policymakers about HIV risks and human rights with respect to the issue of compulsory centres for drug users. Under the auspices of the United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific, UNODC has supported the expansion of the provision of evidence-informed, voluntary, community-based drug dependence treatment services.

27. UNODC has conducted, in partnership with civil society organizations, large-scale advocacy and training events to improve the accessibility and quality of community-based HIV services for people who use drugs and to address stigmatization and discrimination. For example, UNODC has organized, jointly with the Economic and Social Commission for Asia and the Pacific and the UNAIDS Regional Support Team for Asia and the Pacific, and with inputs from civil society, the Second Regional Consultation on Compulsory Centres for Drug Users in Asia and the Pacific, which was co-hosted by the National Anti-Drugs Agency of the Government of Malaysia in October 2012. In September 2013, UNODC co-organized the International Symposium on Drugs: from Coercion to Cohesion, held in Brasilia and attended by over 500 participants, for the sharing of best practices on drug dependence treatment and harm reduction and lessons learned from legislation implemented in various countries worldwide, and for furthering efforts to make people aware of the importance of protecting the human rights of people who use drugs.

¹³ Available from www.unodc.org/documents/southeastasiaandpacific//2012/03/drug-detention-centre/JC2310_Joint_Statement6March12FINAL_En.pdf.

28. In 2013, UNODC updated global estimates on injecting drug use and HIV among people who inject drugs, and established partnerships with other bodies of the United Nations system (UNAIDS, WHO and the World Bank) aimed at improving, in close collaboration with civil society organizations, global, regional and national data on HIV and injecting drug use, and data on HIV services for people who inject drugs. UNODC designed and reached agreement with WHO, UNAIDS and the World Bank on a mechanism to jointly review and reach consensus on the estimates published by the United Nations with regard to people who inject drugs and HIV and to review their methodology for estimates. The first such joint review was conducted in November 2013. UNODC has also formalized its collaboration with civil society organizations regarding the sharing of strategic information on people who inject drugs and HIV through the joint UNODC-civil society organization workplan, which was developed and launched in 2013.

29. In partnership with the World Bank, UNODC has initiated a project aimed at improving estimates of the number of people who inject drugs and the HIV prevalence among people who inject drugs by conducting a review of existing estimates and the estimate methodology used in selected countries, and, as needed, by conducting new studies to estimate the prevalence of injecting drug use and HIV in those countries.

B. Scaling up HIV prevention, treatment and care and the provision of support services

30. UNODC has provided technical assistance in resource mobilization, assessment of programmatic needs, capacity-building and monitoring and evaluation for the scaling-up of HIV prevention, treatment, care and support services in accordance with the comprehensive package of HIV services for injecting drug users¹⁴ and for people in prisons and other closed settings.¹⁵

31. Civil society organizations play a critical role in the provision of HIV prevention, treatment, care and support services for people who use drugs. UNODC has provided financial and technical support to civil society organizations for the provision of harm reduction services, capacity-building, participation in conferences and meetings, advocacy and awareness-raising, and operational research and situation assessments. For example, in 2012, UNODC collaborated with more than 280 civil society organizations worldwide; almost two thirds of them (196 civil society organizations in more than 100 countries) benefited from financial support. Over \$3 million (15 per cent of overall UNODC expenditures in 2012) was provided to country-level and regional civil society organizations; 84 per cent of those resources was allocated to projects that addressed HIV and injecting drug use, and the remaining 16 per cent was allocated to projects addressing HIV in prison settings.

¹⁴ WHO, UNODC, UNAIDS *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users* (Geneva, World Health Organization, rev. 2012).

¹⁵ UNODC/ILO/UNDP/WHO/UNAIDS policy brief entitled “HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions”.

32. Other examples of the work of UNODC with civil society organizations include its work with Harm Reduction Knowledge Hub for Europe and Central Asia and the Eurasian Harm Reduction Network on policy reform with respect to HIV, tuberculosis, hepatitis B and hepatitis C among drug users and in prison settings. In Indonesia, the national network of people who use drugs, Persaudaraan Korban Napza Indonesia (PKNI), has received support to integrate drug overdose programmes in drug dependence treatment and in HIV prevention, treatment and care services. In Myanmar, UNODC has built the capacity of the National Drug User Network of Myanmar. UNODC has also provided financial and technical support to Eurasian Harm Reduction Network in developing a regional funding proposal on harm reduction submitted to Global Fund to Fight AIDS, Tuberculosis and Malaria.

33. In many countries with concentrated HIV epidemics among people who inject drugs, women who inject drugs have limited or no access to harm reduction or general health services. UNODC has advanced the global dialogue and advocacy for gender-responsive HIV programmes and more equitable access to HIV/AIDS prevention and treatment and care services for female drug users and female prisoners. UNODC has contributed to the UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV through global advocacy, promotion and the provision of technical assistance in the delivery of gender-responsive services, including services for the prevention of mother-to-child transmission of HIV for women who use drugs and women living in prisons and other closed settings in several countries.

34. The capacity of service providers to deliver evidence-informed, gender-specific services for women who inject drugs has been enhanced in several countries, for example, in Afghanistan, India, Nepal, Pakistan and Ukraine, where the following activities were carried out:

(a) In Ukraine, UNODC, in partnership with municipal governments and local organizations, launched the “Women 4 Women” initiative, which offers HIV services to women who use drugs, former prisoners and victims of domestic violence. That small grants initiative has enabled civil society organizations to reach more than 2,300 women and their children. A publication has also been launched describing the UNODC-supported models of gender-sensitive services for vulnerable women;

(b) In Afghanistan, UNODC has partnered with 10 local organizations to provide evidence-based HIV prevention, treatment and care services in six major prisons for women (in Kabul, Herat, Parwan, Nangarhar, Badakhshan and Balkh) and in five community sites (in Kabul, Herat, Nangarhar, Badakhshan and Balkh);

(c) In Nepal, UNODC, in partnership with Dristi Nepal, Community Support Group and the Youth Vision Drug Treatment and Rehabilitation Center, has supported the provision of a comprehensive package of HIV services to women who use drugs;

(d) In Pakistan, UNODC, through its grants to 10 civil society organizations, has supported the provision of comprehensive HIV services to female prisoners and female injecting drug users, reaching over 5,500 women;

(e) In India, UNODC has supported a pilot initiative to provide women who inject drugs with HIV prevention, treatment and care services in the four north-eastern states (Manipur, Mizoram, Meghalaya and Nagaland).

35. UNODC has facilitated the scaling-up of the provision of opioid substitution therapy (opioid-agonist assisted therapy) in several Member States. For example, in Kazakhstan, UNODC has provided technical support for the expansion of opioid substitution therapy through a review of guidelines on management of sites of opioid substitution therapy in Kazakhstan in collaboration with the national centre for research on drug addiction of the Ministry of Health. In India, UNODC has supported the mainstreaming of opioid substitution therapy as part of the prison medical services, including the procurement of buprenorphine, which has ensured the sustainability of opioid substitution therapy services in Tihar Prisons. In addition, UNODC launched and disseminated a scientific report on the implementation of opioid substitution therapy in Tihar Prisons (2008-2012) and standard operating procedures for rolling out opioid substitution therapy in prisons to key stakeholders, including the national AIDS control programme in India.¹⁶ In Pakistan, UNODC has started a pilot buprenorphine programme in the city of Rawalpindi and enhanced the capacity of service providers.

36. UNODC has also provided harm reduction services for Afghan refugee drug users in Iran (Islamic Republic of) and Pakistan, and for returnees in Afghanistan, including support for night shelters/drop-in centres and for outreach work that facilitates the provision of HIV services.

37. UNODC recently established the African HIV in Prisons Partnership Network and, through the Network, continued to provide technical and financial support to assist prison officials, public health authorities, members of civil society and national Governments in overcoming significant challenges related to responses to HIV in prison settings.

38. To advocate for increasing domestic investment in harm reduction, a meeting entitled “Economics and financing of effective harm reduction strategies in the context of HIV” was organized by UNODC, the World Bank and UNAIDS during the International Harm Reduction Conference held in Vilnius in June 2013, bringing together senior officials from Azerbaijan, Georgia, the Republic of Moldova, Tajikistan and Ukraine, as well as the Minister of Finance of Kyrgyzstan, together with senior experts from the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNAIDS, UNODC, the World Bank and WHO. Participants in the meeting discussed investing in harm reduction programmes for people who use drugs based on a considerable body of evidence showing that delivering HIV services, such as opioid substitution therapy and antiretroviral therapy, is a good investment leading to significant savings in public health costs, reductions in petty crime, safer environments and longer lives of better quality.

39. In 2013, UNODC conducted workshops for civil society organizations in 10 high-priority countries to increase their capacity to more effectively promote, among law enforcement agencies, the concept of ensuring greater access to harm reduction services for people who inject drugs. The workshops also provided an

¹⁶ UNODC, *Rolling out of Opioid Substitution Treatment (OST) in Tihar Prisons, India: Scientific Report*.

opportunity for civil society organizations to share their positions, concerns and ideas on how to improve working on harm reduction with law enforcement officials.

C. Development and dissemination of tools, guidelines and best practices

40. Production and dissemination of global guidance documents in collaboration with relevant national and international partners, including civil society organizations, has facilitated the scaling-up of needle and syringe programmes, opioid substitution therapy and other evidence-based responses for people who use opioids and/or stimulant drugs and for people in prisons and other closed settings.

41. Initiated by UNODC, the UNODC/ILO/UNDP/WHO/UNAIDS policy brief entitled “HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions” helps countries to mount an effective response to HIV and AIDS in prisons and other closed settings. The policy brief takes into consideration principles of international law, including international rules, guidelines, declarations and covenants governing prison health, international standards of medical ethics and international labour standards. It is intended to support decision makers in ministries of justice, authorities responsible for closed settings and ministries of health, and authorities responsible for workplace safety and occupational health in planning and implementing a response to HIV in closed settings. The document outlines a comprehensive package of 15 interventions that are essential for effective HIV prevention and treatment in prisons and other closed settings.

42. UNODC published the *Handbook on Effective Police Responses to Violence against Women*, designed to assist and guide police officers in the prevention of, and the response to, violence against women. It addresses the rights of both victims and offenders and highlights the links between violence against women and the spread of HIV.

43. A global guidance document entitled “Technical guide to HIV prevention, treatment and care for stimulant users: discussion paper” is being finalized on the basis of the recommendations of the Global Technical Meeting on Stimulant Drug Use and HIV, organized with the Government of Brazil and held in São Paulo, Brazil, in January 2012, and on the basis of further consultations with relevant stakeholders, including civil society organizations.

44. UNODC has contributed to the development of the WHO publication entitled “Guidance on prevention of viral hepatitis B and C among people who inject drugs” and supported WHO in the dissemination of that guide in the field as the first step in the provision of comprehensive guidance on surveillance, prevention and treatment for viral hepatitis for that key population group.

45. In India, UNODC has developed local capacity to provide comprehensive HIV services for people who inject drugs through the development and dissemination of training manuals targeting peer educators, outreach workers, clinical staff, counsellors and project managers. The cross-disciplinary manual on social-medical and legal aspects of accessibility of health and social protection services for people who use drugs and people in detention, for university-level teaching institutions in

the field of health care, criminal justice/penitentiary and social work has been developed as a result of 12 in-country consultative meetings and two regional workshops conducted in Central Asia and Eastern Europe.

46. UNODC has contributed to the revision of the *WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users: 2012 Revision*, supporting the development of the *Guide* and conducting field testing and consultations with experts in the field, particularly in Central Asia. The revised guide provides an expanded framework for assessing the quality of key interventions and guidance on prioritizing indicators with greater focus on drug-user specific interventions, such as needle and syringe programmes, opioid substitution therapy, HIV testing and counselling and antiretroviral therapy.

47. In Central Asia and Eastern Europe (Azerbaijan, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan), nearly 1,300 professionals (health-care professionals, prison medical and non-medical staff, law enforcement officers, civil society organization service providers and outreach workers) have been trained on management of opioid substitution therapy, including in prison settings. In Ukraine, UNODC, in cooperation with the Ukrainian Institute on Public Health Policy and the State Penitentiary Service, has organized a workshop on drug dependence treatment in prisons, held in January-February 2013. The meeting produced recommendations, inter alia, on implementation of opioid substitution therapy in prison settings and in pretrial detention facilities, and building the capacity of medical staff and relevant penitentiary sector officials for the implementation of opioid substitution therapy.

48. UNODC has further disseminated evidence-based good practices in drug dependence treatment in five regions (Africa, Central Asia, North Africa and the Middle East, South America and South-East Asia) through local and national networks of governments, treatment centres, primary health-care services, universities and non-governmental organizations and improved access to drug dependence treatment alongside social integration and rehabilitation. The work has focused on advocacy, capacity-building and service improvement promoting sound understanding of drug dependence treatment and care and the recognition of drug dependence as a health disorder that requires a multidisciplinary and comprehensive approach.

D. Legal and policy reviews and building capacity among law enforcement officials

49. UNODC has facilitated the review and adaptation of national legislation and policies concerning narcotic drugs, criminal justice, prison management and HIV, provided training, produced and disseminated guidelines and tools for improving equitable access to HIV prevention, treatment and care services, including commodities such as sterilized needles and syringes and condoms for people who inject drugs and people in prisons and other closed settings in several countries in Eastern Europe, Central Asia, South and South-East Asia, North Africa and the Middle East, Southern and East Africa and Latin America.

50. UNODC has developed a training programme for sensitizing law enforcement officials about harm reduction in the context of HIV and for enhancing their understanding of how law enforcement practices can influence, positively or negatively, access by people who inject drugs to HIV prevention, treatment and care services. Workshops to pilot the training programme were held in 10 high-priority countries (India, Kazakhstan, Kyrgyzstan, Myanmar, Philippines, Tajikistan, Thailand, South Africa, United Republic of Tanzania and Viet Nam), and implementation of the training programme is planned to continue in other high priority countries in the period 2014-2015. The programme is aimed at institutionalizing HIV training as part of the curricula of national police academies, and enhancing partnerships in harm reduction among law enforcement agencies, civil society organizations and the social, health and other relevant sectors. Additionally, in Pakistan, a toolkit for the training of law enforcement officials on how to enhance communication with and the engagement of people who use drugs and other marginalized populations vulnerable to HIV has been developed and launched for use at police training institutes.

51. UNODC has organized and supported the participation of senior law enforcement and penitentiary officials from Georgia, Kazakhstan and the Republic of Moldova in regional advocacy events, for example, in the First Regional Consultation on Enhancing the Role of Law Enforcement in Planning and Implementation of National Response to HIV/AIDS Epidemics in Central Asia and Eastern Europe, held in Kyiv in October 2012. That event brought together law enforcement officials and public health and civil society representatives from Eastern Europe and Central Asia to explore opportunities for multisectoral cooperation in enhancing the role of law enforcement in the response to the HIV epidemic among people who use drugs, in particular.

52. UNODC has supported the attendance of several high-ranking officials and technical officers from five Central Asian countries and Azerbaijan in a series of international, regional and national advocacy events and conferences on human rights-based and evidence-based policies and interventions on drug use and HIV, and related legislative and other health issues. For example, a regional round-table meeting on the role of law-enforcement agencies in the response to HIV was organized by UNODC jointly with its partners (AIDS Foundation East-West, the Law Enforcement and HIV Network, the Open Society Institute, UNAIDS and UNDP) in Bishkek in November 2013. The event brought together law enforcement and civil society representatives from across Central Asia and Eastern Europe (Armenia, Kazakhstan, Republic of Moldova, Tajikistan, Turkmenistan, Ukraine and Uzbekistan) to share HIV prevention practices among key populations as part of the police work in those countries.

53. UNODC supported the identification of effective policing issues and principles for HIV prevention, treatment, care and support among marginalized communities in the consultative meeting entitled “International consultation on policing of most at risk populations: the role of police services in improving the health of most at risk persons”, held in Rome in May 2012, co-hosted by the Law Enforcement and HIV Network, Forum Droghe and the International Development Law Organization.

54. In Central Asia, in collaboration with the United Nations Population Fund and other partners, UNODC has contributed to improving HIV prevention services in the region for victims of trafficking and smuggled migrants and their sexual partners.

IV. Conclusions and recommendations

55. Even if some countries are considering reducing or ending compulsory treatment for drug users, a public health-centred, human rights-based and evidence-informed approach to drug use and drug dependence has still not been sufficiently implemented: many national drug control systems over rely on sanctions and imprisonment, not health care; compulsory treatment and punitive practices in the name of treatment are widespread; discrimination against and stigmatization and the violation of human rights of people using drugs or dependent on drugs and living with HIV/AIDS are common.

56. In many affected countries, the national AIDS and drugs policies, strategies and programmes need to be reviewed to allow all nine interventions of the WHO/UNODC/UNAIDS comprehensive package¹⁷ for people who inject drugs to be implemented. In countries where the HIV epidemic is driven by unsafe injecting drug use, implementation of needle and syringe programmes and long-acting opioid maintenance therapy should be made a top priority. Programmes should be increased in scale, multiple delivery models should be utilized (including outreach, low threshold drop-in centres and peer education), and barriers to access to the services should be identified and removed. The meaningful involvement of civil society organizations representing and including people who use drugs, and building their capacity, should be intensified.

57. Addressing the HIV epidemic, which is driven by unsafe injecting drug use is a key priority, particularly in Eastern Europe and Central Asia, and South-East Asia. However, risks of HIV associated with injecting drug use are also emerging in regions that already have high rates of HIV infection, particularly in Africa. Globally, the use of stimulant drugs is on the rise, particularly in South-East Asia, Latin America and the Caribbean, and the link of such drug use to HIV transmission among certain key population groups, through both the sexual and injecting drug routes, is of great concern. There is a need to invest in developing additional evidence-based HIV responses for people who use stimulant drugs.

58. Regarding prisons, people who use drugs in prisons should have access to health services, including drug dependence treatment and harm reduction measures that is at least equal to the level of access available to others in the community, and priority should be given to the implementation of the 15 interventions outlined in the UNODC/ILO/UNDP/WHO/UNAIDS policy brief on “HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions”.

59. Interventions in prisons should be integrated into national plans and programmes on drugs, AIDS and tuberculosis, and resources should be allocated for their implementation. National coordination mechanisms, involving prison authorities, ministries of health and labour, national AIDS committees, national tuberculosis programmes and civil society organizations should be established.

60. In many countries, there is overuse of incarceration, instead of putting in place alternative measures that are more effective, especially for people who use drugs. Prisoners and ex-prisoners who are drug users and/or are living with HIV continue

¹⁷ WHO, UNODC, UNAIDS *Technical Guide*.

to face multiple forms of stigmatization, and their rights to health care, education, employment, social integration, food and decent living conditions are often denied. Drug dependence treatment, care and rehabilitation services are scarce in prisons and other closed settings. Access to condoms, needle and syringe programmes and programmes for opioid substitution therapy, HIV testing and counselling, antiretroviral therapy and the prevention of mother-to-child transmission remain limited in prisons and other closed settings. Needle and syringe programmes are available only in some prisons in seven countries and opioid substitution therapy in prisons in only 20 countries. Screening and treatment for tuberculosis, hepatitis and sexually transmitted infections are often unavailable. The absence or interruption of services has serious implications for treatment outcomes and risks for the transmission of HIV and tuberculosis.

61. As part of a comprehensive response to HIV among people who inject drugs, it is necessary to address other common health conditions, including tuberculosis, hepatitis C, sexually transmitted infections and mental health problems. People who inject drugs should be provided with appropriate treatment for these co-occurring conditions.

62. Legislation that prevents the introduction, or inhibits the delivery, of the key HIV prevention, treatment and care services to people who inject drugs and people in prisons and other closed settings should be revised to allow for and support these interventions. In order to achieve this, it is critical that national drug control agencies, law enforcement agencies, ministries of justice, the interior and health, and civil society organizations work closely together.

63. In countries, where adequate investments in research, monitoring and evaluation have been made, and related human resources and systems of government and civil society have been enhanced, more strategic, effective and efficient responses to HIV among people who inject drugs have been put in place. Still, many countries lack reliable data required for evidence-informed, comprehensive policy and programmatic responses, and require technical support to effectively monitor and evaluate HIV epidemic and prevention, treatment and care responses among people who inject drugs, which are urgently required in communities, prisons and other closed settings.

64. It is critical to rapidly increase domestic funding for the essential life-saving HIV services recommended for people who use drugs and people in prisons and other closed settings.
