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Follow-up to the implementation at the national, regional and international levels of all commitments, as reflected in the Ministerial Declaration of 2019, to address and counter the world drug problem

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", and Commission on Narcotic Drugs resolution 60/8, entitled "Promoting measures to prevent HIV and other blood-borne diseases associated with the use of drugs, and increasing financing for the global HIV/AIDS response and for drug use prevention and other drug demand reduction measures". This report provides a brief overview of the global situation and a summary of activities undertaken by the United Nations Office on Drugs and Crime (UNODC) in 2018 and 2019 in response to the spread of HIV/AIDS and other blood-borne diseases among people who use drugs. It also indicates gaps and challenges in the response to HIV/AIDS and other blood-borne diseases among people who use drugs, including in prisons and other closed settings, and contains recommendations.

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

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I. Introduction

1. In Commission on Narcotic Drugs resolution 49/4, entitled “Responding to the prevalence of HIV/AIDS and other blood-borne diseases among drug users”, 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 demonstrate 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). In the same resolution, the Commission requested the United Nations Office on Drugs and Crime (UNODC), in conformity with the *UNAIDS Technical Support Division of Labour* document, 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. In that resolution, the Commission requested the Executive Director of UNODC to report to it biennially, starting at its fifty-first session, on the implementation of the resolution.

3. In its resolution 60/8, entitled “Promoting measures to prevent HIV and other blood-borne diseases associated with the use of drugs, and increasing financing for the global HIV/AIDS response and for drug use prevention and other drug demand reduction measures”, the Commission, inter alia:

(a) Encouraged Member States and other donors to make extrabudgetary contributions to the HIV/AIDS work of UNODC to secure adequately financed, targeted and sustainable responses related to HIV and drug use, and HIV in prison settings, in accordance with the rules and procedures of the United Nations;

(b) Requested UNODC, as the convening agency of UNAIDS for matters relating to HIV/AIDS and drug use and to HIV/AIDS in prisons, to continue to provide, through its HIV/AIDS Section, its leadership and guidance on those matters, in partnership with relevant United Nations and government partners and other relevant stakeholders, such as civil society, affected populations and the scientific community, as appropriate, and to continue to support Member States, upon their request, in their efforts to increase their capacity and mobilize resources, including national investment, for the provision of comprehensive HIV prevention and treatment programmes;

(c) Also requested UNODC to continue to inform Member States, on a yearly basis, about the measures taken to prevent new HIV infections among people who use drugs, and to provide HIV treatment, care and support to people who use drugs, as

well as in prison settings, and about necessary and available funding for relevant programmes and projects of the Office.

4. The UNODC Global Programme on HIV/AIDS is funded from two separate but complementary extrabudgetary sources. The first is core funding from the UNAIDS Unified Budget, Results and Accountability Framework, which is allocated to UNODC as an organization co-sponsoring UNAIDS to support implementation of UNAIDS 2016–2021 Strategy to provide policy and strategy support, normative and operational assistance and strategic partnership, including with law enforcement, the justice sector, prison administrations and civil society organizations, and monitoring and evaluation, at the global, regional and country levels. The second extrabudgetary source is made up of hard-earmarked project funding.

II. Epidemiological situation and required responses

5. In 2018, an estimated 37.9 million (range: 32.7–44.0 million) people globally were living with HIV, 1.7 million (range: 1.4–2.3 million) people became newly infected with HIV, and 770,000 (range: 570,000–1.1 million) people died from AIDS-related illnesses. 24.5 million (range: 21.6 million–25.5 million) people living with HIV were accessing antiretroviral therapy (end of June 2019), up from 7.7 million (range: 6.8 million–8.0 million) in 2010.[1]

6. The joint estimate of UNODC, the World Health Organization (WHO), UNAIDS and the World Bank for the number of people who inject drugs worldwide in 2017 is 11.3 million (range: 8.9 million to 15.0 million), corresponding to 0.23 per cent (range: 0.18 to 0.30 per cent) of the population aged 15–64. The proportion of the population aged 15–64 who inject drugs is relatively high in Eastern and South-Eastern Europe and in Central Asia and Transcaucasia, with rates that are almost four times as high as the global average (3.6 and 3.4 times as high, respectively). In terms of the actual numbers of people who inject drugs, most reside in East and South-East Asia (28 per cent of the global total), even though the prevalence of injecting drug use is relatively low in that subregion. A large number of people who inject drugs also reside in Eastern and South-Eastern Europe (16 per cent of the global total) and North America (16 per cent of the global total). Combined, those three subregions account for almost two thirds (60 per cent) of the global number of people who inject drugs.[2]

7. People who inject drugs are disproportionately affected by blood-borne infectious diseases such as HIV and hepatitis C acquired through the sharing of contaminated needles and syringes. In 2018, the risk of acquiring HIV for people who inject drugs was 22 times as high as the risk for people who do not inject drugs. The joint estimate of UNODC, WHO, UNAIDS and the World Bank of the prevalence of HIV among people who inject drugs worldwide in 2017 is 12.7 per cent, amounting to 1.4 million people who inject drugs that are living with HIV. The available data are based on estimates of the prevalence of HIV among people who inject drugs from 121 countries and cover 95 per cent of the number of estimated people who inject drugs globally. The prevalence of HIV among people who inject drugs is highest in South-West Asia and in Eastern and South-Eastern Europe, which have rates that are 2.3 and 1.8 times the global average, respectively.[3]

8. In 2017, the joint UNODC/WHO/UNAIDS/World Bank estimate for the prevalence of hepatitis C among people who inject drugs worldwide was 49.3 per cent, with an estimated 5.6 million people who inject drugs living with hepatitis C. This estimate is based on information on the prevalence of hepatitis C among people who inject drugs from 102 countries, covering 94 per cent of the estimated global

[1] Joint United Nations Programme on HIV/AIDS (UNAIDS), “Global HIV and AIDS: 2019 fact sheet”. Available at www.unaids.org/.

[2] *World Drug Report 2019* (United Nations publication, Sales No. E.19.XI.8).

[3] Ibid.

population of people who inject drugs. For comparison, the prevalence of hepatitis C infection among the general population (for all ages) worldwide in 2015 was estimated to be 1.0 per cent (range: 0.8–1.1 per cent).[4] There is the potential for these infectious diseases to spread beyond those who inject drugs to the wider community through, for example, sexual transmission.

9. People who are among those most marginalized in society are highly affected by HIV/AIDS: key populations, including people who inject drugs and people in prisons, make up a small proportion of the general population, but are at extremely high risk of HIV infection. Globally, in 2019, the HIV key populations (people most at risk of acquiring or transmitting HIV) and their sexual partners accounted for 54 per cent of all new HIV infections. New HIV infections are rising at an alarmingly rapid pace in countries that have not expanded health and HIV services to reach the areas and the HIV key populations for which such services would be most effective. For example, between 2010 and 2018, the annual number of new HIV infections rose in Eastern Europe and Central Asia (a 29 per cent increase) and the Middle East and North Africa (a 10 per cent increase); in those two regions, 95 per cent or more of all new HIV infections are among HIV key populations and their sexual partners. In 2018, people who inject drugs accounted for an estimated 12 per cent of all new HIV infections globally, and for 41 per cent of new HIV infections in Eastern Europe and Central Asia, 37 per cent of new HIV infections in the Middle East and North Africa, and 13 per cent in Asia and the Pacific.[5]

10. These population groups continue to face major challenges in accessing the human rights-based, public health-focused and gender-responsive HIV prevention, treatment and care they urgently need. Stigma and discrimination in health-care settings and negative attitudes of health-care workers towards people who use drugs can have a significant negative effect on access to services, including HIV testing and treatment. Studies among people who inject drugs found that respondents were almost seven times as likely to avoid HIV testing if they had been previously refused treatment or services by health-care workers.[6,7]

11. Risk behaviour for HIV and hepatitis C transmission among subgroups of people who use stimulant drugs remains widespread. People who inject stimulant drugs such as amphetamine-type stimulants have a higher prevalence of sexual risk behaviours than people who inject opiates, and a prevalence similar to non-injecting ATS users.[8,9,10,11] There seems to be an association between the use of stimulants and an increase in risky sexual behaviour that increases risk of HIV infection. In particular, among men who have sex with men, those who use methamphetamine or amphetamine are more likely to engage in higher-risk sexual behaviours and to be

[4] Ibid.

[5] UNAIDS, *Communities at the Centre: Defending Rights, Breaking Barriers, Reaching People with HIV Services – Global AIDS Update 2019* (Geneva, 2019).

[6] Lianping Ti and others, “HIV test avoidance among people who inject drugs in Thailand”, *AIDS and Behavior*, vol. 17, No. 7 (September 2013), pp. 2474–2478.

[7] Nareerut Pudpong and others, *Measuring HIV-related Stigma and Discrimination in Health Care Settings in Thailand: Report of a Pilot – Developing Tools and Methods to Measure HIV-related Stigma and Discrimination in Health Care Settings in Thailand* (Bangkok, International Health Policy Program, Ministry of Public Health, 2014).

[8] Jennifer Lorvick and others, “Sexual pleasure and sexual risk among women who use methamphetamine: a mixed methods study”, *International Journal of Drug Policy*, vol. 23, No. 5 (September 2012), pp. 385–392.

[9] Shirley J. Semple, Thomas Patterson and Igor Grant, “The context of sexual risk behaviour among heterosexual methamphetamine users”, *Addictive Behaviors*, vol. 29, No. 4 (June 2004), pp. 807–810.

[10] Naomi Braine and others, “HIV risk behavior among amphetamine injectors at U.S. syringe exchange programs”, *AIDS Education and Prevention*, vol. 17, No. 6 (December 2005), pp. 515–524.

[11] James A. Peck and others, “HIV-associated medical, behavioral, and psychiatric characteristics of treatment-seeking, methamphetamine-dependent men who have sex with men”, *Journal of Addictive Diseases*, vol. 24, No. 3 (2005), pp. 115–132.

HIV-positive than those who use other drugs.[12,13,14] Despite evidence showing that certain subgroups of people who use stimulant drugs are at greater risk of HIV and hepatitis, prevention, testing and treatment programmes for those population groups remain very limited in scope and scale across the globe, and their specific needs are often overlooked.[15]

12. Women account for 20 per cent of the global estimate of people who inject drugs[16] in terms of risks, but women who use drugs have greater vulnerability than men to HIV and other blood-borne infections. A review of studies in countries with a high prevalence of HIV among people who inject drugs (greater than 20 per cent) found a higher overall prevalence of HIV among women who inject drugs compared with men who inject drugs.[17] Compared with women in the wider community, women in prison are more likely to have engaged in sex work and/or drug use and be living with HIV owing to the combined risks of unsafe injecting practices and unprotected sex.[18]

13. The prevalence of gender-based violence among women who use drugs is two to five times as high as the prevalence among women who do not use drugs and that factor further contributes to the increased risk of infection with HIV and hepatitis C among women who use drugs. A global review of epidemiology and of interventions to address gender-based violence found that intimate partner violence significantly increases the risk of acquiring HIV by between 28 and 58 per cent among different population subgroups of women, including women who use drugs.[19] Moreover, women who use drugs encounter significant systemic, structural, social, cultural and personal barriers in accessing HIV prevention, drug dependence treatment or social support services.[20]

14. Although favourable health outcomes have been achieved consistent with the scaling-up of the evidence-based HIV prevention, treatment and care for people who inject drugs in line with the comprehensive package of interventions as recommended by WHO, UNODC and UNAIDS, HIV among people who inject drugs remains a major health challenge in many parts of the world. Globally, the coverage of interventions to prevent HIV and hepatitis C among people who inject drugs remains very low and, alarmingly, is likely insufficient to effectively prevent transmission. A systematic review found that in 2017, needle and syringe programmes distributed just 33 needles and syringes per person who injects drugs per year, and only 16 per cent of people who inject drugs had access to opioid substitution therapy. Less than 1 per cent of people who inject drugs lived in countries where the coverage of both of these

[12] Nga Thi Thu Vu, Lisa Maher, and Iryna Zablotska, “Amphetamine-type stimulants and HIV infection among men who have sex with men: implications on HIV research and prevention from a systematic review and meta-analysis”, *Journal of the International AIDS Society*, vol. 18, No. 1 (January 2015).

[13] Claire Edmundson and others, “Sexualised drug use in the United Kingdom (UK): a review of the literature”, International Journal of Drug Policy, vol. 55 (May 2018), pp. 131–148.

[14] Monica Desai and others, “Sexualised drug use: LGTB communities and beyond”, International Journal of Drug Policy, vol. 55 (May 2018), pp. 128–130.

[15] *World Drug Report 2016* (United Nations publication, Sales No. E.16.XI.7).

[16] Louisa Degenhardt and others, “Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: a multistage systematic review”, The Lancet Global Health, vol. 5, No. 12 (December 2017), pp. e1192–e1207.

[17] Don C. Des Jarlais and others, “Are females who inject drugs at higher risk for HIV infection than males who inject drugs: an international systematic review of high seroprevalence areas”, *Drug and Alcohol Dependence*, vol. 124, Nos. 1–2 (July 2012), pp. 95–107.

[18] Steffanie A. Strathdee and others, “Substance use and HIV among female sex workers and female prisoners: risk environments and implications for prevention, treatment, and policies”, *Journal of Acquired Immune Deficiency Syndrome*, vol. 69, Suppl. 2 (June 2015), pp. S110–117.

[19] Louisa Gilbert and others, “Targeting the SAVA (Substance Abuse, Violence and AIDS) syndemic among women and girls: a global review of epidemiology and integrated interventions”, *Journal of Acquired Immune Deficiency Syndrome*, vol. 69, Suppl. 2 (June 2015), pp. S118–S127.

[20] *World Drug Report 2018* (United Nations publication, Sales No. E.18.XI.9).

key interventions is high.[21] Furthermore, in most of the 54 countries reporting data to UNAIDS needle and syringe programme and opioid substitution therapy coverage remained low between 2014 and 2018.[22]

15. In many countries, prisons remain an environment with a high risk for contracting infectious diseases. Globally, an estimated 3.8 per cent (range: 3.2–4.5 per cent) of people in prison are living with HIV, 15.1 per cent with hepatitis C, 4.8 per cent with chronic hepatitis B infection and 2.8 per cent are living with active tuberculosis.[23] The incidence of tuberculosis among people in prison is, on average, 23 times as high as the incidence among the general population,[24] and an estimated two out of every three prisoners with a history of drug use by injection are living with hepatitis C.[25] High levels of drug use in prisons is widely reported, including by injection, and the sharing of contaminated needles and syringes is commonplace,[26] which together with other risk factors are further fuelling a generally higher prevalence of HIV and other infectious diseases in prisons than in the wider community.[27]

16. Even though prisons are a high-risk environment and scientific evidence shows that health interventions can be effective, there are significant gaps in prevention and treatment services in many prisons around the world in order to reduce the transmission of HIV and bring down HIV morbidity and mortality.[28] The availability of epidemiological data in prisons regarding HIV remains limited, while data for the hepatitis C virus, the hepatitis B virus and tuberculosis infections are even scarcer. In the vast majority of countries, there is a lack of monitoring and evaluation data on the coverage and quality of HIV-related and other services in prisons and other closed settings.

III. Global commitment towards ending AIDS by 2030, leaving no one behind

17. UNODC promotes human rights-based, public health-focused and gender-responsive HIV prevention, treatment and care for people who use drugs and people in prisons, and 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 Programme Coordinating Board of UNAIDS.

18. UNODC implements the recommendations related to prevention, treatment and care of HIV/AIDS contained in the outcome document of the thirtieth special session of the General Assembly on the world drug problem, entitled “Our joint commitment to effectively addressing and countering the world drug problem”, and in the 2019

[21] Sarah Larney and others, “Global, regional, and country-level coverage of interventions to prevent and manage HIV and hepatitis C among people who inject drugs: a systematic review”, *The Lancet Global Health*, vol. 5, No. 12 (December 2017), pp. e1208–e1220.

[22] UNAIDS, *Health, Rights and Drugs: Harm Reduction, Decriminalization and Zero Discrimination for People Who Use Drugs* (Geneva, 2019), figure 2.

[23] Kate Dolan and others, “Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees”, *The Lancet*, vol. 388, No. 10049 (September 2016), pp. 1089–1102.

[24] Iacopo Baussano and others, “Tuberculosis incidence in prisons: a systematic review”, *PLoS Medicine*, vol. 7, No. 12 (December 2010).

[25] Sarah Larney and others, “Incidence and prevalence of hepatitis C in prisons and other closed settings: results of a systematic review and meta-analysis”, *Hepatology*, vol. 58, No. 4 (October 2013), pp. 1215–1224.

[26] Ralf Jürgens, Andrew Ball and Annette Verster, “Interventions to reduce HIV transmission related to injecting drug use in prison”, *The Lancet Infectious Diseases*, vol. 9, No. 1 (January 2009), pp. 57–66.

[27] Adeeba Kamarulzaman and others, “Prevention of transmission of HIV, hepatitis B virus, hepatitis C virus, and tuberculosis in prisoners”, *The Lancet*, vol. 388, No. 10049 (September 2016), pp. 1115–1126.

[28] *World Drug Report 2016*.

Ministerial Declaration on Strengthening Our Actions at the National, Regional and International Levels to Accelerate the Implementation of Our Joint Commitments to Address and Counter the World Drug Problem.

19. In the outcome document of the thirtieth special session of the General Assembly, entitled "Our joint commitment to effectively addressing and countering the world drug problem" (Assembly resolution S-30/1), relevant national authorities were invited to consider, in accordance with their national legislation and the three international drug control conventions, including in national prevention, treatment, care, recovery, rehabilitation and social reintegration measures and programmes, in the context of comprehensive and balanced drug demand reduction efforts, effective measures aimed at minimizing the adverse public health and social consequences of drug abuse, including appropriate medication-assisted therapy programmes, injecting equipment programmes, as well as antiretroviral therapy and other relevant interventions that prevent the transmission of HIV, viral hepatitis and other blood-borne diseases associated with drug use, and to consider ensuring access to such interventions, including in treatment and outreach services, prisons and other custodial settings, and promoting in that regard the use, as appropriate, of the technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, issued by WHO, UNODC and UNAIDS.

20. In its resolution 70/266, the General Assembly adopted the Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and Ending the AIDS Epidemic by 2030. In the Political Declaration, Member States reaffirmed their commitment to ending the AIDS epidemic by 2030 and reaching the goals and targets set in the 2030 Agenda. The Political Declaration explicitly emphasizes the importance of promoting, protecting and fulfilling all human rights and the dignity of people living with, at risk of and affected by HIV and AIDS as an objective and means to ending the AIDS epidemic. In the Political Declaration, Member States note that many national HIV prevention, testing and treatment programmes provide insufficient access to services for key populations, including for people who inject drugs and people in prison.

21. The technical assistance provided by UNODC – a co-sponsor of UNAIDS – with regard to HIV/AIDS is aligned with the UNAIDS 2016–2021 Strategy. With its Strategy, UNAIDS seeks to achieve by 2020 a set of ambitious, focused and people-centred goals and targets in order to accelerate the delivery of results that contribute to achieving the 2030 Agenda for Sustainable Development and reach the Agenda's target 3.3 of ending the AIDS epidemic as a public health threat by 2030, while leaving no one behind in the response.[29]

22. In the reporting period, UNODC contributed to the review and revision of the UNAIDS Division of Labour between the UNAIDS co-sponsoring organizations. The updated UNAIDS Division of Labour reflects the new operational model for UNAIDS and is aligned with the UNAIDS 2016–2021 Strategy, the 2016 Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030, and the Sustainable Development Goals. In accordance with the UNAIDS Division of Labour, UNODC is the convening agency of the UNAIDS family for prevention and treatment of HIV among people who use drugs and ensuring access to comprehensive HIV services for people in prisons and other closed settings.[30]

23. The revised UNAIDS Division of Labour is also in line with the vision of the Secretary-General for a repositioned United Nations development system and with the 2030 Agenda, leveraging each organization's comparative advantage to bring added value, capacity and skills to better address country needs. The work on HIV among key and vulnerable populations, co-convened by UNODC (in the area of people who use drugs and prisoners), the United Nations Development Programme

[29] UNAIDS, *UNAIDS 2016–2021 Strategy: On the Fast-Track to End AIDS* (Geneva, 2015).
[30] UNAIDS, "UNAIDS joint programme division of labour: guidance note 2018" (Geneva, 2018).

(UNDP) and the United Nations Population Fund (in the area of men who have sex with men, migrants, sex workers and transgender people) engages all UNAIDS co-sponsors and the UNAIDS secretariat, including the Global HIV Prevention Coalition. This will continue to be done in close, meaningful and participatory collaboration with key and vulnerable populations and their organizations in accordance with the 2030 Agenda, in which Member States pledged to leave no one behind. The co-convenors will forge impactful partnerships with all relevant stakeholders, including partnerships beyond UNAIDS, to foster and support evidence-informed, rights-based responses to HIV and co-infections.

IV. Technical assistance provided by the United Nations Office on Drugs and Crime in 2018 and 2019 with regard to HIV/AIDS

A. HIV/AIDS policy and programme development

24. In 2018 and 2019, UNODC continued to advocate for evidence-informed and human rights-focused public health approaches to HIV prevention, treatment and care for people who use drugs and for people living in prisons and other closed settings, and provided targeted training and technical assistance for the review, adaptation, development and implementation of relevant legislation, AIDS strategies, policies and programmes.

25. UNODC and its partners engaged national policymakers, drug control agencies, prison administrations, public health authorities, justice authorities, civil society organizations including representatives of people who use drugs, and the scientific community in an evidence-informed dialogue on HIV, drug policies and human rights to help identify ways in which drug policies could be strengthened so as to protect the right of people who use drugs to HIV-related health care, including in prisons and other closed settings.

26. Jointly with national and international partners, UNODC supported Member States in effectively addressing HIV at the sixty-first and sixty-second sessions of the Commission on Narcotic Drugs, and the twenty-seventh and twenty-eighth sessions of the Commission on Crime Prevention and Criminal Justice. UNODC also supported stakeholders as they contributed to the ministerial segment of the sixty-second session of the Commission on Narcotic Drugs by taking stock of the implementation of the commitments made to jointly address and counter the world drug problem, sharing their expertise and practical experiences drawn from their work on the ground in HIV prevention, treatment and care for people who use drugs.

27. UNODC contributed to the ongoing work of the Global HIV Prevention Coalition and the implementation of the HIV prevention 2020 road map as a basis for a country-led movement to scale up HIV prevention programmes as part of a comprehensive response to meet global and national prevention targets and commitments to end AIDS as a public health threat by 2030, including for people who inject drugs and for prisoners.

28. UNODC provided targeted training and technical assistance for the review, adaptation, development and implementation of relevant legislation, national AIDS strategies, policies and programmes that are evidence-informed and human-rights focused and that more effectively support public health approaches to HIV prevention, treatment and care for people who use drugs, and in prisons and other closed settings, including in Afghanistan, the Dominican Republic, Ethiopia, India, Indonesia, Kyrgyzstan, Myanmar, the Philippines, Ukraine, Uzbekistan and Zambia, among other countries.

29. UNODC advocated for the removal of legal barriers hindering access to HIV services, including needle and syringe programmes, opioid substitution therapy and condom distribution programmes in prisons, and supported the adaptation of national

standard operating procedures for HIV testing services in prison settings. For example, in October 2019, UNODC and UNAIDS organized a national consultation conference on HIV and tuberculosis interventions in prisons and other closed settings in India to support the development of the state-level action plan on HIV in prisons for the period 2020–2021.

30. In Afghanistan, UNODC provided technical support to the Afghanistan national programme for the control of AIDS, sexually transmitted infections and hepatitis for carrying out a mapping of people who inject drugs and conducting the mid-term review of the national strategic plan of Afghanistan for the period 2016–2020 for HIV prevention, treatment and care services (in coordination with UNDP, WHO and UNAIDS), focusing on activities funded through the Global Fund to Fight AIDS, Tuberculosis and Malaria.

31. In the Dominican Republic, UNODC led the review of the country's legal framework, convened discussions among government partners in the law enforcement and health sectors and other key stakeholders, policymakers and other United Nations agencies (UNDP and UNAIDS) on evidence-informed and human rights-focused policies, and promoted comprehensive HIV services for people who inject drugs, including help to sustain participation in opioid substitution therapy.

32. In Ethiopia, UNODC conducted an assessment on the legislative environment, reviewing the legislative and policy environment to identify opportunities, gaps and challenges with respect to access by people who inject drugs to HIV and other health services, and, in collaboration with the Office of the United Nations High Commissioner for Refugees, UNODC led an assessment on drug use risk factors and vulnerabilities among refugees and the related available health services.

33. In Zambia, UNODC supported the National HIV/AIDS/STI/TB Council in developing a five-year plan for the monitoring and evaluation of key populations in order to achieve the 90-90-90 treatment targets in line with the UNAIDS 2016–2021 Strategy. In collaboration with UNDP, UNODC provided technical advice to the Ministry of Health and the Ministry of National Guidance and Religious Affairs to address the legal and policy barriers for people who inject drugs and people in prisons, which are hindering their access to comprehensive HIV and sexual and reproductive health services. In Nigeria, the first ever national situation and needs assessment of HIV, hepatitis, tuberculosis and drug use in prisons was conducted with the support of UNODC to inform the development of national policies, strategies and evidence-based interventions.

34. In Myanmar, UNODC hosted workshops for over 500 key stakeholders (state-level and regional-level health authorities, community leaders and law enforcement officials) in five priority states and regions, on the newly adopted human rights-centred and public health-focused national drug policy. In the workshops, participants identified the priority activities and challenges in, and planned the activities required for, implementing the new drug policy and improving access to, and the coverage of, prevention, treatment and care of HIV/AIDS, viral hepatitis and other blood-borne infectious diseases for people who inject drugs.

35. UNODC led the compilation and joint review of estimates of the number of people who inject drugs, and of the prevalence of HIV and hepatitis C among people who inject drugs, conducted in collaboration with WHO, UNAIDS and the World Bank. That collaboration enhanced coordination in data collection and analysis, harmonized global data analysis and reporting with the involvement of civil society and expert networks, and produced strategic information on the quality of the estimates currently used by United Nations agencies for identifying country-specific needs in the areas of capacity-building and technical assistance. More robust global data sets also supported planning and programming by the Global Fund to Fight AIDS, Tuberculosis and Malaria for scaling up HIV prevention, treatment and care services for people who inject drugs. The joint UNODC/WHO/UNAIDS/World Bank estimates were published in the *World Drug Report 2018* and *World Drug Report 2019*.

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

36. UNODC continued to provide technical support for Member States and civil society in the implementation of human rights-based, public health-focused and gender-responsive HIV prevention, treatment, care and support services for people who use drugs, including in prisons and other closed settings. In line with the outcome document of the thirtieth special session of the General Assembly as the basis for work by UNODC on HIV/AIDS and other drug-related matters, UNODC promoted in that regard the use, as appropriate, of the technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, issued by WHO, UNODC and UNAIDS.[31]

37. For example, in Kenya, UNODC supported the establishment of injecting equipment and medication-assisted therapy programmes in clinics in public health facilities in Nairobi, Kilifi, Mombasa, Kwale and Kisumu counties, which provide services to over 4,000 patients. Among other major achievements were the mobilization, referral and follow-up efforts for medication-assisted therapy and other HIV prevention services achieved by supporting eight civil society organizations, and the establishment of the country's first methadone dispensing site, at the Shimo La Tewa prison.

38. In Egypt, UNODC, in collaboration with the United Nations Children's Fund, provided training and mentoring for community-based organizations, which strengthened targeted outreach activities aimed at improving access to comprehensive HIV services among people who inject drugs and their sexual partners, and facilitated building sustainable partnerships between government and community-based organizations. Support provided by UNODC helped to reach over 5,000 people who inject drugs with HIV testing and referral services, condom distribution, needle and syringe programmes, and HIV information and education in innovative and more cost-effective ways.

39. In Viet Nam, UNODC supported the Ministry of Health in the review of the opioid substitution therapy guideline and development of an additional component for the guideline on opioid substitution therapy with buprenorphine. UNODC also supported the Ministry of Health and Population and the Global Fund to Fight AIDS, Tuberculosis and Malaria in conducting a pilot programme using buprenorphine in seven provinces (Nghe An, Dien Bien, Son La, Thanh Hoa, Yen Bai, Lai Chau and Hoa Binh) and trained over 60 medical staff members from those provinces.

40. In Indonesia, UNODC led the implementation of uninterrupted and gender-responsive HIV services for people who inject drugs, people in prisons and the broader community. Jointly with the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), UNODC supported the Government in its implementation of gender-responsive HIV services and built the capacity of service providers in comprehensive HIV services for women who inject drugs. UNODC also facilitated collaboration and coordination between the law enforcement and health sectors and working with non-governmental and community-based organizations, and implemented a series of workshops in four provinces for over 80 participants representing 29 prisons and 15 provincial and district-level health offices. The training and technical assistance provided by UNODC helped to establish a referral system and increase collaboration between prisons and local community health service providers for ensuring continuity of care of HIV and tuberculosis services for over 4,000 prisoners in the four provinces.

41. In the Islamic Republic of Iran, UNODC developed a training manual, for drug dependence treatment centres, on peer-driven interventions to ensure linkages to

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

comprehensive HIV testing services and improve the availability of and access to HIV testing services for people who inject drugs and for their sexual partners. In addition, round-table discussions were conducted with key stakeholders from the Ministry of Health and Medical Education, non-governmental and community-based organizations for improving the provision of comprehensive HIV services for people who inject drugs, including HIV testing in short-term residential drug treatment centres and private centres for methadone maintenance treatment.

42. In Myanmar, UNODC strengthened human rights-centred and public health-focused policies for people who inject drugs and improved the delivery of gender-responsive HIV services for women who inject drugs, including by conducting a training-of-trainers programme and supporting national partners in mainstreaming the issue of gender in the monitoring and evaluation of HIV-related services.

43. UNODC supported compliance with general principles for HIV/AIDS prevention and care in prisons[32] and the alignment of HIV and sexual and reproductive health services with the United Nations standard minimum rules in prisons in sub-Saharan Africa, in particular in Angola, Ethiopia, Lesotho, Malawi, Mozambique, Namibia, Swaziland, the United Republic of Tanzania, Zambia and Zimbabwe.

44. In Egypt, Morocco and Tunisia, UNODC built the capacity of senior government officials to address HIV, viral hepatitis, sexually transmitted infections and tuberculosis prevention, treatment and care among male and female prisoners. In India, Kenya and Viet Nam, UNODC trained prison health staff and community-based HIV service providers on HIV testing in prison settings and establishing linkages to care at the post-release stage, and built the capacity of over 100 health-care providers in those three countries on standard operating procedures for HIV service provision and related medical ethics in prisons.

45. UNODC supported assessments on the availability of comprehensive HIV services in prisons and advocated for the alignment of prison health sector plans with the comprehensive package of HIV prevention, treatment and care services for prison settings in India, Nigeria, the Philippines, the United Republic of Tanzania and Viet Nam. For example, in India, the assessment in prisons in Gujarat of HIV, tuberculosis, hepatitis B and hepatitis C and syphilis prevalence, infection risk, treatment availability, accessibility and quality of treatment services provided biobehavioural baseline data and information to help address gaps in health services for over 12,000 people in prisons. Also, in India, the integrated model of service delivery for people who inject drugs and their sexual partners and training on opioid substitution therapy for over 1,000 health service providers supported by UNODC helped to improve outreach strategies and the development of effective service referral systems for people who inject drugs in the community.

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

46. UNODC supported the development, implementation and scaling-up of HIV, hepatitis B and hepatitis C programmes for people who use stimulant drugs and who are at risk of contracting those viruses, through the implementation of training-of-trainers workshops. Over 250 trainers were trained in country workshops in Brazil, the Dominican Republic and Viet Nam and in the regional workshops in the regions of the Middle East and North Africa (Afghanistan, Bahrain, Egypt, Iran (Islamic Republic of), Iraq, Lebanon, Morocco, Pakistan and Tunisia), Eastern Europe (Belarus, the Republic of Moldova and Ukraine) and South-East Asia (Cambodia, China, Indonesia, Myanmar, Thailand and Viet Nam).

[32] United Nations Office on Drugs and Crime, Joint United Nations Programme on HIV/AIDS and the World Health Organization, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: a Framework for an Effective National Response* (New York, 2006).

47. During the reporting period, UNODC built the capacity of civil society organizations and other partners that are providing HIV services for people who inject drugs in the area of how to improve working with law enforcement officials.

48. In partnership with civil society and community-based organizations and with contributions provided by WHO, the UNAIDS secretariat and UN-Women, UNODC addressed the specific needs of women who inject drugs and trained more than 700 service providers, programme managers, health-care workers, outreach workers and other professionals in 13 countries (Afghanistan, Belarus, Dominican Republic, Kazakhstan, Kyrgyzstan, Morocco, Myanmar, Nepal, the Republic of Moldova, Tajikistan, Thailand, the United Republic of Tanzania and Uzbekistan).

49. UNODC increased the capacity of over 700 government and civil society service providers, programme managers and other national and international partners from 13 countries (Belarus, Egypt, Indonesia, Iran (Islamic Republic of), Kazakhstan, Kyrgyzstan, Myanmar, Republic of Moldova, South Africa, Tajikistan, Thailand, Uzbekistan and Viet Nam) in gender-disaggregated data collection and analysis and the monitoring of HIV services for women who use drugs. The training supported the national stakeholders, including partners implementing services funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria, to effectively use the monitoring data for HIV policy and programme development and the scaling-up of HIV services for women who use drugs.

50. During the reporting period, UNODC supported Member States in the review and revision of the annual report questionnaire with regard to data on injecting drug use and HIV, and regarding prisons, and further developed harmonized indicators and methodological guidance for data collection, monitoring and evaluation of HIV services for people who inject drugs, jointly with WHO, UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the President's Emergency Plan for AIDS Relief of the United States of America and other partners.

51. UNODC strengthened partnerships between law enforcement and other relevant sectors, including public health, social welfare, civil society and community-based organizations and trained over 2,300 law enforcement officers, over 250 representatives of civil society and community-based organizations and over 150 parliamentarians and representatives of health, education and social sectors from eight countries (Belarus, Kazakhstan, Morocco, the Philippines, the Republic of Moldova, Tajikistan, Ukraine and Uzbekistan) in collaboration with UNAIDS and UNDP. The UNODC e-learning training tool for law enforcement officials on HIV prevention, treatment and care service provision among people who inject drugs (in English) was finalized and made available on the UNODC Global eLearning Platform.

52. For example, in Central Asia, UNODC and its partners advocated for and built capacity in public health-centred and human rights-based responses to HIV among people who inject drugs and people in prisons.

53. In Kazakhstan, UNODC built the capacity of service providers with a focus on scaling up opioid substitution therapy and facilitated collaboration between law enforcement agencies and community-based organizations for the referral of people who inject drugs to HIV services as an alternative to incarceration.

54. In Kyrgyzstan, UNODC supported the inclusion of training courses on evidence-based HIV prevention, treatment and care for people who inject drugs and gender-based violence in the curricula of training centres of the Ministry of Internal Affairs located in Bishkek and Osh and supported the establishment of an educational centre in the police department of the Osh region for training law enforcement personnel on HIV issues (with the initial target of training at least 60 participants per year) and for facilitating collaboration between law enforcement and community-based organizations in order to increase coverage of HIV services among people who inject drugs and improve service quality. In addition, UNODC, jointly with community-based organizations and the General Prosecutor's Office, developed key performance indicators and supported the establishment of regular monitoring of

the performance of measures taken by police to increase access to referral services as an alternative to incarceration for people who inject drugs, in collaboration with community-based organizations.

55. In Tajikistan, UNODC supported a non-governmental organization in providing regular training for over 200 police officers in evidence-based HIV prevention, treatment and care for people who inject drugs and on how law enforcement officials can support human rights and public health-based approaches to HIV and injecting drug use in collaboration with community-based organizations.

56. In Uzbekistan, UNODC supported the National AIDS Centre and non-governmental organizations in the implementation of a training programme on evidence-based and gender-responsive HIV prevention, treatment and care for people who inject drugs, drug dependence, stigma and discrimination associated with drug use and HIV. The training reached nearly 100 prison health staff members of the Ministry of Internal Affairs and the penal system. In addition, UNODC trained teachers and specialists of the national police academy and the Ministry of Internal Affairs in interacting with people who inject drugs in community settings and implementing police referral services as an alternative to incarceration. The training on HIV prevention among people who inject drugs based on UNODC guidance is being institutionalized as part of a national training curricula for law enforcement officials.

V. Conclusions and recommendations

57. Globally, among people who inject drugs, the prevalence of HIV is high, and new HIV infections are on the increase. HIV infections, together with the high prevalence of hepatitis C among people who inject drugs, pose a serious public health concern. Favourable health outcomes have been achieved through the scaling-up of HIV prevention, treatment and care for people who inject drugs, in line with the comprehensive package of interventions recommended by WHO, UNODC and UNAIDS. Nevertheless, the coverage of these evidence-based HIV and hepatitis C prevention interventions for people who inject drugs, in particular needle and syringe programmes and opioid substitution therapy, remains worryingly low or even non-existent. Despite evidence showing that certain subgroups of people who use stimulant drugs are at greater risk of HIV, their specific prevention, testing and treatment needs are often overlooked.

58. In the reporting period, UNODC was able to maintain its critical core capacity, staff and operational resources in order to support Member States pursuant to relevant resolutions of the Commission regarding HIV/AIDS. This was largely possible with the UNAIDS core funding allocated to UNODC as a UNAIDS co-sponsoring organization and as the UNAIDS convening agency for the prevention and treatment of HIV among people who use drugs and for people in prisons and other closed settings. However, a downward trend in resources and funding, including from UNAIDS, which the Commission noted in its resolution 60/8, continued to adversely affect the implementation of many important strategic and catalytic activities and the provision of technical assistance by UNODC to sufficiently support Member States in their efforts to prevent HIV/AIDS and other blood-borne diseases associated with the use of drugs, including in prisons.

59. Of particularly grave concern is the fact that the insufficient allocation of resources to UNODC work in the area of HIV/AIDS has seriously hampered the capacity of the Office to utilize its comparative advantages, established partnerships and specific technical expertise for reducing new HIV infections among people who use drugs, including in prisons, and to effectively support the implementation and further leverage the investments made through the Global Fund to Fight AIDS, Tuberculosis and Malaria to end AIDS as a public health threat by 2030.

60. Unless evidence-based and gender-responsive services are urgently implemented and maintained on a sufficient scale, it is not likely that the transmission

of HIV and other blood-borne infections among people who inject drugs will be prevented or that target 3.3 of the Sustainable Development Goals on ending AIDS by 2030 will be reached.

61. In order to reverse the trajectory and stop HIV/AIDS and other blood-borne diseases from spreading among people who inject drugs, the Commission on Narcotic Drugs may wish to recommend that Member States:

(a) Consider, in accordance with their national legislation and the three international drug control conventions, including in national prevention, treatment, care, recovery, rehabilitation and social reintegration measures and programmes, in the context of comprehensive and balanced drug demand reduction efforts, effective measures aimed at minimizing the adverse public health and social consequences of drug abuse, including appropriate medication-assisted therapy programmes and injecting equipment programmes, as well as antiretroviral therapy and other relevant interventions that prevent the transmission of HIV, viral hepatitis and other blood-borne diseases associated with drug use, and also consider ensuring access to such interventions, including in treatment and outreach services, prisons and other custodial settings, and promoting in that regard the use, as appropriate, of the technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, issued by the World Health Organization, the United Nations Office on Drugs and Crime and the Joint United Nations Programme on HIV/AIDS;

(b) Identify and remove barriers to accessing these services;

(c) Consider alternatives to imprisonment for petty, non-violent offences, including for people who use drugs;

(d) Put in place laws and policies to facilitate access to equivalent health care for people who use drugs and who are serving prison sentences, with priority given to the 15 interventions outlined by the United Nations Office on Drugs and Crime, the International Labour Organization, the United Nations Development Programme, the World Health Organization and the Joint United Nations Programme on HIV/AIDS in the policy brief entitled “HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions”.

62. Furthermore, the Commission on Narcotic Drugs may wish to recommend that Member States, civil society organizations, communities and other stakeholders:

(a) Significantly and urgently accelerate coordinated, rights-based and people-centred measures for achieving universal health coverage by improving the availability, accessibility and quality of comprehensive HIV prevention, treatment and care for people who use drugs, including in prisons and other closed settings;

(b) Promote measures aimed at eliminating multiple intersecting forms of stigma and discrimination experienced by people who use drugs, including when they seek to access health, legal, education, employment and social protection services, or when they interact with law enforcement;

(c) Eliminate discriminatory laws, policies and practices to reduce barriers to accessing evidence-based and gender-responsive HIV prevention, treatment and care for people who inject drugs, including those in prisons and other closed settings, who epidemiological evidence shows to be globally at higher risk of HIV infection;

(d) Increase financial allocations from both international and national sources focusing on priority interventions in high-priority locations, and adopt measures for optimizing resource allocation, improving implementation efficiency and increasing investment of non-HIV resources for achieving greatest impact on health outcomes among people who use drugs;

(e) Utilize innovation and multiple service delivery models for more targeted, sustainable and accountable responses, including linkages to prevention, treatment and care services in the community, on admission to and upon release from prison;

(f) Promote people-centred approaches by meaningfully involving and supporting community-based and civil society organizations in the design, implementation and monitoring and evaluation of drug policies and programmes, as well as in the design and delivery of HIV, health and social protection services;

(g) Integrate and prioritize both public and individual health, and intensify partnerships between the health, criminal justice, law enforcement, prison administration, civil society and other sectors to address the determinants of vulnerabilities, including discrimination and gender inequality, affecting people who use drugs, including in prisons and other closed settings, in order to end AIDS as a public health threat by 2030, leaving no one behind, in line with the 2030 Agenda for Sustainable Development.