The public health imperative for rights-based drug control policy:
A statement for the
UN General Assembly Special Session on the World Drug Problem

The Global Fund to Fight AIDS, Tuberculosis and Malaria
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The Global Fund to Fight AIDS, Tuberculosis and Malaria welcomes the UN General Assembly Special Session on the world drug problem as an opportunity to bring public health and human rights concerns to the center of drug control policy.

The Global Fund was created as a partnership. Working together, over the past 15 years, we have contributed to great progress in the fight against HIV, as well as TB and malaria. Through a collective effort, combining the contributions of governments, civil society, the private sector and affected communities, the Global Fund disburses nearly $4 billion per year to support local programs that prevent infections and the premature deaths of millions of people from HIV, TB, and malaria.

The HIV response over the past 15 years has been tremendous. In 2000, there was no global public health response to the HIV epidemic. In 2016, almost every country around the world is implementing prevention and treatment programs. Just as important, there is widespread recognition that HIV discriminates, and does not affect people equally. The community of people who use drugs in all their diversity, including women, men, trans* and young people, have been left behind in the global response.

To end the HIV epidemic, we must do more to prevent HIV and other infections among people who use drugs, and ensure that those living with HIV and other infections have access to care, treatment and support. We need to recognize that the level of criminalization, discrimination, and violence that people who use drugs face, can only result in driving risk-taking behaviors, including in detention settings, excluding them from the social and health support systems they need. We must move toward treating everyone, including people who use drugs, as fellow human beings.

As a health financing institution that aims to invest in evidence- and rights-based programs that provide the greatest value for money, we add our voice to that of our technical partners, in particular, UNAIDS and WHO, and express our concern that current drug control policy undermines, rather than supports, the reach and impact of health programs for people who use drugs. Experience and evidence show that the International Community could do much better and dramatically improve health and human rights outcomes.

Opportunities and solutions

The UNGASS on the world drug problem has the opportunity to rethink policies that undermine health programs and to shape drug policy that will facilitate good health outcomes. Good drug policy can help in many ways, including:

- by ensuring adequate investment in essential, cost-effective health services for people who use drugs, including comprehensive HIV, TB, and Sexual and Reproductive Health services;
- by supporting the meaningful participation of people who use drugs in health programs; and
- by ensuring that resources are used for programs that minimize health harms and protect human rights, rather than incarceration of large numbers of people who use drugs.

Essential HIV and TB services for people who use drugs[1]: A large body of evidence shows that needle and syringe programs (NSP) and opioid substitution therapy (OST) are among the most effective and cost-effective prevention and treatment programs in the world – and among the most widely evaluated. (See annex to this statement for a summary of some key research.) People who inject drugs readily utilize harm reduction services when programs are welcoming and non-judgmental. NSP services have the additional benefit of refering people who wouldn't attend mainstream services to other services to address and manage their health and social needs. Many countries have found that NSP yield significant returns on investments, over reduced burden of HIV care on health systems. OST is a not only highly effective in treating opioid dependence but also helps prevent HIV and hepatitis as well as overdose by reducing the frequency of injecting[2]. OST also reduces crime and social instability. Investment in NSP and OST – combined with HIV treatment for people living with HIV who use drugs – is good public health practice, fiscally responsible, and part of the fulfillment of states' human rights obligations to their citizens. NSP and OST services in prisons and in the community are both crucial.

Although data are incomplete, evidence also suggests a substantial and growing population of women injecting drugs worldwide. Women and men have different experiences of injecting drug use and related risks and harms. Even within a community that faces high levels of violence and social exclusion, gender shapes the way people access and receive services. As a result, women who use drugs have significantly higher rates of morbidity and mortality ascompared to their male counterparts, and in particular higher rates of HIV infection. Gender sensitive harm reduction programs are therefore critical to ensure equitable access to services and to address the significant overlap between gender, drug use, sex work, and non-conforming gender identities. The Global Fund urges member states to deal with the issue of gender in the context of drug use as key to ensuring equitable access to services as part of their obligation to their citizens [3].

In spite of the preponderance of public health and economic evidence for harm reduction interventions, including some notable examples from programs implemented with Global Fund

[1] WHO, UNODC and UNAIDS. Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users (WHO, 2009; revision, 2012)

[2] Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence (WHO, 2009).
[3] Women who inject drugs and HIV: addressing specific needs. UNODC, UN Women, WHO, INPUD, 2014.

resources [4], investment in them remains far too low, particularly from national resources, and reliance on external resources such as the Global Fund is unsustainable in the long-term. As a result, a very small percentage of people who use drugs in the world have regular access to NSP and OST; and it is estimated that up to 86% of people who inject drugs who are living with HIV lack access to antiretroviral therapy.[5] The Global Fund urges member states at the UNGASS to support drug policies that enable scale-up of these services.

In some countries, people who use drugs are still held in centers purporting to provide "treatment" or "rehabilitation," with widely reported violations of human rights, little or no judicial process or medical evaluation of those held, and no evidence of effectiveness. In 2012, twelve UN agencies called for the closure of all compulsory treatment facilities, including compulsory drug detention centers. The Global Fund has made repeated calls for the closure of drug detention centers while expressing concerns that those detained illegally within them must not be denied access to essential health care. In October 2014, the Global Fund Board decided that the Global Fund would not fund any interventions in compulsory drug detention centers. The Global Fund urges member states at the UNGASS to call for the immediate closure of all drug detention centers, in line with the call made by the United Nations in 2012.

People who inject drugs are also at **high risk of TB** in many settings, and HIV and TB co-infection is very high among them. As WHO experts note, criminalization and penalization of minor drug offenses undermine national TB responses.[6] [7] People who use drugs who fear that seeking health services will put them in the path of the police are less likely to be reached by TB testing or to complete treatment. Moreover, prison and pretrial detention are very high-risk environments for TB and multi-drug-resistant TB (MDR-TB) in many countries. Overcrowding and poor sanitation and ventilation in prisons contribute to the risk of airborne transmission, and access to testing and treatment is often limited. Global Fund-supported programs have shown that the high TB risks in the prison environment can be effectively addressed by sustained investment in prevention and care, especially when there is continuity of services between prisons and the community.[8]

Meaningful participation of people who use drugs in policy and programs: It is a crucial lesson from 35 years of HIV advocacy and programs that the meaningful participation of people affected by the disease is an essential element for success of health programs. The Global Fund is committed to encouraging program planning, implementation and evaluation processes in which people who use drugs participate significantly where they are affected by HIV, TB or

[4] Good pratcitices in Europe: HIV prevention for people who inject drugs implemented by the International HIV/AIDS Allieance in Ukraine, World Health Organization Europe, 2014.
[5] UNAIDS. A public health and rights approach to drugs. Geneva, 2015.
[6] Getahun H, Baddeley A, Raviglione M. Managing tuberculosis in people who use and inject illicit drugs. *Bull World Health Organ* 2013; **91**(2): 154-6.
[7] Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, World Health Organization, 2014.
[8] Lee D, Lal SS, Komatsu R, Zumla A, Atun R. Global fund financing of tuberculosis services delivery in prisons. *J Infect Dis* 2012; 205 (Supp 2): S274-83.

malaria.[9] We adhere to this goal because we know that programs will be better utilized, more effective and more sustainable when they emerge from processes in which the voices of people most affected by the diseases are meaningfully heard. Currently, drug policies in many countries make this kind of participation very difficult. (See annex for examples of HIV and TB programs in which people who use drugs were meaningfully engaged.)

Better use of resources: As UNAIDS, WHO and UNODC have stated, finding alternatives to incarceration for minor, non-violent drug offenses would greatly lower HIV risk for people who use drugs and improve opportunities for reaching this population with comprehensive HIV services,[10] and the same is true of TB. As a health financing institution that strives to provide the best value for money, we are mindful that this would also free up much needed resources for our collective efforts to end the HIV and TB epidemics.

Conclusions

Consistent with the strategic directions for 2017-2022 that were recently adopted by the Global Fund's Board and the recommendations of the Global Fund's technical partners, we urge the delegates to the UNGASS to endorse drug policies that:

- Enable investment in and scaling up of comprehensive HIV prevention,care and support for people who use drugs, as defined in the *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*[11].
- Respect, protect and fulfill the right of people who use drugs to participate meaningfully in decision-making on programs and policies affecting them; and
- Remove legal, judicial and law enforcement barriers to health services for people who use drugs.

Only if we move towards drug policies that support these aims will we be able to end the HIV and TB epidemics.

ANNEX
The case for policies that support comprehensive prevention, care and harm reduction and meaningful participation of people who use drugs (PWUD)

I. Evidence for comprehensive HIV services for PWUD

Needle and syringe programs: Needle and syringe programs (NSP) provide ready access to clean injecting equipment and in many places also link PWUD to other health services. Political resistance to NSP has sometimes centered on the erroneous idea that they encourage drug use. But an extensive review by the World Health Organization (WHO) found that NSP are highly effective in HIV prevention without encouraging more frequent injection or initiation of drug

[9] Global Fund to Fight HIV, TB and Malaria. Key populations action plan 2014-2017. Geneva, 2014.
[10] UNAIDS, A public health and rights approach to drugs, op. cit.
[11] See supra, note 1.

use.[12] A 2014 meta-analysis estimated that HIV transmission decreased by 58% when people had access to NSP.[13] WHO and many researchers conclude that NSP more than pay for themselves – and rapidly – largely because of infectious disease averted.[14] The government of Australia estimated that over time investment in NSP had a 27-fold yield mostly in cost savings from preventing both HIV and hepatitis.[15]

Opioid substitution therapy: OST, described above, is the treatment for drug dependence with the longest record of success. It is also a central element of HIV (and hepaitis C) prevention because it stabilizes opioid craving and eliminates the need for injection. WHO notes that the benefits of OST are not only in HIV transmission averted but also in reduction in opioid overdose [16], relapse and harms of injection, as well as reduction in crime and improved productivity when OST patients are able to resume productive work.[17] One meta-analysis found a 50% reduction in HIV risk associated with OST.[18] For people who live with HIV and with opioid dependence, OST also improves their adherence to HIV treatment.[19]

Antiretroviral therapy (ART): Outside sub-Saharan Africa, about one third of new HIV infection is linked to unsafe injection.[20] ART for HIV has the effect of both a life-saving treatment and a means of HIV prevention since it lowers the viral load in the blood and makes transmission less likely. This so-called treatment as prevention is difficult to study among PWUD because they are systematically excluded from ART in so many places,[21] a violation of their rights that is counter-productive on public health and economic grounds. Experiences from a wide range of countries shows that ART for people who actively use drugs is both effective and cost-effective in reducing HIV morbidity and mortality.[22]

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[12] Wodak A, Cooney A. Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users. Geneva: World Health Organization; 2004.

[13] Aspinall EJ, Nambiar D, Goldberg DJ, et al. Are needle and syringe programmes associated with a reduction in HIV transmission among people who inject drugs: a systematic review and meta-analysis. *Int J Epidemiol* 2014; 43: 235-48.

[14] Wilson DP, Donald B, Shattock AJ, Wilson D, Fraser-Hurt N. The cost-effectiveness of harm reduction. *Int J Drug Policy* 2015; 26 Suppl 1: S5-11.

[15] Government of Australia, National Centre in HIV Epidemiology and Clinical Research. Return on investment 2: evaluating the costeffectiveness of needle and syringe programs in Australia. Canberra; 2009.

[16] Community management of opioid overdose, World Health Organization 2014

[17] World Health Organization, United Nations Office on Drugs and Crime, UN Joint Programme on HIV/AIDS. Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention. Geneva; 2004.

[18] MacArthur GJ, van Velzen E, Palmateer N, et al. Interventions to prevent HIV and Hepatitis C in people who inject drugs: a review of reviews to assess evidence of effectiveness. *Int J Drug Policy* 2014; **25**: 34-52

[19] Wolfe D, Carrieri MP, Shepard D. Treatment and care for injecting drug users with HIV infection: a review of barriers and ways forward. *Lancet* 2010; **376**: 355-66.

[20] UNAIDS. On the fast track to end AIDS by 2030: focus on location and population. Geneva, 2015, p 101.

[21] Degenhardt L, Mathers BM, Wirtz AL, et al. What has been achieved in HIV prevention, treatment and care for people who inject drugs, 2010–2012? Rview of the six highest burden countries. *Int J Drug Policy* 2014; **25**: 53-60.

[22] Wolfe et al., op.cit.; Long EF, Brandeau ML, Galvin CM, et al. Effectiveness and cost-effectiveness of strategies to expand antiretroviral therapy in St. Petersburg, Russia. *AIDS* 2006;20(17):2207-15.

Combined HIV interventions: A number of studies have shown that NSP and OST together may have a synergistic effect in lowering HIV transmission risk, and an even greater effect when ART is in the picture.[23] Remarkably, even if coverage of NSP and OST are under 50%, over time they can reduce HIV transmission very significantly.[24]

HIV services in prison [25][26]: PWUD are over-represented in prisons in many settings. People in state custody have a right to health services that are the equivalent of those available in the community. Drug use and drug injection occur in prisons, though their existence is often officially denied. Only a few countries in the world provide sterile injection equipment to prisoners, though this is a very effective HIV prevention intervention. OST in prison also has excellent results, but relatively few countries offer it to prisoners. Forcing OST patients to discontinue this treatment in prison can add to the risk of overdose both in prison and upon release.[27] Condoms are also not provided in most countries

II. Program success in HIV and TB through meaningful engagement of people who use drugs

Moldova, like a number of countries in eastern Europe, has had to face the challenge of relatively widespread drug injection and high rates of HIV transmission linked to unsafe injection. Global Fund has supported a pragmatic NSP intervention in prisons made possible with both visionary leadership on the part of some officials and truly meaningful participation of PWID in prison. The needle exchange in Moldovan prisons was originally run by prison staff, but uptake was low because people feared revealing themselves as PWID to wardens and guards.[28] The prison authorities took a chance on what seemed to be a radical solution – let prisoners themselves manage the program. With support from a local NGO with expertise in prison health programs, volunteers were trained among the prisoners, and PWID were able to get both injection equipment and information on HIV from their peers. The program is now in all of Moldova's prisons, and HIV prevalence in prison has declined significantly since its expansion.[29]

It has often been challenging to extend TB services to PWUD who may be marginalized and hidden, as well as poorly housed and not linked to many sources of information about health care and prevention. In the Russian Federation has the third highest national burden of MDR-TB

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[23] Degenhardt L, Mathers B, Vickerman P, Rhodes T, Latkin C, Hickman M. Prevention of HIV infection for people who inject drugs: why individual, structural, and combination approaches are needed. *Lancet* 2010; **376**: 285-301.
[24] Vickerman P, Platt L, Jolley E, Rhodes T, Kazatchkine MD, Latypov A. Controlling HIV among people who inject drugs in Eastern Europe and Central Asia: Insights from modelling. *Int J Drug Policy* 2014; **25**: 1163-73.
[25] *WHO Evidence for Action Series, 2007: Effectiveness of interventions to address HIV in prisons*.

[26] Ralf Jürgens, Andrew Ball, Annette Verster, Interventions to reduce HIV transmission related to injecting drug use in prison, The Lancet, 2009 DOI: http://dx.doi.org/10.1016/S1473-3099(08)70305-0

[27] Rich JD, McKenzie M, Larney S et al. Methadone continuation versus forced withdrawal on incarceration in a combined US prison and jail: a randomized, open-label trial. *Lancet* 2015; 386(9991):350-9.
[28] Hoover J, Jürgens R. Harm reduction in prison: the Moldova model. New York: Open Society Institute, 2009.
[29] Doltu S. Presentation to the UNAIDS Programme Coordination Board. Geneva, 2015. http://www.unaids.org/sites/default/files/media_asset/20151012_UNAIDS_PCB37_15-21_EN.pdf.

in the world, and PWUD and people in prison and pretrial detention – populations that overlap significantly – face very high TB risk.[30] A Global Fund-supported program called Sputnik, led by the NGO Partners in Health in Tomsk, Russia, pioneered an approach to TB care for PWUD based on giving patients control over the logistics of treatment – asking them to specify times and places that work for them rather than requiring them to conform to arbitrary treatment schedules. Sputnik has resulted in reduced TB mortality, lower prevalence of MDR-TB and high rates of completed treatment.[31] While this form of treatment "accompaniment" is more expensive than fixed-site, fixed-schedule care, it more than pays for itself in lives saved and lower disease burden on the health system.

[30] Keshavjee S, Sweeney C, Yedilbayev A, Taran D, Solovyova A, Gelmanova I. The Sputnik Initiative: Patient-centered accompaniment for tuberculosis in Russia. *Partners in Health Reports* 2014; **1**(2).
[31] Ibid.