



Wilton Park



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Report

Slowing the HIV and HCV epidemics among people who inject drugs

Monday 26 – Wednesday 28 February 2018 | WP1578



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Meeting overview and objectives

This meeting convened high-level stakeholders including policymakers, researchers, clinicians, advocates, implementers and industry representatives to discuss how to reach people who inject drugs (PWID) with HIV and HCV prevention, treatment and care measures.

PWID are at much higher risk of HIV, Hepatitis C (HCV) and HIV/HCV co-infection than the general population. Of the estimated 15.6 million PWID globally, approximately one in six (17.8%) is living with HIV and more than half (52.3%) are living with HCV. The vast majority of PWID living with HIV is co-infected with HCV (82.4%). Globally, PWID represent 23% of new HCV infections and 31% of HCV-related deaths. Regionally, Eastern Europe and Latin America are estimated to have the highest prevalence of HIV and HCV among PWID.

In 2011, the United Nations set a target to cut new HIV infections among PWID in half by 2015. However, new HIV infections in PWID increased by 33% between 2011 and 2014. In 2015, the internationally agreed Sustainable Development Goals included a new call to “strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol” (SDG3). Notwithstanding efforts to address HIV and HCV, stakeholders remain concerned that global goals have not generated the support and funding needed to serve PWID.

Adequately serving the needs of PWID to achieve global goals will require proven interventions to be brought to scale and life-saving medicines to be more accessible. Out of 179 countries where injection drug use has been reported, only half provide some level of needle and syringe programmes (52%) or opioid substitution therapy (48%). Less than one per cent of PWID live in countries with high coverage of both needle and syringe programmes and opioid substitution therapy. Significant social and structural barriers to healthcare are rooted in stigma, discrimination and criminalisation. According to UNAIDS, over half of PWID will be incarcerated at some point in their lives. While in prison, PWID are further exposed to HIV and HCV through continued, unsafe drug use. PWID are also more likely to engage in sex work and are at higher risk of homelessness or unstable housing.

This meeting provided a timely opportunity to explore the impact of key global frameworks on reaching PWID with HIV and HCV prevention, treatment and care

measures one year prior to the 2019 United Nations General Assembly Special Session on Drugs (UNGASS) to be held in New York. This report provides an overview of presentations and discussions, highlighting the most salient themes that emerged from the meeting. The recommendations highlighted in this paper are not the consensus of meeting participants, rather suggestions for consideration.

Key themes

Participants discussed the following topics, which are central to slowing and ultimately reversing the HIV and HCV epidemics among PWID:

- Reforming drug policy and adopting public health approaches: National and local governments should adopt policies that decriminalise and regulate drug use and embrace public health strategies. These policies could facilitate an environment conducive to delivering key services for PWID that, in turn, could slow and ultimately reverse the HIV and HCV epidemics among PWID.
- Ensuring access to services in unpredictable financial and political environments: At a time when international donor funding is uncertain and spending on health and harm reduction is declining, stronger arguments are needed to convince local governments to prioritise health services for PWID. This could include demonstrating the broader health impacts and cost-savings of reaching PWID with needed health services.
- Scaling evidence-based and community-informed services: Policy reforms should be complemented by an investment in evidence-based services for PWID to ensure quality care provision and lasting health outcomes. Effective interventions should aim to:
 - Streamline and simplify testing and treatment protocols.
 - Strengthen and scale programmes, for example community-based programmes and services.
 - Integrate harm reduction services, for example needle and syringe programmes (NSPs) and opioid substitution therapy (OST).
 - Monitor, evaluate and disseminate implementation challenges and successes.
- Overcoming Stigma and Discrimination: For PWID, stigma and discrimination are considerable barriers to care. PWID experience stigma and discrimination in almost every community – from law enforcement and policymakers to healthcare providers. Stronger policies, programmes and public campaigns that destigmatize PWID and their behaviours are desperately needed.

Reforming drug policy and adopting public health approaches

1. The increased production of drugs, which are subject to drug prohibition laws, their growing potency and the relative ease of access to purer and cheaper drugs suggests that prohibitive drug policy is not working. The strict prohibition of drugs fuels the HIV and HCV epidemics among PWID by: creating stigma, including by medical professionals, that in turn deters PWID from accessing essential services and driving unsafe drug use, increasing HIV and HCV transmission rates. The arrest and incarceration of PWID interrupts HIV and HCV treatment, undermining health interventions and holding back efforts to achieve health targets.

2. Numerous examples exist worldwide of de jure and de facto drug policy reform that has regulated the drug market, shifting the focus of drug policy away from criminalisation to the health of individuals. Marijuana has been decriminalised in parts of the United States and in Georgia in Eastern Europe; heroin is available in medically controlled environments in Switzerland; and Portugal has decriminalised the possession and use of all drugs (the threshold is set at what amounts to a 10-day supply for personal use). While these reforms have not made drug use entirely safe, they have reduced the health risks of drug use. To do this successfully, however, decriminalisation must be matched by investment in evidence-informed services for PWID (see below). Furthermore, it is critical that decriminalisation is matched by strong regulations regarding the prescription of opiates. The opioid crisis in the US was exacerbated by over-prescription. Data suggest that in some US states the opioid prescription rate was on average more than one prescription per person each year.
3. Building momentum for further national-level drug policy reform partly relies upon greater policy coherence at the global-level. The 2016 UNGASS marked a real shift in global policy on drugs, with important gains made on criminal justice. The 2019 UNGASS on the World Drug Problem provides another key opportunity to further shift global drug policy. The intention of civil society organisations in 2019 is to recast global targets so that they move away from 'drug-free' targets to targets that emphasise reductions in HIV, hepatitis and TB rates and align with the Sustainable Development Goals.
4. Drug policy reform does not always move toward greater liberalisation. The Netherlands had a progressive drug policy – it was one of the first countries to introduce methadone and to provide medicated heroin in limited cases. There now, however, appears to be a general trend towards greater drug control and prohibition. The Dutch Government is now perceived to be tightening regulations regarding coffee shops, for example.

Exemplars:

5. In Switzerland, heroin-assisted treatment (HAT) clinics first opened in 1994 as part of a three-year national trial. In 1997, the federal government approved a large-scale expansion of the trial, aimed at accommodating 15% of the nation's estimated 30,000 heroin users, specifically those long-term users who had not succeeded with other treatments. The Swiss HAT model requires patients to attend a clinic once or twice a day and to use their prescriptions on site under medical supervision. Drug-related deaths in Switzerland have declined steadily since the introduction of the HAT clinics and no overdose has occurred in HAT clinics.
6. The impact of drug policy reform in Portugal will be important to track. Portugal's experience of drug policy reform and public health approaches could demonstrate powerful results and improved health outcomes of broader relevance.

Recommendations

- National and local governments should choose a public health approach to drug use in place of criminalisation to improve access of essential health services for PWID, and to enable law enforcement professionals to refocus limited resources. This should include decriminalising the possession of drugs and drug paraphernalia for personal use, as well as services for PWID (for example safe injection sites, NSPs, OST).
- National and local government should move toward a regulated drug market to ensure access to opiates for medical reasons, subject to regulation regarding their prescription.

- A clear business case and a strong messaging framework should be developed to remove deeply entrenched views regarding the criminalisation of drug use. Modelling of income available from the taxation of drugs (like alcohol duties) could support the business case for drug policy reform.
- Ongoing advocacy and awareness raising regarding the gains made through the decriminalisation of drugs (including reduced infection rates and cost savings) could help to ensure progressive laws and policies are not rolled back. High quality case studies that are re-evaluated at regular intervals to track the unfolding evidence would be valuable.

Ensuring access to services in unpredictable financial and political environments

7. Donor funding for harm reduction services remains critically low in many parts of the world and the overall funding for harm reduction services in low- and middle-income countries is in decline. In 2015, donor contributions to harm reduction services fell by 7% compared to funding in 2014. The Global Fund to Fight AIDS, Tuberculosis and Malaria remains the largest funder of harm reduction services, but many countries that have relied upon Global Fund resources for harm reduction are becoming ineligible due to increasing national income levels.
8. Domestic investment in HIV programmes is increasing in some countries, but very few countries are prioritising HIV prevention for key populations. Of the governments reporting HIV prevention expenditure to UNAIDS, 3.3% of the total spent on HIV prevention is directed towards programmes for PWID - most of which comes from donors. Countries frequently fail to allocate financial resources to harm reduction services. Despite the inclusion of harm reduction in national HIV or drug strategies in 26 countries in Eastern Europe and Central Asia, for example, the majority does not finance harm reduction programmes. In total, 11 of the 26 countries that included harm reduction in national HIV or drug strategies have reported some governmental contribution toward the delivery of harm reduction programmes.
9. Modelling has shown that a shift of 2.5% of the US\$100 billion spent annually on global drug enforcement to harm reduction services (including needle exchange programmes and opioid substitution therapy) has the potential to achieve a 78% reduction in new HIV infections among PWID by 2030 and a 65% reduction in HIV-related deaths. Redirecting 7.5% of the US\$100 billion spent annually on global drug enforcement to harm reduction services would reduce HIV-related deaths among PWID by 94%. The modelling underlines the fact that harm reduction interventions are relatively inexpensive compared to punitive law enforcement and have substantial health benefits.
10. Political pressures in some countries means that shifting resources from law enforcement to harm reduction services often presents a difficult proposition. Low-cost, high-impact interventions are required in financially and politically challenging settings. Political pressures also differ within a country, meaning that success can be local; different cities or provinces are capable of taking significant action outside of programmes designed and implemented by national governments.

Exemplar:

11. In 2015, Georgia launched a national HCV elimination programme that aims to eliminate HCV by 2020. Specific targets include 90% of people living with HCV to be diagnosed, 95% treated and 95% cured. Georgia has also provided universal access to antiretroviral therapy since 2004, treatment to prevent mother-to-child-transmission since 2005 and HCV therapy for HIV/HCV co-infected persons since 2011. These initiatives, complemented by a Treat All approach since 2015 and harm reduction services, has contributed to Georgia avoiding a large-scale epidemic.

Recommendations

- Donors should halt and reverse the trend of reduced funding for harm reduction services.
- National governments should increase funding and support for harm reduction services; funding from the Global Fund could be utilised to leverage additional support.
- Civil society groups should develop a strong messaging framework to tie evidence-informed services for PWID to the Universal Health Coverage agenda and not to specific diseases.
- Action research, a clear business case and a strong messaging framework should be developed to help generate support for shifting funding from punitive law enforcement to harm reduction services, including at the district and municipal levels.
- Case studies should be produced that document low-cost, high-impact interventions that strengthen the delivery of services in resource-limited settings.

Scaling evidence-based and community-informed services

12. Proven harm reduction tools and strategies have been shown to have a significant impact on the health and lives of PWID and their communities, when properly implemented. For example, when opioid substitution therapy is integrated and readily available to PWID, patients are more likely to adhere to HIV and HCV treatment – and substance use declines. However, while some effective health services for PWID that integrate HIV and HCV services already exist, they can continue to improve and be brought to scale, including by being replicated in different settings or increased in scope and size.
13. Significant scope remains for simplifying cascades of care for PWID. Options include providing routine screening, decentralising testing and treatment so that community health workers can provide essential services to PWID and streamlining testing and treatment protocols to ensure PWID are tested and can start treatment on the same day.
14. The stigma and discrimination of PWID that flows from the criminalisation of drug use is a key barrier to evidence-informed services for PWID. Even progressive drug policies or evidence regarding the efficacy of harm reduction tools have little impact if health professionals are not trained or are unwilling to provide services to PWID. Numerous examples exist of PWID being treated as criminals when they attend health centres; discrimination often stops PWID from accessing health services even when essential services are available. In some settings, healthcare workers are expected to share details of drug users with the police, further disincentivising PWID from accessing health services. PWID are also often expected to stop all drug use to receive treatment, discouraging PWID from obtaining healthcare. Given the common links between health centres and law enforcement, an overwhelmingly negative view is often held by PWID of clinical settings.
15. Strengthening community-based programmes that de-stigmatise and decentralise health services for PWID are often effective channels for high quality service delivery. Community-based services are frequently viewed more positively by PWID because stigma is less prevalent and service providers are subsequently trusted more. Many community-based services are located close to PWID and in more comfortable settings, facilitating access to essential services. Building the capacity of community health workers through training and ongoing education to deliver essential services (for example test and treat) is a proven strategy for improving access to health services. It is also important to note that law enforcement can be very strong advocates for community-based harm reduction services and can significantly contribute to their success.

16. PWID themselves can be better engaged in two vital components of the required response to HIV and HCV, testing and treatment. Self-testing by PWID represents a viable approach, as many PWID will have experience of injecting themselves, facilitating taking blood samples. Non-invasive testing, however, remains important for self-testing. Treatment is most effective if it is started early. Working directly with affected communities strengthens efforts to ensure early access to treatment by PWID, including at the community level. The meaningful involvement of PWID in decisions regarding health services, including working with them to design interventions, develop policies and signpost their peers to evidence-informed services for PWID, as well as working with them as advocates can also drive change.
17. PWID and community-based organisations also have a critical role to play in monitoring the HIV and HCV epidemics and evaluating the response. Monitoring the prevalence of HIV and HCV, the suppression of HIV and HCV, infection rates and treatment resistance would all benefit from community input. PWID and community-based organisations also have the capacity to provide data regarding stigma and discrimination, as well as community engagement, to identify challenges regarding access to services.
18. Existing commodities for testing and treatment of HIV and HCV are accessible to many, but not all communities. While the price of HCV treatment has fallen significantly, for example, prices are not consistent in different countries or settings and can still be a barrier to some communities. Further improving the accessibility of existing commodities will strengthen the response to HIV and HCV among PWID. The development of additional commodities will also serve to strengthen the response to HIV and HCV among PWID. Developing a pre-exposure prophylaxis (PrEP) for HCV would provide a valuable commodity for slowing and ultimately reversing the HCV epidemic among PWID. Simplifying diagnostics and testing protocols will help to get more PWID on treatment quicker, and a single-dose treatment for HCV would significantly strengthen the treatment options available.
19. Continued research is also required to monitor and evaluate programmes, identify successful responses and track the HIV and HCV epidemics among PWID. Research regarding the burden of disease among PWID, particularly in local settings will help to design interventions, as will research regarding HCV reinfection rates among PWID and the safety of HCV treatment to pregnant women and infants.

Recommendations

- Health services for PWID (including HIV and HCV services) should be delivered at the community level, in settings and at times that are most likely to increase access.
- Healthcare workers should engage with and consult PWID to significantly strengthen health service delivery for PWID.
- Community health workers should be capacitated to deliver HIV and HCV treatment, including through simplified treatment protocols.
- Self-testing by PWID presents a viable approach that should be championed and rolled out further.
- Treatment protocols that exclude or restrict PWID should be removed.
- Further research is required to strengthen the understanding of HCV transmission and treatment, including HCV reinfection among PWID, and the safety of HCV treatment to pregnant women and infants. Data regarding PWID exposure to TB and HBV should also be strengthened.
- PWID and community-based organisations should be capacitated to provide critical data to help monitor the scale and status of the HIV and HCV epidemics. Indicators could also be developed to help measure the meaningful engagement of PWID at the local level and in broader global context (eg during the design of donor funds).

- Strengthening community advocacy is instrumental to increasing demand for services, including through awareness days and providing testing.
- An action plan to mobilise the PWID community at the global level could help to enable PWID to identify key interventions and critical policy change.

Exemplars:

20. The Department of Health for Punjab, India has established a comprehensive HCV test and treat programme. In India, a national policy for HCV screening and treatment among PWID does not exist. In contrast, screening is available for free at District hospitals in Punjab. Patients are required to pay for genotype testing. HCV treatment is also free in all 22 District hospitals in Punjab. By January 2018, more than 40,000 patients had been treated for HCV. Punjab also delivered an OST programme and is the first Indian state to sign a Memorandum of Understanding with a global diagnostic organization, FIND, which will do free testing.
21. In Ukraine, the Alliance for Public Health implemented a national harm reduction programme targeting PWID that included rapid HIV testing, needle exchange and opioid substitution therapy. Approximately 65% of all PWID service users (200,000 PWID) were reached annually through community outreach; services were deliberately targeted to locations used by PWID and PWID accessing the services were incentivized to refer peers. An evaluation of the programme identified that every US\$1 spent on the harm reduction activities saved US\$6 in treatment costs, demonstrating the value of community-based harm reduction services. The programme is now in the process of transitioning to Government funding.

Overcoming stigma and discrimination: lessons from other epidemics

22. PWID make up approximately 0.3% of the global population; however, there are concentrated hotspots of PWID at the regional, national and community levels. The number of PWID in the US is approximately three-times higher than the global average; in Eastern Europe, the number is four-times higher. The PWID community play an outsized role in HIV and HCV transmission, and the 90-90-90 targets will not be achieved without effective evidence-informed services for PWID.
23. For government policy makers, however, drug use is potentially just one more risk factor to consider alongside alcohol, tobacco and obesity, but with more risk and stigma. Like alcohol, tobacco and obesity, drug use is stigmatised. Alcohol and tobacco are highly regulated, but not criminalised to the same degree as drug use. Discussions also persist regarding the denial of treatment to people for health concerns linked to all four risk factors – alcohol, tobacco, obesity and drug use. There are valuable lessons to be learned from the global and national responses to alcohol, tobacco and obesity, including how to affect incremental change and the use of financial levers, such as taxation, as policy instruments for change.
24. Successfully making the case for evidence-based services for PWID often appears to hinge upon the recognition of a health crisis. High rates of HIV in Vancouver triggered a series of measures that strengthened health service delivery to PWID. A sudden increase in new HIV infections among PWID in rural Indiana in the United States in 2015 led to the reinstatement of harm reduction services. The economic benefits of harm reduction services (for example cost savings around law enforcement and healthcare) have also helped make the case for evidence-informed services for PWID, notably in Ukraine and Moldova. A cost/ benefits analysis conducted in Australia showed that for every AUS\$1 spent on needle exchange services up to AUS\$5.5 was saved in terms of healthcare costs.

25. Striking a balance between making drug use safer, addressing its health impact on PWID, reaping economic benefits and reducing the prevalence of drug use may get sufficient support and interest from a broader audience of policymakers, in turn helping strengthen efforts to slow the HIV and HCV epidemics among PWID. Enabling PWID to advocate for themselves and their right to services free from stigma and discrimination, instead of fearing arrest or judgement for their criminalised behaviour, will also strengthen efforts to slow the HIV and HCV epidemics among PWID.

Recommendations

- Strengthen the human rights framework and messaging around PWID through public education campaigns, ultimately shifting perceptions away from viewing PWID as criminals to viewing PWID as rights holders.
- A systematic review of policies regarding responses to alcohol, tobacco and obesity could help to provide valuable lessons for drug policy reform and/ or services for PWID.
- Health crises that lead to evidence-informed health services for PWID should be leveraged to change the mentality toward PWID in the long-term.
- Stigma and discrimination at health delivery points should be reduced, including through the training of health professionals.
- Law enforcement professionals should receive sensitisation training to enable them to link PWID to key support services.

Conclusion

Slowing the HIV and HCV epidemics among PWID has been especially successful at the local level. Policy, tools, strategies and messaging have had a positive impact in specific cities, districts and some countries. Through sharing sub-national and national achievements there is great potential to shape and inform the global response to drug use, and particularly the HIV and HCV epidemics among PWID. The challenge, remains, however, to replicate and scale up proven approaches and strategies in other settings. This meeting provided a forum for participants to identify how to build upon current successes and create a more coherent global response to the HIV and HCV epidemics among PWID¹.

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¹ For additional reflections on this meeting see Kirby, M. Hon, The HIV and HCV epidemics – Lessons for policy makers and conclusion on action (unpublished)