

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)

Comprehensive HIV Prevention for People Who Inject Drugs, Revised Guidance

July 2010

Introduction

Section 104A of the Foreign Assistance Act, as added by the U.S. Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003 (P.L. 108-25), authorizes the President's Emergency Plan for AIDS Relief (PEPFAR) to conduct HIV/AIDS prevention through activities "to help avoid substance abuse and intravenous drug use that can lead to HIV infection." PEPFAR developed an initial policy guidance document and made it available in 2006 to USG field staff.¹ The 2006 guidance described the scope of U.S. Government (USG) HIV/AIDS prevention-focused activities for injection drug users (IDUs).²

In July 2008, the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act of 2008 (P.L. 110-293) was signed into law.³ This law reauthorized PEPFAR and renewed support for efforts to target IDUs, particularly in partner countries where the HIV/AIDS epidemic is prevalent among this at-risk population. For example, the Act calls on PEPFAR to work "with partner countries in which the HIV/AIDS epidemic is prevalent among injecting drug users to establish, as a national priority, national HIV/AIDS prevention programs."⁴

This document serves as an update to the previous policy and technical guidance on the development of HIV/AIDS prevention-focused programs for IDUs in an effort to reduce their risk of HIV acquisition and transmission. PEPFAR supports a comprehensive HIV prevention package for IDUs which includes the following three central elements: (1) community-based outreach programs; (2) sterile needle and syringe programs (NSPs); and (3) drug dependence treatment, including medication-assisted treatment (MAT)⁵ with methadone or buprenorphine and/or other effective medications as appropriate, based on the country context.

These elements are consistent with the recommendations of the Institute of Medicine (IOM) of the National Academy of Sciences, which assessed evidence-based HIV

¹ The initial guidance document directed PEPFAR to support partner country leadership to address this issue primarily in three areas, namely: 1) offering HIV-infected drug users a comprehensive HIV/AIDS treatment program to reduce the risk of transmission; 2) supporting addiction treatment programs as an HIV prevention measure; and 3) tailoring comprehensive HIV/AIDS prevention programs to help drug users stop using drugs, change their risk behaviors, and reduce their risk for acquiring or transmitting HIV infection. From its inception, PEPFAR has supported all aspects of the comprehensive package of services outlined by UNAIDS, WHO and UNODC with the exception of needle and syringe programs (NSPs).

² The term IDUs can be used interchangeably with People Who Inject Drugs (PWID).

³ The Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act of 2008, P. L. 110-293 July 2008. Available at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:h5501enr.txt.pdf.

⁴ P.L. 110-293, Section 102(2)(F)(X).

⁵ Medication-assisted treatment is also referred to as opioid substitution therapy, which is more commonly used in international literature.

prevention strategies for IDUs in high-risk countries.⁶ These three strategies have also been endorsed by the U.S. Department of Health and Human Services/Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and other public health institutions. PEPFAR also supports additional elements of a comprehensive strategy, and these are identified later in this guidance.

Drug Use and the Risk of HIV Transmission

The burden of HIV disease among IDUs is significant and expanding. There are approximately 16 million IDUs worldwide, with an estimated 3 million living with HIV; of those infected with HIV, 32% live in Eastern Europe, and 22% reside in East and Southeast Asia.⁷ Among IDUs, HIV and other blood-borne infections, such as hepatitis B (HBV) and hepatitis C (HCV), are spread primarily through risk behaviors related to multi-person reuse (sharing) of contaminated syringes and drug injection equipment. It is estimated that there are over 5 million IDUs in 13 PEPFAR bilaterally-supported countries with drug-driven or emerging HIV epidemics.⁸ Within these 13 countries, an estimated 0.8 million IDUs are HIV-positive.⁹ Also of note is the estimate that in some PEPFAR countries, as many as 30% of IDUs are female. Recently emerging twin epidemics of both injecting drug use and HIV infection among IDUs are present in sub-Saharan Africa.^{10,11}

Male and female IDUs are not only at risk for acquiring and transmitting HIV through the sharing of drug injection equipment, but also through high-risk sexual behaviors, including but not limited to unprotected sex and engaging in sexual behaviors under the influence of drugs or in exchange for drugs.¹² This vulnerability underscores the need for responsive programming so that we can better meet the specific and comprehensive needs of both male and female IDUs. Of additional concern is the potential bridging effect, whereby an epidemic, initially fueled by the sharing of contaminated injecting equipment, is spread through sexual transmission from IDUs to non-injecting populations and through perinatal transmission to newborns. This is particularly

⁶ Institute of Medicine. (2007). *Preventing HIV Infection among Injecting Drug Users in High Risk Countries: An Assessment of the Evidence*. Washington, DC: National Academies Press.

⁷ Mathers, B., et al. (2008). Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. *The Lancet*, 372(9651), 1733-1745.

⁸ The thirteen countries referenced here are: Cambodia, China, Indonesia, Vietnam, Georgia, Kazakhstan, Kyrgyzstan, Russia, Tajikistan, Ukraine, Kenya, Tanzania, and South Africa.

⁹ Needle, R., & Zhao, L. (2010). *HIV Prevention among Injection Drug Users: Closing the Coverage GAP, Expanding Access, and Scaling up Core Interventions*. Washington, DC: CSIS Global Health Policy Center.

¹⁰ Needle, R., & Kroeger, K., et al. (2006). Substance abuse and HIV in sub-Saharan Africa: introduction to the special issue. *African Journal of Drug & Alcohol Studies*, 5(2), 83-91.

¹¹ Reid, S. (2009). Injection drug use, unsafe medical injections, and HIV in Africa: a systematic review. *Harm Reduction Journal*, 6(24).

¹² Institute of Medicine. (2007). *Preventing HIV Infection among Injecting Drug Users in High Risk Countries: An Assessment of the Evidence*. Washington, DC: National Academies Press.

concerning in countries where sexual partner networks are highly interconnected.¹³

For IDUs, access to HIV prevention services, including treatment and care for their drug use, has been sub-optimal in low- and middle-income countries and in some developed countries. The report referenced above on NSPs, MAT and anti-retroviral therapy (ART) in thirteen PEPFAR countries found that coverage for each of the interventions is extremely low.¹⁴ Access to and receipt of ART by IDUs remains disproportionately low relative to the burden of HIV they experience in most of these thirteen countries. In some developing countries, IDUs not only have poor access to ART, but they also tend to begin ART later, at a more advanced stage of infection than other groups, resulting in poorer treatment outcomes.

Evidence-Based HIV Prevention for IDUs

Scientific evidence supports a comprehensive package of structural, biomedical and behavioral interventions as the optimal HIV prevention strategy for reducing HIV incident infections among IDUs.^{15,16,17} The *WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*¹⁸ is increasingly being used by countries as a framework for developing a comprehensive package of core public health interventions and as a guiding resource for setting targets and identifying key indicators to monitor the availability, coverage, quality and impact on HIV prevalence of the comprehensive prevention package.¹⁹ There is strong evidence that these interventions, implemented in a variety of settings (including a range of closed settings)²⁰, are effective in reducing risk behaviors, preventing HIV infections, and accessing essential care and treatment services for IDUs.²¹ The *Technical Guide* has been explicitly endorsed by the UN in multiple venues including the Commission on Narcotic Drugs²², the UNAIDS Program

¹³ IBID

¹⁴ Needle, R., & Zhao, L. (2010). Closing the coverage gap, expanding access and scaling up HIV prevention core interventions for injection drug users in PEPFAR countries, 2009-2013. *In press*.

¹⁵ Institute of Medicine. (2007). *Preventing HIV Infection among Injecting Drug Users in High Risk Countries: An Assessment of the Evidence*. Washington, DC: National Academies Press.

¹⁶ Piot, P., Bartos, M., Larson, H., Zewdie, D., & Mane, P. (2008). Coming to terms with complexity: a call to action for HIV prevention. *The Lancet*, 372(9641), 845-859.

¹⁷ World Health Organization, United Nations Office on Drugs and Crime, United Nations Programme on HIV/AIDS. (2009). *WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*. Geneva: WHO/UNAIDS/UNODC.

¹⁸ Available at: <http://www.who.int/hiv/pub/idu/targetsetting/en/index.html>.

¹⁹ IBID

²⁰ UNODC/WHO/UNAIDS Publication, HIV and AIDS in Places of Detention: a toolkit for policymakers, program managers, prison officers and health care providers in prison settings, 2008.

²¹ Jürgens, R., Ball, A., & Verster, A. (2009). Interventions to reduce HIV transmission related to injecting drug use in prison. *The Lancet Infectious Diseases*, 9(1), 57-66.

²² 52nd Commission on Narcotic Drugs, Political Declaration (E/2009/28) para 20.

Coordinating Board²³, and the Economic and Social Council (ECOSOC) of the UN General Assembly²⁴. Country teams should reinforce this broad scientific and political endorsement as they seek to work with partner country governments to develop or strengthen national programs for IDUs. The core interventions, as outlined in the *Technical Guide*, should include a combination of the following HIV prevention interventions and strategies, and they should be carried out in a manner consistent with human rights obligations²⁵:

- Community-based outreach;²⁶
- NSPs;
- Opioid substitution therapy (OST) and other drug dependence treatment;
- HIV counseling and testing (HCT);
- ART for IDUs living with HIV;
- Prevention and treatment of sexually transmitted infections (STIs);
- Condom programs for IDUs and their sexual partners;
- Targeted information, education and communication (IEC) for IDUs and their sexual partners;
- Vaccination, diagnosis and treatment of viral hepatitis²⁷; and
- Prevention, diagnosis and treatment of tuberculosis.

The USG supports progress towards the implementation of a comprehensive package of services. This guidance focuses on three core prevention interventions specific to HIV prevention among IDUs, including community-based outreach, NSPs, and MAT. PEPFAR country teams should seek to build the capacity of countries to implement these core prevention interventions. Teams are encouraged to consider support and wraparound linkages to other related partner country services such as economic development, reproductive health/family planning services for female IDUs, or meaningful economic rehabilitation services as appropriate. Teams may include drug rehabilitation programs in HIV prevention activities.

Community-Based Outreach

Outreach workers reach at-risk populations and deliver services in a range of settings, including but not limited to streets, storefronts, mobile vans, and other places where IDUs often congregate. Supported by WHO, UNODC, and UNAIDS,

²³ 24th UNAIDS Programme Coordinating Board Meeting (June 2009), Decisions, Recommendations and Conclusions, paras 8.1, 8.5 and 8.9.

²⁴ Economic and Social Council Resolution E/2009/L.23, adopted 24 July 2009, para 19

²⁵ United Nations. (2006). United National General Assembly Political Declaration on HIV/AIDS. New York: United Nations.

²⁶ WHO does not include community-based outreach as a separate intervention in the comprehensive package; however, it is recommended as an extraordinarily effective method of overcoming challenges related to accessing populations of PWIDs.

²⁷ To date, there has been only limited programmatic attention to screening, diagnosis and treatment for viral hepatitis in partner countries with PEPFAR support.

community-based outreach is an effective strategy for reducing drug- and sex-related risk behaviors because it increases access to and uptake of HIV prevention information, HCT, important risk-reduction skills and materials (condoms, clean needles and syringes, etc.), and provision of overdose prevention medication. In addition, community-based outreach successfully links IDUs to additional HIV prevention services such as MAT, HCT, and HIV care and treatment.^{28,29,30,31}

Needle and Syringe Programs

Studies have shown that NSPs result in marked decreases in drug-related risk behavior (e.g., sharing of injection equipment, unsafe injection practices and frequency of injections), by as much as 60%,³² and decreases in HIV transmission, by as much as 33-42% in some settings.^{33,34} Consistent findings from evaluation studies of NSPs reveal that these programs increase the availability of sterile injection equipment, reduce the quantities of contaminated needles and other injection equipment in circulation, reduce the risk of new HIV infections, and result in referrals to other services, such as ART for those eligible and HCT.^{35,36,37,38} Additionally, findings from a range of studies indicate that NSPs *do not* increase the numbers of persons who begin to inject drugs or increase the frequency of drug use.^{39,40,41,42}

²⁸ WHO, UNAIDS, UNODC. (2004) *Policy Brief: Reduction of HIV Transmission Through Outreach*

²⁹ Needle, R., et al. (2005). Effectiveness of Community-Based Outreach in Preventing HIV/AIDS Among Injecting Drug Users. *International Journal of Drug Policy*, 16S. S45-S57.

³⁰ Medley, A., et al. (2009). Effectiveness of peer education interventions for HIV prevention in developing countries: A systematic review and meta-analysis. *AIDS Education and Prevention*, 21, 181-206c.

³¹ Institute of Medicine. (2007). *Preventing HIV Infection among Injecting Drug Users in High Risk Countries: An Assessment of the Evidence*. Washington, DC: National Academies Press.

³² IBID

³³ Wodak, A., & Cooney, A. (2006). Do needle syringe programs reduce HIV infection among injecting drug users: a comprehensive review of the international evidence. *Substance Use and Misuse*, 41, 777-813.

³⁴ World Health Organization. (2004). *Evidence for action on effectiveness of needle syringe programmes in HIV prevention*. Geneva: WHO.

³⁵ Institute of Medicine. (2007). *Preventing HIV Infection among Injecting Drug Users in High Risk Countries: An Assessment of the Evidence*. Washington, DC: National Academies Press.

³⁶ Wodak, A., & Cooney, A. (2006). Do needle syringe programs reduce HIV infection among injecting drug users: a comprehensive review of the international evidence. *Substance Use and Misuse*, 41, 777-813.

³⁷ Normand, J., Vlahov, D., & Moses L. (1995). *Preventing HIV transmission: the role of sterile needles and bleach*. Washington, DC: National Academy Press.

³⁸ Farrell, M., et al. (2007). Effectiveness of drug dependence treatment in HIV prevention. *International Journal of Drug Policy*, 18, 271-280.

³⁹ Cox, G., et al. (2000). Syringe exchanges: A public health response to problem drug use. *Irish Medical Journal*, 93(5), 143-146.

⁴⁰ Gibson, D., et al. (2002). Two to sixfold decreased odds of HIV risk behavior associated with use of syringe exchange. *JAIDS*, 31(2), 237-242.

⁴¹ Hart, G., et al. Evaluation of needle exchange in central London: Behavior change and anti-HIV status over one year. *AIDS*, 3(5), 261-265.

⁴² Marmor, M., et al. (2000). Drug injection rates and needle-exchange use in New York City, 1991-1996. *Journal of Urban Health*, 77 (3), 359-368.

PEPFAR-supported NSPs can include the distribution of injection equipment, exchange of sterile syringes for previously-used syringes, and opportunities for safe disposal of injection equipment. Because syringe exchange offers an opportunity for sustained contact between NSP staff and the person exchanging the injection equipment, NSPs are a preferred public health practice. Taking into account the diverse and local nature of epidemics, and recognizing that some governments may not be ready to adopt NSPs either at national scale or at all, PEPFAR teams should support countries in their efforts to determine the number and types of NSP outlets and services necessary to have an impact on the HIV epidemic. To maximize the impact on the epidemic, programs should progress toward regularly reaching as many IDUs as could benefit from these services. Effectiveness also depends on ensuring geographic distribution, and types and numbers of NSP outlets, relative to the size, location, and needs of the population of IDUs. To have an impact on the epidemic there should be a range of outlets (fixed and mobile sites, secondary exchange, 24-hour service through pharmacies), operated by civil society and the government.

Effective NSPs offer a range of wrap-around services, including but not limited to providing condoms, bleach, other injection equipment, risk reduction information, HBV and HCV prevention, screening and services, VCT, and linkages to additional services such as MAT and HIV care and treatment. This represents an effective multi-component program and progress towards implementing the full range of risk reduction strategies and tools to enable IDUs to reduce their risk level for acquiring HIV.

Medication-Assisted Treatment

The use of opioids (injecting or noninjecting) rapidly results in opioid dependence. Studies have shown that the most effective treatment for opioid dependence is MAT.⁴³ MAT uses methadone, buprenorphine, buprenorphine/naloxone (suboxone)/naltrexone or other medications/therapies, as they become available, as an effective option for treatment of heroin dependence and preventing the transmission of HIV. MAT has been shown to be an effective treatment for opioid dependence, reducing risk behaviors related to injection drug use, preventing HIV transmission and improving IDUs adherence to ART,⁴⁴ but to date, availability of MAT in most PEPFAR countries is very limited. For MAT to have an impact on the overall HIV epidemic, services need to reach, treat, and retain in treatment as many IDUs who seek services as possible.

⁴³ Gowing, L., et al. (2004). Substitution treatment of injecting opioid users for prevention of HIV infection. The Cochrane Database of Systematic Reviews. 4.

⁴⁴ Institute of Medicine. (2007). *Preventing HIV Infection among Injecting Drug Users in High Risk Countries: An Assessment of the Evidence*. Washington, DC: National Academies Press.

Opioid injectors who do not enter addiction treatment programs, MAT and/or other cognitive/behavioral therapies, are up to 6 times more likely to become infected with HIV compared to injectors who enter and remain in treatment.^{45,46} The longer an IDU remains in treatment, the better the outcomes. Many IDUs are not currently in or cannot sustain long-term addiction treatment programs because of multiple factors, including the limited availability of these programs. Barriers to MAT or other drug dependence treatment include legislation or strict regulation prohibiting prescription of methadone and/or buprenorphine; restrictive inclusion criteria (e.g., failed previous detoxification efforts); limited governmental support for these programs; limited funding; limited capacity within countries to provide services; stigma and discrimination; and ideological views on drug use, particularly among law enforcement practitioners.

Enabling Environments and HIV Prevention

As notes in the *Technical Guide*, interventions should be provided in an “enabling environment” created by supportive legislation, policies, regulations, and strategies.⁴⁷ Such legislation, policies, regulations, and strategies facilitate implementation of a comprehensive HIV prevention package for IDUs. Coverage rates of core interventions are low in many PEPFAR countries in part because enabling environments are not supportive for the introduction and scaling up of MAT, NSP, and other core HIV prevention interventions for IDUs. More specifically, reasons for the low coverage rates of and limited access to HIV prevention interventions include: unsupportive national policy; lack of adequate funding; restrictive criteria for eligibility; stigma and discrimination; law enforcement harassment; cost of services to user; poor geographic distribution of services; limited hours of operation; and limited technical capacity.

To optimize the effectiveness of interventions to reduce HIV infections, PEPFAR programs in countries should be based on principles related to equity, nondiscrimination, and voluntariness, and should seek to reach IDUs with services regardless of current injection status. In addition, all programs should be conceived with the participation of affected populations. Country leadership, including engagement by multiple sectors of government and collaboration with civil society, is needed to develop and implement, at all levels, the necessary supportive legislation, policies and regulations that facilitate the introduction and scale-up of services.

⁴⁵ Sorensen, J., & Copeland, A. (2000). Drug abuse treatment as an HIV prevention strategy: a review. *Drug and Alcohol Dependence*, 59(1), 17-31.

⁴⁶ Metzger, D., Navaline, H., & Woody, G. (1998). Drug abuse treatment as AIDS prevention. *Public Health Reports*, 113(Suppl.), 97-106.

⁴⁷ http://www.who.int/hiv/pub/idu/idu_target_setting_guide.pdf, p 9.

PEPFAR: Expanding Comprehensive HIV Prevention Services for IDUs

PEPFAR programs for IDUs should be data-driven, offer a comprehensive package of services, and heed principles affirmed in the 2006 Political Declaration on HIV/AIDS of the UN General Assembly that address human rights, stigma and discrimination as critical elements in combating HIV/AIDS.⁴⁸ Several of the core interventions may be at a more advanced stage of implementation due to other aspects of the country program (e.g. HCT or ART provision). Where appropriate, PEPFAR country teams should use existing platforms to accelerate the scale-up of these additional services for IDUs. In cases where guidance exists relative to specific interventions, such as ART provision, such normative guidance should be consulted along with this guidance.

PEPFAR country teams must act creatively to support the development of an enabling environment that facilitates appropriate HIV prevention, care and treatment services for most at-risk populations. PEPFAR should especially support such facilitation of appropriate programs where governments have existing punitive policies that affect IDUs.

The following are some principles that should guide PEPFAR country teams in their interactions with governments around implementing services for IDUs and the establishment of supportive legislation, policies, regulations, and strategies, including discussions around closed settings.

- Based on demography and epidemiology, and guided by evidence, programs should consider implementation and effective adaptation of a combination of core interventions for comprehensive HIV prevention programs for IDUs, taking into account local legal considerations; ethical considerations; cultural traditions; economic circumstances; and technical, human and fiscal resources and capacities.
- While not all interventions may be ready for implementation and scale-up in a given country, PEPFAR country teams should support governments in implementing what is possible, and also work with governments to advocate for progress in improving supportive legislation, policies, regulations and strategies.
- PEPFAR country teams should look for strategic opportunities with implementing partners to build these elements into existing prevention, care and treatment programs. Countries should take the lead in determining the optimal combination and sequencing of programs, with gaps filled in by NGOs and the USG.
- Access to services must be equitable, voluntary and non-discriminatory. PEPFAR country teams should promote progress in aligning drug control and law

⁴⁸ Political Declaration on HIV/AIDS, UN General Assembly Res. 60/262 (2006)

- enforcement practices and national HIV/AIDS policies.
- PEPFAR country teams are encouraged to increase national capacity to set targets for IDUs, based on size estimation methods and other more qualitative strategies to understand the current dynamics of their HIV epidemics in support of planning for implementing core components of a comprehensive HIV intervention program for IDUs.

PEPFAR supports comprehensive HIV prevention core interventions to reduce the burden of HIV disease among IDUs and the growing burden of illicit drug use in countries with diverse epidemics. PEPFAR will support the nine core interventions (see pp. 4-5), along with any necessary technical assistance to develop any intervention and the supportive legislation, policies, regulations, and strategies required to implement any of these interventions. Technical assistance is an expected component of successful PEPFAR programs to scale up services for IDUs.

Specifically, PEPFAR will support the following activities through country budgets:

- **Implementation** of HIV prevention and treatment interventions that benefit IDUs. Specific prevention interventions that should be emphasized include community-based outreach, NSPs, and MAT.
- **Training** of health professionals to increase the capacity for delivering high-quality health care services for IDUs, including training in drug dependence treatment modalities.
- **Monitoring and Evaluation** of programs and intervention through the use of standardized indicators developed by WHO, UNODC and UNAIDS for each core intervention component to monitor accessibility, availability, quality, coverage and impact.
- **Assessments** of laws, policies, regulations and barriers that impede the implementation of comprehensive HIV prevention programs and activities for IDUs to address such structural barriers; size estimation activities to help countries set targets for universal access to HIV prevention, treatment and care for IDUs; rapid assessments using multiple qualitative and quantitative methods to better understand the behavioral and HIV transmission dynamics and estimate coverage needs and costs to have an impact on the HIV epidemic; and activities to support removal of barriers to access for comprehensive services for IDUs.
- **Operational Research** to identify the most effective interventions within each epidemic context, to support delivery of high-quality services to clients, and to evaluate innovative strategies to improve and strengthen comprehensive services for IDUs.

- **Commodity Procurement** of needles and syringes, other risk reduction supplies, naloxone for preventing overdose deaths, and methadone/buprenorphine, when they are conducted as part of a comprehensive package of HIV and drug prevention and treatment services in line with local laws and policies. However, the USG should not supplant existing programs or services, but coordinate for evidence-based coverage, intensity and scale.

Resources for PEPFAR Country Teams

As needed, PEPFAR country teams are encouraged to work with their Country Support Team Leaders to access technical assistance through OGAC and the Most-At-Risk Populations (MARPs) Technical Working Group (TWG) to support the development and implementation of the activities emphasized in this guidance.

Other technical guidance documents can also be made available to support country efforts. Please see Appendix 1 for a brief resource guide.

PEPFAR country teams are also encouraged to take advantage of the support services of other technical areas, such as Treatment and Monitoring and Evaluation, in order to integrate programs that benefit IDUs into the existing framework of services.

For more information, please contact Rich Needle, PhD, Senior Public Health Advisor on Prevention for MARPs at OGAC (NeedleRH@state.gov).

Appendix 1

Suggested List of Resources for PEPFAR Country Teams

This list is meant to highlight some resources that are available to PEPFAR country teams as they plan and implement programs that benefit IDUs. This list is by no means exhaustive, and PEPFAR country teams are encouraged to contact the MARPS TWG and OGAC for more information.

Comprehensive HIV Prevention and Care for People who Inject Drugs Tools

Joint United Nations Programme on HIV/AIDS (UNAIDS). (2006). *High Coverage Sites: HIV Prevention among Injecting Drug Users in Transitional and Developing Countries*. Geneva, Switzerland. http://data.unaids.org/Publications/IRC-pub07/JC1254-highCoverageIDU_en.pdf

United Nations Office on Drugs and Crime (UNODC). (2006). *HIV/AIDS prevention and care for female injecting drug users*. Vienna, Austria. http://www.unodc.org/pdf/india/news_and_events/female_idu_paper.pdf

World Health Organization (WHO). (2005). *Policy and programming guide for HIV/AIDS prevention and care among injecting drug users*. Geneva, Switzerland. <http://www.who.int/hiv/pub/idu/iduguide/en/index.html>

Strategic Information Tools

UNAIDS. (2008). *A framework for monitoring and evaluating HIV prevention programmes for most-at-risk populations*. Geneva, Switzerland. http://data.unaids.org/pub/Manual/2008/jc1519_framework_for_me_en.pdf

WHO/UNODC/UNAIDS. (2009). *Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*. Geneva, Switzerland. <http://www.who.int/hiv/pub/idu/targetsetting/en/index.html>

Outreach Tools

WHO. (2004). *Policy Brief: Reduction of HIV Transmission through Outreach*. Geneva, Switzerland. http://whqlibdoc.who.int/hq/2004/WHO_HIV_2004.02.pdf

WHO. (2004). *Training Guide for HIV Prevention Outreach to IDUs: WHO Workshop Manual*. Geneva, Switzerland. <http://www.who.int/hiv/pub/idu/hivpubidu/en/index.html>

Medication-Assistance Therapies and Other Drug-Dependence Treatment Resources

WHO. (2004). *Evidence for Action: Effectiveness of Drug Dependence Treatment in Preventing HIV among Injection Drug Users*. Geneva, Switzerland. http://www.who.int/hiv/pub/idu/drugdependence_final.pdf

WHO. (2004). *Policy Brief: Reduction of HIV Transmission through Drug-Dependence Treatment*. Geneva, Switzerland. http://whqlibdoc.who.int/hq/2004/WHO_HIV_2004.04.pdf

WHO. (2006). *Basic Principles for Treatment and Psychosocial Support of Drug Dependent People Living with HIV/AIDS*. Geneva, Switzerland.

http://www.who.int/substance_abuse/publications/basic_principles_drug_hiv.pdf

WHO. (2009). *Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence*. Geneva, Switzerland. <http://www.who.int/hiv/pub/idu/opioid/en/index.html>

Needle and Syringe Program Resources

WHO. (2004). *Effectiveness of Sterile Needle and Syringe Programming in reducing HIV/AIDS among Injecting Drug Users*. Geneva, Switzerland.

<http://www.who.int/hiv/pub/idu/e4a-needle/en/index.html>

WHO. (2004). *Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission*. Geneva, Switzerland.

http://www.wpro.who.int/sites/hsi/documents/provision_of_sterile_injecting_eqpt.htm

WHO. (2007). *Guide to Starting and Managing Needle and Syringe Programmes*. Geneva, Switzerland. <http://www.who.int/hiv/pub/idu/needleprogram/en/index.html>

HIV Treatment for People who Inject Drugs Resources

WHO/UNAIDS/UNODC. (2005). *Policy Brief: Antiretroviral Therapy and Injecting Drug Users*. Geneva, Switzerland. http://www.who.int/hiv/pub/idu/antiretroviral_policy/en/index.html

WHO. (2006). *Treatment of injecting drug users with HIV/AIDS: promoting access and optimizing service delivery*. Geneva, Switzerland.

http://www.who.int/substance_abuse/publications/treatment_idus_hiv_aids.pdf

Information on Prevention with Prison Populations

Jürgens, R., Ball, A., & Verster, A. (2009). Interventions to reduce HIV transmission related to injecting drug use in prison. *The Lancet Infectious Diseases*, 9(1), 57-66.

Other Comprehensive Component Resources

WHO. (2006). *Sexually transmitted and other reproductive tract infections*. Geneva, Switzerland. <http://www.who.int/reproductivehealth/publications/rtis/9241592656/en/>

WHO/UNODC/UNAIDS. (2008). *Policy Guidelines for Collaborative TB and HIV Services for Injecting and Other Drug Users: An integrated approach*. Geneva, Switzerland.

http://www.who.int/hiv/pub/idu/tb_hiv/en/index.html

WHO South-East Asia Region and Western Pacific Region/ UNODC Regional Centre for East Asia and the Pacific. (2009). *Guidance on Testing and Counselling for HIV in Settings Attended by People Who Inject Drugs - Improving Access to Treatment, Care and Prevention*. Geneva, Switzerland.

http://www.who.int/hiv/pub/idu/searo_wpro_tc/en/index.html