

GLOBAL FUND ROUND 11: BRIEF ON WHY AND HOW TO ADDRESS HEPATITIS C IN GLOBAL FUND PROPOSALS

Hepatitis C is a critical health issue among people living with HIV and people who inject drugs. While hepatitis C represents an important co-infection and a leading cause of death among people living with HIV,¹ it is disproportionately found among current and former injecting drug users. For this population, the hepatitis C virus (HCV) and HIV are inextricably linked as virtually all HIV-positive people who inject drugs are co-infected with HCV.

Despite the inclusion of viral hepatitis diagnostics and treatment in the “comprehensive package” of HIV services recommended by UNODC, WHO and UNAIDS for people who inject drugs, hepatitis C is rarely addressed in the HIV response for this population. Hepatitis C should be covered in HIV prevention, treatment and care services for people living with HIV, and in relevant community and policy work— particularly in countries where the HIV epidemic is associated with injection drug use.

This brief offers advice on ways to make the case— both to your Country Coordinating Mechanism (CCM) and in your Global Fund proposal itself— that hepatitis C matters for the HIV response.

The Global Fund has indicated its willingness to support hepatitis C-related prevention, treatment, and advocacy efforts². However, that support can only be provided if countries request it and provide strong evidence and arguments in their proposals.

To effectively address hepatitis C among people living with HIV and people who inject drugs, it is recommended to focus on:

1. Prevention and diagnosis of hepatitis C among these populations
2. Provision of hepatitis C diagnostics and treatment to HIV/HCV co-infected people
3. Advocacy to increase access to affordable hepatitis C treatment, and for developing sustainable hepatitis C programs through community mobilization and policy dialogue

HEPATITIS C COMPONENTS SUPPORTED BY THE GLOBAL FUND

Guidance: The Global Fund explicitly indicates that it funds hepatitis C work in the HIV context in its Harm Reduction Information Note released in preparation for Round 11.² These may include prevention and diagnosis of hepatitis C among people who inject drugs, treatment and associated diagnostics for people living with HIV, and advocacy to increase access to affordable hepatitis C treatment

Current Global Fund HCV programming:

- In Georgia, 100 people with HIV/HCV co-infection will annually receive HCV diagnostics and treatment via the Global Fund-supported project in Round 9.
- In Macedonia, the Global Fund-supported Round 10 project will provide 235 HIV/HCV co-infected people who inject drugs with HCV diagnostics and treatment annually.
- The Asia Pacific Network of People Living with HIV/AIDS (APN+) is receiving funding through their regional Round 10 project to create a regional treatment access database, which includes documenting access to hepatitis C treatment barriers for advocacy purposes.

¹ International Harm Reduction Association. *Poor access to HCV treatment is undermining Universal Access: A briefing note to the UNITAID Board*. Available online: www.harm-reduction.org/files/pdf/3-advo/31en.pdf

² The Global Fund to Fight AIDS, Tuberculosis and Malaria. 2011. *Harm Reduction for People Who Use Drugs: Information Note*. Available online at <http://www.theglobalfund.org/en/application/infonotes/>.

FUNDING FOR HEPATITIS C TREATMENT THROUGH THE GLOBAL FUND

While the Global Fund supports hepatitis C treatment, during Round 10 the Technical Review Panel (TRP)—an independent panel that reviews proposals and provides recommendations for funding—recommended funding of hepatitis C treatment only for those co-infected with HIV, and only after provision of “*well-documented evidence that hepatitis C treatment and funding is available to the general population and that funding from the Global Fund is to fill-in the gap for HIV infected individuals.*”³ (See Macedonia Round 10 example in box below.)

It is recommended that requests for treatment funding be based on analysis of national policies that outline who qualifies for treatment—whether through the private sector and insurance schemes, or through the government (full or partial funding)—and shows the gap in coverage in people living with HIV.

In addition to treatment costs, it’s recommended that funding requests include diagnostic tests, like viral load and genotype tests, which are critical for determining who requires hepatitis C treatment, estimating treatment duration and monitoring treatment effectiveness. Procurement support services of the Global Fund, like the Voluntary Pooled Procurement mechanism, which aims to ensure cost-effective and cost-efficient procurement processes, may be requested to procure hepatitis C diagnostics and treatment.⁵

GLOBAL FUND SUPPORT IN ROUND 10: MACEDONIA

During Round 10, only Macedonia received approval for funding of hepatitis C treatment. The Macedonian proposal met the requirements of the TRP by showing that while treatment is covered by Macedonia’s national health insurance plan, uninsured drug users do not have access. Macedonia’s proposal specifically read:

“Given the fact that almost 80% of IDUs [injecting drug users] in Macedonia are Hepatitis C positive, and almost 20% of them have no health insurance, this proposal will support this category of MARPs (most at risk populations). The Government is providing Hepatitis C treatment to all those having health insurance and in order to fill the gap in provision of this service, the Global Fund finances are directly leading to maintaining good health and reduces possibilities for further spread of this infection among IDUs⁴.”

OTHER HEPATITIS C-RELATED ACTIVITIES FUNDED BY THE GLOBAL FUND

In their Round 10 report, the TRP also emphasized their support for the following activities:

- *Increasing the evidence base for the need for hepatitis C treatment.*
Currently, many countries lack hepatitis C epidemiological data among people living with HIV. An important component of advocating for improved hepatitis C treatment access among this population could include research, such as prevalence studies; specifically studies that identify the number of HIV-positive people requiring treatment.
- *Creating awareness and increasing prevention efforts.*
Ukraine’s Round 10 project will include hepatitis C testing for most at risk populations and integration of hepatitis C prevention education into existing harm reduction programs. (See also WHY HEPATITIS C PREVENTION AMONG PEOPLE LIVING WITH HIV MATTERS FOR HIV below.)
- *Supporting advocacy for access and affordability of [new] hepatitis C treatments.*
(See section WHY ADVOCACY FOR INCREASING ACCESS TO HEPATITIS C TREATMENT MATTERS FOR HIV below.)

³ TRP Round 10 Report: available in four languages from <http://www.theglobalfund.org/en/trp/reports/>

⁴ A PDF of Macedonia’s Round 10 Global Fund proposal can be found online at http://www.theglobalfund.org/grantDocuments/MKD-R10-HA_Proposal_0_en.

⁵ For more information, see: <http://www.theglobalfund.org/en/procurement/vpp/>.

WHY HEPATITIS C PREVENTION AMONG PEOPLE LIVING WITH HIV MATTERS FOR HIV

As of 2010, 10 million drug users were estimated to be infected with HCV, with prevalence frequently ranging between 60% and 90%.⁶ For people who inject drugs, HCV represents a major health risk and is the most common infectious disease among this population. In fact, the highest rates of HCV globally are registered among people who inject drugs.

HCV transmission can be greatly reduced through use of sterile cookers, cottons, and alcohol wipes as well as sterile injection equipment,⁷ and HCV prevention can be integrated into existing harm reduction programs with little cost. HCV testing, and ensuring that staff and peer educators have adequate training and information also strengthens HCV prevention efforts. Substitution treatment with methadone or buprenorphine is another critical HCV prevention intervention, since it reduces frequency of injection and can also improve adherence to hepatitis C treatment.⁸

HCV prevention also strengthens HIV prevention among drug users. Evidence for this includes:

- HCV is ten times more infectious than HIV, so measures that successfully prevent HCV also prevent injection-related HIV transmission.
- Integrating HCV prevention into harm reduction services increases their quality and reach, by improving access to the full range of safer injection equipment and harm reduction supplies,¹⁰ helping to meet clients “where they are” and increasing the number served.¹¹

Providing hepatitis B virus vaccination for people living with HIV and people who inject drugs is important to prevent additional damage to the liver, as was done through Kazakhstan’s Round 7 project. Among people living with HIV with no drug injecting background and other HIV risk groups, like men who have sex with men, HCV prevention information could be integrated into existing HIV education programs.

Some argue that HCV prevention and testing may not be worthwhile in the absence of affordable treatment. Evidence, however, indicates that knowing one’s status can motivate an individual to engage in safer practices and/or to engage in behaviors that promote liver-health (i.e. refraining from alcohol consumption). WHO-Europe treatment protocols recommend that all people with HIV should be provided with hepatitis C diagnostics, treatment and care.¹²

HCV PREVENTION IN HARM REDUCTION⁹

Essential tools: Sterile needles/syringes, cookers, cottons, and water for injection.

Essential information & counseling: Guidance on how to prevent HCV with safe injection practices and counseling to empower drug users to not share injection equipment; info on available hepatitis C-related services; and counseling and support to those living with hepatitis C.

Diagnostics & referrals: Hepatitis C antibody testing and the ability to bring those with positive test results to diagnostic centers for follow-up.

Training for harm reduction staff & peer educators on HCV prevention and management.

⁶ Nelson P.K., Mathers B.M., Cowie B., Hagan H., Des Jarlais D., et al. (2011). Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews. *Lancet, early online edition July 28, 2011.*

⁷ Hagan H., H Thiede, NS Weiss, SG Hopkins, JS Duchin & ER Alexander (2001). Sharing of drug preparation equipment as a risk factor for hepatitis C. *American Journal of Public Health, Vol 91, Issue 1 42-46.*

⁸ WHO Europe. *Management of Hepatitis C and Coinfection with HIV: Clinical Protocol for the WHO European Region.* Available online: www.euro.who.int/_data/assets/pdf_file/0008/.../E90840_Chapter_6.pdf.

⁹ Adapted using Harm Reduction Coalition. *Hepatitis C Support Groups for Drug Users: Facilitators Manual.* Available in full online at http://www.harmreduction.org/downloads/HCV%20Support%20Manual%20Eng%20with%20Cover_1.pdf

¹⁰ WHO guide to starting Needle Syringe Programs: http://www.who.int/hiv/idu/Guide_to_Starting_and_Managing_NSP.pdf

¹¹ For example, in Latvia, adding HCV testing increased the number of clients, *Stuikyte, R (2008). Mid-term evaluation of UNODC grant program in Latvia*

¹² WHO Europe. *Management of Hepatitis C and Coinfection with HIV: Clinical Protocol for the WHO European Region.*

WHY HEPATITIS C TREATMENT MATTERS FOR PEOPLE LIVING WITH HIV

High rates of HIV/HCV co-infection have been recorded in many countries with injection-driven HIV epidemics: 53.3% in Ukraine, 48.6% in Georgia, 61% in Latvia.¹³ Eighty percent of people living with HIV/HCV will develop chronic hepatitis, and among those chronically infected, 80% may develop liver damage, and many would benefit from hepatitis C treatment.¹⁴

Despite only moderate effectiveness of the current standard of treatment for hepatitis C (pegylated interferon-alfa and ribavirin)—ranging from 30% to 80% effectiveness for HIV/HCV co-infected people, depending on genotype¹⁵—ensuring treatment for HIV/HCV co-infected patients remains important for several reasons:

1. Hepatitis C-related liver disease is now a leading cause of death among people living with HIV. People co-infected with HIV and HCV have more rapid progression of liver fibrosis than their mono-infected counterparts¹⁵, and should be prioritized to receive hepatitis C treatment.
2. Even on antiretroviral therapy, many people living with HIV/HCV can die of liver disease if hepatitis C treatment is not provided. Treating hepatitis C will reduce the extent of liver toxicity from HIV medications.¹⁵
3. Recent research suggests that hepatitis C treatment for HIV/HCV co-infected drug users improves adherence to HIV treatment.¹⁶

WHY ADVOCACY TO INCREASE ACCESS TO HEPATITIS C TREATMENT MATTERS FOR HIV

The most critical barrier to expanding access to hepatitis C treatment is the high cost. Current standard treatment for hepatitis C costs as much as 15,000-50,000 USD for a treatment course.

HEPATITIS C DIAGNOSTICS, TREATMENT & CARE

Protocol for hepatitis C treatment: WHO-EURO has released a protocol for treatment of HIV/HCV co-infection.¹⁷ For the treatment of people who inject drugs who are co-infected with HIV/HCV, opioid substitution treatment is important to improve HIV and HCV treatment adherence and prevent HCV re-infection.

Capacity of health system to provide quality hepatitis C treatment for co-infected people living with HIV: To meet the comprehensive health needs of HIV/HCV co-infected patients, a coordinated response is needed among health professionals. This includes trained multidisciplinary teams of HIV doctors, psychologists or mental health specialists, peer educators, etc. Additionally, ensure the lab capacity is in place and accessible for diagnostics needed during both initial diagnosis and treatment monitoring. It is important to integrate HIV and HCV treatments and closely monitor/adjust treatment regimes as some antiretroviral therapy medicines are known to be toxic for the liver, in particular, nevirapine, tipranavir and higher doses of ritonavir.¹⁸

Support to those living with hepatitis C: The formation of hepatitis C patient support groups, programs to improve literacy on living with hepatitis C, including treatment literacy among HIV/HCV co-infected.

¹³ EHRN (2007). Hepatitis C Among Injecting Drug Users in the New EU Member States and Neighboring Countries: Situation, Guidelines and Recommendations

¹⁴ Treatment Action Group (2007). Guide to hepatitis C for people living with HIV: testing, coinfection, treatment, and support. *New York, New York*. Available online: <http://www.treatmentactiongroup.org/base.aspx?id=2562>

¹⁵ Ibid.

¹⁶ Roux P., Fugon L., Winnock M., Salmon-Ceron D., Lacombe K., et al. Positive impact of HCV treatment initiation on adherence to HIV treatment in co-infected patients: implications for access to HCV care (*Abstract*). *International AIDS Society, Rome; TUPE 177*. Available online: <http://pag.ias2011.org/abstracts.aspx?aid=1780>

¹⁷ WHO Europe. *Management of Hepatitis C and Coinfection with HIV: Clinical Protocol for the WHO European Region*. Available online: www.euro.who.int/_data/assets/pdf_file/0008/.../E90840_Chapter_6.pdf.

¹⁸ Treatment Action Group (2007).

New antiviral drugs— boceprevir and telaprevir— recently approved in the United States and the European Union for use in combination with the current standard treatment are more expensive, *adding* 30,000-50,000 USD to treatment cost. Other antiviral treatments are in development but will not be available for five to ten years and will likely be priced out of reach of low- and middle-income countries.

To increase access to treatment, it is important to advocate for price reduction. In Egypt, for example, government negotiations have already reduced the price of treatment to as low as 3,000 USD.¹⁹ Given that new medicines are either not yet available in most places or still in development, advocacy for price reduction should focus on hepatitis C treatment and diagnostics currently on the market.

In several countries— including Thailand, Ukraine, and Georgia— advocacy to increase access to hepatitis C treatment is ongoing and includes:

- *Community mobilization and raising awareness*
Increasing awareness about hepatitis C could include prevention, diagnostics and treatment information, and also highlight access barriers like the high cost of treatment. Such awareness-raising could be targeted to most affected groups, medical communities, the general population, and other stakeholders to mobilize and demand improved access to affordable hepatitis C treatment.
- *Assessments of national-level barriers to treatment access*
Investigating and documenting barriers to hepatitis C diagnostics and treatment access, including cost, and policy barriers, could guide the development of a comprehensive national advocacy strategy.
- *Securing political commitment*
Increasing national and international (WHO, UN bodies, donors) commitment to address hepatitis C, with a focus on securing commitment to reduce treatment cost and pay for diagnostics and treatment.
- *Using Hepatitis C treatment as advocacy*
In some countries, the high cost of treatment and/or the belief that people living with HIV and drug users are unlikely or unable to adhere to treatment have led to the exclusion of these groups from treatment programs. Advocates argue that providing hepatitis C treatment to drug users represents an important demonstration of successful treatment for all marginalized groups.
- *Documenting diagnostics and treatment availability and price*
Mapping and documenting diagnostics and treatment availability and price in your country could represent an important advocacy tool to highlight the critical access barriers. APN+'s Global Fund Round 10 project is a case in point (see box HEPATITIS C COMPONENTS SUPPORTED BY THE GLOBAL FUND.) In the event that funding is provided through a Global Fund grant, it is important to document the price at which treatment and diagnostic tests are procured, as well as the criteria of patients who receive treatment. Such information could be used in future advocacy work.
- *Price reduction*
The great variance in prices for treatment across countries indicates the potential to reduce the cost of treatment. For example, medicine costs 3000 USD in Egypt, 18,000

¹⁹ Arab Republic of Egypt, Ministry of Health and Population, National Committee for the Control of Viral Hepatitis (April 2008). Egyptian National Control Strategy for Viral Hepatitis : 2008-2012. Available online at: http://www.hepegypt.org/htdocs/NSP_10_April_2008_final.pdf

USD in Thailand, 11,580 USD in Georgia, and nearly 20,000 USD in Ukraine in 2010.^{20,21} Civil society groups are advised to work with their governments to develop strategies to reduce the cost of hepatitis C diagnostics and treatment, including through negotiations with pharmaceutical manufacturers of medicines and diagnostic tests, and through competition with a generic of proven safety, quality and efficacy. Patents for pegylated interferon-alfa will expire in 2016-2017, opening the way for advocacy on the application of TRIPS flexibilities to improve access to medicines, in line with the Doha Declaration.²²

It may be worthwhile to consider including a 5-year strategy to reduce the price of treatment in proposals, including measures to increase access to cheaper, generic medication once available.

HOW TO MAKE THE CASE FOR FUNDING OF HEPATITIS C-RELATED ACTIVITIES IN GLOBAL FUND PROPOSALS

It is important to give reasons for the inclusion of hepatitis C components in Global Fund proposals and to be prepared with specific and necessary justifications, evidence, and costs if asked for further information. Below are recommendations for what information and supporting materials to gather to make the case for hepatitis C prevention, treatment and advocacy, and to plan an effective hepatitis C response with clear targets.

- *Include national data for HCV prevention and testing*
 - Such as:
 - ✓ Estimated number of people who inject drugs
 - ✓ Estimated number of HIV positive people in your country
 - ✓ Estimated number of people who inject drugs reached through harm reduction programs for calculating the amount of other injecting paraphernalia that would be needed, in addition to new needles and syringes.

- *Include data to justify the need for treatment*
 - A few examples include:
 - ✓ Estimated prevalence of HCV among people living with HIV
 - ✓ Prevalence of HCV among people who inject drugs if no information about HIV/HCV co-infection is available
 - ✓ Estimated proportion of AIDS deaths caused by hepatitis-related complications (i.e. fibrosis or cirrhosis of the liver)
 - ✓ The genotype most prevalent among people living with HIV and/or people who inject drugs (or in the country overall)
 - ✓ Availability of national treatment protocols for HIV/HCV co-infection

²⁰ Treatment Action Group 2007 & Open Society Foundations 2010

²¹ Thai AIDS Treatment Action Group (2010). Illuminating a hidden epidemic: the public health crisis of HIV/HCV co-infection among injecting drug users in Thailand.

²² The 2001 Doha Declaration on TRIPS and Public Health states explicitly that the TRIPS Agreement does not and should not prevent member states from taking measures to protect public health, and specifically reaffirmed the right of all members to use the flexibilities contained in the TRIPS Agreement, including compulsory licenses.

- *No data at the national level? Extrapolate from other countries*
Use data from other countries where epidemics and socio-economic situations are similar to yours.
- *Consider costs of various HCV-related services for budget calculations*
Figures could include:
 - ✓ HCV antibody tests and vaccination for hepatitis B virus
 - ✓ Diagnostics (especially viral load and genotype)
 - ✓ Course of treatment (including the medicine itself, and the related administration and monitoring costs)
 - ✓ Advocacy activities to increase access to affordable hepatitis C treatment
- *Include outcome indicators*
Refer to the Global Fund's Monitoring and Evaluation toolkit²³ or the UN's Technical Guide²⁴ on universal access to HIV prevention for drug users for more indicators.
Examples include:
 - On prevalence
 - ✓ Prevalence of HCV among people living with HIV and people who inject drugs
 - On prevention
 - ✓ Percentage/number of needle syringe program clients receiving other drug injecting paraphernalia
 - ✓ Percentage/number of HIV-positive people, people who inject drugs, and other members of HIV risk-groups vaccinated for HBV
 - On treatment
 - ✓ Percentage/number of HIV/HCV co-infected people receiving HCV treatment (and percentage/number of those who've completed treatment successfully)
- *Get the basics on hepatitis C transmission, prevention, treatment and care*
 - ✓ Check out the Easy Guide to HCV at http://www.hcvadvocate.org/hepatitis/factsheets_pdf/HCV%20Guide%2009.pdf.
 - ✓ Use WHO treatment protocol for HIV/HCV at http://www.euro.who.int/_data/assets/pdf_file/0008/78146/E90840_Chapter_6.pdf.
 - ✓ Ask the Open Society Foundation to send resources in English and Russian
- *Use the Global Fund Information Note on Harm Reduction as a reference and advocacy tool for your CCM and proposal writing team*
This is available in four languages from <http://www.theglobalfund.org/en/application/infonotes/>.
- *Use Macedonia's proposal as an example*
Justification of the need for treatment and description of the work are provided in Macedonia's proposal. Available in English at http://www.theglobalfund.org/grantDocuments/MKD-R10-HA_Proposal_0_en.

This brief was prepared by the International Harm Reduction Development Program at the Open Society Foundations. Further information can be obtained at www.soros.org/harm-reduction.

²³ Global Fund M&E Toolkit: <http://www.theglobalfund.org/en/me/documents/>

²⁴ UN technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users: http://www.who.int/hiv/pub/idu/idu_target_setting_guide.pdf.

GLOBAL FUND ROUND 11: BRIEF ON THE IMPORTANCE OF LEGAL AID IN HIV PREVENTION AND TREATMENT

For criminalized populations such as drug users, sex workers, and men who have sex with men, difficulties with the legal system impose a substantial barrier to HIV prevention and treatment.¹ In multiple countries, HIV prevention programs have documented police harassment at methadone and needle exchange sites, prosecution for possession of sterile injection paraphernalia, and detention or police questioning as a result of being enrolled in drug treatment. Additional legal problems include lack of necessary documents for accessing medical treatment, use of criminalized status or registries to remove child custody or drivers' licenses, and subjecting those seeking treatment to medical or police surveillance. For example, police violence and threat of incarceration are correlated in injection drug users with hurried injection, sharing of injection equipment, and ARV treatment interruption.^{2,3}

LEGAL AID

The provision of legal aid to increase access to justice has resulted in increased access to health services, improved health outcomes, and increased sense of self-efficacy among criminalized groups.⁴ In a variety of low- and middle-income countries, legal aid has been integrated into harm reduction services at minimal cost.

LEGAL AID BOLSTERS HIV PREVENTION

Legal aid increases effectiveness of HIV prevention and treatment by helping with:

- Retrieval of state documents essential for health care
- Protection against health-detering police harassment at needle exchange and methadone sites
- Challenging denial of treatment based on stigmatized or criminalized status
- Strategic litigation to improve access to treatment in communities, pre-trial detention settings and prisons

PRISONS AND PRETRIAL DETENTION

Even with the help of qualified criminal lawyers, drug users are often unable to avoid incarceration. In prisons and pre-trial detention, they are especially prone to a number of health risks, such as transmission of infections through needle sharing due to lack of sterile injection equipment, or overdose. In addition, patients of opioid substitution therapy (OST) or antiretroviral therapy (ART) may experience interruption in treatment that endangers their health. Prison and police officials have been known to use withdrawal or lack of access to treatment to elicit false confessions by offering a full syringe⁵ or by promising access to treatment.

¹ Csete J, Cohen J. "Health benefits of legal services for criminalized populations: the case of people who use drugs, sex workers and sexual and gender minorities." *J Law Med Ethics*. *J Law Med Ethics*, 38(4) 816-31 2010.

² Spicer N, Bogdan D, Brugha R, Harmer A, Murzalieva G, Semigina T. "'It's risky to walk in the city with syringes': understanding access to HIV/AIDS services for injecting drug users in the former Soviet Union countries of Ukraine and Kyrgyzstan." *Global Health*; 2011;7:22

³ Booth, R. E., Kennedy, J. K., Brewster, J. T., Semerik, O. (2003). "Drug injectors and dealers in Odessa, Ukraine." *Journal of Psychoactive Drugs*, 35, 419-426.

⁴ See, e.g., Open Society Institute, *Tipping the Balance: Why Legal Services Are Essential to Health Care for Drug Users in Ukraine* (2008); see also Open Society Institute, *Making Harm Reduction Work for Women: the Ukrainian Experience* (March 2010).

⁵ J. Csete and J. Cohen, "Lethal violations: human rights abuses faced by injection drug users in the era of HIV/AIDS," in K. Malinowska-Sempruch and S. Gallagher, eds., *War on Drugs, HIV/AIDS and Human Rights* (New York: International Debate Education Association, 2004): 212-226.

Particularly important is the engagement of a forensic medical expert who is able to provide independent testimony about health status of detainees. This testimony can later be used in court by the attorney as evidence of need for better conditions of detention, treatment or an alternative to incarceration.⁶

DRUG USERS' HEALTH DEPENDS ON ACCESS TO LAWYERS IN DETENTION SETTINGS

In light of the threat to HIV prevention and treatment posed by pretrial detention and imprisonment, access to criminal lawyers is essential for drug users in detention. These lawyers can argue for:

- non-custodial sentences
- continuation of treatment in pretrial detention or prison improvement in conditions of incarceration

KEY RECOMMENDATIONS

Continued funding should be provided for at least five years to harm reduction programs for incorporating legal aid into provision of their services. Where appropriate, paralegals should be included in these programs. Funding is also recommended for mainstream human rights groups to cultivate a pool of lawyers interested in working with marginalized groups, such as drug users and sex workers. Proposals should include funding for medical-legal partnerships, which can lessen health risks in pretrial detention and decrease overcrowding in pretrial detention centers.

KEY INDICATORS

TO INCLUDE IN PROPOSALS

- ✓ Increase in number of drug users and sex workers who have access to legal aid
- ✓ Increase in number of drug users and sex workers in pre-trial detention who have access to a lawyer
- ✓ Increase in number of drug users and sex workers in pre-trial detention who have access to a medical-legal team
- ✓ Increase in number of harm reduction sites with a lawyer

PROGRAM COMPONENTS NEEDED

Effective programming must include the following provisions:

Service Provision

- Legal aid to drug users and sex workers must be provided at times and places that are safe and convenient for the target group.
- Basic needs, such as food and immediate health problems, must be addressed and resolved before clients are able to address their legal needs.

KEY TARGET GROUPS

TO INCLUDE IN PROPOSALS

- ✓ Injection drug users
- ✓ Sex workers
- ✓ People living with HIV/AIDS
- ✓ Injection drug users who seek access to integrated medical services
- ✓ Drug users/sex workers in pretrial detention and in prisons

⁶ An example of this is Humanitarian Action, a harm reduction NGO in St. Petersburg. The attorney imbedded in the project collaborates with a forensic medical expert to collect health information about every client and uses it to ensure that they receive appropriate treatment or alternate method of punishment to detention.

- Lawyers working with this population group must be willing and able to help this group recognize that there are legal solutions to their problems, since criminalized populations often do not see the usefulness of legal interventions.
- Establishment of trust is crucial to effective legal aid provision to drug users and sex workers; legal services must therefore be provided free of judgment.
- Provision of legal aid should empower the target group, be it through “know your rights” education or inclusion of clients in decision-making and determination of legal options.

Engagement of Paralegals

- Train paralegals on providing basic legal aid and court representation.
- Train paralegals on human rights documentation.⁷

Strategic Litigation

- Lawyers at harm reduction projects should be trained to identify and bring strategic litigation cases.
- Lawyers should strategically engage with UN treaty bodies and international courts to advocate for the rights of marginalized groups.

MODELS OF LEGAL AID INTERVENTION CENTRAL TO PREVENTING AND TREATING HIV

A number of legal-service provision models for drug users have proven successful, such as:

- Placing of lawyers at harm reduction sites, such as needle exchanges or methadone clinics.⁸
 - ✓ Lawyers at harm reduction sites have been crucial to deterring police violence
 - ✓ Lawyers at harm reduction sites have direct access to the target group and can help clients resolve their legal issues while accessing health services
 - ✓ Lawyers at these sites are important for protection of doctors and other clinic staff who experience police harassment
- Web-based consultations, anonymous or otherwise, with regularly scheduled live webinars, during which drug users can ask legal questions and receive answers from attorneys in real time.⁹
 - ✓ Online legal consultations empower vulnerable groups to self-represent in court

⁷ In Indonesia, Lembaga Bantuan Hukum Masyarakat in Jakarta trains paralegals to conduct human rights documentation and some legal representation. They make a special effort to engage former drug users to do this work.

See, e.g., Open Society Foundations, *Improving Health in Pretrial Detention: Pilot Interventions and the Need for Evaluation* (2011). Available at: http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/pretrial-detention-health-20110531/pretrial-detention-health-20110531.pdf (last visited August 11, 2011).

⁸ In Ukraine, Time of Life in Nikolaev, MANGUST in Kherson, and Light of Hope in Poltava implement this model. For description of other such services in Ukraine, see *Tipping the Balance: Why Legal Services Are Essential to Health Care for Drug Users in Ukraine*, *id.*

⁹ See, e.g., “hand-help.ru,” a special website of the Moscow-based Institute for Human Rights, <http://www.hand-help.ru/> (last visited June 29, 2010; in Russian).

- ✓ Online consultations allow vulnerable groups who rarely have positive interactions with the law or lawyers to receive help without putting themselves at risk for judgment
 - ✓ Legal advice websites that archive previously asked questions allow drug users to search and use previously given answers, thus allowing them to receive legal help in minutes
- Street-based legal aid, where lawyers or paralegals work on the streets, interceding with drug users and police, collecting affidavits or testimony in cases of police abuse, and offering help and referrals to other services.¹⁰
 - ✓ Street lawyers are particularly well-positioned to gain trust of drug users and sex workers
 - ✓ Successful street lawyering models involve some elements of traditional harm reduction work, for example, lawyers give out needles on legal-aid outreach
 - ✓ Street lawyers conduct their outreach during hours that are convenient to the target group
 - Incorporating legal services into main-stream medical services, the so-called “medical-legal partnership” is another possibility, though one that has had greater effect with non-criminalized populations.¹¹
 - ✓ Partnering a doctor with a lawyer to help pretrial detainees obtain a health exam can later be used in arguing for a lesser sentence
 - ✓ Medical exams conducted through the partnership can help detainees improve conditions of sentencing
 - ✓ Engagement of doctor in provision of legal representation can help detainees reinstate interrupted treatment

CONCLUSIONS

Criminalized populations regarded as “difficult to reach” become more accessible and engaged when programs offer a legal component that address their immediate fears and needs. Beneficiaries of existing legal aid programs report that legal services have helped them defend themselves against human rights abuses, better protect their health, and improve their overall quality of life.¹² Given these realities, legal support may be as critical to HIV prevention and treatment as clean needles or ART medications.

This brief was prepared by the International Harm Reduction Development Program at the Open Society Foundations. Further information can be obtained at www.soros.org/harm-reduction.

¹⁰ See, e.g., Gadejuristen, a street-lawyering organization in Copenhagen, Denmark; description in English available at: <http://eudrugpolicy.org/node/94> (last visited June 29, 2010).

¹¹ One example is the Hospice Palliative Care Association of South Africa, see http://www.hospicepalliativecaresa.co.za/Legal_Resources.html (last visited July 1, 2010).

¹² As one drug user from Poltava, Ukraine, has put it, “I could not have dealt with my HIV without help with my legal problems.” See *Tipping the Balance*, supra note 1 at 11.

GLOBAL FUND ROUND 11: BRIEF ON WHY AND HOW TO ADDRESS OVERDOSE IN GLOBAL FUND PROPOSALS

For people who inject heroin and other opioids, overdose is an urgent issue. The Global Fund to Fight AIDS, Tuberculosis and Malaria supports overdose prevention and response activities.¹ This brief offers advice on ways to make the case— both to your Country Coordinating Mechanism (CCM) and in your Global Fund proposal itself— that overdose matters for the HIV response.

Global Fund has indicated that the types of activities it supports include:

1. Peer and staff training in overdose prevention
2. Strengthening overdose responses, including legislative and policy reform where needed
3. Provision of the opioid overdose medication naloxone to people who use drugs and through emergency services.

OVERDOSE AMONG PEOPLE WHO USE DRUGS

Overdose is a well-documented major cause of death among opioid users and is an issue for stimulant users as well. A survey in Russia found that 59 percent of injection drug users had experienced an overdose, and 81 percent had witnessed one.² In northern Vietnam, a study found 43 percent of injection drug users had experienced a nonfatal overdose in their lifetime.³ But drug users can and do respond to overdoses that they witness: nearly a third of respondents in a study in Bangkok, Thailand, had experienced an overdose, while 68 percent had witnessed one, and the majority responded by performing first aid or taking the victim to the hospital.⁴ Other drug users are the people most likely to be present at the scene of an overdose, so providing them information and tools to respond can result in lives saved.

THE GLOBAL FUND SUPPORTS NALOXONE TO REVERSE OVERDOSE

Guidance: The Global Fund's Harm Reduction Information Note released in preparation for Round 11 proposals explicitly indicates that it does fund overdose prevention, including naloxone.

Solid overdose programming includes: Information and tools to prevent, recognize, and respond to drug overdose. It may also include advocacy for policies to support programs.

The Global Fund already funds: Overdose prevention and response programs with the provision of naloxone in Kyrgyzstan, Georgia, Kazakhstan, Tajikistan, Russia, and Macedonia.

WHAT IS NALOXONE?

Naloxone—also known by the brand name Narcan—is a safe, highly effective antidote to opioid overdose. It binds to the same receptors in the brain that receive heroin and other opiates; it “kicks out” the opiates and reverses the respiratory depression that leads to death from overdose. Naloxone cannot get you high and has no potential for abuse. Naloxone is not a controlled substance, though in many countries it does require a doctor's prescription.

Naloxone is on the World Health Organization's *Model List of Essential Medicines*.

For more information about naloxone and how it works, see *Take Home Naloxone: The Right to Survive Overdose* at <http://bit.ly/oql8jt>.

¹ The Global Fund to Fight AIDS, Tuberculosis and Malaria. 2011. *Harm Reduction for People Who Use Drugs: Information Note*. Available online at <http://www.theglobalfund.org/en/application/infonotes/>.

² Sergeev B, Karpets A, Sarang A, Tikhonov M. 2003. “Prevalence and circumstances of opiate overdose among injection drug users in the Russian Federation.” *Journal of Urban Health* v. 80, n. 2. p. 212-219.

³ Bergenstom A, Quan VM, Nam LV, et al. 2008. “A cross-sectional study on prevalence of non-fatal drug overdose and associated risk characteristics among out-of-treatment injecting drug users in North Vietnam.” *Substance Use and Misuse*, Vol. 43: 73-84.

⁴ Milloy M, Fairbairn N et. al. 2010. “Overdose experiences among injection drug users in Bangkok, Thailand.” *Harm Reduction Journal* 2010, Vol. 7, Issue 9.

PEERS RESPONDING TO OVERDOSE⁵

Harm reduction programs are training drug users to understand overdose risk factors, and are working to address structural factors that can lead to increased incidence of overdose. Furthermore, studies have shown that drug users are willing and able identify overdose and respond appropriately. In at least 15 countries, harm reduction programs have begun tackling overdose by providing response training to drug users and their families, and giving them naloxone to use in an emergency. Many programs are already showing results, recording overdose reversals among participants and overall reductions in overdose deaths in the same period.⁶

While training laypeople to recognize and respond to an overdose with naloxone is the ideal, in some settings, legal barriers—such as laws restricting who can perform injections—stand in the way. Programs have responded creatively by finding other ways to increase naloxone access while advocating change in restrictive policies. Solutions include ensuring emergency rooms and ambulances have naloxone and understand how to use it, and equipping outreach workers with naloxone and a motorbike to respond to emergency calls.

WHY SHOULD HIV/AIDS SERVICES FOR PEOPLE WHO USE DRUGS INCLUDE OVERDOSE PREVENTION AND RESPONSE EDUCATION?⁷

- Overdose is a leading— and in some cases the number one— cause of death among people who inject drugs living with HIV in many countries (and in many countries, drug users make up the largest proportion of people living with HIV).⁸
- Overdose prevention empowers people who use drugs and who have or are at risk for HIV— including overdose responders and survivors.
- HIV infection puts people who inject drugs at greater risk of fatal overdose.

OVERDOSE PREVENTION IN HARM REDUCTION

Essential tools: Naloxone (typically two 1ml doses per participant trained) and muscle syringes (a thicker needle, usually 22-gauge and 3cm or longer that can easily be injected into the upper arm or thigh).

Essential information: Tips on recognizing opioid and other overdoses; information about the response, including rescue breathing, recovery position, calling for help, and how to use naloxone; strategies for preventing an overdose in the first place.

Training: Staff, peer educators, program participants, and their families.

Staff needs: Peers or drug users can conduct naloxone trainings; you may need to work with a doctor or pharmacist to prescribe naloxone, depending on the regulations in your country.

OVERDOSE PREVENTION AS EMPOWERMENT

One overdose survivor in Hanoi, Vietnam, explained: *“Before I cared about nothing... I thought being a drug addict and having HIV meant my life was worth nothing. But after I was saved [with naloxone], I felt like I was reborn, and I realize how precious life is.”*

⁵ For more information on training drug users to respond with naloxone, see Saucier R. 2011. *Stopping Overdose: Peer-based Distribution of Naloxone*. Available online at http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/naloxone-20110324.

⁶ Ibid.

⁷ For further explanation and citations, see Curtis M., Dasgupta N. 2010. *Why Overdose Matters for HIV*. Available online in English, Russian, and Chinese at http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/why-overdose-matters-20100715.

⁸ IHRD. 2008. *Harm Reduction Developments 2008: Countries with Injection-driven HIV Epidemics*. New York: International Harm Reduction Development Program (IHRD) of the Open Society Foundations, p. 11.

- Though this association is not fully understood, biological, behavioral, and structural factors may contribute.⁹
- Overdose prevention services connect people who use drugs to other basic services like HIV prevention, drug treatment, and primary health care. By addressing the priorities of drug users, HIV prevention services may expand coverage and more effectively fight the HIV epidemic.
 - Overdose may exacerbate HIV related disease, as nonfatal overdose is associated with disease sequelae that can worsen with HIV infection, or may lead to HIV-related complications. Conversely, respiratory illnesses common among HIV-positive people can further put drug users at risk of overdose death following opioid-induced respiratory depression.
 - Many of the same policies (such as incarceration) that increase risk of HIV infection among injection drug users also increase the risk of overdose. Therefore, structural interventions to address overdose also impact HIV risk.
 - Most surveys among people who use drugs reveal that overdose is a major concern, and they are eager to participate in overdose training.

INTEGRATING NALOXONE INTO EXISTING HARM REDUCTION SERVICES

Adding naloxone distribution to existing programming, particularly needle syringe programs, is easy. Here's why:

- Harm reduction programs already reach drug-using populations that would benefit from naloxone distribution. Such programs already educate and train staff and clients

NALOXONE IN ROUND 10 PROPOSALS: HIGHLIGHTS FROM KYRGYZSTAN AND MACEDONIA

Kyrgyzstan¹⁰

Kyrgyzstan's proposal adeptly uses available data to justify the inclusion of naloxone provision:

"According to the database of Republican Bureau of forensic-medical examination in the city Bishkek and Chuiskiy Region, more than 100 drug users are dying every year because of overdose of drugs. The official database on overdose is often not reliable; existing harm reduction projects have pointed out that overdose is the main cause of death among their clients. Longstanding international practice shows that programs to prevent overdoses by providing [naloxone] in MLSS [needle and syringe exchange programs], not only reduce the mortality rate among [IDU] and [IDUs] living with HIV, but also attract new customers to programs to exchange syringes, increasing their effectiveness. While receiving a lifesaving medication, [IDUs] will be motivated to attend prevention programs more often and, therefore, will be involved in other harm reduction services. Within the confines of the present round, through [needle and syringe exchange] in the civil and in penal sector [naloxone] will be provided for up to 8,000 [IDUs] (30% of the total assessed number) per year."

Macedonia¹¹

Macedonia's proposal does not provide much support to justify inclusion of overdose prevention or naloxone provision. Yet Macedonia has set targets for Behavioral Change Communication and Information, Education and Communication such as:

"285 IDUs and 215 professionals in total will be trained on principles of overdose during Y1-Y5 and a total of 15,000 leaflets on the prevention of overdose produced and distributed by the NGOs and clients."

Naloxone is also specifically mentioned in the section of the proposal for budgeted pharmaceuticals:

"The budgeted pharmaceuticals (Peginterferon alfa-2a, Ribavirin and Naloxone) for the needs of the R10 HIV proposal were estimated in accordance with the available market prices in the country."

⁹ Green TC, McGowan SK, Yokell MA, Rich JD. 2011. "HIV infection and risk of overdose: A systematic review." Manuscript under review.

¹⁰ http://www.theglobalfund.org/grantDocuments/KGZ-R10-HA_Proposal_0_en

¹¹ http://www.theglobalfund.org/grantDocuments/MKD-R10-HA_Proposal_0_en

- on safe injection and could include overdose prevention and response with naloxone.
- Naloxone distribution could increase the reach of existing harm reduction programs because they are empowering for the community and provide a service that opiate users really want.

HOW TO MAKE THE CASE FOR FUNDING OVERDOSE RESPONSE WITH NALOXONE

Global Fund proposals approved in the past that included support for overdose prevention have not gone into extensive detail to justify why naloxone is needed, or to explain how it will be operationalized. (See previous page.) It is important, however, to give reasons for the inclusion of overdose response with naloxone in your proposal, and to be prepared with the necessary justifications, evidence and costs, in case you are asked for more information. Below are recommendations for what information and supporting materials to gather to make the case for naloxone and to plan an effective overdose response with clear targets.

Include National Data.

- Such as:
 - ✓ Total number of people who use drugs, and the number who use opioids
 - ✓ The number of overdose deaths in your country, and how this ranks compared to other causes of death, especially among young people
 - ✓ Total number of HIV positive people
 - ✓ Proportion of HIV infections related to drug use
 - ✓ What proportion of deaths among people with HIV were the result of an overdose
- If you're missing data, gather information from countries where the drug use and socio-economic situations are similar to yours.¹²

Supply Supporting Information.

- Investigate if surveys or research has been done in your country on overdose experiences. Look for information such as:
 - ✓ How many have seen a fatal or nonfatal overdose?
 - ✓ What proportion has experienced a nonfatal overdose themselves?

SOME INDICATORS ON NALOXONE TO INCLUDE IN PROPOSALS

- ✓ Number of naloxone vials distributed
- ✓ Number of overdose reversals with naloxone
- ✓ Number of harm reduction staff and clients trained in overdose prevention and response with naloxone

Cost Out Various Components for Budget Calculations.

- Depending on the interventions you decide to include, the proposal may cover:
 - ✓ naloxone (often less than 1 USD per dose, but differs pointedly from one country to the next)
 - ✓ muscle syringes
 - ✓ costs for developing appropriate overdose prevention and response educational materials (Information, Education and Communication materials)

¹² See, for example, Eurasian Harm Reduction Network. 2008. *Overdose: A Major Cause of Preventable Death in Central and Eastern Europe and Central Asia*. Available online at http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/overdose_20080801.

- ✓ costs to conduct trainings and develop training materials (Behavioral Change Communication)
- ✓ costs to conduct advocacy for policy change to increase access to naloxone for the drug-using community

Learn More About Overdose and the Recommended Response.

- Learn the basics about overdose prevention and response at http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/overdose_20090604.
- Get evidence for the effectiveness of peer-led responses to overdose at http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/naloxone-20110324.
- Read about the extent of overdose in Eastern Europe and Central Asia at http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/overdose_20080801.
- Ask the Open Society Foundations to send you resources in English, Russian, or Chinese.

Use the Global Fund Harm Reduction Information Note.

- This document can serve as an excellent reference tool for CCM and proposal writing team. Find it at www.theglobalfund.org/en/application/infonotes/.

Reference “Why Overdose Matters for HIV.”

- This publication can help bolster the link between overdose and HIV when writing country proposals. Find it at http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/why-overdose-matters-201007.

This brief was prepared by the International Harm Reduction Development Program at the Open Society Foundations. Further information can be obtained at www.soros.org/harm-reduction.

GLOBAL FUND ROUND 11: BRIEF ON WHY AND HOW TO ADDRESS INTEGRATION OF HIV/TB SERVICES FOR DRUG USERS IN GLOBAL FUND PROPOSALS

Injecting drug use has gone hand in hand with growing tuberculosis (TB) and HIV epidemics in several regions of the world. In Eastern Europe and Central Asia, home to 3.1 million drug users, HIV rates have tripled between 2000 and 2009¹ while, simultaneously, cases of multidrug-resistant tuberculosis (MDR-TB) continue to rise— Russia alone had the world's third-largest MDR-TB epidemic as of 2009.² Injecting drug users are at increased risk of: (1) HIV and TB infection; (2) having TB go undetected; and (3) developing active TB disease.

KEY BARRIERS TO INTEGRATION

At the same time, significant obstacles stand in the way of accessing and completing treatment for TB and HIV. Some of the key barriers include:

- *Emphasis on inpatient treatment:* With no access to methadone or buprenorphine to treat opioid withdrawal and a lack of community-based alternatives to inpatient treatment, drug users frequently drop out of treatment when admitted to in-patient TB wards due to opioid withdrawal symptoms that go unaddressed. Prolonged hospitalization has been shown to be neither medically justified nor cost-effective.³ Multiple countries— including those with high TB prevalence such as South Africa— have done away with TB hospitalization entirely, while others hospitalize only for the period required to stabilize active infection (approximately two to four weeks) because of data showing that many new MDR and XDR cases are the result of nosocomial transmission while hospitalized.⁴
- *Lack of treatment integration:* Little to no coordination between HIV/TB and drug treatment services means that, in many cities and towns, drug users co-infected with HIV and TB must seek treatment from different providers in different clinics, often in very distant geographical locations. In addition, few measures are in place to ensure continuity of TB treatment when transferring from inpatient to outpatient clinics. This failure to link discharged patients to ongoing outpatient care can result in treatment interruption and the development of MDR-TB. New policy guidelines developed by WHO, UNODC and UNAIDS call for an integrated approach and strengthened collaboration between HIV/TB and drug treatment services to reduce mortality and morbidity among injection drug users.⁵

¹ UNAIDS, 2009 Global AIDS Report fact sheet on Eastern Europe and Central Asia. Available online at http://www.unaids.org/en/media/unaids/contentassets/documents/factsheet/2010/20101123_FS_eeca_em_en.pdf

² Medecins Sans Frontieres, Partners In Health, Treatment Action Group. An Evaluation of Drug-Resistant TB Treatment Scale-Up. (2011).

³ Keshavjee S., I. Y. Gelmanova, et al. "Treating multidrug-resistant tuberculosis in Tomsk, Russia: developing programs that address the linkage between poverty and disease." *Annals of the New York Academy of Sciences* (2008) **1136**: 1-11.

⁴ Basu S., G. H. Friedland, et al. "Averting epidemics of extensively drug-resistant tuberculosis." *Proceedings of the National Academy of Sciences of the United States of America*. (2009)106 (18): 7672-7.

⁵ World Health Organization. Policy guidelines for collaborative TB and HIV services for injecting and other drug users: An integrated approach. *Evidence for Action Technical Papers*. (2008) Geneva, Switzerland.

- *Provider discrimination:* Multiple studies have shown that drug users experience discrimination in health care settings. Discrimination contributes to drug users being significantly less likely to access treatment than other patients with similar conditions. For example, while drug users represent a majority of all HIV cases in Ukraine, patients with a history of drug use represent fewer than 24 percent of those receiving antiretroviral medications. If active users are considered, they represent less than 10 percent of those on HIV treatment in Ukraine.⁶

KEY PRINCIPLES OF INTEGRATION

To address the need to integrate services to tackle HIV and/or TB among drug users, the following important principles must be considered:

- Access to a basic package of essential services for drug dependency, HIV and TB infection, mental illness and psychosocial counseling in the form most convenient to the patient;⁷
- Integration of care through cross-training of providers in TB/HIV and substance use;
- Access to effective drug treatment including evidenced based treatments for opioid-dependent patients (e.g., buprenorphine and methadone);
- Meaningful engagement of NGOs, social workers in all stages of care for patients with HIV/TB and substance use.

KEY INTERVENTIONS IN INTEGRATING TB/HIV SERVICES FOR IDUS

TB and HIV Testing

HIV/TB screening and testing must be made available at all service delivery points. This includes HIV counseling and testing at TB clinics and drug treatment programs (e.g. methadone) as well as tuberculin skin testing at the latter plus screening for substance use and tuberculosis at HIV clinics.⁸ Harm reduction programs are effective in screening and testing for TB/HIV as well as providing follow-up care and referrals. Sputum collection for TB and blood testing for HIV can be done safely in non-health care settings and can take place in mobile or stationary needle and syringe exchange points (NEPs).

Specific interventions include:

- HIV counseling and testing at TB clinics
- HIV counseling and testing plus tuberculin skin testing at drug treatment clinics
- Screens for substance use and tuberculosis in HIV care programs
- Train harm reduction personnel and outreach workers to screen for TB, to conduct voluntary counseling and testing for HIV, and to provide referrals to clients for further testing

INDICATORS ON TESTING TO INCLUDE IN PROPOSALS⁹

- ✓ Number of TB patients offered HIV counseling and testing, received an HIV test, detected as HIV+
- ✓ Number of HIV and drug treatment patients screened for TB
- ✓ Number of HIV and/or TB clients screened for substance abuse
- ✓ Number of patients on drug treatment offered HIV counseling, receiving an HIV test and detected as HIV+

⁶ Kurpita, V. March 2011, Salzburg Seminar Presentation, Session 16; Wolfe, D., Carrieri, P., et al., 2010.

⁷ Curtis, M. Building Integrated Care Services for Injection Drug Users in Ukraine. World Health Organization. (2010) WHO Regional Office for Europe.

⁸ Sylla, L., R. D. Bruce, et al. "Integration and co-location of HIV/AIDS, tuberculosis and drug treatment services." *The International journal on drug policy* (2007) 18(4): 306-312.

⁹ Ibid

- Develop protocols and guidelines for sputum collection in non-health care settings to enable community-based TB screening

Chemoprophylaxis

Isoniazid preventive therapy should be made available at all service delivery points for drug users living with HIV once active TB has been ruled out. Where possible, isoniazid preventive therapy should be administered with other treatments.¹⁰ Combining methadone and directly observed preventive therapy (DOPT) using isoniazid sharply increases retention time and completion rates of preventative therapy. For example, a randomized control study found a 77 percent completion rate of isoniazid preventative therapy in patients on methadone compared to 13.5 percent in patients without access to the medication.¹¹

INDICATOR ON CHEMOPROPHYLAXIS TO INCLUDE IN PROPOSALS

- ✓ Number of HIV-positive clients with LTBI receiving chemoprophylaxis

Specific interventions include:

- Support directly observed isoniazid preventive therapy at harm reduction programs
- Integrate isoniazid preventive therapy with methadone or buprenorphine at drug treatment programs offering evidenced-based pharmacological treatments for opioid dependence
- Train medical providers and harm reduction workers on prophylaxis inclusion criteria

Integrating HIV/TB and Addiction Treatment in the Community

Whether a patient successfully adheres and completes treatment largely depends on his ability to access HIV/substance abuse treatment and other supportive services alongside TB treatment. Co-morbidities—such as viral hepatitis, drug and alcohol dependence, or mental illness— should not be contraindications for the treatment of HIV and TB in drug users.¹²

In the case of HIV medications, adherence to treatment by drug users has been proven to increase through directly observed antiretroviral therapy administered at methadone clinics.¹³ Similarly, studies have shown that DOTS for TB prevention and treatment can be effective when made available at sites where drug users already go on a regular basis, including methadone maintenance programs¹⁴ and syringe exchange programs.¹⁵ Harm reduction programs such as these help to bring a measure of

¹⁰ World Health Organization. Policy guidelines for collaborative TB and HIV services for injecting and other drug users: An integrated approach. *Evidence for Action Technical Papers*. (2008) Geneva, Switzerland.

¹¹ Batki, S. L., V. A. Gruber, et al. "A controlled trial of methadone treatment combined with directly observed isoniazid for tuberculosis prevention in injection drug users." *Drug and alcohol dependence* (2002) **66**(3): 283-293.

¹² World Health Organization. Policy guidelines for collaborative TB and HIV services for injecting and other drug users: An integrated approach. *Evidence for Action Technical Papers* (2008) Geneva, Switzerland.

¹³ Berg, K. M., A. Litwin, et al. "Directly observed antiretroviral therapy improves adherence and viral load in drug users attending methadone maintenance clinics: A randomized controlled trial." *Drug & Alcohol Dependence* (2011) **113**(2/3): 192-199.; Cunningham, C. O., N. L. Sohler, et al. "Strategies to Improve Access to and Utilization of Health Care Services and Adherence to Antiretroviral Therapy Among HIV-Infected Drug Users." *Substance Use & Misuse* (2011) **46**(2/3): 218-232.; Malta M., S. A. Strathdee, et al. "Adherence to antiretroviral therapy for human immunodeficiency virus/acquired immune deficiency syndrome among drug users: a systematic review." *Addiction* (2008) **103**(8): 1242-1257.; Palepu A., M. W. Tyndall, et al. "Antiretroviral adherence and HIV treatment outcomes among HIV/HCV co-infected injection drug users: The role of methadone maintenance therapy." *Drug & Alcohol Dependence* (2006) **84**(2): 188-194.

¹⁴ Altarac, D. and S. F. Dansky. "Tuberculosis treatment through directly observed therapy in a large multisite methadone maintenance treatment program: addressing the public health needs of a high-risk population." *Journal of Public Health Management and Practice* (1995) **1**(4): 40-47.

¹⁵ Perlman, D. C., M. P. Perkins, et al. "Tuberculosis Screening at a Syringe Exchange Program." *American Journal of Public Health* (1997) **87**(5):

stability into the often-chaotic lives of drug users, which, in turn, make these programs ideal locations for the implementation of DOTS. Frequently, these programs are the only place where drug users come into regular contact with healthcare professionals or where they feel accepted.

Specific interventions include:

- Ensure access to evidenced based treatments for opioid-dependent patients (i.e. methadone and buprenorphine) in inpatient TB facilities
- Support cross-training for medical providers in the fields of HIV/TB and substance use to increase providers' ability to manage co-morbidities
- Support social workers/case managers to counsel on TB/HIV treatment adherence, addiction and mental illness for inpatient and outpatient care
- Support engagement of harm reduction groups in the delivery of DOTS for TB and HIV in the community through on-site and mobile outreach
- Provide funding to NGOs for basic harm reduction services (clean needles, condoms etc.) to increase client engagement in ancillary services such as HIV/TB screening, testing and treatment
- Integrate DOTS for TB with methadone and buprenorphine programs in the community
- Ensure continuity of care between pre-trial detention, prisons and the community through a multi-sectoral collaboration and a unified electronic tracking system
- Support community-based palliative care options with access to opioid pain relief and social support.

INDICATORS ON TREATMENT TO INCLUDE IN PROPOSALS¹⁶

- ✓ Number of active TB clients with HIV receiving HAART
- ✓ Number of active TB clients receiving methadone or buprenorphine treatment
- ✓ Number of HIV-positive drug users receiving drug treatment counseling
- ✓ Number of HIV-positive drug users receiving methadone or buprenorphine treatment
- ✓ Number of drug users receiving TB treatment
- ✓ Number and percent of providers participating in cross-training opportunities
- ✓ Number and percent of providers reporting comfort and satisfaction in managing patients with co-morbidities

Patient and Community Involvement, Treatment Literacy, Adherence Support and Stigma Reduction

Patient/peer participation and treatment literacy are critical in promoting patient-centered, evidence-based approaches to treatment and ensuring that the needs and rights of most-at-risk groups are acknowledged and respected at every stage of service delivery. At the same time, training for providers must include the clinical aspects of managing patients with co-morbidities plus education on rights-based approaches to treatment.

Specific interventions include:

- Train patients, peer outreach workers and medical providers on TB/HIV treatment adherence, side effects, and concomitant drug use
- Develop user-friendly information material for injecting drug users and people living with HIV/AIDs on TB signs and symptoms, treatment and follow up care

862-862.

¹⁶ Sylla L., R. D. Bruce, et al. "Integration and co-location of HIV/AIDS, tuberculosis and drug treatment services." The International Journal on Drug Policy (2007) **18**(4): 306-312.

- Institute measures to promote patient adherence and ensure continuity of care (e.g. economic and social support-travel vouchers, food packages, conditional cash transfers)
- Train medical providers at all service delivery points on substance abuse, non-discrimination, and informed consent to reduce stigma and discrimination in health care settings
- Support access to legal aid for patients with problems related to accessing health services, status disclosure and discrimination.

**INDICATORS ON *COMMUNITY ENGAGEMENT*
TO INCLUDE IN PROPOSALS**

- ✓ Number and percent of case managers, outreach workers trained in adherence counseling, HIV/TB diagnostics and treatment
- ✓ Number and percent of clients reporting changes in providers' behavior and attitudes after training
- ✓ Community-based organizations demonstrate greater ability to advocate for evidence-based treatment for HIV/TB and substance abuse
- ✓ Degree to which patient activists are able to influence policy and program development in their city/region
- ✓ Number of legal aid projects providing support to patients

This document was prepared by the International Harm Reduction Development Program at the Open Society Foundations. Further information can be obtained at www.soros.org/harm-reduction.

GLOBAL FUND ROUND 11: BRIEF ON HOW TO INCLUDE GENDER-SENSITIVE HIV PREVENTION AND TREATMENT FOR WOMEN DRUG USERS IN GLOBAL FUND PROPOSALS

The Gender Equality Strategy of the Global Fund recognizes that men and women have unequal access to health services, and urges applicants to prioritize efforts to increase services responsive to the health needs of women and girls. The Fund has also issued guidance emphasizing the importance of HIV prevention interventions for injecting drug users (IDUs). In light of these priorities, and the documented gaps in services for female IDUs, programming and funding to support the development and expansion of the gender-sensitive harm reduction programs is essential.

RISKS FACED BY FEMALE IDUS

Women who inject drugs face specific threats to their health. They include:

- *Last on the needle:* Women IDUs are more likely than men to be “second on the needle,” and so are at greater HIV risk.
- *Transactional sex:* Women drug users often exchange sex for money, drugs, or other commodities, and experience physical and sexual violence, all factors associated with increased vulnerability to HIV risk. Women who use drugs also experience higher rates of sexually transmitted infections¹, often get diagnosed with HIV when already in labor, and have greater rates of treatment interruption than other women.²
- *Reproductive and sexual rights:* Registration as a drug user, required for free drug treatment or as a result of arrest, can imperil women’s custody of their children, and lack of child care in drug dependence treatment forces women to choose between their children and addiction treatment. Many maternity hospitals do not offer methadone or buprenorphine, forcing drug dependent women or those on opiate substitution treatment to have to leave against medical advice to seek drugs or medication.³
- *Violence and access to care:* Despite high prevalence of gender based violence in their lives, women drug users are often excluded from women’s shelters or domestic violence service.
- *No space for women in conventional programs:* Harm reduction and drug treatment programs were designed to cater predominantly to men, and rarely offer gender-sensitive care. Women drug users face greater stigma than men do, and are less likely than male IDUs to visit harm reduction or drop-in centers, depriving them of links to other needed health services.
- *History of incarceration:* For many women, imprisonment in a location separate from her place of residence (there are fewer women’s prisons) results in the loss of support networks. Also, in many places, upon release from prison, women often lack documents needed to access free services for themselves and their children.

KEY PRINCIPLES OF EFFECTIVE INTERVENTIONS FOR WOMEN

Programs worldwide have seen certain targeted services are most effective when working with women drug users. The principles of these programs include:

¹ UNODC, *Substance abuse treatment and care for women: case studies and lessons learned*. United Nations: New York, 2004.

² Wolfe D. *Paradoxes in antiretroviral treatment for injecting drug users: access, adherence and structural barriers in Asia and the former Soviet Union*. *Int J Drug Policy* 2007;18(4):246-54.

³ K. Burns, *Women, Harm Reduction and HIV*, International Harm Reduction Development, Open Society Institute, 2009

- Emphasis on creating safe non-threatening environment, including guaranteed confidentiality and non-judgmental care;
- Low-threshold programming to ensure no woman is excluded from accessing harm reduction and HIV prevention services irrespective of health, economic, legal and social status;
- Access to reproductive and sexual health and to drug treatment including opioid substitution therapy (OST), especially for pregnant women;
- Multidisciplinary approach, case management and legal aid.

KEY COMPONENTS OF GENDER-SENSITIVE INTERVENTIONS

Attracting and Retaining Women in Prevention Programs

Several specific interventions have been shown to work in recruiting women in prevention efforts, such as:

- **Establishing women-friendly low-threshold services:** Drug use by women is severely stigmatized and often leads to violence and abuse. Provision of services in a safe space free from the intimidating presence of men is essential to attract and retain women in HIV prevention programs. This can be achieved through designating a separate space or women-only walk-in hours, and having women on staff as well as engaging women drug users in program development and implementation.
- **Targeting outreach toward women:** Mobile outreach in a specially equipped van is effective in reaching women who do not visit harm reduction programs. Outreach teams that provide pregnancy tests, STI and HIV counseling and testing as well as free STI treatment and referrals to “friendly doctors” will bring these services to women not reached directly by prevention programs.
- **Peer outreach and secondary exchange:** Women specific supplies, such as condoms, hygienic items, deodorants, shampoos, diapers and baby formula is a strong incentive for women to come back to prevention program. By allowing clients to pick up syringes, condoms, and other items and then distribute them within their networks, a harm reduction program will increase its ability to reach women who do not attend services directly, while building trust and encouraging direct contact in the future. As the graph below indicates, if implemented properly, gender-sensitive harm reduction services have proved to increase participation of women in prevention programs by 30% to 60%.

INDICATOR ON *OUTREACH* TO INCLUDE IN PROPOSALS

- ✓ Number of women and their children reached by harm reduction and HIV prevention services

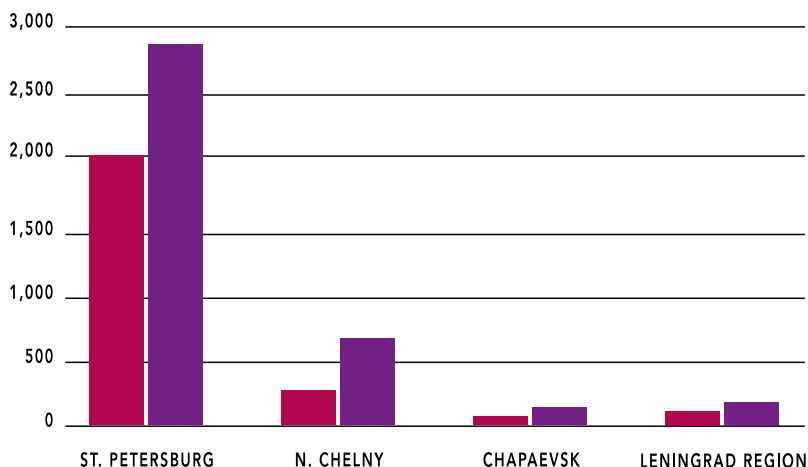
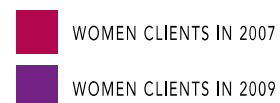


FIGURE 1

As four harm reduction groups across Russia found, more women participate when services are tailored to them specifically.



Better Access to HIV Testing and Treatment

- **Low-threshold counseling and testing:** Provision of free STI and HIV counseling and testing at any service entry point is essential, followed by a referral to friendly doctors at a local AIDS-center and other clinics. Testing should always be accompanied by pre- and post-test counseling, with provision of gender specific information (such as information on sexual health or possibility of having healthy children). Case management will improve follow-up and adherence to ARV treatment for those women who need it.
- **Confidentiality and psychological support:** Any care should be provided in a non-judgmental manner and guarantee confidentiality. Many women will also need support in preparing to disclose their status to family or partner, since this might lead to abuse or exclusion.

INDICATORS ON HIV TO INCLUDE IN PROPOSALS

- ✓ Number of women receiving pre- and post-test counseling or HIV testing
- ✓ Number of women who received case management and other support to access HIV treatment

Improving Access to Reproductive and Sexual Health

- **Access to quality sexual health:** Women who use drugs are at a higher risk of unintended pregnancies and STIs while they have limited access to contraception, family planning and STI diagnostics and treatment. Provision of pregnancy tests, counseling on contraception, access to free STI treatment, and establishing links to friendly sexual health providers are essential to improve health of women who use drugs. Outreach and counseling in primary care or OB/GYN setting will increase likelihood that women will receive better care and come back for a follow up visit.
- **Specialized services during pregnancy:** Counseling on evidence-based safe drug treatment in pregnancy including opioid substitution treatment (OST), prevention of HIV transmission from mother to child (PMTCT), benefits of good nutrition and regular antenatal check-ups improves access of pregnant women DU to antenatal care and PMTCT. Access to uninterrupted substitution treatment in maternity clinics is key to better maternal and baby outcomes.
- **Network of “friendly doctors”:** cultivating relationships with doctors who are informed about, sensitive to and understanding of the realities of women who use drugs will increase access to medical care. Training and education of medical professionals is key in developing a pool of “friendly doctors”.

INDICATORS ON REPRODUCTIVE HEALTH TO INCLUDE IN PROPOSALS

- ✓ Number of women who received access to pregnancy tests, family planning and contraception
- ✓ Number of women who received access to free STI diagnostics and treatment
- ✓ Number of women who accessed quality sexual and reproductive health services, including antenatal care and PMTCT

Increased Availability of Drug Treatment

- **Enabling informed decision:** Pregnant women who use drugs are often denied access to drug treatment or discouraged from enrolling in OST where it is available. Access to reliable, evidence-based facts on benefits and risks of drug treatment in pregnancy is vital for making an informed decision on drug treatment.
- **Comprehensive support:** For many women, pregnancy or already-born children is a strong motivation to stop using drugs. Most drug treatment programs, though, lack child care forcing women to choose their children or drug treatment. Access to child care, psychosocial support, legal aid and case management will increase chances of women to access and complete drug treatment.

SOME INDICATORS ON DRUG TREATMENT TO INCLUDE IN PROPOSALS

- ✓ Number of women in addiction counseling and drug treatment
- ✓ Increased capacity of drug treatment programs to meet needs of pregnant women or women with children

Addressing Parenting and Family Concerns

- **Providing family and children-focused services:** Parenting and relationship counseling to help women re-establish relationship with children and family members reduces stress in women's lives and helps to strengthen their natural support networks. Other family-centered services include provision of baby formula and diapers to young mothers, access to pediatric consults, part-time child care and other support.
- **Addressing domestic violence:** Recognition of the prevalence of violence in the lives of women who use drugs should inform the organization and delivery of services to women; in many locations there is scarcity of crisis centers or shelters, and where they exist, they often do not admit women who use drugs. Training and supporting staff to provide counseling on gender-based violence, support in establishing support networks where women can find safety, and legal empowerment are key interventions for women who survived violence.

INDICATORS ON FAMILY OR PARENTING CONCERNS TO INCLUDE IN PROPOSALS

- ✓ Number of women who received counseling and support on parenting
- ✓ Increased ability of the harm reduction organizations to provide support and counseling to women victims of violence

FUNDING OF GENDER-SENSITIVE HARM REDUCTION PROGRAMS⁴

Increased retention of women in harm reduction services can be achieved with modest expenditures, especially when gender-sensitive programs are implemented based on already existing harm reduction services. In Ukraine and Georgia, positive outcomes have been achieved by pilot projects primarily due to a comprehensive set of services, geared to the specific needs both of women drug users and their children, as well as the effort to establish a lasting tie (therapeutic alliance) with drug-using women. Grant amounts that enabled harm reduction programs in Ukraine to successfully implement pilot gender projects ranged from 22,000USD to 40,000USD, depending on the size and needs of the organization, however the cost may vary per country.

Funding for gender-sensitive harm reduction programs should cover not only the development and provision of direct services, but also provide for capacity building and institutional development of the implementing organizations. It is appropriate to allocate some budget for ongoing staff training and education.

KEY TARGET GROUPS FOR FUNDING

- ✓ Women who use drugs and/or are engaged in sex work and their children
- ✓ Women who are sexual partners of injecting drug users
- ✓ HIV-positive women drug users
- ✓ Women prisoners or recently released from prisons
- ✓ Other marginalized women and their children and partners in high risk to HIV infection
- ✓ Sexual partners of women drug users

This document was prepared by the International Harm Reduction Development Program at the Open Society Foundations. Further information can be obtained at www.soros.org/harm-reduction.

⁴ For additional information on funding gender-sensitive harm reduction, visit www.soros.org/harm-reduction.



HARM REDUCTION FOR PEOPLE WHO USE DRUGS

INFORMATION NOTE

The Global Fund supports evidence-based interventions that aim to ensure access to HIV prevention, treatment, care and support for most-at-risk populations. This includes the “comprehensive package for the prevention, treatment and care of HIV among people who inject drugs”, as defined by WHO, UNODC and UNAIDS [1]. This information note describes how interventions for people who inject drugs are to be incorporated into country proposals to the Global Fund.

To respond effectively to HIV, it is vital to “know your epidemic” through appropriate surveillance and epidemiological research. Applicants must tailor and justify their proposed responses within the context of the epidemiological situation and the needs of the people at risk. In many parts of the world, drug injecting is a major driver of HIV epidemics. It has been documented in 158 countries [2], and between 11 and 21 million people inject drugs globally [3]. HIV infection among people who inject drugs has been reported in 120 countries [3], accounting for at least 10 percent of global HIV infections, and around 30 percent of HIV infections outside of sub-Saharan Africa.

Preventing HIV and other harms among people who inject drugs – and providing them with effective treatment – are essential components of national HIV responses, yet often present major challenges. People who inject drugs in low and middle income countries have limited and inequitable access to HIV prevention and treatment services [4]. In prisons and other closed settings, access to comprehensive HIV prevention, treatment and care is even more limited despite evidence that drug use and sexual activity are prevalent in these settings [5].

WHAT IS THE COMPREHENSIVE PACKAGE OF INTERVENTIONS?

An effective and evidence-based response is required to curtail the rapid spread of HIV among drug-using populations, but also to prevent onward transmission to other populations (including regular sexual partners and sex workers) which may significantly expand the reach of the epidemic. In order to achieve these goals, according to UNODC, WHO and UNAIDS, the implementation of a “comprehensive package” of nine interventions is essential [1]. This package – also widely referred to as a “harm reduction” approach – consists of interventions with a wealth of scientific evidence supporting their efficacy and cost-effectiveness in preventing the spread of HIV and other harms [6]:

1. Needle and syringe programs (NSPs)
2. Opioid substitution therapy (OST) and other drug dependence treatment
3. HIV testing and counseling
4. Antiretroviral therapy
5. Prevention and treatment of sexually transmitted infections

6. Condom distribution programs for people who inject drugs and their sexual partners
7. Targeted information, education and communication for people who inject drugs and their sexual partners
8. Vaccination, diagnosis and treatment of viral hepatitis¹
9. Prevention, diagnosis and treatment of tuberculosis

No single intervention will prevent or reverse HIV epidemics. The greatest impact will be achieved if the nine interventions are implemented as a package [1]. The interventions should also be delivered using a range of modalities, including community outreach and peer-to-peer work [8], and should be implemented both in community and prison settings [5]. Services should also be delivered within a human rights and public health approach, alongside supportive legal and policy frameworks (or advocacy for their development).

INCORPORATING THE COMPREHENSIVE PACKAGE INTO GLOBAL FUND PROPOSALS

Global Fund resources should be used to fund evidence-based interventions, including those targeting key populations in the community and in prisons. As such, the Global Fund is the major source of international funding in low and middle income countries for harm reduction. Between 2004 and 2009, it invested around US\$ 180 million in these interventions in 42 countries [9]. This includes funding for HIV prevention and treatment, the introduction of NSPs and OST in public and prison systems, and advocacy for policy improvements related to drug use and HIV.

According to Global Fund policy, all proposals in the Targeted Funding Pool must focus 100 percent of their budget on underserved and most-at-risk populations and/or highest-impact interventions within a defined epidemiological context [10]. In addition, lower-middle and upper-middle income countries applying to the General Funding Pool must focus 50 percent and 100 percent, respectively, on these populations and/or interventions – and low income countries are strongly encouraged to do so as well. The performance-based funding model of the Global Fund is also designed to encourage the inclusion of interventions with proven and measurable impacts, and the Technical Review Panel consistently places emphasis on interventions that demonstrate [value for money](#).

It is therefore strongly recommended that countries with concentrated HIV epidemics associated with drug injecting include harm reduction in their proposals - as should countries with generalized HIV epidemics and high HIV prevalence among this group, or with significant potential for concentrated epidemics to develop.

Applicants are advised to make use of the full range of information notes and guidance provided by the Global Fund, as well as technical assistance from partners, and the numerous technical guides and support documents available - some of which are listed at the end of this note.

¹ The Technical Review Panel (TRP) has previously stated that applications for funding hepatitis C treatment among people who live with HIV will be recommended “after close scrutiny of the country context, including well-documented evidence that hepatitis C treatment and funding is available to the general population and that funding from the Global Fund is to fill-in the gap for HIV-infected individuals”. The TRP has recommended that Global Fund resources also be used to increase evidence on the need for hepatitis treatment, create awareness of the virus, increase prevention efforts, and support advocacy for treatment access and affordability [7]. Countries that do request funding for hepatitis C treatment should include information on the provision of treatment for those in the general population (beyond the proposal request), as well as comment on what is being done in terms of awareness and prevention.

OTHER IMPORTANT CONSIDERATIONS

In addition to the “comprehensive package” outlined above, there are a range of complementary interventions and approaches that should be considered when developing proposals to the Global Fund. For example, the International HIV/AIDS Alliance identified 15 interventions in their “harm reduction approach to HIV programming” [11].

Community involvement and user-oriented services

It is crucial that people who use drugs are able to actively participate in the planning, delivery and evaluation of the HIV response. Country Coordinating Mechanisms are strongly recommended to include this community in project design, proposal development, and program implementation and oversight. Where necessary, Country Coordinating Mechanisms should also seek to build the capacity of people who inject drugs to participate meaningfully. Involving this population in planning and service delivery recognizes and utilizes their unique experiences, knowledge and contacts, and contributes to effectively addressing their needs and ensuring that proposed services and interventions have the lowest possible thresholds [12].

Community systems strengthening

Many services for people who use drugs are best delivered in community-based settings and by civil society organizations. The goal of [community systems strengthening](#) is to develop the roles of key communities (such as people who use drugs and clients of harm reduction programs) in the design, delivery, monitoring and evaluation of services and activities. Applicants are strongly encouraged to include community systems strengthening interventions in their proposals in order to support and complement harm reduction programs. Such activities seek to expand capacity but must also be accompanied by resources to support extensive and meaningful community engagement.

Gender-sensitive programming

Addressing gender equity is an important consideration in Global Fund proposals and funding decisions. HIV infection rates among women who inject drugs are significantly higher than among male injecting drug users [13], and the sexual partners of men who inject drugs also have elevated risks [14]. In addition, pregnant HIV-positive drug users are frequently excluded from prenatal care, and so have significantly higher rates of mother-to-child transmission than other women [15]. In many countries, women who use drugs have disproportionately poor access to HIV prevention, treatment and care [16]. Where possible, applicants should strive to collect sex-disaggregated data, and to use that data to identify and rectify service gaps when proposing harm reduction interventions. Examples of gender-sensitive programming for people who use drugs include providing childcare at drop-in centers, the use of both male and female outreach workers, supporting access to PMTCT and providing treatment and care for the mother as well as the newborn, and linking with services responding to gender-based violence. Please see the Information Notes on [Gender Equality](#) , [PMTCT](#) and [Equity](#) for further details.

Prisons and pre-trial detention

Imprisonment is a common event for many people who inject drugs [5]. Often, they continue using (and injecting) drugs while in prison, despite efforts by prison systems to prevent this. It is therefore essential to provide harm reduction for people who inject drugs both in the community and in penal institutions. Such programming must address not only injecting risk, but also sexual risk in prison settings. Given the role that prisons play in the spread of HIV and TB (including multidrug-resistant TB), particular efforts are needed to ensure the continuity of antiretroviral therapy and TB treatment as well as NSPs and OST at all stages - upon arrest, pre-trial detention, transfer to prison and within the prison

system, and upon release. This will require strong advocacy interventions and the engagement of different government departments in proposal development.

Drug detention centers

In some countries, extrajudicial detention centers are used in response to drug use, with widely reported violations of human rights and little evidence of effectiveness. The Global Fund has made repeated calls for the closure of these centers, while expressing concerns that those detained illegally within them must not be denied access to essential health care [17, 18]. Where these centers exist, applicants should seek to identify and include more effective, cost-effective and human rights-based alternatives.

Ensuring supportive environments and human rights

Even where interventions such as NSPs and OST are implemented, the lack of a supportive social, policy and human rights environment often creates access barriers. Therefore, applicants should consider interventions such as:

- advocacy and evidence-building activities to ensure high-level political and professional support for harm reduction and policy reform;
- reviews of laws, policies and practices related to injecting drug use and HIV, with a view to changing those that impede service delivery and/or violate human rights;
- legal aid and assistance for people who use drugs, ideally integrated into curative and preventive service delivery sites;
- social mobilization and campaigns for people who use drugs to better understand the law and their rights;
- interventions addressing the double stigma and discrimination related to HIV and drug use;
- training and/or sensitization for police, judges and prison staff in evidence and human rights-based approaches to drug use and HIV; and
- support to ensure that basic needs and underlying psychosocial vulnerabilities are addressed.

Overdose prevention

Although not explicitly mentioned in the “comprehensive package”, overdose prevention should be a core component of “targeted information, education and communication” for people who use drugs. Overdose is a major cause of mortality and morbidity among people who use drugs, impacting directly on HIV-related harm reduction services [19]. Therefore, applicants are strongly encouraged to consider interventions such as peer and staff training in overdose prevention. In addition, applicants should also consider the strengthening of overdose responses – including legislative and policy reform where needed, and the low-threshold provision of naloxone (a WHO Essential Medicine that can reverse opioid overdoses) to communities of people who use drugs as well as through emergency health services. These low-cost approaches can empower health care workers and people who use drugs to save lives [19].

Monitoring and Evaluation

In order to obtain accurate and high quality data, indicators need to be carefully tailored to the applicants’ M&E systems and capacities – especially outcome and impact indicators. When setting targets for service coverage as a percentage, reliable population size estimates must be used as the denominators – such as those from global reviews [2, 3] or developed using available guidelines [20, 21]. In order to help address the known M&E challenges relating to most-at-risk populations, applicants are also encouraged to include in their proposals:

- A clearly defined basic (minimum) package of services to be provided to clients, based on the information provided in this document.
- Improvements to epidemiological surveillance systems where needed, and research to further expand knowledge on HIV, injecting drug use, service coverage, impact and need.
- Systems to avoid the double-counting of individuals in services (such as “Unique Identification Codes”).

When setting targets, programs are strongly recommended to aim for “high” service coverage for people who inject drugs – for example, more than 60 percent being regularly reached by NSPs, more than 40 percent being reached by OST, and more than 75 percent receiving an HIV test in the past 12 months and knowing the results [1].

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FURTHER READING AND RESOURCES

- UNAIDS and UNODC Fact sheet on “Drug Use and the Spread of HIV”: www.unodc.org/documents/frontpage/Facts_about_drug_use_and_the_spread_of_HIV.pdf
- “What Is Harm Reduction?” - definition from Harm Reduction International: http://www.ihra.net/files/2010/08/10/Briefing_What_is_HR_English.pdf
- WHO “Basic Principles for Treatment and Psychosocial Support of Drug Dependent People Living with HIV/AIDS”: www.who.int/substance_abuse/publications/basic_principles_drug_hiv.pdf
- Open Society Foundations Publications and Articles on Harm Reduction and Drug Use: http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/sub_listing