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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: demand reduction and related measures

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". It provides a brief overview of the global situation and a summary of activities implemented by the United Nations Office on Drugs and Crime (UNODC) undertaken in 2016 and 2017 in response to the spread of HIV/AIDS and other blood-borne diseases among people who use drugs. It 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 provides 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. Also 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. Furthermore, noting with concern the downward trend in the availability of resources and funding for the global HIV/AIDS response, in particular for programmes targeting the prevention and treatment of HIV among people who use drugs, the Commission adopted 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”. In that resolution, 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 engage fully in the work and consultations of the Global Review Panel on the Future of the Joint Programme Model of UNAIDS;

(d) Further 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. With respect to the downward trend in resources and funding noted in Commission on Narcotic Drugs resolution 60/8, 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 cosponsoring UNAIDS to support implementation of UNAIDS 2016–2021 strategy. The second extrabudgetary source is made up of bilateral, hard-earmarked funds to implement HIV projects at the country and regional levels. Core UNAIDS funding is used 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 bilaterally funded HIV projects are implemented in countries and regions, but are hard-earmarked and do not allow compensation for any loss from the core UNAIDS allocation. Following the unexpected 50-per-cent cut in the UNAIDS core allocation to UNODC in mid-2016, the UNODC Global Programme on HIV/AIDS had to undergo severe austerity measures and significantly scale down its activities, which adversely affected the implementation of many important strategic and catalytic activities and the provision of technical assistance to Member States.

II. Epidemiological situation and required responses

5. In 2016, an estimated 36.7 million (range: 30.8–42.9 million) people globally were living with HIV, 1.8 million (range: 1.6–2.1 million) people became newly infected with HIV, and 1.0 million (range 830,000–1.2 million) people died from AIDS-related illnesses. Access to HIV treatment has risen significantly from just 685,000 people living with HIV who had access to antiretroviral therapy in 2000 to 20.9 million (range: 18.4–21.7 million) people accessing antiretroviral therapy in June 2017. The people most marginalized in society and most affected by HIV, including people who inject drugs and people in prisons, are still facing major challenges in accessing the health and social services they urgently need. New HIV infections are rising at a rapid pace in countries that have not expanded health and HIV services to the areas and the populations where they are most effective. In Eastern Europe and Central Asia, for example, new HIV infections have risen by 60 per cent since 2010 and AIDS-related deaths by 27 per cent.[1]

6. Drug use by injection continues to drive the spread of the HIV epidemic in many countries around the world. The most recent joint UNODC/World Health Organization (WHO)/UNAIDS/World Bank estimate for the number of people worldwide who injected drugs in 2015 is 11.8 million (range: 8.6–17.4 million), corresponding to 0.25 per cent (range: 0.18–0.36 per cent) of the population aged 15–64 years. The estimate is based on the reporting of drug use by injection from 107 countries that together cover 89 per cent of the global population aged 15–64 years. Subregions where the prevalence of drug use by injection is above the global

[1] Joint United Nations Programme on HIV/AIDS (UNAIDS), *Right to Health* (Geneva, 2017).

average are Eastern and South-Eastern Europe, Central Asia and Transcaucasia, North America, Oceania and South-West Asia.[2] Furthermore, a recent review found recorded evidence of drug use by injection in 179 countries or territories. Based on prevalence estimates of drug use by injection from 83 countries (in the period 1996–2016), the authors suggested a global estimate of 15.6 million people who inject drugs aged 15–64 years (with a 95 per cent uncertainty interval of 10.2–23.7 million).[3]

7. The available data suggest that, globally, new HIV infections among people who inject drugs climbed from an estimated 114,000 in 2011 to 152,000 in 2015.[4] The joint UNODC/WHO/UNAIDS/World Bank estimate for the prevalence of HIV among people who inject drugs in 2015 is 13.1 per cent. This suggests that roughly one in eight people who injected drugs in 2015 were living with HIV, which equates to 1.55 million people worldwide. By far the highest prevalence rates of HIV among people who inject drugs are found in South-West Asia (28.5 per cent) and Eastern and South-Eastern Europe (24.0 per cent), where rates are approximately twice the global average (13.1 per cent).[5] Hepatitis C is highly prevalent among people who inject drugs: the joint UNODC/WHO/UNAIDS/World Bank estimate for 2015 is that 51.5 per cent of people who inject drugs (6.1 million) were infected. For hepatitis B, the equivalent estimate is 7.4 per cent (880,000). Among people who inject drugs who are also living with HIV, co-infection with hepatitis C is highly prevalent, at 82.4 per cent, with hepatitis C among those living with HIV becoming a major cause of morbidity and mortality.[6] Moreover, a recently published review further reinforced the evidence that drug use by injection is an important factor contributing to the global disease burden of blood-borne viruses. The authors estimated that 17.8 per cent of people who inject drugs (95 per cent uncertainty interval of 10.8–24.8 per cent) were living with HIV, 52.3 per cent (range: 42.4–62.1 per cent) were antibody-positive for hepatitis C, and 9.0 per cent (range: 5.1–13.2 per cent) were surface-antigen-positive for hepatitis B. Incidentally, the authors noted substantial geographic variations in those levels.[7]

8. Risk behaviour among subgroups of people who use stimulant drugs remains widespread and HIV prevalence high. In particular, there is strong evidence that, among men who have sex with men, those who use methamphetamine or amphetamine are more likely to engage in higher-risk sexual behaviours and be HIV-positive than those who use other drugs.[8] Studies have also found that people who inject stimulants (cocaine and amphetamines) are more likely to engage in higher-risk sexual behaviours and be HIV-positive than people who inject opiates. People who inject stimulants have been found to have more sexual partners and more frequent intercourse with both casual and regular partners than people who inject other drugs. Moreover, a systematic review found that the risk of acquiring HIV was 3.6 times greater among people who used cocaine by injection than among those who used cocaine other means, and 3.0 times higher among people who used amphetamine-type stimulants by injection than among those who used

[2] *World Drug Report 2017* (United Nations publication, Sales Nos. E.17.XI.7, E.17.XI.8, E.17.XI.9, E.17.XI.10 and E.17.XI.11).

[3] 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 (2017), pp. e1192–e1207.

[4] UNAIDS, *Get on the Fast Track: The Life-cycle Approach to HIV* (Geneva, 2016).

[5] *World Drug Report 2017*.

[6] Lucy Platt and others, “Prevalence and burden of HCV co-infection in people living with HIV: a global systematic review and meta-analysis”, *The Lancet Infectious Diseases*, vol. 16, No. 7 (2016), pp. 797–808.

[7] Degenhardt and others.

[8] 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 (2015).

amphetamine-type stimulants by other means. While, compared with other drugs, it is difficult to quantify the contribution the use of stimulants is making to the increase in HIV infection rates, most evidence points towards a positive association between stimulant use, higher-risk sexual and injecting behaviours and HIV infections.[9,10]

9. Women who inject drugs are often more vulnerable to HIV than their male counterparts. 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.[11] Unsafe injecting practices may be more common among women because of the lack of services tailored to their needs, including the fact that they experience greater difficulty in accessing needle and syringe programmes or treatment for drug dependence. Women in prison often come from socially marginalized groups. Compared with women in the wider community they 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.[12, 13]

10. The coverage of interventions to prevent HIV and hepatitis C among people who inject drugs remains very low and, as a recent systematic review has found, likely insufficient to effectively prevent transmission. This is cause for alarm. Globally, needle and syringe programmes distributed just 33 needles and syringes per person who injects drugs per year, only 16 per cent of people who inject drugs had access to opioid substitution therapy, and less than 1 per cent lived in countries where the coverage of both of these key interventions is high.[14] The greatest benefit from HIV and hepatitis C prevention is reported when needle and syringe programmes are offered in combination with opioid substitution therapy and their coverage is high,[15,16,17] meaning more than 200 needles or syringes per person who injects drugs per year, and more than 40 per cent of people who inject drugs undergoing opioid substitution therapy.[18]

[9] Isabel Tavitian-Exley and others, “Influence of different drugs on HIV risk in people who inject: Systematic review and meta-analysis”, *Addiction*, vol. 110, No. 4, pp. 572–584.

[10] Louisa Degenhardt and others, “Meth/amphetamine use and associated HIV: Implications for global policy and public health”, *International Journal of Drug Policy*, vol. 21, No. 5 (2010), pp. 347–358.

[11] 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 and 2 (2012), pp. 95–107.

[12] *World Drug Report* 2015 (United Nations publication, Sales No. E.15.XI.6).

[13] Steffanie 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, supplement 2, pp. S110–117.

[14] 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, pp. e1208–e1220.

[15] Louisa Degenhardt and others, “Prevention of HIV infection for people who inject drugs: Why individual, structural and combination approaches are needed”, *The Lancet,* vol. 376, No. 9737 (2010), pp. 285–301.

[16] Natasha K. Martin and others, “Combination interventions to prevent HCV transmission among people who inject drugs: Modelling the impact of antiviral treatment, needle and syringe programs, and opiate substitution therapy” *Clinical Infectious Diseases,* vol. 57, supplement 2 (2013), pp. S39–S45.

[17] Katy Turner and others, “The impact of needle and syringe provision and opiate substitution therapy on the incidence of hepatitis C virus in injecting drug users: Pooling of UK evidence” *Addiction*, vol. 106, No. 11 (2011), pp. 1978–1988.

[18] *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 (WHO), 2009).

11. In many countries, prisons remain an environment with a high risk for contracting infectious diseases. A number of studies report high levels of drug use in prison, including by injection, and the sharing of contaminated needles and syringes is commonplace.[19] Globally, an estimated 3.8 per cent (range: 3.2–4.5 per cent) of prison inmates are living with HIV.[20] The prevalence of HIV is generally higher in prisons than in the wider community.[21] Moreover, the incidence of tuberculosis among inmates is, on average, 23 times higher than among the general population,[22] and an estimated two out of every three inmates with a history of drug use by injection are living with hepatitis C.[23] The availability of epidemiological data regarding HIV remains limited. The same is true for the monitoring and evaluation of services in prisons and other closed settings. There is a need to improve the monitoring and evaluation of the HIV situation in prisons to inform action to reduce the transmission of HIV and bring down HIV morbidity and mortality.

12. Health in prisons is a general public health issue. For the vast majority of people in prison, detention or imprisonment is a temporary condition, and after their release they will return to enter their communities. Therefore it is essential to ensure continuity of care on admission to and after release from prison. The period shortly after release from prison is associated with a substantially increased risk of drug-related death, primarily from a fatal overdose. The drug-related mortality rate among people recently released from prison is much higher than that of the general population from all causes combined.[24, 25] 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.[26]

III. Reinvigorated global commitment towards ending AIDS by 2030 leaving no one behind

13. 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 UNAIDS Programme Coordinating Board.

14. UNODC, a co-sponsor of UNAIDS, is the convening agency in the UNAIDS family for prevention and treatment of HIV among people who use drugs and ensuring

[19] 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 (2009), pp. 57–66.

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

[21] 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 (2016), pp. 1115–1126.

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

[23] 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 (2013), pp. 1215–1224.

[24] Ingrid Binswanger and others, “Mortality after prison release: Opioid overdose and other causes of death, risk factors, and time trends from 1999 to 2009”, *Annals of Internal Medicine*, vol. 159, No. 9 (2013), pp. 592–600.

[25] WHO, *Preventing Overdose Deaths in the Criminal Justice System* (Copenhagen, 2014).

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

access to comprehensive HIV services for people in prisons and other closed settings, in accordance with the UNAIDS Division of Labour.[27] The Division of Labour is used to accentuate the comparative advantages of the UNAIDS cosponsors and to leverage organizational mandates and resources to work collectively to deliver results, including by strengthening joint work and maximizing partnerships.

15. UNODC implements the recommendations related to prevention, treatment and care of HIV/AIDS contained in the outcome document of the special session of the General Assembly on the world drug problem held in 2016, entitled "Our joint commitment to effectively addressing and countering the world drug problem". Moreover, the technical assistance provided by UNODC with regard to HIV/AIDS is aligned with the UNAIDS strategy for 2016–2021. With its strategy, UNAIDS seeks to achieve a set of ambitious, focused and people-centred goals and targets by 2020 in order to accelerate the delivery of results against the 2030 Agenda for Sustainable Development and reach the Agenda's target 3.3 of ending AIDS as a public health threat by 2030, leaving no one behind.[28]

16. Furthermore, 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 that Political Declaration, Member States reaffirmed their commitment to end the AIDS epidemic by 2030 and to reach 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.

17. At the global policy level, the decisions made by the Commission on Narcotic Drugs, the Programme Coordinating Board of UNAIDS and the Economic and Social Council reflect the common understanding of United Nations entities about the responses required to prevent new HIV infections among people who inject drugs. Those responses are based on a comprehensive package of HIV prevention, treatment and care services, which contains the following:[29]

(a) Needle and syringe programmes;

(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.

[27] *UNAIDS Division of Labour: Consolidated Guidance Note — 2010* (Geneva, 2011).
[28] *UNAIDS 2016–2021 Strategy: On the Fast-Track to end AIDS* (Geneva, 2015).
[29] 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* (Geneva, 2012).

IV. Technical assistance provided by the United Nations Office on Drugs and Crime in 2016 and 2017 with regard to HIV/AIDS

A. HIV/AIDS policy and programme development

18. In 2016 and 2017, UNODC advocated and provided targeted training and technical assistance for the review, adaptation, development and implementation of relevant legislation, 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 people living in prisons and other closed settings.

19. UNODC and its partners engaged in an evidence-informed dialogue on HIV, drug policies and human rights with 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. UNODC and its partners helped to identify ways in which drug policies could be strengthened so as to protect the right to HIV-related health care, including in prisons and other closed settings, of people who use drugs.

20. Jointly with national and international partners, UNODC supported Member States in effectively addressing HIV at the special session of the General Assembly on the world drug problem held in 2016, the General Assembly's high-level meeting on ending AIDS, the fifty-ninth and sixtieth sessions of the Commission on Narcotic Drugs, and the twenty-fifth and twenty-sixth sessions of the Commission on Crime Prevention and Criminal Justice.

21. UNODC encouraged stakeholders to contribute to the preparatory process for the special session of the General Assembly by sharing their expertise and practical experiences from their work on the ground among people who inject drugs. For example, with the participation of the UNAIDS secretariat, UNODC facilitated an informal interactive stakeholder consultation in support of the preparatory process for the special session and a round table on drugs and health that focused on perspectives from experts at the grass-roots level.

22. In March 2016, UNODC held a scientific consultation entitled "Science addressing drugs and HIV: State of the art (an update)" on the margins of the fifty-ninth session of the Commission on Narcotic Drugs and presented the latest scientific evidence at side events during the special session of the General Assembly on the world drug problem and the high-level meeting on ending AIDS. The side-events were co-sponsored by UNODC, WHO and the UNAIDS secretariat.

23. UNODC contributed to the work of the UNAIDS Global HIV Prevention Coalition and the development of the UNAIDS HIV Prevention 2020 Roadmap 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 prison inmates and people who inject drugs.

24. UNODC was fully engaged with the Global Review Panel on the Future of the Joint Programme Model, which was established to make recommendations for a sustainable and fit-for-purpose UNAIDS by revising and updating its operating model, in particular its joint work, financing and accountability, and governance. UNODC contributed to the development of the UNAIDS action plan entitled "Innovation for impact: Refining the operating model of the UNAIDS Joint Programme". The action plan is aimed at strengthening the coherence and effectiveness of UNAIDS support to countries, in line with the recommendations of

the Global Review Panel. At its fortieth meeting, held in Geneva from 27 to 29 June 2017, the UNAIDS Programme Coordinating Board welcomed the final report of the Global Review Panel, welcomed and affirmed the UNAIDS action plan, and requested its implementation by UNAIDS.

25. At the country level, UNODC backed efforts to update national drug policies. For example, in Myanmar, UNODC supported three rounds of drug policy consultations convened by the Ministry of Home Affairs, the Myanmar Police Force and the Central Committee for Drug Abuse Control. The consultations lay the foundation for a new drug policy and for related legal reforms. UNODC provided expert input to develop human-rights-centred and health-focused approaches, promoting the adoption of the comprehensive package of HIV prevention, treatment and care services for people who inject drugs and encouraging discontinuation of the compulsory registration of people who use drugs. Since 2016, together with WHO and the UNAIDS secretariat, UNODC has supported the development of standard operating procedures for health-care services in prisons in Myanmar with the inclusion of the 15 key interventions of the comprehensive package.

26. In Afghanistan, UNODC provided technical assistance to the Ministry of Public Health as it developed a national strategic framework for the prevention and control of HIV for 2016–2020. In addition, UNODC advocated for the removal of legal barriers hindering access to HIV services, including needle and syringe programmes, opioid substitution therapy and condom programmes in prisons. An assessment study on alternatives to incarceration for drug-using offenders who have committed non-violent crimes was finalized. A regional assessment report covering Afghanistan, the Islamic Republic of Iran, Kazakhstan, Kyrgyzstan, Pakistan, Tajikistan and Uzbekistan was launched in June 2016.

27. In Ukraine, UNODC and its partners successfully advocated for introducing opioid substitution therapy in prison settings, which the Government approved in 2016. In addition, UNODC provided technical support to prison health authorities as they developed standard operating procedures on HIV testing, HIV counselling and antiretroviral therapy. Finally, UNODC provided training on the management of HIV and tuberculosis cases and on HIV testing and counselling in prison settings.

28. In Kyrgyzstan, UNODC led a dialogue between the Ministry of Health, other Government bodies and civil society partners aimed at developing a road map for the transition to domestic funding for HIV prevention. Furthermore, UNODC contributed to the allocation of domestic funding for needle and syringe programmes in prisons.

29. In Kyrgyzstan, Tajikistan and Viet Nam, UNODC reviewed indicators, methods and tools for monitoring of HIV services in prisons and pretrial detention centres in consultation with prison, health and drug control authorities, as well as with civil society organizations and other national and international partners. UNODC identified country-specific needs and provided targeted technical assistance for the development of electronic tools and the harmonization of data collection in prisons.

30. In Nigeria, UNODC supported the inclusion in the national drug control master plan and in the national policy for the control of viral hepatitis of evidence-based activities to address HIV among people who inject drugs. Furthermore, UNODC contributed to the inclusion of such activities in the workplan of the Economic Community of West African States for 2016–2020. In addition, UNODC, jointly with the Coalition of Lawyers for Human Rights facilitated access to legal services for people who inject drugs.

31. In the Philippines, UNODC and its partners advocated for a health-centred approach that included delivering the comprehensive package of HIV services to people who inject drugs. Furthermore, UNODC supported the Department of Health in its adaptation and application of *Guidance for Community-based Treatment and Care Services for People Affected by Drug Use and Dependence in South-East Asia.*

32. UNODC, in collaboration with WHO, UNAIDS and the World Bank, led the gathering of strategic information on people who inject drugs and on the prevalence of HIV among them. In doing so, it enhanced coordination between the relevant United Nations agencies in data collection and analysis, and harmonized the global review and reporting of data with the involvement of civil society and expert networks. This effort produced valuable information on the quality of the estimates currently used by United Nations agencies and helped to identify country-specific needs for technical assistance. The joint UNODC/WHO/UNAIDS/World Bank estimates were published in *World Drug Report 2016* and *World Drug Report 2017*.

33. UNODC supported a systematic review of interventions to prevent and manage HIV and hepatitis C among people who inject drugs and an update of the global, regional, and country-level estimates of coverage of those interventions. The updated coverage estimates were presented at the Lisbon Addictions 2017 conference and published in *The Lancet Global Health* in October 2017.[30]

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

34. In 2016 and 2017, UNODC supported Member States and civil society in providing human-rights-based, public-health-focused and gender-responsive HIV services for the population at large and for people living in prisons and other closed settings. The two guiding documents for the provision of such services were *WHO, UNODC and UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users* for the population at large, and the UNODC/International Labour Organization (ILO)/United Nations Development Programme/WHO/UNAIDS policy brief entitled "HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions" for prisons and other closed settings.[31]

35. In Kenya, UNODC continued to support the scaling up and delivery of comprehensive HIV services reaching more than 1,000 people who use drugs. That number included about 600 enrolled for medically assisted therapy. UNODC assisted national health authorities in assessing the spread of hepatitis C among clients undergoing medically assisted therapy using methadone and supported the development of a policy for hepatitis C treatment and hepatitis B vaccination. Moreover, UNODC supported the provision of other essential health services for people who inject drugs, such as the promotion of condom use and family planning, nutritional counselling, mother and child health care for clients undergoing medically assisted therapy, antiretroviral therapy, mental health care, overdose management and dental services. Continued access to medically assisted therapy was assured for clients who had been hospitalized or incarcerated.

36. In Pakistan, in two women's prisons, UNODC supported the establishment of HIV services for inmates who use drugs. The prisons were located in Karachi and in Hyderabad. Furthermore, UNODC provided information and education on HIV prevention, safe sex, safe injecting practices, condom use, health education, hygiene (for both inmates and prison staff), voluntary counselling and testing, primary health care and treatment for sexually transmitted infections.

37. In Afghanistan, UNODC provided technical assistance for the provision of services in 15 sites supported by the Global Fund and the World Bank. Of those 15 sites, 7 were prisons (Badakhshan, Balkh, Ghazni, Herat, Kandahar, Kunduz and

[30] 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, pp. e1208–e1220.

[31] UNODC (Vienna, 2013)

Nangarhar) and 8 were communities (Badakhshan, Ghazni, Herat, Kabul, Kandahar, Kunduz, Mazari Sharif and Nangarhar). In addition, UNODC reached about 500 key community members by organizing events in three provinces (Balkh, Herat and Kabul) to increase public awareness of HIV as it relates to drug use and to reduce the stigma and discrimination that accompany drug use.

38. In Egypt, UNODC collaborated with two civil society organizations, one in Alexandria and one in Luxor, to support the screening of people who inject drugs and other HIV key populations for infections. More than 1,500 people were screened for HIV and more than 2,150 for hepatitis B and hepatitis C.

39. In Viet Nam, UNODC provided technical support to the Government in conducting legal and policy reviews and scaling-up the implementation of the national opioid substitution therapy programme in line with international guidelines. UNODC advocated for and supported increasing access to voluntary and evidence-based HIV support services in community settings for people who use drugs, including education.

40. Also in Viet Nam, UNODC and its partners successfully supported the Government as it expanded the provision of opioid substitution therapy in prisons. UNODC supported the Ministry of Public Security in its review of the pilot phase of a project to deliver opioid substitution therapy in prisons, initiated in 2015 with UNODC support, in association with the national authorities responsible for health care, AIDS, drugs control, security and prisons, as well as with and community-based organizations. UNODC organized meetings with 180 senior prison officials from 57 national prisons in order to take stock of the lessons learned from the pilot phase. The meetings led to the recommendation to expand opioid substitution therapy services to other prisons. UNODC was requested to continue to support the Government in the ongoing scaling-up of opioid substitution therapy in prisons. In addition, UNODC provided training on HIV prevention and care, including opioid substitution therapy, for members of staff and peer educators in prisons. To date, more than 80 male peer educators from Phu Son prison (Thai Nguyen Province) received trainer training on HIV prevention and drug dependence treatment, expected to benefit as many as 1,200 inmates of various prisons.

41. In the context of the UNODC-civil society group on drug use and HIV, collaborative efforts focused on implementing and scaling-up evidence-based HIV prevention, treatment and care for people who inject drugs and people in prison settings. Moreover, the members of the group were developing the technical guide for the implementation of HIV services for people who use stimulants.

42. Despite an unexpected financial shortfall in core UNAIDS funding available to UNODC as of mid-2016 within the in the Unified Budget, Results and Accountability Framework, UNODC supported more than 80 civil society organizations worldwide. Examples include Viet Nam, where UNODC gave support for the holding of workshops on partnership building and community/home-based care for people who use drugs; South Africa, where UNODC supported the engagement of civil society organizations in the development of a new national master plan for drug control; and in Kenya, in Mombasa and Malindi, where UNODC supported selected civil society organizations in the provision of HIV services to people who use drugs.

43. In 2017, UNODC awarded civil society organizations five grants for projects to empower communities in their HIV responses. The projects were aimed at building the capacity of civil society and community-based organizations working among people who use drugs in 12 African countries; strengthening the capacity of community-based organizations of women who use drugs in Indonesia; increasing access to HIV prevention, treatment and care for people who use drugs in prisons in Ukraine; developing a practical guide for civil society organizations on working with

people who use drugs, including in prisons, in the Philippines; and improving the monitoring of gender-sensitive services for women who use drugs.

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

44. During the reporting period, UNODC, jointly with the Law Enforcement and HIV Network and the International Network of People Who Use Drugs, published the *Practical Guide for Civil Society HIV Service* Providers *among People Who Use Drugs: Improving Cooperation and Interaction with Law Enforcement Officials*. The *Practical Guide* is build the capacity of civil society organizations and other partners providing HIV services to people who inject drugs to work and interact with law enforcement officials.

45. UNODC published a guide entitled *Addressing the Specific Needs of Women who Inject Drugs: Practical Guide for Service Providers on Gender-Responsive HIV Services* in partnership with the International Network of Women Who Use Drugs, the Women and Harm Reduction International Network and the Eurasian Harm Reduction Network and with contributions provided by WHO, the UNAIDS secretariat and the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women). The publication was launched at the International AIDS Conference held in Durban, South Africa, in 2016.

46. In addition, UNODC, in partnership with the International Network of Women Who Use Drugs, developed a training programme on addressing the specific needs of women who inject drugs. In 2017, more than 70 service providers, managers, health-care workers, outreach workers and other professionals were trained in Egypt, Indonesia and Viet Nam. The training was followed by policy-level dialogues with national stakeholders. In addition, UNODC conducted workshops and policy dialogues to engage people who inject drugs in the response to HIV and trained more than 120 representatives of Governments, civil society organizations and community-based organizations in Belarus, Egypt, South Africa, the United Republic of Tanzania and Viet Nam.

47. UNODC initiated and developed a training module on Gender Mainstreaming Monitoring and Evaluation of HIV Services for Women Who Use Drugs and piloted it at a workshop held in Nagarkot, Nepal, from 10 to 13 October 2017. Over 30 service providers, programme managers and other national and international partners participated in the pilot training and contributed to the finalization of the module under the UNODC project “HIV/AIDS prevention, treatment and care for female injecting drug users and female prison inmates in Afghanistan, Nepal and Pakistan”.

48. UNODC reviewed existing indicators, methods and tools for monitoring and evaluating HIV services in prisons, identified country-specific needs in consultation with national prison and health authorities, and national and international partners, and provided targeted technical assistance for developing and improving harmonized approaches and tools to monitor and evaluate HIV services in prisons in Kyrgyzstan, Tajikistan and Viet Nam.

D. Building capacities of government agencies, civil society organizations and other national partners

49. During the reporting period, UNODC, jointly with civil society, trained more than 230 service providers to improve access to HIV services for people who inject drugs in Belarus, Egypt, South Africa, the United Republic of Tanzania and Viet Nam, and to address the specific needs of women who inject drugs in Egypt, Indonesia, Nepal and Viet Nam.

50. In collaboration with the International Network of Women Who Use Drugs, UNODC organized a capacity-building workshop at the International AIDS Conference 2016 held in Durban, South Africa, and at the International Harm Reduction Conference 2017 held in Montreal, Canada, on mainstreaming gender into services for people who inject drugs. In total, nearly 200 conference participants attended the workshops.

51. UNODC continued to strengthen partnerships between law enforcement and other relevant sectors. The Office trained more than 650 law enforcement officers, 200 representatives of civil society and community-based organizations, and nearly 200 members of parliament and representatives of the health, education and social sectors in Afghanistan, Armenia, Belarus, Kazakhstan, Nigeria, the Republic of Moldova, South Africa, Tajikistan, Ukraine, the United Republic of Tanzania and Uzbekistan. The training was aimed at increasing knowledge about and skills in interacting with people who inject drugs, implementing police referral services as an alternative to incarceration, and supporting addressing HIV at the workplace as it relates to the work of law enforcement officials. In addition, UNODC developed an e-learning tool to further increase the reach of its HIV training among law enforcement officials.

52. UNODC continued implementation of a project on HIV prevention, treatment, care and support in prison settings in sub-Saharan Africa, in particular in Angola, Ethiopia, Lesotho, Malawi, Mozambique, Namibia, Swaziland, the United Republic of Tanzania, Zambia and Zimbabwe. To date, the project has helped to build the capacity of more than 30,000 policymakers and more than 33,000 prison inmates, prison staff and health professionals. The project has produced the first HIV service delivery toolkit for prisons in sub-Saharan Africa. The toolkit comprises guidelines, standard operating procedures and training manuals. In 2017, UNODC initiated a new programme on HIV prevention, treatment and care in prisons in sub-Saharan Africa for 2017–2020, building on its experience and achievements in the region.

53. In Kenya, UNODC provided technical support to the federal prison administration on HIV interventions in prison settings, including in the development and implementation of a standard operating procedure for peer education and addressing the health needs of women in prisons. UNODC supported the translation of the HIV training manual “An integrated approach to HIV and AIDS in prison” into Amharic for use in capacity-building activities in Ehtiopia.

54. In Viet Nam, in 2016 and 2017, UNODC and its partners held several capacity-building activities. Among those were two training events for more than 50 staff of community-based organizations aimed at building their capacity in the domains relating to HIV and other blood-borne diseases among drug users. The topics treated included HIV, tuberculosis and viral hepatitis prevention and care, drug dependence treatment and relapse management, first-aid responses to drug overdoses, and psychosocial care and support for people who use drugs. At other events, 22 practitioners from 12 institutions were trained to become national master trainers and nearly 50 representatives of civil society organizations were trained in facilitating collaboration with local police in Ho Chi Minh City and Hai Phong, which have high HIV burdens.

55. In Eastern Europe and Central Asia, UNODC contributed to a regional workshop held in Tbilisi in 2016 under the title “Women against violence” with civil society. In addition, UNODC facilitated joint training for law enforcement agencies and civil society organizations, and organized study visits for representatives of police and civil society organizations from Belarus, Kazakhstan, Lithuania, the Republic of Moldova and Ukraine to learn from the implementation of gender-sensitive HIV services for people who inject drugs in Austria.

56. In Ukraine, UNODC helped to ensure that prison staff are regularly trained on HIV, human rights, stigma and discrimination as part of existing staff training and development schemes. UNODC supported five training facilities for prison staff and the development of an on-the-job training manual on HIV, and facilitated a training-of-trainers-workshop. In cooperation with the National Police of Ukraine and the Ukraine National Academy of Internal Affairs, UNODC produced video learning materials on HIV, occupational safety and the role of police in improving access to HIV services in communities for people who use drugs. The materials reached nearly 14,000 police officers.

57. In the Republic of Moldova, UNODC built the capacity of civil society and community-based organizations to improve the availability of HIV-related and other health services in prison settings, including by supporting needle and syringe programmes and opioid substitution therapy in prisons. In addition, together with civil society and community-based organizations, UNODC held advocacy events for various partners, including law enforcement and prison authorities. Finally, UNODC contributed to the development of a manual for prison staff on comprehensive HIV prevention in prisons.

58. In the Middle East and North Africa, UNODC continued to advocate and build capacity for aligning prison health sector plans with the recommended comprehensive package of HIV prevention, treatment and care services in prison settings. To that end, UNODC supported three workshops on health in detention in collaboration with the International Committee of the Red Cross; implemented capacity-building activities for senior officials of various line ministries and directorates in Egypt, Morocco and Tunisia; conducted HIV and drug use assessment activities in five prisons and implemented training to address the health needs of women in prisons in Morocco; supported the establishment of three HIV testing and counselling centres in Egypt; and held a training session and conducted a study tour in Beirut for 14 professionals from the National Centre for Disease Control of Libya and civil society organizations working on HIV prevention, treatment and care, including in prisons.

59. In Tehran, in 2016, UNODC conducted a regional advocacy and capacity-building workshop on HIV prevention, treatment and care in prison settings for senior prison officials, national HIV programme managers and health professionals working on HIV in prisons from Afghanistan, the Islamic Republic of Iran, Kazakhstan, Kyrgyzstan, Pakistan, Tajikistan and Uzbekistan. The recommendations underlined, inter alia, the need to extend evidence-informed, rights-based, age- and gender-responsive HIV and other health services to all people in prisons, improve the quality and optimize the coverage of effective HIV services in prisons, and improve the availability of strategic information to guide policies and actions and ensure accountability.

V. Conclusions and recommendations

60. Globally, among people who inject drugs, the prevalence of HIV is high and new HIV infections are on the increase. There is also a disproportionally high prevalence of hepatitis C infection. Yet, in some countries where HIV transmission through unsafe drug use by injection is a driving factor of the HIV epidemic, the coverage of 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. The high prevalence of HIV and hepatitis C among people in prisons who also inject drugs, the very low availability of and very limited access to relevant services in prisons, and the lack of continuity of recommended services on admission to and release from prisons and other closed settings are all major barriers to reducing new HIV infections among

inmates. Unless evidence-based and gender-responsive services are urgently implemented and maintained to scale, it is not likely that the transmission of HIV and other blood-borne infections among people who use drugs, including in prisons and other closed settings, will be prevented, nor 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 new HIV infections from spreading among people who inject drugs, the Commission on Narcotic Drugs may wish to recommend that Member States:

(a) Implement the interventions described in the WHO/UNODC/UNAIDS comprehensive package as a whole and scale them up through multiple service delivery models, including outreach, low-threshold drop-in centres and peer education, to effectively reduce the sharing of injecting equipment, improve quality of life, decrease mortality, reduce crime and public disorder, improve social functioning and provide a bridge to drug dependence treatment;

(b) Identify and remove barriers to accessing the services provided through those interventions;

(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 are serving prison sentences, with priority given to the 15 interventions outlined by UNODC, the International Labour Organization, the United Nations Development Programme, WHO and UNAIDS 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 Member States, civil society organizations, communities and other stakeholders:

(a) To significantly and urgently enhance coordinated rights-based and people-centred measures to improve the availability, accessibility and quality of comprehensive HIV prevention, treatment and care services for people who use drugs, including in prisons and other closed settings;

(b) To eliminate stigma and discrimination, so that the implementation of and access to evidence-based and gender-responsive HIV and hepatitis C services for people who use drugs can be ensured;

(c) To increase financial allocations from both international and national sources focusing on priority interventions in high-priority locations;

(d) To 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;

(e) To 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;

(f) To integrate and prioritize both public and individual health to end AIDS as a public health threat by 2030, leaving no one behind, in line with the 2030 Agenda for Sustainable Development.