
Harm reduction for people who use drugs

MARCH 2020

GENEVA, SWITZERLAND

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Introduction

This technical brief describes how interventions for people who use drugs are to be incorporated into funding requests to the Global Fund. The Global Fund is the major source of international funding in low- and middle-income countries for harm reduction, and it supports evidence-based interventions aimed at ensuring access to HIV prevention, treatment, care, and support for all key populations, including people who use drugs.

According to Global Fund policy, lower-middle and upper-middle income countries applying for funding must focus 100% of budget on key populations and 50% of budget on underserved populations, as well as on the highest-impact interventions. Low-income countries are also strongly encouraged to target resources to those at highest risk.

It is therefore strongly recommended that all countries with evidence of HIV transmission among people who use drugs include in their proposals harm reduction programs for people who use drugs, both in the general community and in prison and other closed settings.

The harm reduction interventions outlined in this brief include those recommended in the World Health Organization's (WHO) Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2016). Those guidelines expanded upon the ones issued by WHO, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Office on Drugs and Crime (UNODC) in the WHO, UNAIDS, UNODC Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users – 2012 Revision.

This technical brief is also aligned with the programmatic guidance in Implementing Comprehensive HIV and HCV Programmes with People Who Inject Drugs: Practical Guidance for Collaborative Interventions (the "IDUIT", 2017), which combines the experience and expertise of United Nations agencies, other international partners, and organizations and networks of people who use drugs.

- Section 1 of this brief outlines the vulnerability of people who use drugs to HIV and other infectious diseases.
- Section 2 outlines the comprehensive package of harm reduction interventions recommended by WHO and other partners.
- Section 3 provides further detail on the delivery of some components of the comprehensive package of interventions: needle and syringe programs, opioid substitution therapy, overdose management, pre-exposure prophylaxis (PrEP), antiretroviral therapy (ART), and interventions for preventing, diagnosing, and treating viral hepatitis C.
- Section 4 describes approaches to incorporating harm reduction within funding proposals.
- Section 5 offers a list of publications, and organizations and networks of people who use drugs, that may be of assistance in compiling proposals, as well as for technical support in programming. Publications on specific areas are also mentioned throughout this brief and referenced in the footnotes.

1. Drug use and vulnerability to HIV and other diseases

The [World Drug Report](#) (2019) estimates that as of 2017, an estimate 271 million people worldwide used drugs at least once in the previous year (range: 201 million-341 million).¹ Of these, 11.3 million people injected drugs (range: 8.9 million–15.0 million).⁵

The criminalization of drug use, along with associated law-enforcement practices, increases vulnerability and negatively impacts access to services, and is among the factors driving the epidemics of HIV, viral hepatitis C (HCV), and tuberculosis (TB) among people who use drugs.² In many parts of the world, people who inject drugs are denied access to essential health services and support, including the provision of sterile equipment, antiretroviral therapy (ART), opioid substitution therapy (OST),³ and the opioid overdose antidote naloxone. As a result, they are often forced to share and reuse equipment such as needles and syringes, placing themselves and their sexual and injecting partners at significant risk of HIV infection and other harms, including overdose and death.

The estimated prevalence of HIV among people who inject drugs is 12.7%, suggesting that 1.4 million of this population are living with HIV.⁵ People who inject drugs accounted for 9% of new HIV infections globally in 2017, but there is significant regional variation. In Eastern Europe and Central Asia, the proportion of new infections among people who inject drugs was 39%, and in the Middle East and North Africa it was 38%.⁵ People living with HIV are also highly susceptible to TB if their immune systems are suppressed, especially if they are living in close quarters with other people, such as in prison and other closed settings.⁴ In sub-Saharan Africa, Global Fund-funded programs in Benin, Côte D'Ivoire, Kenya, Mozambique, Nigeria, Senegal, South Africa, and Togo have identified an increase in drug use and injecting practices.⁵

People who inject drugs are even more vulnerable to HCV than to HIV. Globally, around 50% of people who inject drugs are living with HCV; it is estimated that between 23% and 39% of all new HCV infections globally are attributable to injecting drug use.^{6,7} Among people who inject drugs who are living with HIV, an estimated 82% are coinfected with HCV, yet uptake of HCV treatment remains low due to policy, regulatory, and financial barriers.⁵

People who inject drugs are susceptible to *Mycobacterium tuberculosis* in several ways.⁸ A 2017 study on people who inject drugs in California showed that the prevalence of *M. tuberculosis* infection was 23.6%, with 0.8% co-infection with HIV and 81.7% co-infection with HCV.⁹ Drug use weakens the immune system, making people who use drugs more susceptible to TB infection.

¹ UNODC (2019). [World Drug Report 2019](#).

² UNDP (2012). [Rights, Risk and Health: Report of the Global Commission on HIV and the Law](#).

³ This technical brief uses the term “OST”, which may also be known as OAT (opioid assisted therapy), MAT (medically assisted therapy), or MMT (methadone maintenance therapy).

⁴ The term “prisons and other closed settings” refers to all places of detention within a country, and “prisoners” refers to all those detained in criminal justice and prison facilities, including adult and juvenile males and females, during the investigation of a crime, while awaiting trial, after conviction, before sentencing, and after sentencing.

⁵ See also UNODC (2018). [Drug Use in Nigeria 2018](#).

⁶ WHO (2017). [Global Hepatitis Report, 2017](#).

⁷ Trickey A et al. (2019). The contribution of injection drug use to hepatitis C virus transmission globally, regionally, and at country level: a modelling study. *The Lancet Gastroenterology & Hepatology*; 4(6):435-44.

⁸ Stop TB Partnership. (2015) [Key Populations Brief: People Who Use Drugs](#).

⁹ Armenta RF et al. (2017). *Mycobacterium tuberculosis* infection among persons who inject drugs in San Diego, California. *The International Journal of Tuberculosis and Lung Disease*; 21(4):425-31.

Drug use is also often associated with homelessness, alcohol abuse, smoking and incarceration, which all contribute to the increased risk of contracting TB.¹⁰

HIV prevention interventions for people who use drugs tend to focus on those who inject, because of the substantial risk of infection if injecting equipment is shared. However, other forms of drug use can also be associated with HIV risk, and it is appropriate to include them in harm reduction interventions. The use of stimulant drugs and so-called “new psychoactive substances”, whether injected or by other routes of administration, can cause harm and can play a role in the sexual transmission of HIV, by lowering inhibitions and leading people to engage in unprotected sex, to increase the frequency or length of sexual activity, and to have sex with a greater number of casual partners.⁵ “Chemsex” – the use of stimulant drugs to facilitate, prolong, and enhance sex – has been linked to sexual behaviors that increase the risk of HIV and HCV transmission.^{11,12} Chemsex is likely to be a factor in the rapid increase in HIV prevalence among young men who have sex with men in some Asian countries (e.g. Indonesia and Malaysia) since 2010.

Sex workers are another key population who face intersecting factors for HIV risk and vulnerability, since they may be coerced into drug use with their clients and consequently have less control over safe sex.¹⁵

Preventing HIV and other harms among people who use drugs and providing them with evidence-based health services are essential components of national HIV responses, yet often present major challenges. People who use drugs in most low- and middle-income countries have limited and inequitable access to HIV prevention and treatment services.^{13,14} In prisons and other closed settings – where people who use drugs are disproportionately represented across the world – access to comprehensive HIV prevention, treatment, and care is even more limited, despite the occurrence of drug use in these settings,¹⁵ and despite evidence that the prevalence of HIV and HCV is much higher in prisons among people who inject drugs than among the non-injecting prison population.²

Coverage of harm reduction interventions for people who inject drugs remains poor across much of the world. Less than 1% of all people who inject drugs live in settings with high coverage of both NSP and OST.¹⁶ NSP operate in only 93 of the 179 countries and territories where injecting drug use is known to occur, and even within these countries, on average only 33 needles and syringes are distributed annually for each person who injects drugs. At the population level, this is very far from the amount of equipment that needs to be available in the community to prevent injecting with used equipment.²⁰ Similarly, OST is implemented in just 86 countries and territories, and only a small proportion of people who are opioid-dependent and seeking treatment receive it.²⁰

¹⁰ WHO (2016). Integrating Collaborative TB and HIV Services within a Comprehensive Package of Care for People who Inject Drugs: Consolidated Guidelines. See also: TBCAB (2017). [Injection drug users fall through the gaps in India's TB program.](#)

¹¹ UNODC (2019). [HIV Prevention, Treatment, Care and Support for People Who Use Stimulant Drugs: Technical Guide.](#)

¹² For further information on chemsex, see the websites and publications produced by Mainline at <https://english.mainline.nl/posts/show/8360/chemsex>

¹³ Larney S et al. (2017). [Global, regional, and country-level coverage of interventions to prevent and manage HIV and hepatitis C among people who inject drugs: a systematic review.](#) *Lancet Global Health*; 5:e1208-20.

¹⁴ Degenhardt L et al. (2017). [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.](#) *Lancet Global Health*; 5:e1192-207.

¹⁵ Dolan K et al. (2015). [People who inject drugs in prison: HIV prevalence, transmission and prevention.](#) *International Journal of Drug Policy*; 26(Suppl 1):S12-S15.

¹⁶ Harm Reduction International (2018). [The Global State of Harm Reduction 2018.](#)

The review and revision of laws and policies can facilitate access to services and decrease HIV and HCV vulnerability. This includes efforts to decriminalize drug consumption and possession for personal use, as recommended by UNAIDS¹⁷ and WHO.² This kind of drug policy reform can help create an enabling environment for large-scale and effective HIV and HCV programming, improve health and reduce transmission of infectious diseases such as HIV, and reduce prison populations and the misuse of law-enforcement resources. For further information, see the [IDUIT](#).

2. What is harm reduction?

As defined by Harm Reduction International,¹⁸ the term “harm reduction” refers to:

“policies, programs and practices that aim to minimize negative health, social and legal impacts associated with drug use, drug policies and drug laws. Harm reduction is grounded in justice and human rights – it focuses on positive change and on working with people without judgment, coercion, discrimination, or requiring that they stop using drugs as a precondition of support.”

The UNAIDS report [Health, Rights and Drugs: Harm Reduction, Decriminalization and Zero Discrimination for People Who Use Drugs](#) (2019) notes:

“Study after study has demonstrated that comprehensive harm reduction services—including needle-syringe programmes, drug dependence treatment, overdose prevention with naloxone, and testing and treatment for HIV, tuberculosis, and hepatitis B and C—reduce the incidence of blood-borne infections, problem drug use, overdose deaths and other harms.”²¹

The comprehensive package of HIV and harm reduction interventions

The WHO [Key Populations Consolidated Guidelines](#) describe a comprehensive package of interventions, implementation of which is essential to ensure reduction of HIV and other blood-borne infectious disease among people who inject drugs.² The comprehensive package includes the following harm reduction interventions:

Harm reduction for people who use drugs

- All people from key populations who inject drugs should have access to sterile injecting equipment through needle and syringe programs (NSPs)
- All people from key populations who are dependent on opioids should be offered and have access to opioid substitution therapy
- All people from key populations with harmful alcohol or other substance use should have access to evidence-based interventions, including brief psychosocial interventions involving assessment, specific feedback and advice
- People likely to witness an opioid overdose should have access to naloxone and be instructed in its use for emergency management of suspected opioid overdose.

¹⁷ UNAIDS (2019). [Health, Rights and Drugs: Harm Reduction, Decriminalization and Zero Discrimination for People Who Use Drugs](#).

¹⁸ Harm Reduction International (2019). [What is Harm Reduction?](#) [Website].

WHO also recommends for all key populations, including for people who use drugs:

a) Essential health sector interventions

- HIV prevention (condoms, lubricants, pre-exposure prophylaxis, post-exposure prophylaxis)
- Harm reduction (including NSP, OST, naloxone *as per above*)
- HIV testing and counseling
- HIV treatment and care (ART, prevention of mother-to-child transmission of HIV)
- Prevention and management of co-infections and other comorbidities, including viral hepatitis, TB, and mental health conditions
- Sexual and reproductive health interventions (sexually transmitted infection screening, diagnosis and treatment, access to range of reproductive options, abortion laws and services, cervical cancer screening, conception and pregnancy care)

b) Essential strategies for an enabling environment

- Antidiscrimination and protective laws to address stigma and discrimination
- Review and revision of laws, policies and practices (including decriminalization of drug use and drug possession for personal use)
- Available, accessible and acceptable health services for key populations
- Enhanced community empowerment
- Addressing violence against people from key populations

These interventions are based on longstanding scientific evidence of their efficacy and cost-effectiveness in preventing HIV and other harms.¹⁹

Although the greatest impact will be achieved when all the interventions in the comprehensive package are implemented together, applicants should prioritize NSP, OST, and testing and treatment for HIV and hepatitis for people who inject drugs.² Further details are given in Section 3.

3. Essential considerations for selected interventions

3.1 Needle and syringe programs

Ensure the provision of a full range of sterile injecting equipment:

- Needles and syringes should be those appropriate for the local drug-use context, determined in consultation with people who inject drugs, even if these are not the cheapest available on the market.

¹⁹ WHO (2004). [Evidence for Action: Effectiveness of Community-based Outreach in Preventing HIV/AIDS among Injecting Drug Users](#).

- Services should provide a range of needles and syringes, including low-dead-space syringes wherever possible: these reduce the amount of blood that remains once the plunger has been fully depressed and lower the risk of transmission of blood-borne diseases, and they will be preferred by some people who inject drugs.²⁰
- Both the Global Fund and WHO recommend against the provision of retractable or auto-destructible syringes in NSP.

Consider providing other supplies that are important to harm reduction for people who inject drugs: These include safe disposal boxes for used equipment, filters, sterile water, single-use cooking utensils, acidifier powders, tourniquets, iodine and gauze for wound care, and male and female condoms. For details, see the [WHO Guide to Starting and Managing Needle and Syringe Programmes](#) (2007).

Distribution models should not require “one-for-one” exchange: Although NSP clients should always be encouraged to return used injecting equipment to the NSP or mobile service, this should not be a condition for provision of new equipment. People should also be provided with the information and materials to safely dispose of used equipment themselves.

Consider differentiated service delivery: This approach can help ensure the best possible coverage by NSP. Differentiated service delivery may include a combination of fixed-site delivery, pharmacy provision, mobile clinics, outreach, provision in related health services (such as sexual and reproductive health services and ART clinics), and secondary syringe distribution. Networks of people who inject drugs can be effective in engaging new clients in NSP, for example if a program provides an active client with a large quantity of syringes to distribute to their peers. This can enhance access to sterile injecting equipment for people who wish to remain hidden or who cannot come to a service delivery location. For more information, see the Global Fund [HIV Information Note](#).

Establish a protocol for the collection and disposal of used needles and syringes: It is important that NSP take measures to make it simple for people to return or deposit used syringes. This may include installing safe-collection boxes in hotspot areas. Not only is this important for public health, but it will also improve the acceptability of harm reduction by the wider community.

Ensure staff safety: This is a critical issue for outreach workers in the field and staff at drop-in centers. Outreach or peer workers often visit abandoned buildings, slum areas, forests and other places which can be dangerous. There is also a risk of needle-stick injuries during outreach. At drop-in centers, clients who are intoxicated by stimulants or poly drug use can be violent. Harm reduction service providers may be targeted by law enforcement and subject to harassment and abuse, particularly in settings with punitive drug policies. All program implementers are encouraged to develop an occupational health and safety policy for the organization. This should include emergency procedures, medical contact points, and post-exposure prophylaxis for all staff who need it.

For more information on NSP, see the WHO [Guide to Starting and Managing Needle and Syringe Programmes](#), the UNODC [Handbook for Starting and Managing Needle and Syringe Programmes in Prisons and Other Closed Settings](#) (2014), and the [IDUIT](#).

²⁰ Zule W et al. (2013). [Are major reductions in new HIV infections possible with people who inject drugs? The case for low dead-space syringes in highly affected countries](#). *International Journal of Drug Policy*, 24(1):1-7.

3.2 Opioid substitution therapy

Develop a national clinical guideline for delivery of OST: This should be based on the global evidence and guidelines, including for dosage and the length of therapy.^{2,21} It is important that restrictions placed on facilities dispensing OST not be so burdensome that they prevent the opening of clinics or satellite facilities that enable the scale-up of OST.

Develop training: This should be provided to both medical and non-medical staff at facilities providing OST, and should take place before and during the implementation of the program. Law-enforcement officials should also be sensitized to the existence of the OST program so that they do not harass clients or prevent them from accessing these services.

Offer psychosocial support to OST clients: Program experience indicates that offering psychosocial support improves patient retention and the effectiveness of OST. Wherever feasible, programs should offer peer support and counseling to address issues related to side-effects, employment, housing, barriers to access, transport, etc.²⁵ The best services also screen for, and seek to address, the common mental-health issues experienced by some people who use drugs.

Facilitate take-home dosages for patients to increase adherence to OST and improve its effectiveness, particularly for those who may not live close to the OST service, or those with jobs, children, or other responsibilities that do not allow them to travel to the clinic every day.

Consider differentiated service delivery: OST can be delivered through primary healthcare centers, NGO-run drop-in centers attended by people who use drugs, mobile clinics, or pharmacies, in order to make services as effective, useful, and low-threshold as possible in each setting. For more information, see the Global Fund [HIV Information Note](#).

For further information, see the WHO [Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence](#) (2009).

3.3 Overdose management

The WHO [Key Populations Consolidated Guidelines](#) (2016) include opioid overdose management with the community distribution of naloxone; this is an important addition to the intervention package originally described in the WHO/UNAIDS/UNODC [Target-setting Tool](#) (2012).² Overdose remains a primary cause of death among people who inject drugs. Interventions for overdose prevention and management related to opioids with the provision of naloxone are particularly important for this population.² Naloxone can be administered by both medical and non-medical first responders. Evidence from around the world shows that community distribution of naloxone to peers and family members through outreach, is effective at preventing fatal opioid overdose.²² Overdose management – including ensuring access to naloxone – should therefore be a core component of harm reduction services.

People released from prison or from drug-free treatment settings are at particularly high risk of overdose and should be prioritized for naloxone provision.²⁶ In addition, research suggests that

²¹ WHO (2009). [Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence](#).

²² WHO (2014). [Community Management of Opioid Overdose](#).

people living with HIV who use drugs are 74% more likely to have an overdose than those without HIV.²³ Applicants are therefore strongly encouraged to consider low-cost interventions, such as:

- reform of provisions limiting naloxone distribution or administration
- provision of naloxone prior to release from prison and other closed settings
- community distribution of naloxone to people who inject drugs, their peers, and family members
- peer, family, and staff training in overdose management
- strengthening of response to overdose by emergency health services
- advocacy workshops to ensure that law-enforcement practices do not interfere with the provision of naloxone on the ground.

For further information, see the WHO guidelines on [Community Management of Opioid Overdose](#) (2014).

3.4 Pre-exposure prophylaxis (PrEP)

WHO recommends that PrEP be offered to all individuals at substantial risk of acquiring HIV,²⁴ as part of combination prevention approaches. It is important to stress that the priority interventions for HIV prevention for people who inject drugs – NSP, OST, and HIV and hepatitis testing and treatment – should not be replaced by PrEP. Applicants should consider offering PrEP in addition to these priority interventions, in particular to prevent sexual transmission of HIV between people who use drugs and their sexual partners.² For information on the perspective of INPUD (the International Network of People who Use Drugs) on PrEP, see [An Introduction to Pre-Exposure Prophylaxis \(PrEP\) for People Who Inject Drugs: Pros, Cons and Concerns](#) (2015).

3.5 Antiretroviral therapy

People who use drugs who are HIV positive have the same need for access to ART and adherence support as any other population. It is therefore essential when designing programs to consider linkages to ART for people who use drugs who test positive for HIV, and to provide support for adherence, ensuring that these services are accessible and acceptable to people who use drugs. For more information, see the WHO [Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection](#) (2016).

3.6 Viral hepatitis

There are important synergies between HIV and HCV, and HCV testing and management will improve public-health outcomes, including for HIV. Among people who inject drugs, co-infection rates are particularly high for HCV, and it is globally estimated that the use of injecting drugs contributes around 39% of new HCV infections globally.¹¹ The prevention, diagnosis and treatment of hepatitis B and C (and vaccination for hepatitis B) are included in the WHO comprehensive package of interventions and should be offered. WHO comprehensive guidance on viral hepatitis

²³ Green TC et al. (2012). [HIV infection and risk of overdose: a systematic review and meta-analysis](#). *AIDS*; 26(4):403-17.

²⁴ “Substantial risk” is defined by WHO as HIV incidence in the population of more than 3%.

testing and treatment,^{25,26} and on hepatitis prevention among people who inject drugs,²⁷ recommends that people who inject drugs be a priority group for offering HCV testing and treatment without restrictions. It is important to note that harm reduction as defined above has a considerable prevention impact on HIV as well as on viral hepatitis. Global Fund policy allows for the full harm reduction package to be included in funding requests, including HCV testing and treatment. WHO recommends a 12-24-week treatment of all people with chronic HCV (around 75% of people who test positive for antibodies) with pan-genotypic direct-acting antivirals (DAAs). These treatments have an overall cure rate of 95%. The cost of medicines and diagnostics for HCV management – including antibody-testing, confirmatory viral load testing, liver assessment, treatment and test of cure – can be as low as US \$100 in low- and middle-income countries. Global Fund resources can be used to increase HCV prevention, testing and management efforts and support advocacy for treatment access and affordability, especially in settings where this provides a catalytic investment to support local regulations, registration and procurement.

4. Incorporating harm reduction interventions into Global Fund proposals

This section outlines key elements of harm reduction approaches that should be part of Global Fund proposals, beginning with the critical enablers listed in the WHO [Key Populations Consolidated Guidelines](#). It continues with issues of gender- and age-sensitive programming, service provision in prison and other closed settings, and concerns around compulsory drug detention centers. The section concludes with the use of data in program planning and design, and issues of scale, coverage, and sustainability.

4.1 Removing human rights-related barriers to access

The Global Fund is committed to rights-based and gender-responsive approaches to delivery of health services, including harm reduction services as well as HIV and TB services for people who use drugs. Strategic Objective 3 in the fund's 2017-2022 strategy commits the fund to “introduce and scale up programs that remove human-rights barriers to accessing HIV, tuberculosis and malaria services and promoting and protecting gender equality”.²⁸ The seven categories of programs recognized by the Global Fund and UNAIDS²⁹ to address human-rights barriers to HIV programs are:

- reduction of stigma and discrimination
- provision of legal services and access to justice
- monitoring and reform of harmful regulations, policies, and laws

²⁵ WHO (2017). [Guidelines on Hepatitis B and C Testing](#).

²⁶ WHO (2018). [Guidelines for the Care and Treatment of Persons Diagnosed with Chronic Hepatitis C Virus Infection](#).

²⁷ WHO (2012). [Guidance on Prevention of Viral Hepatitis B and C among People Who Inject Drugs](#).

²⁸ Global Fund (2016). [The Global Fund Strategy 2017-2022: Investing to End Epidemics](#).

²⁹ UNAIDS (2012). [Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses](#).

- legal literacy (“know your rights) programs
- sensitization of law-makers and law-enforcement agents
- training for healthcare providers on human rights and medical ethics
- reduction of discrimination against women and gender-based violence.

In addition, the Global Fund convened a TB expert working group to develop a set of human-rights programs that are essential in the context of TB. The additional programs that are considered particularly important for the TB context are:

- programs to ensure confidentiality and privacy
- mobilizing and empowering patient and community groups
- programs in prisons and other closed settings.

Examples of programs to address human rights-related barriers to access include:

- creation of training modules for health or social services on stigma, discrimination, and respect for medical confidentiality and privacy, as these relate to people who use drugs
- rights training for harm reduction service providers, or providing an emergency response mechanism for crisis situations where the lives and well-being of people who use drugs and human-rights defenders are in danger
- programs related to discrimination against women and gender-based violence, including sensitization of police and lawmakers, particularly around women who use drugs, women’s and girl’s empowerment programs, and victim-oriented support and referral services for victims of gender-based violence.
- changing policies to ensure young people can access harm reduction services without parental or guardian permission
- supporting and building the capacity of civil society and communities to advocate for their rights through coalition-building, ensuring they can engage at national and international levels
- monitoring and reporting human-rights violations, in particular community-led and community-based monitoring, or undertaking research on stigma and discrimination faced by people who use drugs
- peer support and paralegal programs to improve access to justice
- law and policy reform to remove punitive sanctions for activities related to personal drug use, or to remove compulsory treatment and detention centers, or to change law-enforcement practices to support, rather than block, harm reduction services
- strategic litigation at the local, national, regional, or international level, including both judicial and non-judicial mechanisms

The programs may be broad in nature, or targeted at particular groups, for example young people, women who use drugs, or sex workers who use drugs.

For more information on rights-centered approaches to services, including harm reduction, see the Global Fund technical briefs³⁰ on [HIV, Human Rights and Gender Equality](#) and on [TB, Gender and Human Rights](#), as well as the [IDUIT](#), the UNAIDS guides on [Fast-Track and Human Rights](#) (2017) and [Do No Harm: Health, Human Rights and Drugs](#) (2016), and the UNAIDS [ALIV\(H\)E Framework on gender-based violence](#) (2017).

4.2 Drug law reform toward ending criminalization

The criminalization of people who use drugs contributes to the ongoing stigmatization and discrimination that they face. It hinders access to lifesaving harm reduction services and prevents people who use drugs from coming forward to receive these services, thus increasing their vulnerability to HIV and other harms. Criminalization also contributes to mass incarceration, with one in five people incarcerated worldwide being charged with (mainly minor) drug offences.³¹ Overcrowded prisons and other closed settings exacerbate the health risks associated with drug use.

One of the WHO critical enablers recommends that countries review and revise laws and legislation and work toward the decriminalization of drug use and possession for personal use. The removal of criminal sanctions for drug use and drug possession for personal use, an approach commonly known as “decriminalization”, has been proven to improve health outcomes for people who use drugs. For example, in Portugal, where the possession and use of up to 10 days’ supply of illicit drugs have been decriminalized since 2001, the rates of incarceration, HIV, overdose deaths and other health-related risks have shown marked decreases. The fear that decriminalization will increase drug use has proven to be unfounded, while the number of people who access health services has increased. Numerous other countries have also adopted approaches to decriminalization.³²

The removal of criminal sanctions for drug use and possession for personal use has now been formally endorsed by all 31 specialized UN agencies in the [United Nations System Common Position Supporting the Implementation of the International Drug Control Policy through Effective Inter-Agency Collaboration](#) (2019), which commits:

“To promote alternatives to conviction and punishment in appropriate cases, including the decriminalization of drug possession for personal use, and to promote the principle of proportionality, to address prison overcrowding and overincarceration by people accused of drug crimes, to support implementation of effective criminal justice responses that ensure legal guarantees and due process safeguards pertaining to criminal justice proceedings and ensure timely access to legal aid and the right to a fair trial, and to support practical measures to prohibit arbitrary arrest and detention and torture”.

In addition to legal change, measures to reform police practice are essential, as is incentivizing referral to health services, rather than the harassment, demands for informal payments, and arrest that often deter health-seeking.

³⁰ In this technical brief, hyperlinks to Global Fund publications are to the English-language versions, but many are also available in other languages at <https://www.theglobalfund.org/en/funding-model/applying/resources/>.

³¹ United Nations (2015). [State of Crime and Criminal Justice Worldwide. Report of the Secretary General, Thirteenth United Nations Congress on Crime Prevention and Criminal Justice](#).

³² Release (2017). [A Quiet Revolution: Drug Decriminalisation across the Globe](#).

Decriminalization is a critical enabler for reducing the health and social risks and harms associated with drug use. Countries are therefore strongly encouraged to invest in advocacy and steps to change drug laws, policies, and practices that criminalize and punish the behavior of all key populations, including people who use drugs.

These advocacy activities could include:

- forming a national committee to review existing drug laws and recommend drug policy changes
- reviewing police practice and facilitating the use of police discretion to refer people voluntarily to harm reduction and health services, rather than arresting them
- building the local capacity of civil society, community networks, and the media on issues of drug policy and decriminalization
- undertaking a national assessment or feasibility study on decriminalization
- working to change laws, regulations, and practices that are used to enforce compulsory treatment or detention in locked facilities
- sensitizing policymakers, religious leaders, law-enforcement and health officials, judges and lawyers, and other key stakeholders on drug policy and its impacts on health.

For further information, see the [International Guidelines on Human Rights and Drug Policy](#) (2019)³³ and the UNAIDS publication [Health, Rights and Drugs: Harm Reduction, Decriminalization and Zero Discrimination for People Who Use Drugs](#) (2019).²¹

4.3 User-friendly, low-threshold, and non-judgmental services

User-friendly programs for people who use drugs are based on their needs, are easy to access, and operate at a time and place which is suitable for them. An example is locating a methadone clinic close to where people who use drugs live, rather than at an already established but distant healthcare facility.

Likewise, TB screening and treatment programs should be designed to be inclusive of people who use drugs, and make cross-referrals to other harm reduction services that people who use drugs may need. For more information, see the Global Fund's [Tuberculosis Information Note](#) (2019) and the WHO consolidated guidelines on [Integrating Collaborative TB and HIV Services within a Comprehensive Package of Care for People Who Inject Drugs](#) (2016).

Low-threshold services are those with fewer rules and barriers for access, such as community-based NSP that do not require one-for-one needle exchanges. By contrast, an OST program requiring overly complex registration procedures, regular mandatory urine test with threat of discontinuing treatment in case of drug use, counseling, and allowing on-site consumption only—rather than take-home dosages—even for long-term stable patients, would be considered **high-threshold**. Similarly, fees charged for diagnostics required to enter OST—even if the medicine itself is free—can be a serious barrier for people who want to start treatment for their opioid dependence. Such services often experience a low uptake and/or a high drop-out rate among patients.

³³ UNDP and International Centre on Human Rights and Drug Policy (2019). [International Guidelines on Human Rights and Drug Policy](#).

Non-judgmental programs are those that do not discriminate against the clients on the basis of their actions or drug use. For example, if a service reprimands a methadone patient each time they report “topping up” their methadone with another drug, the patient may not come forward to offer similar information in the future. If the program instead uses that information for service improvement (such as adjusting the dosage of the methadone), the patient benefits and the program’s effectiveness will improve. Services should also be designed to appeal to people who use different drugs, noting that specific approaches may be required to reach those who use stimulant drugs or new psychoactive substances.

Drug consumption rooms are professionally supervised healthcare facilities where people can consume illicit drugs in a safe environment. They are an example of a user-friendly, low-threshold, and non-judgmental harm reduction service. Evidence shows that by removing the risk of injecting with unsterile equipment, preventing death from overdose, and providing linkages to other services, drug consumption rooms are an effective approach to harm reduction.^{34,35}

Situation assessments of the drug-use context are usually the best way to identify what, where, and how services should be developed to be user-friendly, low-threshold, and non-judgmental. Ensuring that people who use drugs, in particular women and youth who inject drugs, are part of the design and evaluation process will help identify and address potential programming difficulties. Programs should ensure that there are linkages to other necessary services, especially sexual and reproductive health services, ART for those who test HIV positive, and TB screening and treatment for those with suspected symptoms.

Regular trainings should be scheduled and implemented for all staff on HIV, harm reduction principles, HCV, TB, overdose, safer drug use, and other health and social services that may be useful to people who use drugs. Training should also address barriers to access, sensitivity to age, gender, and ethnicity, changing drug scenes and markets, and poly drug use, as well as the prevention of burnout among staff.

4.4 Community involvement and community systems strengthening

People who use drugs should be supported to participate meaningfully in program decision-making, planning and delivery of harm reduction services. Services for people who use drugs are best delivered in community-based settings and by civil-society organizations, including peer-led organizations of people who use drugs. People who use drugs and people who are on OST can be involved as advisors, outreach workers, peer navigators, treatment-support managers and program evaluators. Programs should establish systems to ensure regular feedback from service users.

Community systems strengthening (CSS) is an approach to developing the roles of key communities (such as people who use drugs) and community organizations in the design, delivery, monitoring, and evaluation of services and interventions. The goal is to build capable, coordinated community organizations and structures, in order to increase the long-term effectiveness and sustainability of health and structural interventions. Applicants are strongly encouraged to include CSS interventions in their proposals. CSS activities must be accompanied by resources to support extensive and meaningful community engagement and empowerment. For more information, see the Global Fund’s CSS [information note](#) (2019) and [technical brief](#) (2016).

³⁴ European Monitoring Centre for Drugs and Drug Addiction (2017). [Drug Consumption Rooms: An Overview of Provision and Effectiveness](#).

³⁵ Harm Reduction International (2018). [Drug Consumption Rooms: Global State of Harm Reduction 2018 Briefing](#).

The meaningful involvement of people who use drugs in harm reduction programs can be incorporated in several other ways:

- Country Coordinating Mechanisms are strongly recommended to include people who use drugs and their organizations in country dialogues, project design, proposal development, and program implementation and oversight. Global Fund program implementers must ensure that these representatives are given the necessary support and capacity-building to actively participate and are allowed to express their views without fear of repercussions. In contexts where people who use drugs do not wish to be publicly identified as such, implementers should discuss ways to facilitate their participation while respecting their anonymity.³⁶
- Countries should ensure that partners implementing projects appoint people who use drugs to provide monitoring and oversight of programs, manage community consultations, and be involved in the design and implementation of program evaluations.
- Countries should support the development of independent networks of people who use drugs at the national and local levels. Funding should be allocated, including for administration/logistics and for programs.

4.5 Gender- and age-responsive programming

In many countries, women who use drugs have disproportionately poor access to HIV prevention, treatment, and care as well as TB-related services.³⁷ HIV infection rates among women who inject drugs are often higher than among their male counterparts,³⁸ and the sexual partners of men who inject drugs also can be very vulnerable to HIV.³⁹

Women who are pregnant, use drugs, and are living with HIV are frequently excluded from prenatal care, and therefore risk having significantly higher rates of mother-to-child transmission than other women,⁴⁰ as well as being more vulnerable to other health problems throughout their pregnancy. These women require harm reduction services that are tailored to their needs.

Where possible, applicants should collect gender-disaggregated data to inform the service gaps in harm reduction, HIV, HCV, and TB epidemiology, and access to services across the cascade of care, while always respecting the key principle of doing no harm.⁴¹

Examples of gender-responsive programming for people who use drugs include:

- Safe spaces for women who use drugs (separate from male-centered spaces)
- providing free childcare at, or linked to, drop-in centers

³⁶ Global Fund (2019). [Guidance on CMM Eligibility Requirements 1 & 2](#).

³⁷ UNODC (2016). [Addressing the Specific Needs of Women Who Inject Drugs: Practical Guide for Service Providers on Gender-responsive HIV Services](#).

³⁸ Larney S et al. (2015). [Global epidemiology of HIV among women and girls who use or inject drugs: current knowledge and limitations of existing data](#). *Journal of Acquired Immune Deficiency Syndromes*; 69(Suppl 2):S100-9.

³⁹ WHO, UNAIDS (2010). [Guidelines on Estimating the Size of Populations Most at Risk to HIV](#).

⁴⁰ Global Commission on Drug Policy (2012). [The War on Drugs and HIV/AIDS: How the Criminalization of Drug Use Fuels the Global Pandemic](#).

⁴¹ International AIDS Society (2019). [Women Who Inject Drugs: Overlooked, yet Visible](#).

- the availability of both male and female outreach workers
- integration of harm reduction services into sexual and reproductive health services
- supporting women's access to harm reduction services in prison and other closed settings, on an equal basis to men
- supporting access to prevention of mother-to-child transmission (PMTCT) for pregnant women who use drugs, including in prison and other closed settings
- linkages with gender-based violence services
- services tailored for women who use drugs who are also engaged in sex work
- supporting access to OST for pregnant women who use drugs.

For further details, see the Global Fund information note on [Addressing Gender Inequalities and Strengthening Responses for Women and Girls](#) (2014) and the UNODC publication [Addressing the Specific Needs of Women Who Inject Drugs](#) (2016). In addition, the [UNAIDS Gender Assessment Tool](#) (2018) is a guide for ensuring that programming and strategies are gender-inclusive and identifying broader human-rights barriers faced by women in relation to HIV services and prevention.

Similarly, program implementers are encouraged to ensure a focus on young people, including street-involved children who use drugs. Young people who use drugs have specific developmental, social, and environmental vulnerabilities. They are less likely than adults to use harm reduction and treatment services and may be less informed about risks and their rights. National population size estimates for this age group are rare.

Early onset of injecting and being a new injector are associated with increased risks of HIV and HCV transmission, while specific groups of young people, especially those that are street-involved, are at considerably higher risk. Harm reduction services for this age group, the interventions required, and their manner of delivery may differ from those for older people who inject.² The legal status of being a minor raises additional challenges for the development of targeted harm reduction interventions. These include issues relating to informed consent, parental consent, and legal age restrictions on services.

4.6 Prisons and other closed settings

Globally, 10.7 million people live in prisons and other closed settings on any given day.⁴² Experts estimate that the annual prisons population can exceed 30 million people, emphasizing the direct contact of the prison population with the community and its impact on public health.⁴³ High incarceration rates may also perpetuate the cycle of disease transmission, including HIV, hepatitis, and TB.

Due to the widespread criminalization of minor drug offenses in many countries, detention and imprisonment may be common experiences for people who use drugs.²¹ Often, people continue injecting drugs while in prison, while others may initiate drug use while incarcerated. Therefore,

⁴² World Prison Brief, Institute for Criminal Policy Research (2018). [World Prison Population List, Twelfth Edition](#).

⁴³ References to "prison" in this section should be understood to include other closed settings also.

harm reduction services in prison are important. Services must address not only injecting risks but also the risk of sexual transmission of HIV in prison settings.

Women in prison are at a higher risk of HIV and TB than men in prison and women in the community. The same challenges that lead to women becoming incarcerated are often those that lead to increased HIV infection risks, including punitive laws on sex work and drug use. Their situation is exacerbated by stigma, gender-based violence, inequality, and discrimination. Not only are HIV prevention and care services often poor in prisons, but women's specific health needs, including access to SRH services, are frequently neglected.

People in prisons are entitled to the same standard of healthcare services as are provided in the community, free of charge and without discrimination, as indicated in the [United Nations Standard Minimum Rules for the Treatment of Prisoners](#) (the "Nelson Mandela Rules"). However, evidence-based interventions such as NSP and OST are extremely limited in prisons. In 2018, only 10 countries implemented NSP in at least one prison, and OST was provided in prisons in only 54 countries.²⁰ The quality of OST and NSP in prisons varies considerably, and serious barriers, including stigma and discrimination, persistently impede access to this essential service where it does exist.

Given the role that prisons play in the spread of HIV, HCV, and TB (including multidrug-resistant TB), it is crucial to ensure the continuity of OST, ART (including for PMTCT), HCV and TB treatment, and NSP at all stages of contact with the detention system – upon arrest, pre-trial detention, transfer to prison and within the prison system, and upon release. For more information, see the WHO consolidated guidelines on [Integrating Collaborative HIV and TB Services within a Comprehensive Package of Care for People who Inject Drugs](#) (2016). The Global Fund also recommends ensuring access to legal aid for people who inject drugs, including those held in jail, prison, and other detention facilities. People released from prison or from drug-free treatment settings are at particularly high risk of overdose and should be prioritized for naloxone provision.^{26,38}

Addressing HIV in prisons cannot be separated from the wider questions of human rights, drug policy reform, and prison reform. Small changes to drug policies can have a huge impact on prison populations. For example, there is a growing body of evidence to show that decriminalization policies that deal with drug use and possession for personal use as a public-health issue dramatically decrease prison populations and related health issues.³⁶

The Global Fund recommends that program implementers also refer to the UNODC, ILO, WHO, and UNAIDS publication [HIV Prevention, Treatment and Care in Prisons and Other Closed Settings: A Comprehensive Package of Interventions](#) (2013), and to the WHO [Key Populations Consolidated Guidelines](#).

4.7 Compulsory drug detention centers

In some countries, people who use drugs are held in centers purporting to provide "treatment" or "rehabilitation," with widely reported violations of human rights, little or no judicial process, oversight mechanisms, or medical evaluation of those held, and no evidence of effectiveness in addressing drug dependence. In 2012, 12 UN agencies called for the closure of these compulsory "treatment" facilities.⁴⁴ The Global Fund has made repeated calls for the closure of drug detention centers, while expressing concern that those detained illegally within them must not be denied access to essential health care.⁴⁵ In October 2014, the fund's Board decided that the Global Fund

⁴⁴ United Nations (2012). [Joint Statement: Compulsory Drug Detention and Rehabilitation Centers](#).

⁴⁵ Global Fund (2014). [Strategy, Investment, and Impact Committee Decisions and Recommendations to the Board](#) (p.13).

would not fund any interventions in compulsory drug detention centers. Where these centers exist, applicants should seek to identify and support more effective, cost-effective, and human-rights-based alternatives, as well as measures to end detention and permanently close these facilities.

However, consistent with its commitment to addressing gaps in lifesaving treatment for key populations, the Global Fund may finance scientifically sound medical services in exceptional circumstances: for instance, ensuring access to life-saving treatment to detainees when delivered at **voluntary, community-based treatment programs located outside of such detention facilities**. These exceptions will be determined based on consultation with UN partners and will require independent oversight to verify the conditions and use of the financing. The Global Fund Secretariat will consult with community organizations within the country, and with INPUD, in making these decisions.

4.8 Data for program planning and design

Harm reduction programs should be based on available local data. Population size estimates and behavioral risk surveys provide important data for national-level programming, as do more targeted efforts in prisons and other closed settings, or among those unlikely to be reached by household surveys. Data should also be generated about local drug use patterns, trends, and markets. This can enable targeted use of resources and design of the most appropriate strategies for people who use drugs.

However, the lack of population size estimates and other national-level data is no reason for inaction. When there is evidence of injecting drug use, priority interventions (NSP, OST, and HIV and HCV testing and treatment) can be implemented while investing in research and data-collection initiatives to further develop the evidence base. For further information, see the Global Fund's [Strategic Framework for Data Use 2017-2022](#).

In the absence of a national population size estimate, program implementers should undertake local-level assessments, including:

- situation assessments or needs assessment and response
- mapping exercises
- community consultations, and supporting community-led research on population size estimates
- stakeholder mapping.

It is important that all research and data-collection operate on the principle of “do no harm”, i.e., it must not endanger the safety or well-being of people who use drugs, or of those gathering data. Collaboration with local organizations or networks of people who use drugs is advised in order to ensure that research and data collection are conducted effectively and safely.

4.9 Scale, coverage, and sustainability

Programs should be designed to achieve high coverage, in line with the United Nations' global prevention target of 90% coverage of people at risk of HIV – including people who inject drugs –

with comprehensive HIV prevention services,⁴⁶ to achieve the goal of reducing new HIV infections by 75% compared with 2016 levels.⁴⁷

Adequate coverage of HIV testing and treatment is essential to address HIV transmission among people who use drugs (and any other key population) and to meet the UNAIDS Fast-Track targets, i.e., that 90% of people living with HIV know their status, 90% of these are enrolled in ART, and 90% of those on ART have a suppressed viral load.⁴⁸ All people who inject drugs who attend harm reduction services should be offered HIV testing, and those who test positive should be linked to ART.

WHO/UNODC/UNAIDS recommend that around 60% of people who inject drugs be regularly reached by NSP, with a population-level average of at least 200 needles/syringes per person per year.³ Likewise, around 40% of people dependent on opioids should be enrolled in OST programs.³

Pilot programs are important to demonstrate program design and implementation. However, they should be time-limited, and lessons from the monitoring and evaluation process should be used to scale up interventions across the country, focusing on locations and sub-populations where the HIV need is greatest.

The long-term sustainability of programs must be considered from the initial planning stage, with a view to integrating programming for people who use drugs within national health and welfare programs and budgets. Sustainability planning should include services provided by nongovernmental organizations, community-based organizations, and organizations led by people who use drugs. Proposals should address the following key points: a) how the quality and cost-effectiveness of programs will be ensured, b) how programming will be continued after Global Fund funding ends, and the process (transition plan) that will be used to achieve this, and c) what steps the recipients plan to take to change laws and policies to create an enabling environment for sustainable programming. For more information, see [The Global Fund Sustainability, Transition and Co-financing Policy](#) (2016).

5. Resources for proposals and programming

There is a wealth of resources within and beyond the Global Fund for countries seeking further details on program planning and implementation, as well as more general information on drug use, HIV risk and vulnerability, and harm reduction. Section 5.1 lists relevant publications, and Section 5.2 gives information on global, regional, and national organizations and networks. Applicants are strongly encouraged to refer to these publications and organizations in order to strengthen their proposals.

⁴⁶ Global HIV Prevention Coalition (2017). [HIV Prevention 2020 Road Map](#).

⁴⁷ United Nations (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](#).

⁴⁸ UNAIDS (2014). [Fast-Track: Ending the AIDS Epidemic by 2030](#).

5. Publications

Global Fund

- [HIV Information Note](#) (2019)
- Key Populations technical brief (2019)
- [HIV, Human Rights and Gender Equality Technical Brief](#) (2017)
- [Maximizing Impact by Strengthening Community Systems and Response Technical Brief](#) (2016)
- [Tuberculosis Information Note](#) (2019)
- [Tuberculosis, Gender and Human Rights Technical Brief](#) (2017)
- [Addressing Gender Inequalities and Strengthening Responses for Women and Girls Information Note](#) (2014)
- [Community, Rights and Gender \(CRG\) Technical Assistance Program](#)
- [Strategic Framework for Data Use for Action and Improvement at Country Level 2017-2022](#)
- [Sustainability, Transition and Co-financing Policy](#) (2016)
- [Global Fund Support for Co-infections and Co-morbidities](#) (2015)
- [The Global Fund Strategy 2017-2022: Investing to End Epidemics](#) (2016)

Overarching guidance and technical support

- UNODC, INPUD, UNAIDS, UNDP, UNFPA, WHO, USAID (2017). [Implementing Comprehensive HIV and HCV Programmes with People Who Inject Drugs: Practical Guidance for Collaborative Interventions](#) (the “IDUIT”)
- WHO, UNODC, UNAIDS (2012). [WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users – 2012 Revision](#)
- WHO (2016). [Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations – 2016 Update](#)
- UNAIDS (2018). [UNAIDS Technical Support: Optimizing Global Fund Grants in Asia and the Pacific 2017-2018](#)

Policy

- Global HIV Prevention Coalition (2017). [HIV Prevention 2020 Road Map](#)

- United Nations (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](#)
- UNAIDS (2014). [Fast-Track: Ending the AIDS Epidemic by 2030](#)
- International Drug Policy Consortium (2016). [IDPC Drug Policy Guide](#) (2016)
- *Lancet* (2016). [Public Health and International Drug Policy: Report of the Johns Hopkins – Lancet Commission on Drug Policy and Health](#)
- Open Society Foundations. [Harm Reduction and Global Drug Policy Program](#) (publications on drug policy and harm reduction programming)

Drug use and harm reduction

- UNODC (2019). [World Drug Report](#)
- Harm Reduction International (2019). [What is Harm Reduction?](#) [Website]
- Harm Reduction International (2018). [The Global State of Harm Reduction 2018](#)
- UNODC and UNAIDS (2010). [Facts about Drug Use and the Spread of HIV](#)
- International Harm Reduction Association (2010). [What is Harm Reduction? A Position Statement from the International Harm Reduction Association](#)

Law and human rights

- UNAIDS (2019). [Health, Rights and Drugs: Harm Reduction, Decriminalization and Zero Discrimination for People Who Use Drugs](#)
- UNDP and International Centre on Human Rights and Drug Policy (2019). [International Guidelines on Human Rights and Drug Policy](#)
- United Nations (2019). [United Nations System Common Position Supporting the Implementation of the International Drug Control Policy through Effective Inter-Agency Collaboration](#)
- Release (2017). [A Quiet Revolution: Drug Decriminalisation across the Globe](#)
- UNAIDS (2016). [Do No Harm: Health, Human Rights and Drugs](#)
- INPUD (2015). [INPUD Consensus Statement on Drug Use under Prohibition: Human Rights, Health and the Law](#)
- United Nations (2012). [Joint Statement: Compulsory Drug Detention and Rehabilitation Centers](#)
- Global Commission on Drug Policy (2012). [The War on Drugs and HIV/AIDS: How the Criminalization of Drug Use Fuels the Global Pandemic](#)

- UNAIDS (2017). [Fast-Track and Human Rights: Advancing Human Rights in Efforts to Accelerate the Response to HIV](#)
- United Nations (2016). [United Nations Standard Minimum Rules for the Treatment of Prisoners \(the “Nelson Mandela Rules”\)](#)
- Global Commission on HIV and the Law (2012). [Rights, Risk and Health: Report of the Global Commission on HIV and the Law](#)
- UNAIDS (2012). [Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses](#)
- UNAIDS (2018). [UNAIDS Gender Assessment Tool: Towards a Gender-transformative HIV Response](#)
- UNAIDS (2017). [ALIV\(H\)E Framework: Action Linking Initiatives on Violence Against Women and HIV Everywhere](#)

Programmatic guidance

- WHO (2007). [Guide to Starting and Managing Needle and Syringe Programmes](#) (2007)
- UNODC (2014). [Handbook for Starting and Managing Needle and Syringe Programmes in Prisons and Other Closed Settings](#)
- UNODC, ILO, WHO, UNAIDS (2013). [HIV Prevention, Treatment and Care in Prisons and Other Closed Settings: A Comprehensive Package of Interventions](#)
- WHO (2009). [Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence](#)
- UNODC (2019). [HIV Prevention, Treatment, Care and Support for People Who Use Stimulant Drugs: Technical Guide](#)
- WHO (2014). [Community Management of Opioid Overdose.](#)
- WHO (2004). [Evidence for Action: Effectiveness of Community-based Outreach in Preventing HIV/AIDS among Injecting Drug Users](#)
- UNODC (2016). [Addressing the Specific Needs of Women Who Inject Drugs: Practical Guide for Service Providers on Gender-responsive HIV Services](#)
- WHO (2016). [Integrating Collaborative TB and HIV Services within a Comprehensive Package of Care for People Who Inject Drugs](#)
- Harm Reduction International (2018). [Drug Consumption Rooms: Global State of Harm Reduction 2018 Briefing](#)
- European Monitoring Centre for Drugs and Drug Addiction (2017). [Drug Consumption Rooms: An Overview of Provision and Effectiveness](#)
- WHO (2017). [Guidelines on Hepatitis B and C Testing](#)

- WHO (2018). [Guidelines for the Care and Treatment of Persons Diagnosed with Chronic Hepatitis C Virus Infection](#)
- WHO (2012). [Guidance on Prevention of Viral Hepatitis B and C among People Who Inject Drugs](#)
- WHO (2016). [Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection](#)
- INPUD (2015). [An Introduction to Pre-Exposure Prophylaxis \(PrEP\) for People Who Inject Drugs](#) (2015)
- WHO, UNAIDS (2010). [Guidelines on Estimating the Size of Populations Most at Risk to HIV](#)

5.2 Organizations and networks

International

- [INPUD – International Network of People who Use Drugs](#)
- [INWUD – International Network of Women who Use Drugs](#)
- [Youth RISE](#) (international network of young people involved in drug policy, education, and harm reduction)
- [International Drug Policy Consortium](#)
- [Harm Reduction International](#)
- [Harm Reduction Academy](#) (global learning, dialogue, and skills-building course)
- [Mainline](#) (information on drugs and health, including [stimulants](#) and [chemsex](#))
- [Initiative 5%](#) (technical assistance for Global Fund beneficiaries)

Regional and national

INPUD maintains a list of regional and national networks of people who use drugs, available [here](#).

List of abbreviations

ART antiretroviral therapy

CSS community systems strengthening

HCV hepatitis C virus

IDUIT *Implementing Comprehensive HIV and HCV Programmes with People Who Inject Drugs: Practical Guidance for Collaborative Interventions*

ILO International Labour Organization

INPUD International Network of People who Use Drugs

NSP needle and syringe program

OST opioid substitution therapy

PMTCT prevention of mother-to-child transmission (of HIV)

PrEP pre-exposure prophylaxis

TB tuberculosis

UNAIDS Joint United Nations Programme on HIV/AIDS

UNDP United Nations Development Programme

UNFPA United Nations Population Fund

UNODC United Nations Office on Drugs and Crime

USAID United States Agency for International Development

WHO World Health Organization