



Technical Brief

Harm Reduction for People Who Use Drugs: Priorities for Investment and Increased Impact in HIV Programming

Allocation Period 2023-2025

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Introduction

For people who inject drugs, **harm reduction** is critically important to reduce the risk of infection with HIV or viral hepatitis and to improve prevention, diagnosis and treatment. People who use opioids or amphetamines by snorting, smoking or taking them orally can also be at increased risk of HIV when combining drug use and sex. **“Harm reduction” refers to policies, programs and practices that minimize negative health, social and legal impacts of drug use and drug laws and policies.** Harm reduction approaches focus on supporting positive change without requiring that people stop using drugs.

This brief is meant to help applicants to the Global Fund plan for and scale up effective HIV and hepatitis C programming for people who use drugs, particularly those who inject. Applicants should consult the Global Fund [HIV Information Note](#) and [Modular Framework Handbook](#), which detail the full range of biomedical, behavioral and structural interventions that the Global Fund supports as part of a comprehensive HIV response. This brief, drawing on review of past programming and guidance from UN partners, highlights specific lessons and recommendations for harm reduction programming. Closing the HIV prevention gap for key populations, including people who inject drugs, is a priority in the Global Fund’s [2023-2028 strategy](#). Removing human rights-related barriers to services, and ensuring that community leadership is at the heart of the HIV response, are also strategic priorities.

The Global Fund considers harm reduction a “program essential” — that is, a critical part of a country’s comprehensive HIV response. Countries are requested to address the status of and progress toward achieving program essentials in their applications for Global Fund support, and Core and High-Impact countries are required to include plans to scale up those not yet fully implemented in their funding narrative. The Global Fund requires upper-middle-income countries to focus 100% of their country grant budget on maintaining or scaling up services to key populations, including people who inject drugs, and asks all countries to prioritize evidence-based, rights-respecting, highest-impact interventions. Evidence shows that harm reduction is high-impact (and cost-effective) HIV prevention for people who inject drugs in countries of all income levels.¹

Some countries report that they do not have a full enough picture of drug use to begin services for people who use drugs, or that they have not made the necessary changes in laws in order to start harm reduction. Others decline to collect current information on drug use and HIV risk, or keep harm-reduction programs small for years (“perpetual pilot”). Injecting drugs with non-sterile equipment spreads HIV, hepatitis C (HCV) and other blood-borne diseases quickly, so **it is very important not to wait before starting or scaling up programming.** While good data about drug use and police agreement not to interfere with harm reduction services are both important, countries do not need to wait for perfect

¹UNAIDS (2016). [Do No Harm: Health, Human Rights and People Who Use Drugs](#); Harm Reduction International (2020); [Making the investment case: Cost-effectiveness evidence for harm reduction](#).

information or for Parliament to pass new laws to begin programming. **This brief includes information about steps that countries can take at different stages in their harm reduction programming:** whether starting, increasing the numbers of people reached, or maintaining a program at scale.

HIV risk comes not just from non-sterile injecting equipment, but from policies, practices, and attitudes that keep people who use drugs from accessing services. Police harassment, for example, has been shown to increase the likelihood of needle sharing and to discourage people who use drugs from accessing harm reduction services or other healthcare.² Failure to meaningfully engage people who use drugs in creating, delivering and evaluating harm reduction services can result in programs that fail to meet the needs of the people they are meant to serve.³

The Global Fund evaluates proposals for plans to deliver services to people who use drugs and on how countries plan to remove human rights-related barriers to those services. It also evaluates whether proposals recognize the **leadership of people who use drugs** in strengthening services, increasing health system accountability and addressing structural barriers. Integrating these approaches is essential to increase the impact of HIV prevention programs.

Box 1. Global AIDS Strategy: Some Key Targets

By 2025:

- 90% of people who inject drugs have access to comprehensive harm reduction services integrated with or linked to hepatitis C, HIV and mental health services.
- 50% of people who inject drugs and are opioid dependent have access to OST.
- 80% of HIV prevention services, 30% of testing and treatment services, and 60% of programs to address societal enablers for people who inject drugs are community-led.
- Less than 10% of people who inject drugs or living with HIV experience stigma or discrimination, less than 10% of women who use drugs or living with HIV experience gender inequality/violence, and less than 10% of countries have punitive legal or policy environments that lead to denial or limitation of services.

The Global AIDS strategy calls on countries to sharply scale up harm reduction to ensure that 90% of people who inject drugs have access to harm reduction services (see Box 1). The Global AIDS strategy, the Global Fund strategy, and the 2021 Political Declaration on HIV and AIDS endorsed by the UN General Assembly all emphasize the need to change laws and policies so that HIV services can be effectively delivered.⁴ This brief helps countries receiving funding from the Global Fund to move toward that goal.

² UNAIDS (2016). [Do No Harm: Health, Human Rights and People who use Drugs](#)

³ APMG Health (2019). [Global Summary of Findings of An Assessment of HIV Services Packages for Key Populations in Six Regions](#).

⁴ UNAIDS (2021). [Global AIDS Strategy 2021-2026](#). The Global Fund (2022). [Fighting Pandemics and Building a Healthier and More Equitable World: Global Fund Strategy \(2023-2028\)](#). UN General Assembly (2021). [Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030](#)

Executive Summary

Harm reduction programming is high impact in preventing infection with HIV and hepatitis B and C, and can help link those infected to diagnosis, treatment and care. By contrast, counselling or behavioral interventions that aim to get people to stop using drugs have not been shown to reduce HIV or viral hepatitis epidemics.⁵

For **HIV prevention**, priority harm reduction both in the community and in prisons and other closed settings includes:

- Needle and syringe programming (NSP) that offers people who inject drugs the recommended quantity of sterile injection equipment (~300 needles per person per year for HCV prevention, ~200 for HIV prevention, calculated based on total population of people who inject drugs), at a variety of places and times. To maximize access, sterile injection equipment should be offered without confidentiality violations, without requirements for 1:1 exchange, without requirements for identity documents, and without police interference. Outreach, staffing and services should be sensitive to the needs of women who inject drugs, of youth, of sex workers, and of trans and gender-diverse people.
- Opioid substitution therapy (OST) that is easy for people to start and continue for as long as necessary; that can be scaled up or complemented via take-home doses, mobile units, satellite clinics and distribution at pharmacies and community centres; and that can be integrated with HIV, hepatitis B and C, and TB testing and treatment.
- Overdose (OD) prevention with the opioid OD antidote naloxone distributed to those most likely to witness an OD (people who inject drugs, their families and friends), along with training on use, mechanisms for peer distribution, and changes to law enforcement to prevent police interference.

The Global Fund supports additional HIV prevention interventions including condoms and lubricant; sexual and reproductive health services; pre- and post-exposure prophylaxis for people who use drugs and their sexual partners; hepatitis B and C testing and treatment for people who inject drugs; health communication and demand creation; and harm reduction for people using drugs other than opioids such as methamphetamine or cocaine, including mental health support.

People who use drugs are experts on needs for and barriers to HIV services, and should be meaningfully engaged in planning, delivery, monitoring and evaluation of harm reduction services.

Removing human rights- and gender-related barriers to HIV services is essential for impact in harm reduction programming, and should be costed, planned for and implemented. Programs should address the structural barriers faced by people with specific needs, such as women and adolescents who use drugs. **The Global Fund defines four**

⁵ WHO (2022) Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations

approaches to reducing human rights-related barriers to HIV services as “program essentials,” and asks all applicants to provide an update on their status and progress toward achieving these approaches. As with harm reduction, applicants from Core and High-Impact countries must also describe in their funding narrative how they plan to introduce or scale up those human rights program essentials that are not yet fully implemented.

These four human rights program essentials are:

1. Integration of **measures in HIV programs to reduce human rights- and gender-related barriers.**
2. **Activities to reduce stigma and discrimination** in healthcare and other settings, including with law enforcement.
3. **Accessibility of legal literacy and access to justice activities.**
4. Support for **efforts, including community-led efforts, to reform criminal penalties** for drug use, possession of harm reduction equipment/drugs for personal use, and other harmful laws and policies.

In addition to advocacy, the Global Fund supports work by people who use drugs to lead monitoring of service quality and delivery, to engage meaningfully in program planning, and to increase community safety and build capacity.

Testing and treatment, whether for HIV, hepatitis B and C, sexually transmitted infections (STIs) or TB, should be voluntary, confidential, and link people who use drugs to services that are acceptable, accessible (including affordable), of adequate quality, and easy to start and continue. This means making sure that testing links people to care, and minimizing requirements for additional fees, multiple medical tests, or extensive paperwork. Stigmatizing practices at health facilities, including restrictions on treatment for those actively using drugs, should be stopped.

Effective HIV programming focuses both on which commodities and services to provide, and on how to get services to the people who use drugs who need them most.⁶ In evaluating plans for harm reduction, the Global Fund recommends proposals that:

- **Understand the HIV and related needs of people who use drugs, including through biobehavioral surveillance or rapid assessment** to determine which people are at highest risk based on their injecting and sexual practices. These assessments should also look at the environment where risk occurs, and the barriers to harm reduction and other services. The Global Fund encourages assessment methods (and service design and delivery) that recognize the expertise and leadership of people who use drugs and who can provide technical assistance to support this.⁷
- **Design a mix of harm reduction interventions that strengthen each other, including in prisons and other closed settings.** Combining OST, NSP, HIV and

⁶ Global HIV Prevention Coalition (2017). Discussion Paper 3: [Systematic and Efficient Service Delivery at Scale](#).

⁷ Global Fund (2022). [Community Systems Strengthening \(CSS\) Technical Brief](#).

hepatitis testing and treatment reduces community transmission more than any one of these interventions alone. STI treatment reduces risk of HIV infection. Provision of naloxone for OD prevention can increase uptake of HIV prevention. Since people who use drugs often move between communities and detention, prevention and treatment should be equally available to them within and outside prisons and other closed settings, with mechanisms in place to ensure continuity of care.

- **Deliver effective and efficient services, as gauged by people who use drugs as well as by those delivering services.** This includes supporting community-led monitoring and drawing on peer networks and navigators in the design and delivery of prevention, diagnosis and treatment services. Differentiated NSP and OST delivery (at pharmacies, drop-in centres, mobile units, and fixed sites) can increase reach, as can integration of NSP and testing and treatment for HIV, HCV, TB and STIs. Countries should plan to evaluate impact from the start, including real time tracking of service delivery, regular HIV prevention performance review and accountability processes that include community. Review should include ongoing assessment of service gaps and consider changes to drug markets and to the environment and policies that shape drug use and risk.
- **Sustain services by creating mechanisms and providing national/municipal funding for service continuation** during and after the Global Fund grant. This can be achieved through “social contracting” with networks and groups led by people who use drugs, with community-based, non-governmental organizations, and with funding from and collaboration between health, social welfare, and law enforcement/drug control agencies.

Resources for harm-reduction planning and programming are included in sections of this brief (see section 5 for a complete list). In addition to the Global Fund [HIV Information Note](#) and [Modular Framework Handbook](#), two resources are particularly useful for applicants preparing harm reduction funding requests:

- WHO (2022). [Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations, the](#) key source of guidance for this brief and for the Global Fund on evidence-based programming for people who inject drugs.
- UNODC, INPUD, et al (2017). [Implementing comprehensive HIV and HCV programmes with people who inject drugs](#), offering practical guidance and case studies on creating and delivery programs with and for people who use drugs.

Other Global Fund briefs on key populations and community response complement the information on harm reduction here. See, for example, briefs on:

- Prisons and Other Closed Settings.
- Removing Human Rights-related Barriers to HIV.
- Removing Human Rights-related Barriers to TB.
- Key Populations.
- Community System Strengthening.

- Gender Equity.
- Undertaking a rapid assessment of information on human rights-related barriers to HIV and TB services: guidance and tools

1. Priorities for Investment

1.1. HIV Prevention

Many countries counsel people about the risks of drugs and advise them to stop using them. Because this kind of behavior change counselling has not been shown to reduce the incidence of HIV, hepatitis or STIs, it is not recommended by the World Health Organization (WHO) and is not a priority for the Global Fund.⁸ In contrast, the Global Fund prioritizes approaches proven to reduce HIV and HCV transmission such as sterile injecting equipment and OST.

People who use drugs are experts on their service needs and barriers and prefer services that are led by their peers.⁹ Global Fund staff and technical reviewers consider the level and extent of community engagement when evaluating both the Country Coordinating Mechanism and the soundness of proposed programming.

The Global Fund supports the range of prevention approaches for people who inject drugs identified by WHO, the UN Office on Drugs and Crime (UNODC), and the Joint United Nations Programme on AIDS (UNAIDS) as essential for impact. When combined with HIV testing and treatment and approaches to remove human rights and legal barriers, these measures can reduce transmission of HIV among people who inject drugs to virtually zero.

Priority Prevention Programming

Among people who use drugs, those who inject are at greatest risk for HIV, HCV and overdose. **Harm reduction approaches for people who inject drugs are considered a “program essential” by the Global Fund**, and all country proposals should describe the status and plans for them. Three are highest priority: needle and syringe programming, opioid substitution therapy, and naloxone for overdose prevention.

Needle and syringe programming. Providing sterile injecting equipment is the approach with the single greatest impact in preventing the transmission of HIV and HCV for people who inject drugs. Lessons to increase impact of this approach:

Put the knowledge and needs of people who inject drugs at the center of determining what kinds of injection equipment are needed and where and when they can best be distributed.

- **Peer design and delivery** has been critical to the success of NSP both in communities and inside prisons. People who inject drugs who are committed to harm

⁸ WHO (2022) [Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations](#)

⁹ INPUD (2022). [Key Populations' Values and Preferences for HIV, Hepatitis and STI services: A Qualitative Study.](#)

reduction and familiar with current patterns of drug use should be consulted in creating, delivering and evaluating NSP.

- Ask people who inject drugs about preferred size, variety and brand of needles, rather than just buying the cheapest available. **Low-dead-space syringes** keep less blood in them, reduce risk of infection with HIV or hepatitis C, and are recommended by WHO. If people who inject drugs say these are acceptable, use them. People injecting stimulants may require more needles daily. One-time use/autodestructing needles are not suitable for NSP, and not recommended.
- **Other injection equipment**, such as water, filters, spoons, “cookers”, tourniquets, acidifiers and materials for wound care, are important to reduce risk of HIV, hepatitis C, abscesses, and other kinds of infections.

Set targets and plan for scale. Programs reaching people who inject drugs only a few times a year, or providing only a few needles a month, will not significantly impact HIV transmission. Even if starting small, plan to reach the recommended average (~300 needles per person per year for HCV prevention, ~200 per person per year for HIV prevention) and eventually to reach 90% of people who inject drugs regularly.¹⁰

- **Avoid 1 for- 1 exchange requirements**, and instead offer clients the number of needles and syringes they need and materials (e.g., puncture proof containers) to help dispose of them safely.
- “Secondary distribution” (when NSP clients give injection equipment to their peers) can be important to reach those unable or reluctant to come to an NSP site.
- Offer a variety of NSP at a variety of times. Possibilities for **differentiated service delivery** include integration of NSP with other health and social services (such as sexual and reproductive health services; programming tailored to sex workers, women and adolescents who use drugs); as well as use of pharmacy vouchers, street outreach, and mobile distribution (via bus, van, motorbike or bicycle).
- **Include gender- and youth-sensitive services.** Women who use inject drugs face higher HIV risk, and high levels of violence from intimate partners, from police, or when engaged in sex work. Despite this, they have little or no access to gender-sensitive drug dependence or harm reduction services. Trans and gender-diverse people who use drugs also experience violence and police harassment, and limited support or protections. Adolescents who inject drugs are frequently excluded from services, or are required to provide parental permission.

Protect safety of clients, staff, and communities to help make NSP sustainable.

- **Reduce law enforcement interference.** Laws criminalizing possession of injecting equipment or of drugs for personal use reduce the impact of HIV prevention (see

¹⁰ WHO (2016). [Combating Hepatitis B and C to Reach Elimination by 2030](#). UNAIDS (2019). [Needles and syringes distributed per person who injects drugs](#).

section 1.6, below). Agreement with senior police leadership not to arrest/harass clients or staff, or authorization from health or drug control authorities for NSP pilots, can help programs start even before formal legal change.

- **Plan for ongoing consultations with local stakeholders** to combat misinformation, highlight the benefits of harm reduction, and work together to address concerns. This will help address any opposition from local residents or businesses, which are a frequent cause for NSP interruption.
- **Prioritize safety of program staff, clients and operations** by reducing risks and creating a crisis response plan. Safety protocols should include measures for safe collection and disposal of used injection equipment, and medical support and post-exposure prophylaxis in the event of a needle stick injury. Harm reduction programs also face security threats, service interruptions or seizure of supplies by police or community vigilantes. Program staff and clients, peer outreach workers and advocates should be offered training, legal, psychosocial and logistical support on violence de-escalation, data safety, and physical protection, as well as on their human rights (see section 1.6, below).

For more information on NSP, see:

- UNODC, INPUD et al, 2017. [Implementing comprehensive HIV and HCV programmes with people who inject drugs.](#)
- UNODC (2016). [Addressing the specific needs of women who inject drugs. Practical guide for service providers on gender-responsive HIV services.](#)
- WHO (2007). [Guide to starting and managing needle and syringe programmes.](#)

Opioid Substitution Therapy¹¹. The medicines methadone and buprenorphine help people dependent on opioids reduce injection, stay on HIV treatment, and reduce risk of overdose. Because these medicines are controlled substances that require some additional tracking and planning by government, some programmers over-emphasize control, making it difficult for people to enter treatment or for programs to expand.

The Global Fund prioritizes support for OST programming that is:

- **Person-centered**, allowing for easy entry into and continuation of treatment for all those who are opioid dependent.
 - How long people have to wait for OST often determines whether or not they enter treatment. Avoid demanding entry requirements like extensive paperwork, inpatient hospital stays, multiple medical tests or long waitlists. Offer treatment to all those dependent on opioids, rather than limiting entry to those who are

¹¹ This brief uses the term “OST”, opioid substitution therapy. This is also known as opioid substitution treatment, opioid agonist maintenance treatment (OAMT), opioid agonist treatment (OAT), or medication-assisted treatment (MAT). Methadone maintenance therapy is also known as MMT.

injecting, who are living with HIV, or who have a documented history of previous, abstinence-based treatment.

- Make clinics accessible to clients in terms of hours, fees and location. Provide psychosocial support where needed, though not as a requirement for continued treatment. Do not share data with the police. Facilitate treatment for women (cis- and transgendered) who use drugs, including pregnant women and women engaged in sex work.
- Offer OST for as long as necessary, at a dosage level that the client indicates is effective. WHO recommends treatment of 60-120 milligrams daily of methadone or 8-24 mg of daily buprenorphine.¹² Patients receiving rifampin for TB often require higher doses of methadone, since that medicine sharply reduces the amount of methadone available in the body. Interaction between OST and certain HIV antiretrovirals may also require OST dosage adjustment.
- Make treatment voluntary, with option to stop and restart, with adequate medical support and without penalties. Time limits on treatment, or use of medicine for detoxification only, is not recommended. Urine testing is not required, but if used, should be to confirm opioid use at start of treatment or to help identify patients in need of higher doses or additional support, not as a reason for OST discontinuation.
- **Designed for scale**, to help reach the WHO/UNODC/UNAIDS target of 50% of people dependent on opioids enrolled in OST.
 - When creating national guidelines, set policies for staffing, storage or service delivery that allow for service expansion without high expense or delay.
 - Offer take-home doses for people stable on their medication, in sufficient quantity to minimize client burden and allow for work, childcare, travel or other social participation (see Box 2).
 - Consider other forms of differentiated service delivery—delivery of OST through primary care clinics, at community drop-in centers, via mobile units and at pharmacies
 - When requesting authorization to import medications, include a buffer supply, adequate time to prevent stockouts and a risk management plan in case of delivery delay, medication expiration or emergencies.

For more information on OST, see:

- UNODC, INPUD et al, 2017. [Implementing comprehensive HIV and HCV programmes with people who inject drugs](#)
- WHO (2009). [Guidelines for the psychosocially-assisted pharmacological treatment of opioid dependence](#).

¹² WHO (2009). [Guidelines for the psychosocially-assisted pharmacological treatment of opioid dependence](#) (2009)

- WHO (2014). [Guidelines for the identification and management of substance use and substance use disorders in pregnancy](#).

Box 2. Harm Reduction in a Pandemic: Lessons from COVID-19

COVID-19 forced contraction of many services and heightened risk for people who use drugs across the world. Some changes to HIV prevention and treatment, however, improved services for people who use drugs, even temporarily. These offer lessons important for future harm reduction programming.

- Initiation or extension of period for take home methadone (Cambodia, Nepal, Thailand, Vietnam).
- Lifting of limits on needles distributed and permission for “secondary distribution” to reach those unable to travel to an NSP site (Bangladesh).
- Decreased police harassment or detention in police lockup (Mexico, Russia).
- Prescription refills by phone, no longer requiring long trips to designated AIDS centres (Russia).
- Release of thousands of prisoners held for minor offenses, including people who use drugs (Kenya).
- Remote mental health support via hotlines, virtual interventions (Indonesia, Ukraine).

Overdose prevention. Opioid overdose is a primary cause of death for people who inject drugs. Naloxone, the medicine to reverse opioid overdoses, is safe, effective, easy to administer and cannot be abused. WHO recommends that the medicine—given as a nose spray (intranasal) or by injection (either in a muscle or vein) — be available to all those most likely to witness an overdose.

Naloxone availability and basic training are lifesaving. Proposals to the Global Fund should prioritize:

- **Provision of naloxone to people who inject opioids released from prison or drug-free treatment settings**, who are at particularly high risk.
- **Supply of medicine, basic training on use and communications campaigns** to raise awareness among people inject drugs, their families and peers, and emergency medical workers. Peer distribution by and for people who inject drugs is especially important.
- **Changes in regulation or law enforcement practice** to ensure that people who inject drugs and their peers face no penalties for naloxone use or possession, and that police action does not discourage use of medicine or calls for medical assistance.

Some countries use additional measures to prevent OD and other adverse events, including safe spaces and professional supervision for drug injection and on-site oxygen provision.

For more on naloxone and OD prevention, see:

- UNODC, INPUD et al (2017). [Implementing Comprehensive HIV and HCV programmes with people who inject drugs.](#)
- WHO (2014). [Community Management of Opioid Overdose](#) (2014).

1.2. Chart: Scaling Harm Reduction Programming

Whether starting, increasing or maintaining harm reduction, high-impact programming is possible. The chart below offers some key steps in planning and implementing programming for people who inject drugs.

Know your Epidemic and your Stage of Harm Reduction Programming			
	New to Harm Reduction Programming	Pilot Programming Established (all in column to left and:)	Bringing programming to scale and maintaining (all previous interventions but also:)
Assessment	<p>People who use drugs are key to understanding the drug scene and service/policy needs.</p> <p>If no bio-behavioral survey data available, use rapid assessment instead.</p> <p>Assess drug and disease prevalence and risk practices, but also environmental factors and laws/policies impacting health protections for and engagement by people who use drugs.</p> <p>Involve key stakeholders (government agencies on drugs, HIV, prisons, mental health, peer-led networks).</p> <p>Include attention to needs of women, adolescents, PLHIV, sex workers, geography.</p> <p>Protect client and data safety.</p>	<p>People who use drugs are key to the design and delivery of services, so prioritize community-based and community-led services, with adequate salary, safety and psychosocial support for peer providers.</p> <p>Broaden assessment to new neighborhoods, geographies and populations.</p> <p>Look for those missed in previous surveys (adolescents, stimulant users, rural residents).</p>	<p>People who use drugs are key to service evaluation, as well as the identification of policy barriers and practical barriers.</p> <p>Through rolling assessments, learn from those missed or excluded from existing services and identify structural barriers to approach and delivery.</p> <p>Monitor for and adjust services to address changes in drug markets and use/policy environment.</p> <p>Plan for regular HIV prevention performance reviews (including community) and accountability processes.</p>
Needle and syringe programming	Work with organizations/networks led by people who inject drugs and those	Implement staffing by and services for women who use drugs.	Secure national/provincial or municipal funding.

Know your Epidemic and your Stage of Harm Reduction Programming

	New to Harm Reduction Programming	Pilot Programming Established (all in column to left and:)	Bringing programming to scale and maintaining (all previous interventions but also:)
	<p>committed to harm reduction.</p> <p>Agree with police to not harass or arrest clients.</p> <p>Procure needles/syringes clients want –including low-dead-space or others.</p> <p>Do not require 1:1 exchange and use unique identifiers rather than names.</p> <p>Plan for safe disposal and staff/data safety.</p> <p>Set targets and timelines: plan for at least ~200 needles/syringes per person per year.</p> <p>Consult with local residents/businesses/government to educate/resolve concerns.</p>	<p>Increase reach—pharmacy vouchers, mobile/secondary distribution</p> <p>Offer full range of sterile injection equipment and materials.</p> <p>Integrate or link to hepatitis B and C, STI, mental health, TB and HIV testing and treatment.</p> <p>Make NSP available in prisons/other closed settings.</p> <p>Get political support/permission to expand (e.g. ministerial order, legal waiver, police commander authorization).</p> <p>Develop domestic funding streams and interagency working group (with participation of people who inject drugs).</p>	<p>Create mechanisms to fund NGOs and community-led networks and groups.</p> <p>Reach 90% of people who inject drugs regularly.</p>
Opioid substitution therapy	<p>Create operating procedures for clinics.</p> <p>Secure authorization to import medicine with sufficient supply/planning to avoid stockouts.</p> <p>Make requirements flexible enough to scale up easily later.</p> <p>Put treatment close to neighborhoods/“hotspots” where people use opioids.</p> <p>Eliminate collateral fees and extensive paperwork/medical requirements</p> <p>Do not share data with law enforcement.</p>	<p>Formulate national guidelines</p> <p>Allow take-home doses, in adequate supply to allow for travel, work, social participation.</p> <p>Provide psychosocial counselling for those who need, not as requirement.</p> <p>Use urine testing to confirm opioid use at start or to increase support/ or medicine dosage, not to expel clients.</p> <p>Ensure OST continuation for those in hospital, prisons, pre-trial detention.</p>	<p>Secure mechanisms to support non-governmental partners and national/municipal funding.</p> <p>Provide OST in prisons and pre-trial detention.</p> <p>Reach 50% of people who are opioid dependent.</p>

Know your Epidemic and your Stage of Harm Reduction Programming

	New to Harm Reduction Programming	Pilot Programming Established (all in column to left and:)	Bringing programming to scale and maintaining (all previous interventions but also:)
	Provide treatment for all opioid dependent: no requirement that people be injecting.	Provide OST at satellite clinics, community centres, mobile units. Integrate OST with HIV, hepatitis, STI and TB treatment. Explore pharmacy storage/delivery, offer of voluntary, long-acting OST.	
Overdose prevention	Procure and distribute OD antidote naloxone (intranasal or intramuscular). Prioritize delivery to those at highest risk—recently released from prison or abstinence-based residential treatment. Work with law enforcement to ensure no arrest for those using naloxone/calling for assistance.	Distribute naloxone to/train people who use drugs, friends and family members, police, emergency medical staff. Review/reform regulations limiting naloxone accessibility, particularly for peers, harm reduction groups. Include communications and training to widen awareness/use.	Get naloxone added to country's essential medicines. Authorize harm reduction organizations and peers to distribute and supply them with medicine. Pass laws/financing to increase access and protect those using medicine from police interference or prosecution.
HIV/HCV testing and treatment	Provide information/education to build trust/awareness among people who inject drugs. Provide free, anonymous (unique identifier) or confidential HIV and/or HCV test option. Do not share data with police or non-health staff. Ensure minimal fees and paperwork or lessen medical exam requirements to start treatment. Train peer navigators to support those starting or entering treatment.	Provide testing, treatment and harm reduction services together (one stop). Provide tailored efforts for youth, women, sex workers trans and gender-diverse people. Make testing and treatment available in prison and pre-trial detention. Provide self-testing for those unable to reach or distrustful of government clinics and those requiring frequent tests (for PrEP, HCV).	Implement network approaches (index testing, peer-driven interventions) to increase reach—but with data and safety protections. Provide antiretroviral treatment refills at community centers, harm reduction sites, etc. to reduce barriers/requirements for trips to multiple clinics. “Task shift” to enable nurses, peer navigators, and community health workers to expand reach and to reduce need for doctors/specialists.

Know your Epidemic and your Stage of Harm Reduction Programming

	New to Harm Reduction Programming	Pilot Programming Established (all in column to left and:)	Bringing programming to scale and maintaining (all previous interventions but also:)
	<p>If not yet completed, register direct acting antiviral treatments.</p>	<p>Integrate HIV, OST, HCV and TB treatment (see OST, above).</p> <p>Provide long-acting HIV treatment, on voluntary basis, to reduce burden on patients and clinics.</p> <p>Provide HCV treatment for all with active infection (except pregnant women), regardless of HIV status and without wait times, demand to see specialist, etc.</p> <p>Provide hepatitis B vaccination and treatment for those who need it.</p>	
Removing human rights-related barriers to services	<p>Integrate rights and gender programming into HIV plans/programs (including legal support at point of care, services for women and youth who use drugs).</p> <p>Reduce stigma and discrimination in health settings. End restrictions on treatment for those actively using drugs. End sharing of health data with police.</p> <p>Stop medical-police roundups or other forced HIV testing of people suspected of drug use or sex work.</p> <p>Create know-your-rights materials and link harm reduction staff and people who use drugs to legal literacy trainings</p> <p>Support assessment of and advocacy to improve harmful laws and policies, including through</p>	<p>Increase programming for violence prevention and support for women, sex workers, trans and gender-diverse people who use drugs through main shelter system and community-led efforts.</p> <p>Provide legal services joined with HIV prevention or treatment (one stop).</p> <p>Train people who use drugs and others (healthcare staff, etc) on duty of care, avoidance of stigma in health settings and other locations; monitoring and reform of rights violations</p> <p>Train those in police academies and officers in service on harm reduction and create harm reduction-friendly operating procedures.</p> <p>Support community paralegals, and street</p>	<p>Decriminalize drug use, possession of drugs for personal use and possession of harm reduction equipment</p> <p>End compulsory treatment/forced rehabilitation/detention based on forced urine testing.</p> <p>End arbitrary penalties against people who use drugs—denial of health insurance, child custody, employment or tuition support, on basis of positive drug test alone.</p> <p>Repeal requirements for registries of people who use drugs or sharing of health data with police.</p> <p>Capacitate and fund community-led groups and networks for ongoing monitoring and advocacy on</p>

Know your Epidemic and your Stage of Harm Reduction Programming			
	New to Harm Reduction Programming	Pilot Programming Established (all in column to left and:)	Bringing programming to scale and maintaining (all previous interventions but also:)
	community-led monitoring and advocacy.	lawyering to decrease arbitrary arrest and increase access to justice. Support community advocacy to remove criminal penalties, challenge compulsory treatment, loss of child custody, confidentiality violations, and others.	laws and policy formation and implementation.

Additional Prevention Interventions

Hepatitis B and C prevention, testing and treatment for people who inject drugs and people in prisons—regardless of HIV status — can be supported by the Global Fund when part of a comprehensive package of HIV programming.

- Applicants seeking funding for hepatitis B or C treatment should **make the investment case**, noting service gaps, known prevalence of HBV and HCV, and/or recent trends in infection among people who inject drugs.
- Testing should be **confidential and voluntary**.
- **Avoid fees for testing, diagnosis or treatment**, which discourage participation of people who inject drugs.
- Register and make direct-acting antiviral treatment for hepatitis C available. Recent decreases in the price of medication can **make HCV diagnosis and treatment more affordable** (<\$100 USD) even in resource-limited settings.
- WHO recommends use of **the rapid hepatitis B vaccination** (three doses in three weeks) for people who inject drugs who do not have chronic HBV.
- “The Global Fund can support **treatment of chronic hepatitis B** for people who inject drugs, as well as provision of **tenofovir to prevent vertical transmission during pregnancy**, in line with [WHO guidelines and eligibility criteria](#) .”
- WHO recommends **treatment for all people who inject drugs with active HCV infection** except those who are pregnant. There is no need to wait for possible viral clearance or to require that people stop drug use before treatment,¹³ and treatment

¹³ WHO (2022) [Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations](#)

can be effectively provided at harm reduction sites by non-specialist doctors, nurses or pharmacists.¹⁴

- **HCV self-testing** can be especially useful for people who inject drugs (see section 1.3, below) who may not feel safe at or be able to go to a health clinic regularly.

For more on testing and treatment of hepatitis B and C, please see:

- Global Fund (2022). [Prioritization Framework for Supporting Health and Longevity among People Living with HIV](#)
- WHO (2022) [Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations](#).
- WHO (2018). [Guidelines for the care and treatment of persons diagnosed with chronic hepatitis C virus infection](#).
- WHO (2015). [Guidelines for the prevention, care and treatment of persons with chronic hepatitis B infection](#).
- WHO (2012). [Guidance on prevention of viral hepatitis B and C among people who inject drugs](#).

Sexual and reproductive health (SRH) services, including condoms, STI testing and treatment. People who use drugs also have sex, and need condoms and lubricants, STI checkups and treatment, screening for human papilloma virus (HPV) and anal cancer, and a range of pregnancy and contraception services. NSP sites and drop-in centers should train staff and *integrate SRH* or develop linkages to affordable, accessible testing, treatment and care nearby.

- To reduce barriers to treatment, **syndromic STI treatment** and case management (not waiting for lab results when people show common signs and symptoms) is prioritized.
- People who use drugs, particularly women, trans and gender-diverse people report high levels of sexual violence. SRH services should include **post-violence counselling, referral and linkages to care** (including mental health, medical care and management, access to post-exposure prophylaxis for STIs and HIV (see PrEP/PEP, below), as well as voluntary forensic examination and legal services.
- Those using stimulants to facilitate sexual activity (“chemsex”) should be supported to reduce HIV risk (see “Harm Reduction for Drugs Other than Opioids,” below).

PrEP/PEP. Medication taken before HIV exposure (pre-exposure prophylaxis, or PrEP) or immediately after (post-exposure prophylaxis, or PEP) can greatly reduce the risk of getting HIV. The Global Fund supports offering PrEP or PEP to people who use drugs and their sexual partners.

¹⁴ WHO (2022). [Simplified service delivery and diagnostics for hepatitis C infection](#).

These should be **in addition to**, not as a substitute for, NSP and OST for people who inject drugs. Whether used in closed or community settings, both PrEP and PEP should be **voluntary and delivered with full, informed consent**.

- **PrEP** that is started before HIV exposure and continued during periods of HIV risk is effective for people who inject drugs.
 - Recommended forms of PrEP include **a daily oral medication** (tenofovir disoproxil fumarate), **or long-acting formulations** (dapivirine vaginal ring, long-acting injectable cabotegravir).
 - Since regular HIV testing is needed for PrEP. **self-testing** can be especially useful for people who use drugs and for their sexual partners (see section 1.3, below) who may not feel safe at or be able to go to a health clinic.
 - PrEP can be safely integrated with OST and/or NSP. **Integrating the provision of PrEP with community-based programs** is likely to be the most effective method of reaching people who inject drugs.
 - People who inject drugs and those in prisons and other closed settings have sharply higher rates of HBV and HCV infection. Since data is limited on the effects of long-acting cabotegravir for those with impaired liver function, **consider other forms of PrEP or HIV prevention for those with acute hepatitis or advanced liver disease.**¹⁵
- **PEP** involves starting oral antiretroviral treatment within 72 hours of exposure and continuing for 28 days.
 - PEP is useful for health workers, harm reduction program staff, people who use drugs and others exposed to needle stick injuries, instances of sexual intercourse unprotected by PrEP or condoms, or for other isolated instances of exposure (such as a single injection with nonsterile equipment).
 - While PEP should be offered to rape victims, additional support is also needed (see sexual and reproductive health services, above).

For more information on planning, budgeting for and delivering PrEP/PEP, see:

- WHO (2022). [Differentiated and simplified pre-exposure prophylaxis for HIV prevention](#).
- WHO (2022). [Guidelines on long-acting injectable cabotegravir for HIV prevention](#).
- WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach](#).

Health Communication and Demand Creation. With many governments and communities favouring a “zero tolerance” approach, people frequently have few sources of accurate information about drugs or ways to reduce risk of HIV or HCV while using them.

¹⁵ WHO (2022). [Differentiated and simplified pre-exposure prophylaxis for HIV prevention](#)

The Global Fund supports efforts to inform people who use drugs and their sexual partners about HIV and HCV prevention, diagnosis and treatment, and to build demand for services. The Global Fund supports efforts in both communities and in prisons, and can include:

- **Individual or community-level interventions to educate and build demand** for safer injection, safer sex, PrEP, HIV, hepatitis B and C testing and treatment, and overdose and violence protection.
- **Internet-based information, education and communications**, including social media, and efforts targeting youth, women, or trans and gender-diverse people who use drugs (with attention to data security and to not increasing risk to participants).
- **Social marketing-based information, education and communications**, including on newer approaches such as long-acting OST, PrEP and peer distribution of naloxone and NSP.
- **Venue-based outreach** at hotspots for drug use, or at clubs, festivals or other locations for youth.

Health communication is most effective when paired with approaches such as distribution of condoms and sterile injecting equipment, access to PrEP and OST, and reform of laws and policies- to help people who use drugs protect themselves, their sexual partners and their social networks.

Harm reduction for drugs other than opioids. The use of stimulant drugs and so-called “new psychoactive substances”, whether injected or not, can increase risk of the transmission of HIV, STIs and hepatitis. The use of stimulant drugs to enhance sex (often referred to as “**chemsex**” when referring to gay and other men who have sex with men, but common to many key populations) has been linked to increases in the frequency or length of sexual activity and to unprotected sex with a greater number of casual partners.

The Global Fund supports harm reduction for drugs other than opioids, and for combinations of sex and stimulant drugs. Examples include:

- **Integration of SRH, PrEP, mental health, and harm reduction for those combining sex and stimulants**, including at organizations reaching gay men and other men who have sex with men, transgender people, and sex workers. As with other harm reduction efforts, peer-led services are preferred by clients who use them.
- **Sterile needles/syringes for those injecting stimulants.**
- Information, peer education and support on **reducing risks of prolonged stimulant use** (“bingeing,” lack of sleep and food, sexual risk-taking), and work to combat stigma compounded by negative attitudes toward both drug use and sexual orientation or practices.
- **PrEP (see above) as a priority for HIV-negative people who are combining sex and drug use** in a risky manner.

For more on programming for drugs other than opioids, see:

- WHO (2022). [Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations](#)
- WHO (2022). [Rapid Assessment and Response Guide on Psychoactive Substance Use and Sexual Risk Behaviour](#)
- UNODC (2019). [HIV Prevention, Treatment, Care and Support for People Who Use Stimulant Drugs](#)

1.3. HIV Testing

Testing is the gateway to treatment for HIV, hepatitis C, STIs, and TB. Testing alone, however, is not sufficient. **The Global Fund supports testing that links people who test positive to accessible, affordable and available quality prevention and treatment** (see sections 1.1 and 1.3).

- **Testing should be voluntary and confidential**, conducted with informed consent and without sharing results with police or non-health staff. Forced HIV testing violates human rights and is not supported by the Global Fund. “Medical-police raids” involving forced HIV/drug testing, or any testing—whether in prisons or community settings—that does not inform those tested of the results also violates human rights and the Global Fund does not support them (see Box 3)¹⁶.
- Voluntary notification and testing of injection or sexual partners (“**index testing**”) **should be conducted with attention to data and participant safety** in ways that do not increase risk of arrest, violence, or discrimination for people who use drugs¹⁷.
- HIV testing using **rapid tests**, administered by laypeople with basic training, can increase access for people who use drugs in community settings.
- **Self-testing** for HIV and HCV is important for people who use drugs who may fear stigma in government clinics or who may not be able to reach them for the frequent testing required for HCV prevention or PrEP. Countries should consider distribution of self-test kits through community centres, NSP, OST sites, or online and with pharmacy vouchers. Linkages to support for those testing positive for HIV are also needed.

For more on HIV testing, see:

- WHO (2022). [Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations](#)
- WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach](#)
- WHO (2019). [WHO recommends HIV self-testing – evidence update and considerations for success](#)

¹⁶ Fully anonymous testing for HIV surveillance purposes, without collecting names or identifying information, is permissible.

¹⁷ Global Fund (2022). [HIV Information Note](#)

1.4. HIV Treatment and Retention

Managing opioid dependence, threat of arrest, and stigma in health settings, people who inject drugs face barriers at multiple points in the testing/ treatment “cascade.” Offered proper support, however, people who inject drugs experience HIV treatment benefits similar to other patients. As with OST, a key is offering **quality treatment that is easy to start, to afford, and to continue.**

The Global Fund prioritizes proposals for treatment for people who use drugs that:

- **Minimize paperwork, waiting periods, collateral fees, or multiple medical examinations** required for entry.
- **Use peer navigators** to help people to start treatment, and to remain in care.
- **Make sure health data is not shared with police** and that confidentiality is protected.
- Train and **support people who inject drugs and health workers to reduce stigma and negative attitudes** (see section 1.6, below).
- **Integrate OST, HIV, hepatitis and TB services** so patients do not have to visit many clinics (see section 2.3, below).
- Reduce burden on patients, and allow for **prescription refill at community centres, mobile clinics, harm reduction sites and pharmacies.**
- Reduce burdens on health care systems and **allow primary care doctors, nurses or community health workers to provide treatment** in settings where physicians/specialists are in short supply.

For more on HIV treatment, see:

- WHO (2022). [Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations.](#)

1.5. Harm Reduction in Prisons and Other Closed Settings

People who use drugs are a significant proportion of those in pre-trial detention, prison or other closed settings in all countries. The Global Fund prioritizes reducing imprisonment by removing criminal penalties for drug use and possession of drugs or harm reduction equipment for personal use. Drug use, and risk of HIV, hepatitis B and C, and TB continues or is elevated in prisons and other closed settings. This makes providing harm reduction, testing and treatment services in these settings particularly important.

- Programmers should plan for people in detention to have **the same access to harm reduction services as they would have outside the prison or closed setting.**
- **OST can be delivered in pre-trial detention and detention settings** and should be available without delay, including to those continuing or beginning treatment. UN experts have found denial of OST to detainees undergoing painful withdrawal

symptoms to be cruel and degrading and to rise to the level of torture in some circumstances.¹⁸

- In prison, as outside, **NGO-supported, peer-led needle syringe programming** is trusted by people who inject drugs and can be implemented safely and effectively.
- **Condoms, lubricant and SRH services** are key for people who use drugs and other prisoners/people in detention.
- TB rates are sharply higher in prisons and other closed settings, making **TB screening, preventive therapy, and treatment for those with active infection** essential for impact. Those with latent TB infection, and those with HIV and without symptoms of active TB, should be offered tuberculosis preventive therapy.
- **Women in prison should have access to the same harm reduction measures as men (adapted to their needs)**, as well as to emergency contraception and other reproductive health/pregnancy support.
- People in prison should have access to **post-violence treatment and care**, including mental health services, post-exposure prophylaxis for HIV and STIs, HBV vaccination, emergency contraception and other reproductive health support, and voluntary forensic medical examination/legal support.
- Those in state custody retain their **rights to informed consent, confidentiality and healthcare**. The Global Fund does not support testing that informs prison staff about who is infected with HIV or hepatitis but does not share information with detainees (see Box 3).
- Those released from prison are at higher risk for overdose and should be offered naloxone and referrals to community harm reduction services upon release.

Box 3. Work Not Supported by the Global Fund

- **Work inside compulsory drug detention centers.** The Global Fund has joined UNAIDS, UNODC, WHO and nine other UN agencies to call for the closure of such facilities.
- **Medical-legal raids/roundups** detaining and conducting involuntary HIV tests on those suspected of drug use or sex work.
- **Involuntary HIV testing, or HIV testing in prisons and other closed settings** that withholds results from those tested but informs prison staff.

For more on harm reduction services in prisons and other closed settings, including examples of best practice, please see:

- Global Fund (2022). [Prisons and other closed settings: priorities for investment and impact](#)

¹⁸ UNAIDS (2016). [Do No Harm: Health, Human Rights and People who use Drugs](#)

- [UNODC publications on needs assessment and implementation of harm reduction programming in prisons](#), including:
 - UNODC (2020). [HIV prevention, testing, treatment, care and support in prisons and other closed settings : a comprehensive package of interventions](#).
 - UNODC (2015). [Handbook for Starting and managing needle and syringe programmes in prisons and other closed settings](#).
- WHO (2014). [Preventing Overdose Deaths in the Criminal-justice System](#).

1.6. Removing Human Rights-related Barriers to Services

The Global Fund requires applicants seeking HIV funding for key and vulnerable populations to address human rights-related barriers to services. Applicants should describe existing barriers to services and the interventions in place to address them, as well as proposed new programming. Ending gender inequality and discrimination is a strategic priority for the Global Fund, and applicants should also include particular attention to gender analysis and gender-responsive solutions. Applicants are asked to attach assessments of human rights-related barriers, as well as gender assessments, to their funding request. Countries that are part of the Global Fund’s “Breaking Down Barriers” initiative have completed comprehensive assessments and are expected to base their funding requests on the results of the most recent assessment.¹⁹ Countries without assessments are encouraged to use the Global Fund’s new rapid assessment tool as part of the process of developing the funding request.²⁰

UNAIDS, WHO, UNDP, UNODC and the Global Fund have a set of effective, evidence-based approaches to removing human rights-related barriers to HIV services (see Box 4). **All of these are relevant for people who use drugs, and can be included in funding requests. The Global Fund considers four human rights approaches “program essentials”** and requires all applicants to provide an update on their status toward achieving these. Applicants from “Core” and “High Impact” countries will also be asked to describe how they plan to introduce or scale up all program essentials that are not yet fully implemented.

¹⁹ The 20 countries involved in the Breaking Down Barriers initiative are Benin, Botswana, Cameroon, Côte d’Ivoire, Democratic Republic of the Congo, Ghana, Honduras, Indonesia, Jamaica, Kenya, Kyrgyzstan, Mozambique, Nepal, the Philippines, Senegal, Sierra Leone, South Africa, Tunisia, Uganda and Ukraine.

²⁰ [Undertaking a rapid assessment of information on human-rights related barriers to HIV and TB services: guidance and tools](#)

Box 4. Key program areas to reduce human rights-related barriers to services for people who use drugs.

- Eliminating stigma and discrimination in all settings.
- Ensuring non-discriminatory provision of health care.
- Improving legal literacy (“know your rights”).
- Increasing access to justice.
- Ensuring rights-based law enforcement practices.
- Improving laws, regulations and policies relating to HIV and HIV/TB.
- Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity.
- Supporting community mobilization and advocacy for human rights.

Program Essential: HIV programs integrate interventions to reduce human rights- and gender-related barriers to services. People who use drugs frequently face legal problems, such as outstanding administrative fines, loss of documents and no legal address following incarceration, that make it hard for them to access health services. Women who inject drugs face high risk of HIV and violence, yet frequently are excluded from support services and have no access to gender-sensitive harm reduction. Restrictive age policies frequently mean adolescents who inject drugs have no access to information or programming for HIV prevention, despite being at substantial risk.

Building human rights and gender-sensitive programming into HIV prevention and treatment, rather than creating separate, stand-alone efforts, can decrease service barriers and increase service reach and efficiency for people who use drugs.

The Global Fund supports **integration of interventions in HIV services to end discrimination and increase equitable access** for all people who use drugs. Examples include:

- **Provision of legal services at harm reduction sites** and OST programs.
- **Inclusion at NSP programs of services for women who use drugs in all their diversity**, including efforts that help women access sterile injecting equipment rather than being “second on the needle” and injected by/after men.
- **Training and regulation reform to end exclusion of women, trans and gender-diverse people who use drugs from violence services**, shelters or support programs for women with HIV.
- **Services tailored to and targeting adolescents who use drugs in HIV prevention programming**, including virtual health education and revision of age requirements/increased provider discretion in delivering services.

Program Essential: Reducing stigma and discrimination in healthcare and other settings. Clinic staff often treat people who use drugs harshly or have policies that bar those actively using drugs from treatment. Staff may reveal the drug use or HIV status of clients to others, or alert police when people who use drugs seek healthcare. Drug dependence “treatment” frequently includes isolation, beating, or other cruel and degrading measures.

The Global Fund supports **activities to reduce discrimination and the exclusion of people who use drugs in healthcare settings**, including

- Training (ongoing, rather than one-off) for healthcare staff, including by people who use drugs, on **duty to treat, confidentiality protection and other rights**.
- Development of **community-led and other monitoring/accountability mechanisms** to document rights violations and address discrimination, confidentiality violations, and service quality for people who use drugs (including for women and adolescents).
- Advocacy to **remove discriminatory provisions** such as restrictions preventing treatment of those actively using drugs, requiring addition of patient names to police registries, or requiring reporting of drug use by family members or health authorities.

Consistent with the goals of the Global Partnership for the Elimination of HIV-related Stigma and Discrimination, the Global Fund also supports work to remove stigma in other settings.

Box 5. Rights-Respecting Law Enforcement and Harm Reduction Programming

For many people who use drugs, their main contact with government “services” is with law enforcement. People who use drugs and harm reduction program staff, particularly peer outreach staff, are often subject to arrest, forced drug tests, and/or police extortion or harassment. In some countries, people arrested for possession of relatively small amounts of drugs are sentenced more severely than those convicted of rape, murder, kidnapping or bank robbery.²¹

The Global Fund supports **development of trainings and incentive programs to increase sensitization of police and judges to harm reduction**; to decrease arrest/incarceration and to increase referral to services. This can include:

- Community-led monitoring of law enforcement abuses, sentencing patterns, arrest quotas, and punitive detention practices.
- Curriculum creation and training at police academies and for officers already in service, with participation by people who use drugs where they are safe and supported.
- Programs strengthening police engagement with harm reduction and community-led organizations, and incentives for referral to services.
- Sensitization of judges and prosecutors on the benefits of decriminalization and alternatives to incarceration, and the risks/rights violations of disproportionate sentencing and compulsory treatment.

²¹ UNAIDS (2016). [Do No Harm: Health, Human Rights, and People Who Use Drugs](#).

This includes stigma in families and communities, in the workplace, educational, emergency/humanitarian settings, and the justice system (see Box 5 and next item).

Program Essential: Legal literacy (Know your rights) and Access to Justice. People who use drugs are subjected to mob violence, denial of treatment, coerced confessions and arbitrary arrest. Many are held for months while awaiting trial or sentenced to spend years in facilities where HIV risk continues but where prevention and treatment are unavailable.

Box 6. Mobilizing and empowering people who use drugs.

The Global Fund prioritizes putting communities at the centre of health and strengthening community-based and community-led systems that link to and complement formal health services. This is particularly critical for people who use drugs, who are often excluded from or stigmatized by formal health systems and who require funding and support to build the community leadership critical to harm reduction success.

The Global Fund supports programming for people who use drugs to **build a collective sense of power and to engage and participate fully in work to achieve health and remove barriers to services**, including through:

- **Community-led monitoring**, research and advocacy on stigma and discrimination, on program implementation and service quality, and on law and policy.
- **Support for people who use drugs to organize** community roundtables, create safe spaces, and participate in trainings on HIV, human rights, sexual and reproductive health and sexuality.
- **Capacity and organizational development support for groups led by people who use drugs..**
- **Participation in technical working groups, national, provincial and local decision-making bodies** that shape harm reduction and other HIV service delivery and funding.

People who use drugs are also sex workers, gay, bisexual and other men who have sex with men, trans and gender diverse people and people in prison. Community system strengthening and rights protection work can and should intersect with other “key populations” work to improve HIV services and protect human rights.

For people who use drugs, access to justice is therefore critical to the success or failure of HIV programs.

The Global Fund supports **activities to increase the legal literacy of people who use drugs and to increase their access to justice**, including

- “Know your rights” and legal training for people who use drugs, peer outreach workers, those doing secondary needle exchange, and advocates.
- Training and salary support for community/peer paralegals and “street lawyers” working with people who use drugs.
- Creation of hotlines and other legal crisis response mechanisms for people who use drugs, peer outreach workers, and other program staff to help address arbitrary arrest, community violence, gender-based violence, and refusal of emergency or other medical support.

- Development of communications materials on legal and client rights and distribution to NSP, OST, HIV and other harm reduction and treatment programs.
- Engagement of national legal boards and legal aid providers to increase protections as well as strategic litigation to reform harmful laws and practices.

Program Essential: Support for efforts, including community-led efforts, to analyze and reform harmful laws and policies. The Global Fund — aligned with the UN common positions on [drug policy](#) and [incarceration](#) — supports strengthening the HIV response through decriminalizing drug use and possession of drug/harm reduction equipment for personal use. Criminalization increases the risk to people who use drugs, particularly those who inject, in multiple ways, discouraging use of needle and syringe programs, encouraging hurried or unsafe injection, and discouraging people from talking honestly with or receiving support from health professionals.

Other laws and policies — such as those pertaining to child removal, compulsory treatment, and prosecution of those using naloxone to reverse overdoses — also impact the health and rights of people who use drugs. The Global Fund supports programs that involve **legal reviews, action plans and advocacy to reform laws and policies that hurt the health of people who use drugs**, including:

- **Community-led monitoring** of the effects of forced urine testing, drug user registries, compulsory abstinence-based drug treatment and criminalization of drug use and possession of harm reduction equipment or drugs for personal use.
- **Activities to inform and sensitize parliamentarians, relevant ministries, and religious and traditional leaders** on the negative health and social impacts on people who use drugs of punitive laws and policies.
- **Advocacy, including community-led advocacy, for legal and policy reform**, including for decriminalization, end to compulsory treatment for drug dependence, and removal of restrictions prohibiting distribution of harm reduction information, medications or materials.

For more on planning, costing and acting to remove human rights- and gender-related barriers to services for people who use drugs, see

- Global Fund (2022). Technical brief: [Reducing human rights-related barriers to HIV services.](#)
- Global Fund (2022). [Undertaking a rapid assessment of information on human rights-related barriers to HIV and TB services: guidance and tools](#)
- [Youth LEAD, Youth RISE and Y+ \(2021\). Harm Reduction Services for Young People Who Inject Drugs.](#)
- Frontline AIDS (2020). [Implementing and scaling up programmes to remove human rights-related barriers to HIV services.](#)
- UNODC, INPUD, et al (2017). [Implementing comprehensive HIV and HCV programmes with people who inject drugs](#)

2. Investment Approach

2.1. Understand: Continue to know your epidemic and its updated resource needs.

Understanding the HIV epidemic among people who use drugs requires more than a list of drugs and estimates of numbers of people using them. Key questions include: what drug use is riskiest for HIV and what is known about the prevalence of HIV, hepatitis B and C, STIs and TB among people who use drugs? What environmental conditions and policies shape risk? Does risk vary by geographic area, age or gender? What do people who use drugs identify as their most pressing health needs and barriers?

- **Biobehavioral surveys** should include questions about drug use and HIV risk, but should also ask about experiences of stigma, discrimination, police violence and other human rights violations.
- **Assessment of laws, policies and practices contributing to/ protecting against stigma and discrimination** is essential to understanding harm reduction needs (see section 1.6).
- **Demand for complete size estimates should not delay start** of programming. If national estimates are not easily available, **rapid assessment** can help assess drug use and service needs for users of both opioids and stimulants.
- **People who use drugs remain a critically important source of information** on how programs need to evolve/improve and should be actively involved as data sources and funded, if necessary, to support their meaningful participation. This includes reaching out to people who use drugs who are not supported by current programming.
- **Needs assessment, such as hotspot mapping, should be conducted in ways that do not create risk** (of arrest, stigmatization or harassment) for people who use drugs. All collection, storage and analysis of data should ensure **protection of confidentiality and security** of health information.

For more on biobehavioral surveillance and needs assessment, see:

- WHO (2022). [Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations](#)
- Global HIV Prevention Coalition (2020). [HIV Prevention Self-Assessment Tool for People who Inject Drugs](#)
- UNAIDS (2019). [The Privacy, Confidentiality and Security Assessment Tool: Protecting personal health information](#)
- Global HIV Strategic Information Working Group. (2017). [Biobehavioural Survey Guidelines](#).

- UNDP (2014). [Legal Environment Assessment for HIV: An Operational Guide to Conducting National Legal, Regulatory and Policy Assessments](#)
- UNODC (2011). [HIV in prisons: Situation and Needs Assessment Toolkit](#)
- WHO (1998). [Rapid Assessment and Response Guide on Injecting Drug Use \(IDU-RAR\)](#)

2.2. Design: Develop a mix of interventions that maximizes impact.

Proposals for services for people who use drugs often overinvest in one aspect of harm reduction while under-resourcing other aspects. People who use drugs are often dealing with multiple health challenges, making a combination of services most effective.

The Global Fund prioritizes proposals that recognize how harm reduction approaches reinforce each other and that plan and budget for:

- **A mix of harm reduction services to protect investment and increase impact.** OST, for example, increases adherence to HIV treatment. Hepatitis C treatment for people who inject drugs is undermined if NSP programs do not provide a full range of sterile injecting equipment to prevent reinfection. Offering naloxone for OD prevention can increase uptake in HIV prevention services, and offering STI treatment at harm reduction sites can reduce risk of HIV infection.
- **Service creation after needs assessment.** Assessment makes little sense if not followed up with service provision.
- **Integration of viral hepatitis, TB, and HIV treatment with OD prevention.** People who inject drugs are at elevated risk of hepatitis B and C, TB and OD as well as being at risk of HIV infection. Integration of services, peer-led programming, and elimination of requirements that people complete one treatment before starting another increases uptake and retention. As noted in section 1.6, inclusion of legal services with health services also helps remove barriers and increase access.
- **Continuity of prevention and treatment between closed settings and the community.** People who use drugs move between community, pre-trial detention and prison, and between prisons. Programs should aim to ensure continuity of services across the different settings.
- **Gender-sensitive programming and staffing.** Women, trans and gender-diverse people who use drugs are often underserved by harm reduction despite high risks for HIV infection, gender-based violence, and, for those who are pregnant, risk of mother-to-child HIV transmission.
- **Virtual interventions** to help with outreach, health information, case management, or adherence support. These should be in addition to (not a replacement for) face-to-face services and should include privacy and data protections.

For more on comprehensive and integrated services, see:

- Global Fund (2022). [Reducing human rights-related barriers to TB services](#)

- Global HIV Prevention Coalition (2020). [Considerations in planning and budgeting for a key population trusted access platform](#)
- UNODC, INPUD et al, 2017. [Implementing comprehensive HIV and HCV programmes with people who inject drugs](#)
- WHO (2016). [Integrating Collaborative TB and HIV Services within a Comprehensive Package of Care for People Who Inject Drugs](#)
- UNODC (2016). [Addressing the Specific Needs of Women Who Inject Drugs: Practical Guide for Service Providers on Gender-responsive HIV Services](#)
- Stop TB Partnership (2015). [Key populations brief: people who use drugs](#)

2.3. Deliver: Ensure high quality and efficient service delivery for optimal scale-up.

As noted, making quality prevention, diagnosis and treatment easy to access and to

Box 7. Five human rights standards required of all Global Fund programming.

- Grant non-discriminatory access to services for all, including people in detention.
- Employ only scientifically sound and approved medicines or medical practices, in line with UN guidance.
- Do not employ methods that constitute torture or cruel, inhumane or degrading treatment.
- Respect and protect informed consent, confidentiality and the right to privacy concerning medical testing, treatment or health services rendered.
- Avoid medical detention and involuntary isolation, which, consistent with WHO guidance, are to be used only as a last resort.

Grant recipients are required to advise the Global Fund of risks to these human rights standards. The Global Fund’s independent Office of the Inspector General has a [mechanism to investigate complaints](#) regarding the standards.

continue — in terms of fees, location, and integration with other services — is critical to reaching people who use drugs. Service efficiency should be evaluated by people who use drugs, not just by the health system and staff. All services must meet the minimum human rights standards the Global Fund requires (see Box 7).

Important lessons from past Global Fund programming:

- **Requiring names, IDs, fingerprints, or other biometric scans for NSP scares away people in need**, even if it may help track numbers served or reassure government that there is not duplication of services. Use of unique identifiers can help

track services while protecting confidentiality.²¹ Medical records that include names should be confidential.

- Since OST requires regular visits, it is critical to **site services near where people who use drugs live and use**, as opposed to at a distant hospital or hard-to-reach clinic. Satellite clinics, reimbursement for transport costs, and provision through mobile units can help. Take-home doses are especially important.
- As noted in Section 1.1, **differentiated service delivery** — through pharmacies, peer visits to homes and hotspots, and community drop-in centres — is recommended. Where available, affordable and acceptable, long-acting OST offered on a voluntary basis can reduce the burden on patients and clinics.
- Effective service delivery builds on community-led networks/resources, including **peer support for starting or staying in services**, and prescription refill, testing, and medical and legal services at community drop-in centers.
- Since drug control, health, social welfare and prison authorities are all involved in responding to drug issues, **mechanisms to facilitate communication and agreement between government agencies** can be critical for problem-solving and for reducing delays.

Evaluation. Ongoing evaluation is critical to assessing impact. Key questions include how to strengthen services to those reached, who is not being reached, and the right balance of biomedical, behavioral and structural approaches. Real-time tracking of service delivery, and regular HIV prevention performance reviews (including by the community and by other partners), are recommended. Evaluation should also consider changes to the drug market, use environment, or policies shaping risk of use.

For more on planning for and evaluating efficient service delivery, see:

- Global HIV Prevention Coalition (2022). [HIV Prevention 2025: Roadmap](#).
- Global Fund (2022). Program Outcome Monitoring Tool
- Global Fund (2022). Prevention Results Framework
- UNAIDS (2021). [Establishing community-led monitoring of HIV services--Principles and process](#)

2.4. Sustain: Strengthen the sustainability of health systems.

Global Fund grants are designed for a three-year period, making it important to plan for longer-term sustainability from the start. Including programming for people who use drugs in national health and social welfare budgets involves a number of steps, including:

- Formation of national or municipal plans, and of a technical advisory group which includes people who use drugs and other key stakeholders.

²¹ APMG Health (2019). [Global Summary of Findings of an Assessment of HIV Services Packages for Key Populations in Six Regions](#).

- Clarity on what will be funded from health and what from social welfare, and mechanisms, if needed, to pool funding (e.g. creation of an interagency entity to administer services).
- Mechanisms such as “social contracting” to fund community organizations and to strengthen community-led monitoring and advocacy are critical to harm reduction success, as is the need to address structural barriers to health services for people who use drugs.

For more on budgeting for and strengthening the sustainability of health systems, please see:

- Global HIV Prevention Coalition (2022). [HIV Prevention 2025: Roadmap](#).
- Global Fund (2022). [Resilient and Sustainable Systems for Health Information Note](#)
- Global HIV Prevention Coalition (2020). [Considerations in planning and budgeting for a key population trusted access platform](#)
- UNDP (2019). [Guidance note for the analysis of NGO social contracting mechanisms: the experience of Europe and Central Asia](#).

3. Good Practice Examples

3.1. Sustaining Harm Reduction and the Right to Health in Ukraine

In Ukraine, harm reduction services have included community-based and gender-sensitive needle and syringe programming, as well as the dispensing of OST to 18,000 patients through clinics and prescriptions filled at pharmacies. Other innovations have included HIV self-testing campaigns; peer-driven interventions to connect previously unreached people who use drugs to hepatitis C and HIV services; online HIV prevention education for young people; and community paralegal training and rights defence. An estimated 67% of Ukrainians who injected drugs had been reached by harm reduction programs by 2019, with HIV prevalence among people new to injecting (< 3 years) falling from 30% to less than 7%. Harm reduction program clients with HIV were also twice as likely as other HIV-positive people who inject drugs to be enrolled in HIV treatment.

Harm reduction services—and the collaboration between the government and NGOs to deliver them—have proved resilient enough to continue even after the Russian invasion and the massive disruptions of war. There has been heavy shelling, disruption of multiple supply chains and the displacement of more than 12 million Ukrainians within and outside the country. Yet harm reduction provision—including needle and syringe programs and OST—has continued, with support from the Ukrainian government, the Global Fund and other partners.

At the outbreak of the war, the Ukrainian government moved to protect continuity of methadone and buprenorphine. The Ministry of Health amended regulations to allow take-home doses for up to a month of OST in conflict hotspots, and permitted internally displaced patients to pick up medicine from a different city. With support from the Global Fund and technical partners, OST was secured from a Ukrainian manufacturer, and additional doses were procured from outside the country. With most people who use drugs remaining in Ukraine rather than fleeing abroad, community organizations also remained. These groups supported evacuation and linkage to services, continued to deliver needle and syringe programming despite sniper fire, adapted the shelters they ran for the homeless to accommodate internally displaced Ukrainians with and without a history of drug use, and assisted with medication delivery.

The Ukrainian government had increasingly been funding HIV services from the national budget and was expected to fully cover harm reduction in 2022. With war disrupting normal operations, the Global Fund approved reprogramming of grant funds to ensure continued support to civil society groups providing HIV prevention and treatment support on the ground. This flexibility in regulation, the blending of national and international financing, and close work between government and NGOs to provide services to people who use drugs is a powerful example of country-led harm reduction in action. Because the Russian government declines to support needle and syringe programming, and outlaws use of

methadone and buprenorphine despite the evidence base for these medicines, this work was also a rebuke to the Russian invaders and an affirmation of Ukrainians' right to health.

3.2. Access to Justice and Advocacy for Law Reform in Indonesia

Lembaba Bantuan Hukum Masyarakat, a Jakarta-based NGO, has used Global Fund support to train people who use drugs (along with sex workers, transgender women and people living with HIV) as paralegals. In addition to leading discussions on rights and due process, community paralegals help to collect testimony from witnesses following arrests, visit police stations to interview detainees or help ensure their continued access to HIV medications, and, where procedural violations have occurred, to help secure their release. Paralegals and peer educators also engage in the ongoing monitoring of stigma, discrimination and violence, and work with lawyers to help pursue strategic litigation to protect due process and health. Challenges include ongoing rights violations by police toward people who use drugs, and reluctance by victims to trust the justice system or to believe that they will gain anything by speaking out.

Global Fund support has helped join this work on access to justice with broader advocacy for decriminalization. In 2019, for example, LBHM worked with UNAIDS and the Indonesian AIDS Coalition to rally public opinion against a bill that would have further criminalized drugs, as well as same-sex relations, sex work, extramarital sex, and "promotion of contraception". In addition to participating in a civil society-led social media campaign and organizing press conferences and marches outside of Parliament, LBHM met with and mobilized other civil society organizations working on behalf of groups that would be criminalized by the bill. Thousands of demonstrators took to the streets, resulting in the largest student movement in Indonesia since 1998, and deferral of the proposed legislative amendments. Ongoing advocacy and community mobilization is required, as calls by some legislators to crack down on drug use, LGBT people, and "free sex" in the name of protecting Indonesian families have continued.

List of Abbreviations

HBV	Hepatitis B virus
HCV	Hepatitis C virus
HPV	Human papilloma virus
INPUD	International Network of People who Use Drugs
NSP	Needle and syringe programming
OD	Overdose
OST	Opioid substitution therapy
PEP	Post-exposure prophylaxis
PrEP	Pre-Exposure Prophylaxis
SRH	Sexual and reproductive health
STI	Sexually transmitted infections
TB	Tuberculosis
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Resources

Global Fund

1. [HIV Information Note](#) (2022)
2. [TB Information Note](#) (2022)
3. [Modular Framework Handbook](#) (2022)
4. [Gender Equality Technical Brief](#) (2022)
5. [Key Populations Technical Brief](#) (2022)
6. [Removing Human Rights-related Barriers to HIV Services Technical Brief](#)
7. [Community Systems Strengthening \(CSS\) Technical Brief](#)
8. [Removing Human Rights-related Barriers to TB Services](#)
9. [Strengthening Community Engagement Technical Assistance](#)
10. [Strategic Framework for Data Use for Action and Improvement at Country Level 2017-2022](#)
11. [Sustainability, Transition and Co-financing Guidance Note](#) (2020)
12. [Fighting Pandemics and Building a Healthier and More Equitable World: Global Fund Strategy \(2023-2028\)](#).
13. Prioritization Framework for Supporting Health and Longevity among People with HIV
14. Prisons and Other Closed Settings: Priorities for Investment and Increased Impact
15. Program Outcome Monitoring Tool
16. Prevention Results Framework
17. [Undertaking a rapid assessment of information on human rights-related barriers to HIV and TB services: guidance and tools](#)

Global Strategies and Commitments

18. UNAIDS (2021). [Global AIDS Strategy 2021-2026](#)
19. UN General Assembly (2021). [Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030](#)
20. Global HIV Prevention Coalition (2017). HIV Prevention 2020 Road Map.
21. UNAIDS (2016). [Do No Harm: Health, Human Rights and Drugs](#).

Programmatic Guidance and Review (UN)

22. Global HIV Prevention Coalition (2022). [HIV Prevention 2025: Roadmap](#)
23. WHO (2022) [Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations](#)
24. WHO (2022). [Rapid Assessment and Response Guide on Psychoactive Substance Use and Sexual Risk Behaviour](#)

25. UNAIDS (2021). [Establishing community-led monitoring of HIV services — Principles and process](#)
26. WHO (2021). [Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach](#)
27. [Youth LEAD, Youth RISE and Y+ \(2021\). Harm Reduction Services for Young People Who Inject Drugs.](#)
28. Global HIV Prevention Coalition (2020). [Considerations in planning and budgeting for a key population trusted access platform](#)
29. Global HIV Prevention Coalition (2020). [HIV Prevention Self-Assessment Tool for People who Inject Drugs](#)
30. Global HIV Prevention Coalition (2020). [Considerations in planning and budgeting for a key population trusted access platform to deliver scaled, quality HIV prevention and treatment services and for addressing critical enablers](#)
31. UNODC (2020). [HIV prevention, testing, treatment, care and support in prisons and other closed settings : a comprehensive package of interventions;](#)
32. UNODC (2019). [HIV Prevention, Treatment, Care and Support for People Who Use Stimulant Drugs: Technical Guide](#)
33. UNAIDS (2019). [The Privacy, Confidentiality and Security Assessment Tool: Protecting personal health information](#)
34. UNDP (2019). [Guidance note for the analysis of NGO social contracting mechanisms: the experience of Europe and Central Asia \(UNDP, 2019\);](#)
35. WHO (2018). [Guidelines for the Care and Treatment of Persons Diagnosed with Chronic Hepatitis C Virus Infection](#)
36. UNAIDS (2018). [Global Partnership for Action to Eliminate All Forms of HIV-Related Stigma and Discrimination.](#)
37. UNODC, INPUD, et al (2017). [Implementing comprehensive HIV and HCV programmes with people who inject drugs](#)
38. Global HIV Prevention Coalition (2017). [Strengthening HIV Primary Prevention: Five Thematic Discussion Papers to Inform Country Consultation and the Development of a Global HIV Prevention Roadmap \(](#)
39. Global HIV Strategic Information Working Group. (2017). [Biobehavioral Survey Guidelines.](#)
40. WHO (2017). [Guidelines on Hepatitis B and C Testing](#)
41. UNODC (2016). [Addressing the Specific Needs of Women Who Inject Drugs: Practical Guide for Service Providers on Gender-responsive HIV Services](#)
42. WHO (2016). [Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection](#)
43. WHO (2016). [Integrating Collaborative TB and HIV Services within a Comprehensive Package of Care for People Who Inject Drugs](#)
44. Stop TB Partnership (2015). [Key populations brief: people who use drugs](#)
45. UNODC (2015). [Handbook for Starting and managing needle and syringe programmes in prisons and other closed settings](#)

46. UNDP (2014). [Legal Environment Assessment for HIV: An Operational Guide to Conducting National Legal, Regulatory and Policy Assessments](#)
47. UNODC (2014). [Training manual for law enforcement officials on HIV service provision for people who inject drugs](#)
48. WHO (2015). [Guidelines for the prevention, care and treatment of persons with chronic hepatitis B infection.](#)
49. WHO (2014). [Preventing Overdose Deaths in the Criminal-justice System](#)
50. WHO (2014). [Guidelines on Community Management of Opioid Overdose](#)
51. UNODC, ILO, WHO, UNAIDS (2013). [HIV Prevention, Treatment and Care in Prisons and Other Closed Settings: A Comprehensive Package of Interventions](#)
52. WHO, UNAIDS (2010). [Guidelines on Estimating the Size of Populations Most at Risk to HIV](#)
53. WHO (2012). [Guidance on prevention of viral hepatitis B and C among people who inject drugs](#)
54. UNODC (2011). [HIV in prisons: Situation and Needs Assessment Toolkit](#)
55. WHO (2009). [Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence](#)
56. WHO (2007). [Guide to Starting and Managing Needle and Syringe Programmes](#)
57. WHO (2004). [Evidence for Action: Effectiveness of Community-based Outreach in Preventing HIV/AIDS among Injecting Drug Users](#)
58. WHO (1998). [Rapid Assessment and Response Guide on Injecting Drug Use \(IDU-RAR\)](#)

Additional Resources

59. INPUD (2022). [Key Populations' Values and Preferences for HIV, Hepatitis and STI services: A Qualitative Study](#)
60. Harm Reduction International (2020); [Making the investment case: Cost-effectiveness evidence for harm reduction](#)
61. APMG Health (2019). [Global Summary of Findings of an Assessment of HIV Services Packages for Key Populations in Six Regions.](#)
62. Global Network of People Living with AIDS (2018). [People Living with HIV Stigma Index 2.0](#)
63. European Monitoring Centre for Drugs and Drug Addiction (2017). [Drug Consumption Rooms: An Overview of Provision and Effectiveness](#)
64. INPUD (2015). [An Introduction to Pre-Exposure Prophylaxis \(PrEP\) for People Who Inject Drugs](#) (2015).