

**WHO, UNODC, UNAIDS TECHNICAL GUIDE
FOR COUNTRIES TO SET TARGETS FOR
UNIVERSAL ACCESS TO HIV PREVENTION,
TREATMENT AND CARE FOR INJECTING
DRUG USERS**

2012 REVISION



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CONTENTS

ACKNOWLEDGEMENTS	3
ACRONYMS AND ABBREVIATIONS	5
1. INTRODUCTION	7
1.1 Background	7
1.2 Revisions in this publication	7
1.3 Function and scope of this document	8
2. HIV PREVENTION, TREATMENT AND CARE AMONG PEOPLE WHO INJECT DRUGS	10
2.1 The Comprehensive Package	10
1. Needle and syringe programmes	12
2. Opioid substitution therapy and other drug dependence treatment	13
3. HIV testing and counselling	15
4. Antiretroviral therapy	16
5. Prevention and treatment of sexually transmitted infections	17
6. Condom programmes for people who inject drugs and their sexual partners	18
7. Targeted information, education and communication	19
8. Prevention, vaccination, diagnosis and treatment for viral hepatitis	20
9. Prevention, diagnosis and treatment of tuberculosis	21
2.2 Outreach	21
2.3 Other interventions not included in the Comprehensive Package	22
2.4 Structural factors influencing risk and intervention impact	23
2.5 The principles of universal access	24
2.6 Service delivery and service integration	25
2.7 PWID in prisons and other detention settings	26
3. THE MONITORING AND TARGET-SETTING PROCESS	27
3.1 Monitoring “drug-user-specific” versus “general population” interventions	27
3.2 Measuring population size	29
Estimating the size of PWID populations	29
Ensuring denominators and numerators match	30
Quality of population size estimates	31
3.3 Measuring the availability of interventions	32
Restrictions on access	32
Type of intervention available	33
Number of sites where intervention is available	33
Location of sites where intervention is available	34
3.4 Measuring intervention coverage	35
Reporting period	36
Unique identifier code	36
Collecting and aggregating data from programmes	37
3.5 Measuring intervention quality	38

3.6 Measuring the outcome and impact of interventions	39
HIV incidence	39
HIV prevalence	40
HIV risk behaviours	40
3.7 Disaggregation.	41
Disaggregation by gender	41
Disaggregation by age	41
Disaggregation by type of drug injected	41
3.8 Setting targets	42
3.9 Next steps after setting targets	44
4. INDICATORS	45
4.1 Summary of indicators	45
4.2 Population size estimates	48
4.3 The comprehensive package	50
1. Needle and syringe programmes	50
2. Opioid substitution therapy and other drug dependence treatment	59
3. HIV testing and counselling	72
4. Antiretroviral therapy	74
5. Sexually transmitted infection prevention, diagnosis and treatment	82
6. Condom distribution programmes for PWID and their sexual partners	83
7. Targeted information, education and communication for PWID and their sexual partners	84
8. Prevention, vaccination, diagnosis and treatment for viral hepatitis	86
9. Prevention, diagnosis and treatment of tuberculosis	92
4.4 Outcome/impact indicators	96
REFERENCES	101

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ACRONYMS AND ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ARQ	Annual Reports Questionnaire (of the Commission on Narcotic Drugs)
ART	antiretroviral therapy
ATS	amphetamine-type stimulants
BMT	buprenorphine maintenance treatment
BSS	behavioural surveillance survey
Comprehensive Package	the comprehensive package of nine interventions endorsed by WHO, UNODC and UNAIDS for the prevention, treatment and care of HIV among people who inject drugs
EC	European Commission
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
FHI 360	formerly Family Health International
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GAR	Global AIDS Report
HAV	hepatitis A virus
HBV	hepatitis B virus
HCV	hepatitis C virus
HDSS	high dead-space syringes
HIV	human immunodeficiency virus
HTC	HIV testing and counselling
IDU	injecting drug use (<i>see also note below</i>)
IEC	information, education and communication
ILO	International Labour Organization
IPT	isoniazid preventive therapy
LDSS	low dead-space syringes
MMT	methadone maintenance treatment
NCPI	National Composite Policy Index
NGO	non-government organization
NSP	needle and syringe programme
OST	opioid substitution therapy
PEPFAR	The United States President's Emergency Plan for AIDS Relief
PITC	provider-initiated testing and counselling
PLHIV	people living with HIV

PMTCT	prevention of mother-to-child transmission (of HIV)
PSI	Population Services International
PWID	people/person who inject/s drugs (<i>see note below</i>)
RITA	recent infection testing algorithm
STI	sexually transmitted infection
TB	tuberculosis
UIC	unique identifier code
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Note: In this document the abbreviation IDU is used to refer to *injecting drug use* as was written in the 2009 version. In other documents, IDUs is also commonly used to denote *injecting drug users*. Currently, the term *people who inject drugs* is preferred.

1. INTRODUCTION

1.1 BACKGROUND

This document provides technical guidance to countries on monitoring efforts to prevent and treat HIV infection among people who inject drugs (PWID) and for setting ambitious but achievable national targets for scaling up towards universal access.

This tool has been developed collaboratively by three United Nations (UN) agencies—the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC) and the Joint United Nations Programme on HIV/AIDS (UNAIDS)—and through a process of consultation with international experts in the field.

The first version of this Technical Guide built on earlier WHO, UNODC (1) and UNAIDS (2) guidance and adhered to the principles therein. The Guide is intended to provide consistent methods of measuring and comparing countries' progress towards national targets to scale up comprehensive programmes for universal access to prevention, treatment, care and support for HIV and AIDS (3,4). These aims are based upon the 2006 Political Declaration on HIV/AIDS, in which countries committed to scale up towards universal access, and the earlier Declaration of Commitment on HIV/AIDS (5). Member States reaffirmed these commitments in the 2011 *Political declaration on HIV/AIDS: Intensifying our efforts to eliminate HIV/AIDS*. The UNAIDS Secretariat and its cosponsors have supported the launch of this broader effort by developing further, more specific operational guidance to countries (3,4,6,7).

Since the publication of the first version in 2009, the Technical Guide has been endorsed by high-level political bodies including the UN General Assembly (8), the Economic and Social Council (9), the UN Commission on Narcotic Drugs (10), and the UNAIDS Programme Coordinating Board (11). In addition, donor agencies, including the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), have committed to using this framework.

The Technical Guide has been rolled out, and training on its application has been provided in numerous countries across all world regions.

1.2 REVISIONS IN THIS PUBLICATION

The revisions made for the current version of the Technical Guide were informed by findings from a study examining the application of the guide in a range of countries, by systematic reviews, conducted by the Reference Group to the United Nations on HIV and Injecting Drug Use, assessing the availability of relevant data, and through consultation with a broad range of stakeholders and experts from around the world.

In this revision efforts have been made to make the guide more readable, with more explanation provided on each of the indicators and with guidance on how the indicators may be reported if some data are lacking. The package of evidence-based interventions has not been modified.

A number of indicators included in the first version have been excluded, as field experience has revealed limitations in the feasibility of their application or in their relevance to policy and programming.

Also, a more extensive framework for assessing the quality of intervention delivery has been included.

1.3 FUNCTION AND SCOPE OF THIS DOCUMENT

This document provides countries with:

- a comprehensive package of interventions for the prevention, treatment and care of HIV infection among people who inject drugs, which has not changed from the 2009 version of this guidance;
- a set of indicators to monitor and evaluate the implementation and impact of these interventions;
- advice on setting targets for scale-up, to maximize the impact of HIV prevention and care among people who inject drugs;
- examples of data sources and useful tools to assist with programme development, implementation, monitoring and evaluation.

This Technical Guide is intended to assist government agencies, non-government organizations (NGOs), communities and service providers involved in developing, implementing, monitoring and evaluating HIV prevention, treatment and care programmes for people who inject drugs (PWID). The framework proposed can be applied at regional, national, sub-national and service-delivery levels.

There are a number of international reporting mechanisms that include indicators related to injecting drug use or to the monitoring and evaluation of HIV prevention, treatment and care services for PWID. These include:

- Monitoring progress in the health sector towards achieving universal access to HIV prevention, treatment and care (WHO);
- Global AIDS Response progress reporting ⁽¹²⁾ (formerly, Reporting on monitoring the UNGASS Declaration of Commitment on HIV/AIDS) (UNAIDS);
- Commission on Narcotic Drugs Annual Report Questionnaire (ARQ) (UNODC).

Member States are obligated to submit reports for each of these global data collection processes. The indicators related to injecting drug use included in these obligatory reporting mechanisms can be considered the minimum set of indicators needed to gain a broad understanding of the response to injecting drug use and HIV, useful in particular for comparing data from different countries and for building a picture of regional and global progress.

The majority of the 22 indicators related to injecting drug use included in these global reporting mechanisms are also included in this Technical Guide. This guide goes further and includes additional indicators that enable a more in-depth assessment of HIV prevention, treatment and care programmes for PWID. Countries are not obligated to report on these additional indicators as part of any international data collection process. Instead, the information that these additional indicators provide is important for HIV policy development and effective programming.

These indicators can also be used for the preparation of proposals or reporting on progress to donor organizations; such as the Global Fund and PEPFAR.

The primary focus of this document is on interventions for people who inject drugs. Dependent or problematic non-injecting drug users may also face significant levels of HIV risk associated with drug use and may also be at risk of initiation into injecting drug use. Hence, it is also important to consider non-injecting drug users in the response to HIV, and it is relevant to set targets for HIV interventions targeting these individuals as well. Further, with the exception of needle and syringe programmes, the interventions included in the Comprehensive Package presented in this Technical Guide are also applicable to the prevention, treatment and care of HIV among non-injecting drug users.

2. HIV PREVENTION, TREATMENT AND CARE AMONG PEOPLE WHO INJECT DRUGS

2.1 THE COMPREHENSIVE PACKAGE

Addressing HIV associated with injecting drug use is one of the key challenges in the health sector response to HIV.

A **Comprehensive Package** of interventions for the prevention, treatment and care of HIV among people who inject drugs has been endorsed widely, by WHO, UNAIDS, UNODC, the UN General Assembly (8), the Economic and Social Council (9), the UN Commission on Narcotic Drugs (10), the UNAIDS Programme Coordinating Board (11), the Global Fund and PEPFAR. The Comprehensive Package includes:

- ① **Needle and syringe programmes (NSPs)**

- ② **Opioid substitution therapy (OST) and other evidence-based drug dependence treatment**

- ③ **HIV testing and counselling (HTC)**

- ④ **Antiretroviral therapy (ART)**

- ⑤ **Prevention and treatment of sexually transmitted infections (STIs)**

- ⑥ **Condom programmes for people who inject drugs and their sexual partners**

- ⑦ **Targeted information, education and communication (IEC) for people who inject drugs and their sexual partners**

- ⑧ **Prevention, vaccination, diagnosis and treatment for viral hepatitis**

- ⑨ **Prevention, diagnosis and treatment of tuberculosis (TB).**

Note: In this document this suite of interventions will be referred to as the “*Comprehensive Package*”.

These interventions are included in the Comprehensive Package because of the scientific evidence available supporting their efficacy in preventing the spread of HIV, in addition to reducing other harms associated with drug use (13–15). It is beyond the scope of this document to provide a thorough discussion of the evidence available on the effectiveness of the interventions included in the Comprehensive Package; this information is well documented elsewhere (see box). The Comprehensive Package may be revised in the future in light of emerging evidence.

The interventions included in the Comprehensive Package are commonly referred to as a *harm reduction* approach to injecting drug use (8,9,11). Harm reduction in response to drug use may also encompass other interventions; those included in the Comprehensive Package relate in particular to HIV and other co-infections.

Models for the delivery of interventions included in the package are discussed in section 2.6. It is important to note that these interventions can contribute the most to preventing and treating HIV when available *in combination* (15). Each intervention addresses different factors relating to HIV transmission and illness. Therefore, to successfully halt the spread of HIV, and its consequences, a comprehensive approach is required. Empirical studies and extensive modelling have demonstrated that single interventions alone have only limited impact; to significantly reduce HIV transmission and other harms, combined interventions with high levels of coverage are required (15).

For the development and monitoring of programmes to deliver the interventions in the Comprehensive Package, it is useful to distinguish between services that can be regarded as *drug-user-specific* (NSPs and drug dependence treatment) and interventions that are not drug-user-specific and often function as services relevant to the wider community.

To successfully address HIV where injecting drug use occurs, countries should prioritise implementing NSPs and evidence-based drug dependence treatment (specifically OST).

Countries should also ensure that people who inject drugs are successfully reached by the other interventions of the Comprehensive Package. Most countries have some level of provision of the interventions from the Comprehensive Package that are not specific to drug users.

It is also important to understand the context in which injecting drug use occurs and in which interventions to address drug use and HIV are implemented. So-called *structural factors*, which relate to the physical, social and legal environment, can shape HIV risk, just as access to, coverage and impact of HIV-focused interventions can (16). While interventions that specifically address structural factors are not included in the Comprehensive Package, investing in such measures is essential to the broader HIV response (17). Structural factors and responses to address them are discussed further in section 2.4.

Documents that review and summarize evidence relating to the interventions included in the Comprehensive Package

- The WHO/UNODC/UNAIDS Evidence for Action series and policy briefs (18): http://www.who.int/hiv/pub/idu/evidence_for_action/en/index.html
- Institute of Medicine. Committee on the Prevention of HIV Infection Among Injecting Drug Users in High-Risk Countries. *Preventing HIV infection among injecting drug users in high-risk countries: an assessment of the evidence*. Washington, DC, National Academies Press, 2006 (14).
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- MacArthur G et al. Opiate substitution treatment and HIV transmission in people who inject drugs: systematic review and meta-analysis. *BMJ*, 2012, 345 (137).

1 NEEDLE AND SYRINGE PROGRAMMES

Distributing sterile injecting equipment to people who inject drugs facilitates the use of clean needles and syringes and reduces the number of injections with used needles and syringes (14,15,21–23). Various models of needle and syringe distribution and service delivery may be implemented. Needle and syringe programmes (NSPs) are defined in this document to include programmes in which needles and syringes are provided free of charge. NSPs may operate at fixed sites as well as through mobile and outreach services.

Other types of distribution, such as the sale of injecting equipment, are considered separately. Injecting equipment may be available for purchase through pharmacies or other outlets. Where access to NSPs is difficult or places people who use drugs at risk of being apprehended by police, pharmacy sales of injecting equipment are an important, and sometimes the most significant, source of sterile injecting equipment accessible to people who inject drugs (24,25). Automated vending machines may also be used to dispense injecting equipment, either free or for purchase (26).

For many PWID needle and syringe programmes often are a rare point of contact with a health service. For that reason NSPs may serve as an important point of entry to other services. NSPs should aim to engage people who use drugs on a regular basis and to facilitate access to drug dependence treatment, to HIV treatment, care and support and to other important health and welfare services. If they have the capacity, some NSPs may themselves offer basic health care, addressing specific issues that may commonly affect PWID, such as wound care.

The injecting equipment available should be appropriate for the local context, taking into account factors such as the type and preparation of drugs that are commonly injected. It may be beneficial to encourage the use of low dead-space syringes (LDSS), as there is evidence that the provision of LDSS leads to a reduction in the transmission of HIV and HCV. LDSS commonly have a nondetachable needle joined directly to the syringe barrel and are designed to reduce the amount of blood remaining in the syringe after completely pushing down the syringe plunger. WHO suggests that needle and syringe programmes also offer LDSS and provide information about their potential prevention effect (27–29,95).

In addition to needles and syringes, other injecting-related paraphernalia may also be provided, including alcohol swabs, vials of sterile water, filters, tourniquets, mixing vessels (e.g. spoons or “cookers”) and acidifiers (e.g. ascorbic acid or citric acid powders) to assist with dissolving the substance to be injected. The safe disposal of used injecting equipment is also important. NSPs can encourage and facilitate safe disposal by receiving used syringes or by providing puncture-resistant safe disposal containers to clients. If the carrying of used needles and syringes is a criminal offence or may be used as evidence of drug use, however, PWID may be reluctant to take used equipment to NSPs for disposal.

Sources of guidance on needle and syringe programmes

- *Guide to starting and managing needle and syringe programmes*. Geneva, World Health Organization, Department of HIV/AIDS, 2007 (27).
<http://www.who.int/hiv/pub/idu/needleprogram/en/index.html>
- *Evidence for action: Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users*. Geneva, World Health Organization, 2004 (22).
<http://www.who.int/hiv/pub/idu/e4a-needle/en/index.html>

2 OPIOID SUBSTITUTION THERAPY AND OTHER DRUG DEPENDENCE TREATMENT

Interventions that are effective in controlling drug dependence can reduce illicit drug use and, hence, the frequency of injection, as well as improving health and social functioning.

For the purpose of the monitoring and evaluation framework outlined in this document, drug dependence treatment interventions are grouped into the following categories, adapted from those used in the WHO *ATLAS on substance use* (31):

- agonist opioid substitution therapy (OST) (as maintenance treatment)
- inpatient detoxification
- outpatient drug dependence treatment
- inpatient short-term treatment
- inpatient or residential long-term treatment
- peer-based support groups (such as 12-step Narcotics Anonymous groups)
- brief intervention delivered in non-specialist settings.

Agonist opioid substitution therapy (OST) as maintenance is highly effective in reducing injecting behaviours that put opioid-dependent injectors at risk for HIV (14,15,19,32). In addition, OST has been demonstrated to improve both access and adherence to ART and to reduce mortality (33–36). Accordingly, OST is particularly important in the response to HIV associated with drug use, especially because in many countries the majority of people who are opioid-dependent are also injecting drug users, and, globally, a substantial, although currently unquantified, proportion of people who inject drugs inject opioids.

A number of different opioid agonists are used for opioid substitution therapy, the most common being methadone and buprenorphine, both of which are listed as essential medicines by WHO (37). Other preparations, including pharmaceutical heroin (diamorphine) and slow-release morphine preparations, also are used in a limited number of countries. OST for non-injecting opioid-dependent people is also considered in the indicators presented here. Transition to injecting among this group is not uncommon (38); treatment for opioid dependence reduces the likelihood of initiation into injecting and, hence, can be considered part of an HIV prevention strategy.

To be most effective, it is important that maintenance OST is provided at adequate doses and for sufficient duration (see *Guidelines for psychosocially assisted pharmacotherapy for the management of opioid dependence*. Geneva, WHO, 2009 (39)).

While the evidence currently available on the impact of other forms of drug dependence treatment on HIV incidence is less compelling than that for OST (40), these other interventions remain strongly recommended for settings where non-opioid drugs such as amphetamine-type stimulants (ATS), cocaine and benzodiazepines are widely used and also where OST remains unavailable. Such treatment should be evidence-based. Interventions might include cognitive-behavioural therapy (41) or contingency management for amphetamine dependence (42); brief psychosocial interventions

delivered in non-specialized settings (i.e. those that are not specialized drug treatment services) are also recommended (43). Inpatient, medically supervised drug withdrawal (detoxification) can assist in the completion of the withdrawal process, but it is not effective on its own in achieving sustained abstinence from drug use (44). Detoxification may comprise symptomatic relief to reduce the discomfort of withdrawal; opioid withdrawal can be managed with opioid substitution therapy in diminishing doses (39).

In a number of countries drug users are apprehended and confined to detention centres, ostensibly for the purpose of drug treatment and rehabilitation, but without trial or clinical assessment of dependence, and the duration of detention is rarely determined by clinical treatment outcomes. Typically, in these centres there is no medical supervision of drug withdrawal, and evidence-based drug dependence treatment is not offered; detainees are frequently forced to participate in unpaid labour or military-style drills and may be subject to physical punishment. Following release from these centres, many relapse to drug use; risk of overdose may be increased (45). There is no evidence that these types of approaches are effective in reducing drug dependence. Hence, they do not fall into the category of drug dependence treatment as part of the Comprehensive Package described in this document.

Sources of guidance on drug dependence treatment

- *Guidelines for psychosocially assisted pharmacotherapy for the management of opioid dependence.* Geneva, World Health Organization, 2009 (39).
<http://www.who.int/hiv/pub/idu/opioid/en/index.html>
- *Operational guidelines for the management of opioid dependence in the South-East Asia Region.* New Delhi, WHO Regional Office for South-East Asia, 2008 (46).
http://www.who.int/hiv/pub/idu/op_guide_opioid_depend/en/index.html
- *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings.* Geneva, World Health Organization, Department of Mental Health and Substance Abuse, 2011 (43).
http://www.who.int/mental_health/publications/mhGAP_intervention_guide/en/index.html
- WHO, UNODC. *Principles of drug dependence treatment—discussion paper.* Geneva, World Health Organization, 2008 (47).
http://www.who.int/substance_abuse/publications/principles_drug_dependence_treatment.pdf
- *Basic principles for treatment and psychosocial support of drug dependent people living with HIV/AIDS.* Geneva, World Health Organization, 2006 (48).
http://www.who.int/substance_abuse/publications/basic_principles_drug_hiv.pdf
- Technical briefs on amphetamine type substances. Manila, World Health Organization Regional Office for the Western Pacific, 2011 (49).
http://www.who.int/hiv/pub/idu/ats_tech_brief/en/index.html

3 HIV TESTING AND COUNSELLING

HIV testing and counselling (HTC) is an important gateway to HIV treatment and care.

Rapid testing techniques make possible testing and obtaining results during the same contact. Rapid testing can be offered in a variety of settings and ways, including by out-reach workers in the field. This community-based testing has the potential to reach greater numbers of people, including those who inject drugs, who may be unlikely to go to a facility for testing or to return for a later follow-up visit to receive test results.

It is important that, wherever testing is performed, there are clear and robust links to HIV care and treatment for those who test positive. When this linkage is poor, it impedes the effective and timely uptake of care and ART. It is also important to have clear procedures in place, which follow national HIV testing strategies, to confirm positive field HIV test results.

In most circumstances provider-initiated HIV testing and counselling (PITC) for people who inject drugs is recommended, as long as it is *not compulsory* and is linked to the provision of HIV treatment and care in line with WHO guidelines. When PITC is undertaken, particular attention should be given to providing accurate information, and informed consent must be obtained. PITC may also be appropriate for PWID's intimate partners.

Support and counselling concerning disclosure of HIV status should be provided; couples counselling for PWID and their intimate partners may be appropriate.

Sources of guidance on HIV testing and counselling

- WHO, UNAIDS. *Guidance on provider-initiated HIV testing and counselling in health facilities*. Geneva, WHO, 2007 (50).
<http://www.who.int/hiv/topics/vct/PITC/en/index.html>
- UNODC, WHO, UNAIDS. *Testing and counselling in prisons and other closed settings*. Vienna, UNODC, 2009.
http://www.who.int/hiv/pub/idu/tc_prisons/en/index.html
- WHO-SEARO, WHO-WPRO, UNODC. *Guidance on testing and counselling for HIV in settings attended by people who inject drugs: improving access to treatment, care and prevention*. Manila, WHO WPRO, 2009 (51).
http://www.who.int/hiv/pub/idu/searo_wpro_tc/en/index.html
- EMCDDA. *Guidelines for testing HIV, viral hepatitis and other infections in injecting drug users: a manual for provider-initiated medical examination, testing and counselling*. Lisbon, European Monitoring Centre for Drugs and Drug Addiction, 2010 (52).
www.emcdda.europa.eu/attachements.cfm/att_120808_EN_Guidelines_HIVtesting_Final.pdf
- *Delivering HIV test results and messages for re-testing and counselling in adults*. Geneva, World Health Organization, 2010 (53).
http://www.who.int/hiv/pub/vct/hiv_re_testing/en/index.html
- *A handbook for improving HIV testing and counselling services: field-test version*. Geneva, World Health Organization, 2010 (54).
<http://www.who.int/hiv/pub/vct/9789241500463/en/index.html>

4 ANTIRETROVIRAL THERAPY

The provision of antiretroviral therapy (ART) to people who inject drugs has population-wide health benefits. People who inject drugs can successfully undergo treatment and benefit from ART (36, 55–57). There is also increasing evidence that ART may have a role in HIV prevention through lowering viral load and reducing HIV transmission (58–63). People who inject drugs, however, typically have poorer levels of access to ART than non-injectors; this may be due to multiple factors including restrictions or health-care provider practices limiting the provision of ART for people who inject drugs (36).

Drug dependence treatment, particularly OST where indicated, improves treatment outcomes and adherence to ART among people living with HIV who are opioid dependent (36).

It is difficult to determine the number of people who inject drugs receiving ART. Countries may have registries of patients on ART as well as pre-ART registers recording patients who have yet to start treatment. Most of these systems, however, do not report whether or not patients have a history of injecting drug use. If these systems do record a patient's history of injecting drug use, it is critical that client confidentiality is maintained, that injecting drug use history or current status should not be shared with law enforcement agencies, and that drug use history or status should not prejudice access to treatment.

In addition, it is critical to consider the prevention of mother-to-child transmission (PMTCT) in the case of HIV-positive pregnant women who may inject drugs or who are sexual partners of male PWID. Management of drug dependence during pregnancy, particularly the provision of OST during pregnancy to women who are opioid-dependent, should also be provided.

Sources of guidance on antiretroviral therapy

- *Antiretroviral therapy for HIV infection in adults and adolescents: recommendations for a public health approach—2010 revision*. Geneva, World Health Organization, 2010 (64).
<http://www.who.int/hiv/pub/arv/adult2010/en/index.html>
- Chapter 5. HIV/AIDS treatment and care for injecting drug users. In: *HIV/AIDS treatment and care: clinical protocols for the WHO European Region*. Copenhagen, World Health Organization Regional Office for Europe, 2006 (65).
http://www.who.int/hiv/pub/idu/euro_treatment/en/index.html
- *Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants*. Geneva, World Health Organization, 2010 (66).
<http://www.who.int/hiv/pub/mtct/antiretroviral2010/en/index.html>

5 PREVENTION AND TREATMENT OF SEXUALLY TRANSMITTED INFECTIONS

Sexually transmitted infections (STIs) can biologically increase the sexual transmission of HIV (67). Potential exposure to STIs is elevated for PWID who engage in sex work and for male PWID who have sex with other men (68,69).

Condom distribution programmes and promotion of safer sex practices through information and education are two important strategies for the prevention of STIs and are components of the Comprehensive Package, listed as interventions 6 and 7, respectively.

Strategies to increase STI treatment rates among PWID might include:

- the development of the STI screening and treatment capacity of health services that are accessed by PWID;
- the co-location of STI diagnosis and treatment services at sites accessed by people who inject drugs (such as NSPs or drug treatment services);
- the establishment of active referral pathways and the integration of screening and testing programmes between STI treatment services and other services that are accessed by PWID;
- ensuring that mainstream STI treatment services are accessible and responsive to the needs of people who inject drugs.

Sources of guidance on prevention and control of sexually transmitted infections

- *Global strategy for the prevention and control of sexually transmitted infections: 2006–2015: breaking the chain of transmission*. Geneva, World Health Organization, 2007 (70).
<http://www.who.int/reproductivehealth/publications/rtis/9789241563475/en/index.html>
- *Training modules for the syndromic management of sexually transmitted infections*. Geneva, World Health Organization, 2007 (71).
<http://www.who.int/reproductivehealth/publications/rtis/9789241593407/en/index.html>
- *Sexually transmitted and other reproductive tract infections*. Geneva, World Health Organization, 2005 (72).
<http://www.who.int/reproductivehealth/publications/rtis/9241592656/en/index.html>
- *Guidelines for the management of sexually transmitted infections*. Geneva, World Health Organization, 2004 (73).
<http://www.who.int/hiv/pub/sti/pub6/en/>

6 CONDOM PROGRAMMES FOR PEOPLE WHO INJECT DRUGS AND THEIR SEXUAL PARTNERS

Sexual transmission of HIV among people who inject drugs, and between people who inject drugs and their sexual partners who do not inject drugs, constitutes an important pathway of HIV infection. There is also a significant association between stimulant use, through both injecting and non-injecting routes of administration, and risky sexual behaviours (74,75). People who inject drugs and also engage in sex work and male injectors who have sex with men may be further exposed to risk (76).

Increasing the accessibility and use of condoms among people who use drugs and their partners through targeted distribution programmes is, therefore, an important component of the Comprehensive Package. While condoms may be widely available for purchase in most countries, provision of free condoms to populations at high risk aims to significantly increase accessibility and use by removing any barrier that cost may pose.

Provision of both male and female condoms plus lubricants may further increase condom acceptability and use (76,77). It is also important to offer family planning to women who may inject drugs or who are sexual partners of male PWID.

Sources of guidance on condom programming

- *Condom programming for HIV prevention: a manual for service providers*. New York, United Nations Population Fund, 2005 (78).
<http://www.unfpa.org/public/global/pid/1291>
- UNFPA, WHO, PATH. *Condom programming for HIV prevention: an operations manual for programme managers*. New York, UNFPA, 2005 (76).
<http://www.unfpa.org/public/global/pid/1292>

7 TARGETED INFORMATION, EDUCATION AND COMMUNICATION

When combined with other measures, such as the provision of sterile injecting equipment and of condoms and treatment for drug dependence, targeted information and education help to increase and sustain positive change in HIV risk behaviours (13,79). Repeated exposure is important to maintain the benefit from these strategies.

Specific content will vary among settings but should always address: HIV risk associated with drug use and how to reduce it; sexual risk and risk reduction strategies; other risks associated with drug use and how to reduce them; how to obtain services and support; basic information on the drugs being used; access to legal rights and support; and overdose prevention.

Communication for behavioural change can take various forms and use various media. Information materials produced should be relevant to the local context, be appropriate to the needs of people who use drugs, and communicate effectively to the intended audience. Individual, couples and group counselling can support adoption of safer sex and injecting practices; peer-led interventions have been shown to be particularly effective (80).

Given that overdose remains a primary cause of death among people who inject drugs, even in the context of an HIV epidemic, IEC strategies focusing on overdose prevention are particularly important. In addition to information on preventing overdose, information might also include how to respond to overdose if it occurs. This might include training on resuscitation for people who inject drugs, their families, partners and peers and on the role of naloxone (an opioid antagonist able to reverse respiratory depression in opioid overdose), if available (81–84).

Sources of guidance on targeted information, education and communication

- Salem RM et al. Communication for better health. *Population Reports*, Series J, No. 56, 2008 (85).
- International HIV/AIDS Alliance, Asia Pacific Network of Sex Work Projects. *Guide to participatory production of resources for HIV prevention among vulnerable populations*. Brighton, International HIV/AIDS Alliance, 2005 (86).
<http://www.aidsalliance.org/Publicationsdetails.aspx?Id=194>
- *HIV/AIDS and human rights advocacy and training resource manual*. Windhoek, Namibia, AIDS Rights Alliance for Southern Africa, 2008 (87).
<http://www.arasa.info/index.php/trainingmanuals/83-hivaids-and-human-rights-advocacy-and-training-resource-manual18>
- Curtis M, Guterman L. *Overdose prevention and response: a guide for people who use drugs and harm reduction staff in Eastern Europe and Central Asia*. New York, Open Society Institute, 2009 (88).
http://www.soros.org/sites/default/files/overdose_20090604.pdf

8 PREVENTION, VACCINATION, DIAGNOSIS AND TREATMENT FOR VIRAL HEPATITIS

While this document and the Comprehensive Package of interventions focus primarily on HIV, it is important to consider and address the transmission and treatment of other blood-borne viruses, in particular hepatitis B and C viruses (HBV and HCV). Recent reviews indicate that, worldwide, 10 million people who inject drugs may be living with hepatitis C (89), compared with the 3 million estimated to be living with HIV (90). HCV co-infection is common among PWID who are living with HIV (91). Also, hepatitis B is typically more prevalent among people who inject drugs than in the general population (89,92,93). Viral hepatitis is, accordingly, a significant cause of disease burden among PWID. HIV co-infection is associated with more rapid progression of liver disease and mortality among those infected with HCV or HBV (91).

Since blood-borne transmission is common to HIV and hepatitis viruses, interventions effective in preventing HIV among people who inject drugs help to prevent HCV/HBV transmission and vice versa. Because HCV is more virulent than HIV, however, higher levels of intervention coverage may be necessary to achieve comparable reductions in incidence (14,94).

WHO has issued guidance on prevention of viral hepatitis B and C among people who inject drugs (95). This guidance recommends offering PWID the rapid hepatitis B vaccination regimen and to offer incentives to increase PWID's uptake and completion of the hepatitis B vaccine schedule. It is suggested that needle and syringe programmes also provide low dead-space syringes and that there are peer intervention programmes in place. Such programmes need to be flexible and pragmatic, making use of opportunistic contact with the target population.

It is important to appropriately manage HIV co-infection with HBV or HCV (or both) among people who inject drugs (93). Chronic active HBV infection necessitating treatment is an indication for initiation of ART among those living with HIV (64).

Sources of guidance on prevention, diagnosis and treatment of viral hepatitis

- *Guidance on prevention of viral hepatitis B and C among people who inject drugs*. Geneva, World Health Organization, 2012 (95).
<http://www.who.int/hiv/pub/guidelines/hepatitis/en/index.html>
- In: *HIV/AIDS treatment and care: clinical protocols for the WHO European Region*. Copenhagen, World Health Organization Regional Office for Europe, 2006 (65).
Chapter 6. Management of hepatitis C and HIV coinfection.
Chapter 7. Management of hepatitis B and HIV coinfection.
Chapter 8. Prevention of hepatitis A, B and C and other hepatotoxic factors in people living with HIV.
<http://www.euro.who.int/en/what-we-publish/abstracts/hiv-aids-treatment-and-care.-clinical-protocols-for-the-who-european-region>

9 PREVENTION, DIAGNOSIS AND TREATMENT OF TUBERCULOSIS

People who inject drugs may have an increased risk of acquiring tuberculosis (TB) disease independent of their HIV status. HIV infection further increases their risk of developing TB disease (20).

It is recommended that services used by those at elevated risk of TB, such as PWID, as well as facilities that serve those in confined and crowded conditions, such as prisons, implement a TB infection control strategy and have a case-finding protocol for both TB and HIV (96).

Isoniazid preventive therapy (IPT) should be accessible to drug users living with HIV, once active TB is reasonably ruled out (97), and treatment for active TB should be provided as indicated (96). PWID should be informed about their risk of TB and how to obtain screening regularly.

Active referral pathways between TB treatment services and services for PWID, and integrated screening and testing programmes, also are important. Mainstream TB treatment services should be accessible and responsive to the needs of people who inject drugs.

Sources of guidance on prevention, diagnosis and treatment of tuberculosis

- WHO, UNODC, UNAIDS. *Policy guidelines for collaborative TB and HIV services for injecting and other drug users: an integrated approach*. Evidence for Action Technical Papers. Geneva, WHO, 2008 (96). http://www.who.int/hiv/pub/idu/tb_hiv/en/index.html
- *Guidelines for intensified tuberculosis case finding and isoniazid preventive therapy for people living with HIV in resource-constrained settings*. Geneva, World Health Organization, 2011 (97). <http://www.who.int/hiv/pub/tb/9789241500708/en/index.html>
- *Treatment of tuberculosis guidelines, fourth edition*. Geneva, World Health Organization, 2010 (98). <http://www.who.int/tb/publications/2010/9789241547833/en/index.html>

2.2 OUTREACH

Community-based outreach accesses and engages populations of PWID in locations where they may spend time rather than through fixed-site services. In many contexts community-based outreach is a highly effective means of delivering HIV/AIDS prevention interventions, such as NSPs, condom programmes and targeted IEC, to people who inject drugs, as well as a useful access point for the referral of people who inject drugs to interventions such as OST, other drug dependence treatment and ART (30).

Because it is a modality for delivering services rather than a service per se, community-based outreach is not included as a separate intervention in the Comprehensive Package. However, outreach is strongly recommended as an essential component of all HIV prevention and care programmes and as an especially effective method for reaching people who inject drugs, a group often difficult to reach (30).

Other diverse service delivery models may also be appropriate and effective in different contexts; see section 2.6 for further discussion of models of service delivery for interventions from the Comprehensive Package.

Sources of guidance on outreach

- *Effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users.* Evidence for Action Series. Geneva, World Health Organization, 2004 (30).
<http://www.who.int/hiv/pub/idu/e4a-outreach/en/index.html>
- *Training guide for HIV prevention outreach to injecting drug users: workshop manual.* Geneva, World Health Organization, 2004 (99).
<http://www.who.int/hiv/pub/idu/hivpubidu/en/index.html>
- *Practical guidelines for intensifying HIV prevention.* Geneva, UNAIDS, 2007 (100).
http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2007/20070306_prevention_guidelines_towards_universal_access_en.pdf

2.3 OTHER INTERVENTIONS NOT INCLUDED IN THE COMPREHENSIVE PACKAGE

A number of interventions have not been included in the Comprehensive Package because of the relative lack of evidence of their effectiveness or other considerations. This should not, however, rule out the delivery of additional interventions—as pilot programmes or full-scale interventions—where the local context requires them.

For interventions intended to address injecting drug use and HIV that are not included in the Comprehensive Package, emphasis should be placed on building evidence and on evaluation. For example, although WHO has not reviewed the evidence on the effectiveness of supervised drug consumption/injection facilities in preventing HIV infection, evaluations in high-income countries where these facilities have been implemented have reported reduced risk behaviours among attending clients (101,102).

Strategies to address structural factors that influence HIV risk and intervention impact are discussed in section 2.4.

Source of guidance on other interventions to address injecting drug use and HIV

- *Good practice guide—HIV and drug use: community responses to injecting drug use and HIV.* Brighton, International HIV/AIDS Alliance, 2010 (103).
http://www.aidsalliance.org/includes/Publication/GPG_drug%20use_07.06.12.pdf

2.4 STRUCTURAL FACTORS INFLUENCING RISK AND INTERVENTION IMPACT

It is important to consider the context in which injecting drug use occurs and in which services for people who inject drugs are delivered. This consideration involves identifying structural factors such as societal norms, policies and laws and other factors that may influence HIV risk or impede the delivery of interventions. Successfully addressing those factors creates a more supportive environment, conducive to reducing HIV risk and other harms.

PWID are commonly marginalized, criminalized and subjected to stigma, discrimination and, due to the illegality of drug use, often face legal sanctions or limited access to essential services. Changes in drug supply can bring about changes in injecting practices that may consequently affect HIV transmission. Laws and law enforcement practices can inadvertently increase the risk of HIV transmission and impede the delivery and scaling up of HIV prevention services.

Steps to address these structural factors are an important part of the broader HIV response. Structural barriers that restrict access to interventions can be addressed directly; strategies to do so are outlined in section 2.5 on universal access. Strategies to create a more supportive environment include the following *critical enablers* (17):

- securing political commitment and investing in advocacy
- reviewing, and revising where necessary, laws, legal policies and practices
- community mobilization
- stigma reduction.

A number of items included in the National Composite Policy Index (NCPI) of the UNAIDS Global AIDS Report HIV monitoring and reporting process relate to a structurally based response to injecting drug use and HIV (available at: http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2009/jc1676_core_indicators_2009_en.pdf) (7).

Sources of guidance on addressing policy and structural factors

- Reshevska I et al. *Policy advocacy toolkit for medication-assisted treatment (MAT) for drug dependence*. Washington, DC, The Futures Group, Health Policy Initiative, 2010 (104). <http://www.healthpolicyinitiative.com/index.cfm?ID=publications&get=pubID&pubID=1449>
- *A new investment framework for the global HIV response*. Geneva, UNAIDS, 2011 (17). http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2244_InvestmentFramework_en.pdf

2.5 THE PRINCIPLES OF UNIVERSAL ACCESS

The High-Level Meeting on HIV/AIDS in 2006 adopted the goal of universal access as a commitment to scale up national programmes for HIV treatment, prevention, care and support for all those who need them (105). While clearly an ambitious and desirable goal, universal access is also a concrete process, driven by countries that have organized national consultations to identify critical obstacles to scaling up and have planned measures to address these obstacles.

Universal access encompasses the principles of equity, equality, non-discrimination, comprehensiveness, accessibility and sustainability, which guide the development of interventions in the Comprehensive Package. These interventions must:

- be physically accessible (geographically distributed, e.g. available beyond major cities and to those living in hard-to-reach locations);
- be affordable (cost at the point of service should not be a barrier, e.g. patients should not have to pay for their treatment);
- be equitable and non-discriminatory (there should be no exclusion criteria except medical ones; e.g. OST should not be limited only to those who use drugs who are HIV-infected or who have failed on other drug dependence treatment; likewise, access to ART should not be conditional on the cessation of drug use);
- be unrationed (supply should be determined by need and not limited by cost or other considerations; e.g. NSPs with strict limits on the number of syringes provided to each client are less successful than those that do not impose such restrictions) (106).

Furthermore, access to the interventions included in the Comprehensive Package should *not* be restricted by socio-demographic or other criteria such as:

- age: programmes should not impose age restrictions (i.e. there should be no minimum age requirement for accessing services; in the case of children and young people who inject drugs, special provisions may be required where parental consent is ordinarily required for children to obtain medical or other services);
- sex/gender, sexual orientation or sexual behaviour;
- citizenship, nationality, country of origin, race/ethnicity, asylum-seeking status, or religion/religious convictions;
- employment status and profession, including sex work, illegal employment, etc.
- confinement to a facility/setting—imprisonment, military service, health institution, orphanage, etc.;
- health insurance status;
- substance use status—for example, current injecting should not be a barrier to access;
- housing status (for example, homelessness);
- mental health status;
- pregnancy status.

All interventions should be offered on a voluntary basis in an enabling environment created by supportive legislation, policies and strategies.

2.6 SERVICE DELIVERY AND SERVICE INTEGRATION

The development of service delivery models in different settings should be pragmatic and responsive to local conditions.

As noted in section 2.1, the interventions included in the Comprehensive Package can be characterized as either *drug-user-specific* interventions (NSPs and drug-dependence treatment) or interventions that are not drug-user-specific and that are generally present as services relevant to the wider community.

To successfully address HIV, countries where injecting drug use occurs will need to implement NSPs and evidence-based drug dependence treatment (including specifically OST) as a priority as well as to ensure that people who inject drugs are successfully reached by the other interventions of the Comprehensive Package that are also relevant to the wider community. Typically, most countries have some level of provision of these other interventions, even if these are not targeted to PWID specifically.

Some of the interventions in the Comprehensive Package are commonly delivered by the same service or by the same workers. For example, OST and ART can be effectively and efficiently delivered at the same location. Similarly, NSP outreach workers may, in addition to providing sterile injecting equipment, distribute condoms, deliver targeted information, education and communication (IEC), perform rapid testing for HIV and refer PWID to drug dependence treatment and other medical and welfare services.

Services that are targeted to people who inject drugs, such as NSPs and drug treatment services, can function as important points of entry to other interventions included in the Comprehensive Package and to the health care system more broadly. Access to these other interventions can be enhanced through various *integrated service delivery models* including the co-location of interventions at a single site or through strong and coordinated linkage and referral between different service providers. Establishing active referral pathways and protocols fosters such linkages; this is discussed in more detail in section 3.1.

As previously noted, PWID commonly have poor access to health services. This may be due to a variety of reasons, which can include hostility or discrimination experienced when accessing services previously, apprehension that health services will disclose sensitive information, including drug use history, to government authorities; requirements that clients be drug-free to be eligible for services; prohibitive costs; and staff inexperienced in providing services for PWID. To succeed in reaching PWID, services must be accessible and acceptable to PWID and responsive to their needs. Approaches to make services more “drug-user friendly” include:

- co-location of interventions and cross-training of providers (for example, the provision of ART at drug treatment services);
- scheduling service hours that are routine and dependable and that suit clients' lifestyles;
- strategic location of services (for example, in hotspots);
- peer-community involvement in service development, promotion, delivery, monitoring and evaluation;
- staff training on working with PWID;
- taking steps to ensure that law enforcement activities do not interfere with clients' access to a service.

2.7 PWID IN PRISONS AND OTHER DETENTION SETTINGS

Drug users have high rates of incarceration, and, globally, a disproportionate number of inmates have a history of drug use. Drug use, including by injection, is consistently documented to occur in prisons throughout the world. High rates of sharing of injecting equipment, unsafe sex and often high levels of HIV prevalence produce elevated HIV risk in prison environments.

The principle of equivalency of care (107) declares that prisoners are entitled, without discrimination, to the same standard of health care that is found in the outside community, including preventive measures and ART. In addition, it is critical that there be continuity of care for those entering closed settings who have been receiving ongoing treatment (such as ART, OST or treatment for TB) in the community; interruption of treatment has serious consequences for the health of these detainees and may also, in the case of treatment of HIV or TB, lead to drug resistance.

The interventions in the Comprehensive Package to address injecting drug use and HIV are appropriate for implementation in prisons and other closed settings such as pre-trial, refugee or immigration detention facilities. UNODC, UNAIDS, WHO, United Nations Development Program (UNDP) and the International Labour Organization (ILO) have defined a specific comprehensive package of interventions for HIV prevention, treatment and care in prisons and other closed settings. This package of 15 interventions includes all 9 interventions in the Comprehensive Package targeting PWID as well as additional interventions to address broader HIV risk, including interventions for the prevention of mother-to-child transmission of HIV, measures to combat sexual violence, post-exposure prophylaxis, precautions to prevent transmission through medical and dental services, measures to make tattooing, piercing and other forms of skin penetration safer, and interventions for staff (108). It is anticipated that a technical guide on monitoring and evaluating these interventions in prisons and other closed settings will be developed as a companion to this guide.

It is recommended that the indicators included in this guide assessing the availability of interventions be applied to prisons and other closed settings.

Sources of guidance on HIV prevention and treatment in prisons and other detention settings

- Status paper on prisons, drugs and harm reduction. Copenhagen, World Health Organization Regional Office for Europe, 2005 (109).
http://www.euro.who.int/__data/assets/pdf_file/0006/78549/E85877.pdf
- WHO, UNODC, UNAIDS. Policy Brief: Reduction of HIV transmission in prisons. Geneva, WHO, 2004 (23).
http://www.who.int/hiv/pub/idu/prisons_reduction/en/index.html
- WHO, UNODC, UNAIDS. Effectiveness of interventions to address HIV in prisons. Geneva, WHO, 2007 (110).
http://www.who.int/hiv/pub/idu/prisons_effective/en/index.html
- UNODC, WHO, UNAIDS. HIV/AIDS prevention, care, treatment, and support in prison settings: A framework for an effective national response. New York, United Nations, 2006 (111).
http://www.unodc.org/pdf/HIV-AIDS/prisons_July06.pdf
- UNODC, ILO, UNDP. HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions. Vienna, UNODC, 2012 (108).
http://www.unodc.org/documents/hiv-aids/HIV_prisons_advance_copy_july_2012_leaflet_UNODC_ILO_UNDP_Ebook.pdf

3. THE MONITORING AND TARGET-SETTING PROCESS

The following framework provides a method to monitor the implementation of the Comprehensive Package, explains how to interpret the results of this process and describes how to determine the targets that should be pursued.

This process requires participation from multiple stakeholders, including civil society and, in particular, people who use drugs. These groups have an invaluable role to play in contributing to programme design and evaluation of progress, highlighting strategies for improvement and developing targets. Many donor organizations and international reporting mechanisms stipulate active participation by civil society groups in these processes.

Monitoring national progress requires data collection at the service delivery level and for these data to be collated and analysed centrally. For data from different services to be aggregated, data collection systems must be consistent across services. This guide outlines a set of indicators that assess the *availability, coverage, quality* and *outcome/impact* of the components of the Comprehensive Package.

As discussed above, maximum benefit is gained from the Comprehensive Package when all nine components are implemented together. Therefore, it is advantageous to conduct ongoing monitoring and evaluation for all of these interventions. However, countries are at different stages of establishing a comprehensive response, and there may be limitations on the extent of monitoring and evaluation possible. It is advised that at least NSP, OST, HTC and ART are monitored, if capacity to monitor all nine interventions of the Comprehensive Package is limited.

3.1 MONITORING “DRUG-USER-SPECIFIC” VERSUS “GENERAL POPULATION” INTERVENTIONS

The distinction between interventions in the Comprehensive Package that are drug-user-specific (NSPs and drug dependence treatment) and those that are also provided for the wider population has important implications for the approach taken to monitoring service provision for people who inject drugs.

When examining interventions that are not specific to drug users, it is important to determine whether or not people who inject drugs are being effectively *reached* by these services. For a range of reasons, drug users typically underutilize health care services. Drug users may not have equitable access to mainstream services, and in some cases they may be actively excluded from them. Mainstream services are commonly not designed to meet the needs of specific populations; staff may not be experienced with providing services to people who use drugs; and these services may be unsuited to the needs of people who use drugs. Accordingly, it is necessary to evaluate efforts to facilitate access to these services by people who inject drugs as well as the levels of access achieved.

As outlined above, people who inject drugs can be reached by services delivering these non-drug user specific interventions by: (a) providing equitable access to these interventions through services that specifically target people who use drugs; for example, by providing ART at drug treatment centres; and (b) by making mainstream services more accessible, sensitive and responsive to the needs of people who inject drugs.

Access can be facilitated through the co-location of interventions at a single site or through strong and coordinated linkage and referral between different service providers. Establishing active referral pathways and protocols that foster such linkages might require the following:

- The referring service has a roster of services to which clients may be referred and has links with these services.
- Services to which clients are referred are sensitive, supportive and responsive to the needs of people who inject drugs, are located close to the referring service or are easily accessed by the client.
- Follow-up and continuity of care is strengthened through case management instituted by the referring service.

Strategies such as accompanied or peer-facilitated referral may also help to increase the success of referral.

A number of the proposed indicators examine the extent of this integration and related levels of coverage.

Availability

HTC.A.1:	• Number of PWID-targeted services where HTC is provided
ART.A.2:	• Number of PWID-targeted services where ART is provided
Hep.A.1:	• Number of PWID-targeted services providing HBV vaccination
Hep.A.2:	• Number of PWID-targeted services and ART provision sites providing HBV treatment
Hep.A.4:	• Number of PWID-targeted services and ART provision sites providing HCV management and treatment
TB.A.2:	• Number of PWID-targeted services providing TB preventive therapy
TB.A.3:	• Number of PWID-targeted services providing TB diagnosis and treatment

Coverage

STI.C.1:	• PWID screened or treated for STIs at services targeting PWID
Cdm.C.1:	• Quantity of condoms distributed by services targeting PWID
Hep.C.1:	• PWID receiving HBV vaccination from PWID-targeted services
Hep.C.2:	• PWID receiving HBV treatment from PWID-targeted services and ART provision sites
Hep.C.3:	• PWID receiving HCV treatment from PWID-targeted services and ART provision sites.

3.2 MEASURING POPULATION SIZE

To measure whether services are of sufficient scale, it is necessary to know the size of the population being targeted.

Many of the indicators of coverage described here involve measuring the proportion of the target population who have been reached or who have received an intervention.

For example, a generic coverage indicator to determine the percentage of the target population who have received an intervention can be defined as:

$$\frac{\text{Number of people who received intervention}}{\text{Total number of people in the target population}} \times 100$$

Thus, estimates of the target population are required for the denominator in these indicators (hence, these are sometimes referred to as “denominator populations”); programme data are used for the numerator.

The indicators described in this document relate to interventions that target a number of different, specifically defined populations. Accordingly, to determine coverage for these specific populations, it is necessary to make size estimates for each population.

To be able to disaggregate indicator data, it is necessary for these population size estimates to be disaggregated as well. Therefore, population estimates need to be made for different gender and age groups and in some cases for the type of drug injected.

ESTIMATING THE SIZE OF PWID POPULATIONS

Estimates of the prevalence of injecting drug use and the number of people who inject drugs are required as the denominators for many of the indicators described in this Guide.

Estimating the prevalence of injecting drug use requires defining a PWID. Various criteria may be applied, depending on the purpose of the estimate. Generally, the most important defining criterion relates to the time period *when* a person has injected a drug.

Estimating the prevalence of “*lifetime injecting drug use*”, or the number of people “*who have ever injected drugs*”, is applicable to determining how many people may have ever been exposed to injecting-related harms; for example, it may be relevant to look at those who engaged in injected drug use in the period since the emergence of HIV in a particular location in order to estimate the number of people potentially exposed to HIV through injecting drug use.

A variety of definitions for “*current injecting drug use*”, or “*active PWID*”, exist in the literature or are used by different bodies. Such estimates are needed to determine the size of the target population for

interventions such as NSPs. **For the purpose of the indicators in this guide, the definition of an active PWID is a person who has injected at any time within the past 12 months.** This definition of active PWID is particularly relevant for an indicator that looks at the provision of services for PWID over a 12-month period. It is important to note, however, that some data reporting systems use other definitions. For example, the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) defines people who inject drug as those who have injected in the last four weeks.

In some countries people may self-inject medicines for medical purposes. This practice is commonly referred to as therapeutic injection and is distinct from injecting drug use, which is the focus of this guide. Those who have self-injected medicines for medical purposes only (rather than self-injection of pharmaceuticals for *non*-medical purposes) are not included in the definition of injecting drug use given above.

Because injecting drug use and drug dependence occur predominantly amongst adults, it is common practice to calculate estimates of injecting drug use prevalence and population size for *adult* populations—for example, those ages 15 to 64 years. This approach is taken by organizations such as the EMCDDA and in global reviews undertaken by the Reference Group to the United Nations on HIV and Injecting Drug Use (90).

Determining the size of PWID populations can be challenging. Surveys of the general population, such as household surveys, may markedly underestimate the prevalence of injecting drug use—because injectors are less likely to be included in the sample and because drug injecting is an illicit and stigmatized behaviour that respondents are likely to be reluctant to disclose. Indirect estimation methods, such as multiplier and benchmark calculations that make use of existing data sources (police arrest data, drug-dependence treatment data, drug-related deaths) and capture–recapture methods are extremely useful; guidance on these methods is available (see box).

It is important to clarify here that use of data from multiple sources for the purpose of population size estimation does not require linkage of these data sources or sharing identifying data from treatment or other services with law enforcement agencies. As stated elsewhere in this document, it is important to maintain the confidentiality of individuals utilizing drug treatment services and other HIV prevention programmes.

ENSURING DENOMINATORS AND NUMERATORS MATCH

Most of the interventions in the Comprehensive Package target PWID irrespective of the type of drug they may use. OST programmes, however, obviously are relevant specifically to people who are opioid-dependent, including both those who inject and those who use opioids via non-injecting routes of administration. Hence, for the purpose of estimating coverage of OST programmes, it is necessary to estimate *the number of people who are opioid-dependent* and *the number of PWID who are opioid-dependent*.

If interventions specific to other substances are also underway, the relevant population size estimates should be made. For example, if the coverage of a programme that specifically addresses stimulant dependence is to be measured, an estimate of the number of stimulant-dependent PWID is required.

QUALITY OF POPULATION SIZE ESTIMATES

When interpreting an indicator that has been calculated using an estimate of population size, it is important to consider the source of the data and how it was derived. Some methods of estimation are more reliable than others, particularly when attempting to measure the size of drug-using populations.

The following framework ranks methods used to estimate prevalence and population size. It is adapted from a grading system used in global reviews undertaken by the Reference Group to the United Nations on HIV and Injecting Drug Use (90). Grades range from *Grade A*, the highest, to the *Grades C or D*, the lowest.

Estimates of the prevalence of drug dependence and injecting drug use

Grade A:	• Indirect prevalence estimation methods (e.g. capture–recapture, multiplier methods, etc.)
Grade B:	• General population surveys
Grade C:	• Experts' judgement informed by evidence gathered through various methods (e.g. rapid assessment) • Delphi method or other consensus estimates • Government registration of drug users.

Estimates of the prevalence of HIV, hepatitis C virus among people who inject drugs

Grade A:	• Sero-prevalence studies involving samples from multiple sites (including sentinel surveillance sites) and sample types (e.g. treatment service or outreach-based samples)
Grade B:	• Sero-prevalence studies involving a single sample type and/or a single site
Grade C:	• Registration or notification of cases of HIV or HCV infection
Grade D:	• Prevalence studies using self-reported HIV or HCV status.

The *most recent* and *highest graded* prevalence and population size estimates available should be used when calculating coverage indicators.

The limitations of estimation methods should be acknowledged and considered when interpreting indicators that involve prevalence and population size estimates.

There may be some instances in which an estimate of prevalence or population size is given in a document or report, but there is no indication of the method by which the estimate was derived. It is strongly recommended to avoid using estimates if their methodology is unknown, as any limitations and related uncertainty cannot be accounted for.

The use of HIV prevalence estimates based on self-reported HIV status (Grade D), rather than on diagnostic tests of sero-status, also should be avoided.

It is recommended that national expert group meetings be held regularly to evaluate available data and to reach consensus on the estimate or range of estimates that should be used. These meetings should involve researchers and key government personnel, NGOs and organizations of people who use drugs. Member States are encouraged to organize such meetings annually to facilitate response to the mandated UNODC Annual Reports Questionnaire, which includes items related to population size estimates.

Where recent, high-quality estimates are not available, it is recommended that countries make efforts to acquire such estimates. Technical and financial resources are required for such estimation research activities. If resource constraints exist, countries can seek external donor assistance for these types of research activities as part of funding for the broader response to HIV. The Global Fund encourages countries to include population size estimation activities in funding applications and in ongoing grants, as one of the monitoring and evaluation system strengthening activities for improving the availability of data on key populations at risk (112). Similarly, PEPFAR supports operational research and strengthening of monitoring and evaluation systems (113).

If an appropriate population size estimate is not available for use as the denominator, it is still useful and important to record and report the indicator numerator. The numerators alone can provide some useful, although limited, indication of the extent of programme delivery and may be particularly useful in monitoring progress over time as well as assist with estimating population size.

Sources of guidance on population size estimation methods

- UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance. *Guidelines on estimating the size of populations most at risk to HIV*. Geneva, World Health Organization, 2010 (114).
http://www.who.int/hiv/pub/surveillance/final_estimating_populations_en.pdf
- *Estimating prevalence: indirect methods for estimating the size of the drug problem*. Vienna, United Nations Office on Drugs and Crime, 2003 (115).
http://www.unodc.org/documents/data-and-analysis/statistics/Drugs/GAP_module_2.pdf
- Hickman M et al. Estimating the prevalence of problematic drug use: a review of methods and their application. *UN Bulletin on Narcotics*, 2002, 54:15–32 (116).
http://www.unodc.org/pdf/bulletin/bulletin_2002_01_01_Art2.pdf
- U.S. Department of Health and Human Services, Centers for Disease Control (HHS-CDC), GAP Surveillance Team. *Most at risk populations sampling strategies and design tool*. Atlanta, HHS-CDC, 2009 (117).
<http://globalhealthsciences.ucsf.edu/sites/default/files/content/pphg/surveillance/CDC-MARPs/index.htm>

3.3 MEASURING THE AVAILABILITY OF INTERVENTIONS

To assess the availability of interventions in the Comprehensive Package, several types of indicators are proposed.

RESTRICTIONS ON ACCESS

For ART and HCV treatment, the presence of restrictions on access for people who inject drugs should be recorded (i.e. specifically whether or not a person who currently injects or who has previously injected drugs is excluded from access to treatment).

TYPE OF INTERVENTION AVAILABLE

For drug dependence treatment, the type of treatment available is recorded. It is useful when evaluating and reporting on the provision of drug dependence treatment to describe the specific treatment modalities available. Several main categories are defined; these are based on categories used by the WHO Mental Health and Substance Abuse department in the *ATLAS on substance use (31)*. They include:

- agonist opioid substitution therapy (OST) (as maintenance treatment)
- inpatient detoxification
- outpatient drug dependence treatment
- inpatient short-term treatment
- inpatient or residential long-term treatment
- peer-based support groups
- brief interventions provided in non-specialized settings.

NUMBER OF SITES WHERE INTERVENTION IS AVAILABLE

Definitions of what constitutes an intervention *site* differ for each intervention; suggested definitions are provided for each indicator in section 4.

For the purpose of assessing the provision of *non-drug-user-specific* interventions to people who inject drugs, this guide includes indicators examining the delivery of these interventions by services targeting people who inject drugs as well as the integration and linkage with mainstream services.

For example, in the case of HIV testing and counselling, the following indicators are proposed:

- Number and percentage of NSP sites providing HIV testing and counselling;
- Number and percentage of drug dependence treatment sites providing HIV testing and counselling;
- Number of other services that target PWID (such as drop-in services or health centres targeting PWID specifically) and that offer HIV testing and counselling;
- Are there any mobile or outreach services targeting PWID that provide HIV testing and counselling in community settings?

If data from the first three of these indicators are aggregated, it is important to avoid multiple counting of single service provision sites. This can be done by using a unique identifier code system common across multiple services (see section on unique identifier codes, page 46).

Part of the assessment of the *quality* of NSPs examines the processes of drug dependence treatment services for referral of clients to other services providing essential interventions (for example, HIV testing and counselling). Referring a client or patient to another service is only the first step in the referral process. Follow-up by the service from which the client is referred and support of the client by both services to facilitate a successful referral may also be required.

An established referral pathway may involve the following:

- The referring service has a roster of services to which clients may be referred and has formalized arrangements with these services.

- Services to which clients are referred are sensitive, supportive and responsive to the needs of PWID, are located close to the referring service or are easily accessible to the client.
- Follow-up and continuity of care are strengthened through case management instituted by the referring service.

LOCATION OF SITES WHERE INTERVENTION IS AVAILABLE

Because NSP and OST typically require daily access, indicators are proposed that seek to map the availability of the intervention in areas where people who inject drugs are located.

In an assessment of availability at the national level, it is recommended that the presence or absence of the intervention in different sub-national areas be examined. For the purpose of this assessment, various levels of sub-national division may be used.

For the simplest application of this assessment, a country's administrative divisions could be used: for example, in the Russian Federation it may be useful to look at availability in oblasts and in China, in provinces; while in India or Pakistan states might be examined.

The percentage of cities/states/provinces/oblasts where injecting occurs and where the intervention is present is calculated using the following:

Numerator the number of cities/states/provinces/oblasts where the intervention in question is present.
Denominator the number of cities/states/provinces/oblasts where injecting drug use is known to occur.

Injecting drug use may not be present throughout a country; it may be absent in some states or provinces. For the purpose of this indicator, the intervention in question is counted as present only in those cities/states/provinces/oblasts where injecting is known to occur.

Because different countries will have different types and sizes of sub-national areas defined, it may not be possible to compare findings from different countries for this indicator.

It is also possible to use other geographic units with this indicator. For example, it might be useful to look just at urban centres and to measure the percentage of cities where an intervention is present. Programme planners may even wish to look at the availability of an intervention within a city and so may look at the percentage of city districts or suburbs where an intervention is present.

This indicator offers a crude means to identify areas where people who inject drugs are located but services are lacking. Access to services is not determined by location alone, however, but also by factors such as hours of operation, acceptability of services to the intended clients, police activity and many other factors. These other factors are examined in more detail as part of indicators assessing service quality.

3.4 MEASURING INTERVENTION COVERAGE

The term “coverage” in the context of preventing HIV among people who inject drugs has been used to describe various aspects of reach and intervention effectiveness (118).

In this guide “coverage” describes the extent to which an intervention is delivered to the target population. Various indicators are defined to estimate the scale of services delivered relative to the estimated size of the target population.

The majority of the coverage indicators included in this Technical Guide involve the use of programme data and population size estimates to estimate percentage levels of coverage. For example, a generic coverage indicator to determine the percentage of the target population who have received an intervention can be defined as:

$$\frac{\text{Number of people who received intervention}}{\text{Total number of people in the target population}} \times 100$$

If a suitable population size estimate is not available to be used as a *denominator*, collecting and reporting the *numerator* data is still recommended. Even by themselves these data are valuable for assessing the scale of service delivery and progress over time. As noted above, it is important that countries still make efforts to estimate population size even where reliable and recent estimates are unavailable. It is important, also, that the population size estimate used as the *denominator* in these coverage indicators is appropriate for the intervention and *numerator* being measured. The reliability of coverage estimates derived by these methods depends upon the completeness and quality of both the programme data and the population size estimate.

Different coverage measures are defined for the different interventions in the Comprehensive Package. These different indicators reflect the varied nature of these interventions, the manner in which they are provided and the type of exposure that is required for them to have the desired impact. For example, in order to be effective, some interventions such as OST require ongoing or daily exposure, while for others, such as HIV testing and counselling, contact needs to occur only periodically.

Coverage may also be assessed using surveys of samples from the target population. Many of the injecting drug use-related indicators in the Global AIDS Response progress report (previously referred to as UNGASS core indicators) involve this survey methodology. The reliability of the findings from such surveys depends on how representative the sample is of the broader population of people who inject drugs. Bias may be introduced, particularly when measuring intervention exposure, if a sample is recruited at a point of service delivery.

It is important to recognize the limitations of these different methods of estimating coverage. Triangulation may be possible if coverage estimates derived by several of these methodologies are available.

REPORTING PERIOD

The majority of the recommended coverage indicators described in this document measure the delivery of interventions over a defined reporting period. For the proposed indicators the duration of the recommended reporting period is typically 12 months, this being a natural reporting period for many registry and programmatic data collection systems. It may be useful and appropriate in some contexts, however, to define different reporting periods. In particular, donors such as the Global Fund or PEPFAR may require reporting at 3- or 6-month intervals.

UNIQUE IDENTIFIER CODE

For some of the recommended indicators, it is important to distinguish between the number of clients accessing a service and the number of client contacts for that service. A common problem in data collection is that programmes record the number of contacts with clients and then confuse this with the number of clients reached. To avoid such double-counting, a strictly anonymous system of identifying clients and recording their return visits may be necessary. A common method is to provide each client with a *unique identifier code* (UIC). This code enables a service to record individual clients' patterns of attendance. In particular, it can reveal whether a client is reached regularly by a service such as a NSP (27,119), without the need to collect identifying information such as names or government-issued ID numbers. Coverage can be even more accurately measured if the same UIC is used across different services. Services in different countries have developed various but similar UIC systems.

The coding system should be easy for a client to recall and must protect clients' confidentiality by ensuring that the UIC cannot be decoded to reveal the identity of the client.

Below is an example of the unique identifier code developed by Population Services International (PSI). Other organizations, including the WHO Western Pacific Regional Office, have developed similar approaches.

Below is an example of the unique identifier code developed by Population Services International (PSI). Other organizations, including the WHO Western Pacific Regional Office, have developed similar approaches.

Each individual is given a simple 7-character code composed of the following

- *the first two letters of the client's mother's first name*
- *the first two letters of the father's first name*
- *gender (single letter M/F or number)*
- *year of birth (last two digits).*

For example, for a male client in Ukraine, born in 1972, whose mother's name is Anastasiya and whose father's name is Grigor, the unique identifier code would be: AN GR M 72.

These coding systems can be adapted to local contexts as needed. For example, in Viet Nam many names have the same first letters. Therefore, an additional 3-letter code for the client's province of birth was inserted to ensure that codes are unique.

It is important that services targeting PWID are easily accessible. To avoid creating any barriers to access, any identification coding system should not be compulsory or otherwise deter people from accessing a service. Maintaining privacy and confidentiality should be paramount, and clients should feel safe using these services.

Sources of guidance on unique identifier code systems

- *Unique identifier code. USAID-funded drug demand reduction program in Uzbekistan, Tajikistan and the Ferghana Valley region of Kyrgyzstan.* DDRP Best Practice Collection. Almaty, Alliance for Open Society International, 2007 (119).
http://www.aidsprojects.com/wp-content/themes/apmg-1.0.1/documents/UIC_Eng.pdf
- *Guide to starting and managing needle and syringe programmes.* Geneva, World Health Organization, 2007 (27).
<http://www.who.int/hiv/pub/idu/needleprogram/en/index.html>
- Nga NT et al. *Innovative data tools: a suite for managing peer outreach to key affected populations in Viet Nam.* Western Pacific Surveillance and Response Journal, 2012 (136).
http://www2.wpro.who.int/NR/rdonlyres/42837210-F3DB-4FCC-9C26-220202E9CD55/0/201232003_LFF_HIV_VNM_Nga.pdf

COLLECTING AND AGGREGATING DATA FROM PROGRAMMES

Most of the coverage indicators described in this document require collecting data from services either on the number of people who use that service or receive an intervention or else on the total quantity of condoms or injecting equipment distributed. These data must be gathered from multiple sources. To allow for aggregation of these data from multiple sources, the methods used need to be consistent across all sites. In most countries, however, these data are not collected by a single agency and not centrally organized or collated. Having a single, national-level agency responsible for regularly collating and reporting national data is highly advantageous. Web-based databases can facilitate data aggregation from different services. If the Internet is not available, offline computers or paper-based recording systems can be used. Use of UICs across different services avoids double counting when collating data from multiple services.

It is important that data remain confidential and that data and medical records identifying people as users of drugs are not shared with law enforcement agencies, particularly in countries where drug use is criminalized.

An example of a system collating data from different services is described in the following report:

- HIV/AIDS Asia Regional Program Technical Support Unit, Yunnan Provincial HIV/AIDS Prevention and Control Bureau, Yunnan Public Health Bureau. *Making it count: using online data for effective monitoring and evaluation of harm reduction activities in Yunnan Province, China.* Bangkok, Commonwealth of Australia, AusAID, 2011 (120).
http://www.haarp-online.org/LinkClick.aspx?fileticket=Hbx6twF4x_E%3d&tabid=2348&mid=4554

3.5 MEASURING INTERVENTION QUALITY

Quality encompasses the scope, completeness, effectiveness, efficiency and safety of interventions and, importantly, acceptability to the target group. The quality of an intervention makes a vital difference to its impact on the epidemic (121). For example, the efficacy of OST in reducing drug use and HIV incidence is well established, but how OST is delivered influences the effectiveness of the programme: OST programmes delivering low-dose methadone have less impact than those delivering higher doses; OST provided in combination with psychosocial support is more effective and will have a greater impact; programmes that allow for take-home doses and referral for transfer to other OST programmes facilitate better coverage and better adherence to treatment (32,122).

Defined quality standards for the implementation of an intervention can be understood as either enhancing the effectiveness of the intervention or improving access to and, hence, the coverage of the intervention.

The first version of the Technical Guide recommended that countries report whether or not interventions from the Comprehensive Package were implemented adhering to relevant national or international guidelines. In this revision a similar but expanded method of assessing quality is proposed for the two drug-user-specific interventions of the Comprehensive Package (NSP and OST) and for ART for PWID. *Policy* and *service delivery* checklists have been developed of “*quality factors*” that are important for these interventions to be most effective. These checklists are based on endorsed guidelines developed by WHO and other organizations.

The *policy checklists* assess the presence of policy or legislation that facilitate or enhance the delivery and effectiveness of these interventions.

The *service delivery checklists* assess how these interventions are implemented at the programme or site level. These can be used individually (i.e. for a single site or programme), or the results can be aggregated at the national level to determine what proportion of sites adhere to a particular quality standard. For example, if 30 of the 40 NSP sites in a country report adhering to the quality standard “Systems are in place to ensure that stock-outs do not occur”, then 75% of the sites in the country adhere to this standard.

Not all the items in these checklists will be relevant in every context; these lists should be adapted to local settings. Adaptation should take into account evidence concerning which factors are important to the effectiveness of interventions.

In addition to these checklists, several recommended indicators measure the percentage of clients receiving an intervention that meets specific quality criteria. These include:

OST.Q.3:	• Individuals receiving OST continuously for at least six months
OST.Q.4:	• Patients receiving maintenance OST dose greater than or equal to the recommended minimum dose
OST.Q.5:	• Patients on maintenance OST receiving psychological support
ART.Q.3:	• PWID on ART receiving adherence support
ART.Q.4:	• PWID on ART receiving case management

Several of the *coverage* and *access indicators* may also be considered to measure quality. These include:

HTC.A.1:	• Number of PWID-targeted services where HTC is provided
IEC.C.1:	• Frequency of NSP occasions of service where IEC is provided

3.6 MEASURING THE OUTCOME AND IMPACT OF INTERVENTIONS

These guidelines are not primarily concerned with directly measuring the impact of interventions. However, a number of indicators measuring various outcomes are briefly described.

HIV INCIDENCE

Changes in HIV incidence give the best indication of the impact of HIV prevention interventions, but they may be difficult to measure among populations of people who inject drugs. Various methods may be used to estimate incidence indirectly, but limitations of each method must be considered when interpreting results.

HIV prevalence among new initiates to injecting drug use or among young people who inject drugs can be used as a proxy measure of incidence. Measurement of prevalence among new injectors requires integrated behavioural and sero-surveillance—the latter to measure prevalence and the former to allow for disaggregation on the basis of duration of injecting history. Measurement of prevalence among young people also requires surveillance data to be disaggregated by age.

Inferring incidence from case reporting systems for newly noted infections is problematic. An individual's injecting drug use status or history may not be identified in these systems, and other transmission categories may be recorded even if an individual has a history of injecting drug use. In addition, presenting late, a considerable time after the initial infection, is not uncommon among people who inject drugs.

Using a serological recent infection testing algorithm (RITA) to identify new infections can offer some precision in estimating incidence (123). Its routine use in HIV surveillance systems may be beyond the resources and technical capacity available in many settings, however.

In addition, mathematical modelling may be used to estimate HIV incidence at the population level (124).

HIV PREVALENCE

HIV prevalence can be measured more easily than incidence, but it must be interpreted carefully when attempting to discern changes in rates of new infection. Increases in observed HIV prevalence could be the result of improved surveillance and testing techniques; apparent decreases could be the result of increased stigmatization and, thus, greater reluctance of people who inject drugs to be tested, while real decreases could be the result of mortality or out-migration of PWID living with HIV. In addition, when access for PWID to effective HIV treatment and care is improved, HIV prevalence is likely to increase as the life expectancy of HIV-positive people who inject drugs increases, even if the incidence of HIV infection remains stable or decreases.

HIV RISK BEHAVIOURS

Model projections suggest that interventions that reduce injecting frequency and the sharing of used injecting equipment can reduce HIV transmission. Case studies suggest that high coverage of HIV prevention interventions for people who inject drugs may avert or delay a potential HIV epidemic in this group and its further spread to the general population (125,126).

Therefore, outcome indicators that examine changes in HIV risk behaviour, such as the use of injecting equipment used previously by someone else, frequency of injecting and condom use, can be useful in assessing the impact of the Comprehensive Package. Of course, observed changes in these behaviours will always be due to multiple factors and a combination of interventions. In most cases, changes cannot be attributable to a single, isolated intervention or to a single project or programme.

Of the nine outcome and impact indicators described in this document, five rely on data from behaviour surveillance surveys. Many countries already undertake such surveys as part of the ongoing monitoring of the HIV epidemic and may periodically survey injecting drug users as a specific population. The Family Health International Behaviour Surveillance Survey (BSS) (127) is commonly used; it assesses HIV risk-related behaviours such as condom use and safe injecting practices as well as access to HIV testing.

When undertaking behavioural or sero-surveillance studies of people who inject drugs, and when interpreting results from them, it is important to consider the representativeness of the samples recruited and the extent of potential bias associated with how and where participants are recruited. It may be difficult to recruit samples of people who inject drugs that are representative of the broader PWID population. Significant bias may result if samples are drawn from a limited number and range of locations or if recruitment occurs primarily through services such as treatment centres or NSPs. Methods such as respondent-driven sampling may reduce such bias, but they require specific technical capacity and resources and take time to complete (128).

Collection of demographic and other data in surveillance studies makes possible useful disaggregation and analysis. For example, differences can be discerned between younger and older individuals and between men and women.

Sources of guidance on HIV surveillance

- UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance. *Guidelines on surveillance among populations most at risk for HIV*. Geneva, Joint United Nations Programme on HIV/AIDS, 2011 (129).
http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2011/20110518_Surveillance_among_most_at_risk.pdf
- *Surveillance surveys: guidelines for repeated behavioural surveys in populations at risk of HIV*. Raleigh, Family Health International, 2000 (127).
<http://www.fhi360.org/en/HIVAIDS/pub/guide/bssguidelines.htm>
- Salganik M, Heckathorn D. Sampling and estimation in hidden populations using respondent-driven sampling. *Sociological Methodology*, 2004, 34(1):193–240 (128).

3.7 DISAGGREGATION

Injecting drug user populations are diverse. Within these populations various characteristics may be associated with differing HIV risk, rates of service utilization and health outcomes. In the monitoring of the coverage and impact of the Comprehensive Package, it is valuable to disaggregate data in order to identify disparities that may exist and that should be addressed.

DISAGGREGATION BY GENDER

Compared with their male peers, women and girls who inject drugs often face additional barriers to accessing HIV prevention and care services (130). Furthermore, PWID who identify as transgender typically face significant levels of discrimination and marginalization. Therefore, it can be useful to collect gender-disaggregated data and to use these along with gender-specific denominator estimates to assess and monitor this disparity.

DISAGGREGATION BY AGE

In many settings young people may have poorer rates of access to HIV prevention and care services. This may be due to a variety of reasons, including age discrimination by programmes, laws or policies that deny services to people under a certain age, and young people's feeling that services do not meet their needs.

Therefore, we propose to disaggregate indicator data into three age groups¹:

- 18 years of age or younger (≤ 18 years)
- older than 18 years of age and younger than 25 years of age (>18 years and <25 years)
- 25 years of age and over (≥ 25 years).

DISAGGREGATION BY TYPE OF DRUG INJECTED

The type of drug that a person injects can have some impact on HIV risk. For example, use of amphetamine-type stimulants is associated with elevated sexual risk and, in some instances, with increased frequency of injection. Also, the type of drug on which a person is dependent has important

¹ These age disaggregations were decided following consultation with partners.

implications for treatment options. Disaggregating by drug type injected is recommended as follows:

- opioids (including pharmaceutical opioids, heroin, other opium derivatives)
- stimulants (including cocaine and amphetamine-type stimulants)
- other (might include benzodiazepines, barbiturates and other depressants or psychotropic substances).

It is important to note that poly-drug use is common in many settings, with people using more than one type of drug, including some via injecting and others via other routes of administration.

3.8 SETTING TARGETS

It is important to set targets for each of the indicators described in the preceding sections in order to strategically plan and build an effective response to the epidemic among people who inject drugs. Targets should be set with the aim of achieving reductions in HIV risk sufficient to control the epidemic. Targets for outcome measures—in particular, the prevalence and incidence of HIV—also are important. In the 2011 Political Declaration on HIV/AIDS, Member States committed to reducing transmission of HIV among people who inject drugs by 50% by 2015 (8).

Targets will differ in different countries and should reflect local factors, including the nature of the HIV epidemic and of injecting drug use, the current stage of the response, the available resources and capacity, and structural factors that shape risk and influence the impact of interventions. It is therefore necessary for countries to undertake a process for setting targets relevant to their own epidemic and context. Targets should be aspirational but also achievable; a pragmatic approach is necessary.

It is useful to measure first the scale of the current response and then to consider how much scale-up is possible within a set time period, given available resources and technical capacity and how much additional capacity and resources can be mobilized.

Because the interaction of the numerous factors determining HIV risk and intervention impact in a particular setting is complex, there is no universal formula for target setting. It is possible, however, to draw on the various types of evidence available, gathered from a range of different settings, to propose evidence-based targets relevant to the local setting.

Multiple factors may affect the impact of an intervention in preventing HIV and should be considered when setting targets. In the case of preventing injecting-related HIV transmission, such factors include:

- availability and coverage of other interventions from the Comprehensive Package (interventions delivered in combination have the greatest impact)
- existing prevalence of HIV among people who inject drugs
- HIV prevalence among the general population
- the prevalence and frequency of using injecting equipment previously used by another person
- the length of time used syringes remain in circulation, during which time they may be reused multiple times

- methods of disposal of used syringes, including the coverage and utilization of safe disposal systems for used equipment
- size and connectedness of injecting drug user networks and the mobility of people who inject drugs
- on average, the number of other people whose used injecting equipment a PWID re-uses
- frequency of injecting
- types of drugs injected
- types of syringes used (those with larger dead-space volume may pose greater risk of transmission) (28,29).

This Technical Guide presents *indicative target levels* for selected indicators, defined broadly as low, mid or high. For example:

- *Percentage of PWID who were regularly reached by NSPs over the last 12 months* (NSP.C.2)
Low <20%; Mid 20% – 60%; High >60%
- *Percentage of opioid dependent people on OST* (OST.C.1)
Low <20%; Mid 20% – 40%; High >40%
- *Percentage of PWID living with HIV on ART* (ART.C.1)
Low <25%; Mid 25% – 75%; High >75%

These targets are intended to be broadly indicative only, and countries will need to consider the local context to assess what levels they should aim to achieve. The targets selected should enable those implementing programmes to know whether they are making a difference to the epidemic and to what level services should be maintained or expanded to effectively control the epidemic. In the future, as new and more robust evidence emerges, these indicative target levels may be revised.

It is important to note that when setting targets for indicators that require a reliable population size estimate, but where no such estimates are available it is still important to set targets for the numerator of these indicators. For example, if there is no population size estimate for PWID when setting targets for the distribution of clean injecting equipment it would be useful to set targets for the total dispense number of needles-syringes.

General principals to consider when setting target levels

- ***Intervention impact is greatest when multiple interventions are available—most significantly, when NSP, OST and ART are all available.***
- Higher quality interventions deliver greater impact than those that are implemented at lower quality.
- Greater levels of coverage are superior to lower levels, usually until a maximum optimal level is reached.
- While greater intervention coverage brings about greater reductions in HIV risk and, hence, incidence, this relationship is not necessarily linear.
- The higher the level of HIV prevalence (both in the general population and among people who inject drugs), the greater the level of prevention coverage that will be required (131).
- The earlier in an epidemic that an intervention is introduced, the more effective it can be in controlling the spread of HIV.

How should countries go about setting targets?

- The target setting process should be collaborative and should involve input from a range of stakeholders, including representatives from government and civil society, PWID representatives, service providers and clinicians.
- A useful starting point is for countries to map available services countrywide, disaggregated by types of services.
- Following the mapping of services, the next step would be to measure current levels of coverage, to serve as a baseline for gauging future progress.
- Population size estimates also should be undertaken, in order to understand the scale of the response required; these population size estimates are used to calculate estimates of coverage indicators.
- Countries are encouraged to determine realistic and achievable target levels that they wish to achieve and the time period in which to achieve them.
- It is also recommended to establish or refine existing service monitoring practices to improve the tracking of progress toward these targets.
- Countries should consider what resources are available and what additional resources are required to reach targets and have an impact on the HIV epidemic.

3.9 NEXT STEPS AFTER SETTING TARGETS

Once targets have been set, they need to be operationalized and monitored. This requires an operational plan and a monitoring and evaluation framework based on these targets. Guidance on this process is beyond the scope of this document but is provided in the documents listed below.

Sources of guidance on operationalization and on monitoring and evaluation of interventions

- *Guide to starting and managing needle and syringe programmes*. Geneva, World Health Organization, Department of HIV/AIDS, 2007 (27).
<http://www.who.int/hiv/pub/idu/needleprogram/en/index.html>
- *Guidelines for psychosocially assisted pharmacotherapy for the management of opioid dependence*. Geneva, World Health Organization, 2009 (39).
<http://www.who.int/hiv/pub/idu/opioid/en/index.html>
- *Drug abuse treatment and rehabilitation: a practical planning and implementation guide*. Vienna, United Nations Office on Drugs and Crime, 2003 (132).
http://www.unodc.org/pdf/report_2003-07-17_1.pdf
- *A framework for monitoring and evaluating HIV prevention programmes for most-at-risk populations*. Geneva, Joint United Nations Programme on HIV/AIDS, 2008 (133).
http://www.unaids.org/en/media/unaids/contentassets/documents/document/2010/17_Framework_ME_Prevention_Prog_MARP_E.pdf

4. INDICATORS

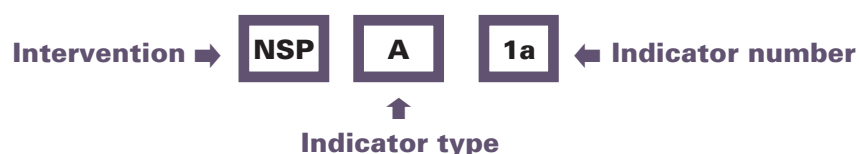
4.1 SUMMARY OF INDICATORS

Listed below are indicators proposed for estimating **population size** and examining **availability, coverage, quality** and **outcome/impact** of the Comprehensive Package.

In the sections that follow each indicator is explained in greater detail.

Indicators in **bold** and noted with an asterisk (*) can be considered **key indicators** that countries should attempt to measure, as a minimum. **Priority key indicators** are noted with two asterisks (**). Other indicators listed are useful to more fully monitor and evaluate the implementation of the Comprehensive Package, contributing to strategic programme development and improvement.

Each indicator has a reference number relating to the *type* of indicator and the *intervention* it examines; the following convention is used:



Abbreviations used to denote indicator type:

Pop	Population size estimate
A	Availability
C	Coverage
Q	Quality
OI	Outcome/impact

Abbreviations used to denote intervention:

NSP	Needle and syringe programmes
OST	Opioid substitution therapy
ODT	Other drug dependence treatment
HTC	HIV testing and counselling
ART	Antiretroviral therapy
STI	Sexually transmitted infection prevention, diagnosis and treatment
Cdm	Condom distribution programmes for PWID and their sexual partners
IEC	Targeted information, education and communication for PWID and their sexual partners
Hep	Prevention, vaccination, diagnosis and treatment for viral hepatitis
TB	Prevention, diagnosis and treatment of tuberculosis

POPULATION SIZE ESTIMATES

* Pop.1	Estimated number of people who inject drugs
Pop.2	Estimated number of opioid-dependent people
Pop.3	Estimated number of opioid-dependent people who inject drugs
* Pop.4	Estimated number of people who inject drugs living with HIV
Pop.5	Estimated number of people living with HIV
Pop.6	Estimated number of people who inject drugs living with HCV

NEEDLE AND SYRINGE PROGRAMMES

** NSP.A.1	Number and location of sites where needles and syringes are available
** NSP.C.1	Quantity of needles-syringes distributed
NSP.C.2	PWID <i>regularly</i> reached by NSPs
NSP.C.3	PWID reached by NSPs
NSP.C.4	NSP occasions of service (total contacts)
* NSP.Q.1	National policy and legislation—needle and syringe programmes
* NSP.Q.2	Quality of NSP service delivery

OPIOID SUBSTITUTION THERAPY AND OTHER DRUG DEPENDENCE TREATMENT

OST.A.1	Presence of maintenance OST
** OST.A.2	Number and location of maintenance OST sites
OST.A.3	OST programme capacity
ODT.A.1	Presence of drug dependence treatment, other than maintenance OST
ODT.A.2	Number of drug dependence treatment sites, other than maintenance OST
** OST.C.1	Individuals receiving maintenance OST
ODT.C.1	Individuals receiving drug dependence treatment, other than maintenance OST
* OST.Q.1	National policy and legislation—opioid substitution therapy
* OST.Q.2	Quality of OST programme service delivery
* OST.Q.3	Individuals receiving maintenance OST continuously for at least 6 months
* OST.Q.4	Individuals receiving maintenance OST dose greater than or equal to the recommended minimum dose
OST.Q.5	Individuals on maintenance OST receiving psychological support

HIV TESTING AND COUNSELLING

* HTC.A.1	Number of PWID-targeted services where HTC is provided
** HTC.C.1	PWID tested for HIV in the last 12 months

ANTIRETROVIRAL THERAPY

* ART.A.1	Availability of antiretroviral therapy for PWID
ART.A.2	Number of PWID-targeted services where ART is provided
** ART.C.1	PWID receiving ART
ART.C.2	Relative access to ART

*** ART.Q.1 National policy and legislation—antiretroviral therapy for PWID**

*** ART.Q.2 Quality of ART service delivery for PWID**

ART.Q.3 PWID on ART receiving adherence support

ART.Q.4 PWID on ART receiving case management

SEXUALLY TRANSMITTED INFECTION PREVENTION, DIAGNOSIS AND TREATMENT

STI.C.1 PWID screened or treated for STIs at services targeting PWID

CONDOM DISTRIBUTION PROGRAMMES FOR PWID AND THEIR SEXUAL PARTNERS

*** Cdm.C.1 Quantity of condoms distributed by services targeting PWID**

Cdm.C.2 PWID receiving condoms in a 12-month period

TARGETED INFORMATION, EDUCATION AND COMMUNICATION FOR PWID AND THEIR SEXUAL PARTNERS

*** IEC.C.1 Frequency of NSP occasions of service where IEC is provided**

IEC.C.2 PWID receiving IEC

PREVENTION, VACCINATION, DIAGNOSIS AND TREATMENT FOR VIRAL HEPATITIS

Hep.A.1 Number of PWID-targeted services providing HBV vaccination

Hep.A.2 Number of PWID-targeted services and ART provision sites providing HBV treatment

*** Hep.A.3 Availability of hepatitis C treatment for PWID**

Hep.A.4 Number of PWID-targeted services and ART provision sites providing HCV management and treatment

*** Hep.C.1 PWID receiving HBV vaccination from PWID-targeted services**

Hep.C.2 PWID receiving HBV treatment from PWID-targeted services and ART provision sites

*** Hep.C.3 PWID receiving HCV treatment from PWID-targeted services and ART provision sites**

PREVENTION, DIAGNOSIS AND TREATMENT OF TUBERCULOSIS

TB.A.1 TB infection control at PWID-targeted services

TB.A.2 Number of PWID-targeted services providing TB preventive therapy

*** TB.A.3 Number of PWID-targeted services providing TB diagnosis and treatment**

TB.C.1 Assessment of PWID TB status by HIV treatment and care services

TB.C.2 PWID living with HIV starting isoniazid preventive therapy (IPT)

OUTCOME/IMPACT OF INDICATORS

*** OI.1 Reduced HIV incidence among PWID**

*** OI.2 Reduced HIV prevalence among PWID**

*** OI.3 Increased use of sterile injecting equipment by PWID**

OI.4 Reduction in frequency of injection

OI.5 Increased awareness of HIV status among PWID

*** OI.6 Decreased incidence of AIDS cases among PWID**

OI.7 Decreased AIDS-related mortality among PWID

OI.8 Decreased incidence of sexually transmitted infections among PWID

*** OI.9 Increased use of condoms among PWID**

* Key indicator

** Priority key indicator

4.2 POPULATION SIZE ESTIMATES



Pop.1	ESTIMATED NUMBER OF PEOPLE WHO INJECT DRUGS (PWID) <i>Estimated number of active PWID, defined as the number of people who injected drugs at any time within the past 12 months</i>
Suggested disaggregations	Gender: Male, female, transgender Age: ≤18 years; >18 years and <25 years; ≥ 25 years Type of drug injected (see also Pop.3, below): opioids, stimulants (including amphetamine-type stimulants and cocaine preparations), other (including benzodiazepines)
Indicators using estimate	NSP.C.1 NSP.C.2 NSP.C.3 NSP.C.4 OST.C.1 ODT.C.1 HTC.C.1 STI.C.1 Cdm.C.1 IEC.C.2

Pop.2	ESTIMATED NUMBER OF OPIOID-DEPENDENT PEOPLE
Suggested disaggregations	Gender: Male, female, transgender Age: ≤18 years; >18 years and <25 years; ≥ 25 years
Indicators using estimate	OST.C.1

Pop.3	ESTIMATED NUMBER OF OPIOID-DEPENDENT PEOPLE WHO INJECT DRUGS
Suggested disaggregations	Gender: Male, female, transgender Age: ≤18 years; >18 years and <25 years; ≥ 25 years
Indicators using estimate	OST.C.1



Pop.4	ESTIMATED NUMBER OF PEOPLE WHO INJECT DRUGS LIVING WITH HIV
Recommended disaggregations	Gender: Male, female, transgender Age: ≤18 years; >18 years and <25 years; ≥ 25 years Type of drug injected (see also Pop.3, above): opioids, stimulants (including amphetamine-type stimulants and cocaine preparations), other (including benzodiazepines)
Indicators using estimate	ART.C.1 ART.C.2
Comments	Derived by applying estimated HIV prevalence to estimated number of PWID. There is likely to be significant uncertainty around both PWID population size and HIV prevalence estimates; consequently, when combined, the uncertainty around estimates of the number of PWID living with HIV may be substantial. HIV register data may be used also but are likely to be an underestimate.

Pop.5	ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV
Recommended disaggregations	Gender: Male, female, transgender Age: ≤18 years; >18 years and <25 years; ≥ 25 years
Indicators using estimate	ART.C.2

Pop.6	ESTIMATED NUMBER OF PEOPLE WHO INJECT DRUGS INFECTED WITH HEPATITIS C VIRUS
Recommended disaggregations	Gender: Male, female, transgender Age: ≤18 years; >18 years and <25 years; ≥ 25 years Type of drug injected: opioids, stimulants (including amphetamine-type stimulants and cocaine preparations), other (including benzodiazepines)
Indicators using estimate	Hep.C.3
Comments	Derived by applying estimated HCV prevalence to estimated number of PWID. There will likely be significant uncertainty around both PWID population size and HCV prevalence estimates; consequently, when combined, the uncertainty around estimates of the number of PWID living with HCV may be considerable. HCV register data may be used also but are likely to be an underestimate.

4.3 THE COMPREHENSIVE PACKAGE

1 NEEDLE AND SYRINGE PROGRAMMES

**

NSP.A.1

NUMBER AND LOCATION OF SITES WHERE NEEDLES AND SYRINGES ARE AVAILABLE

These indicators look at the number of sites where clean injecting equipment is available either free or for purchase, as well as the presence or absence of these outlets in locations where people who inject drugs are known to be present.

Recommended disaggregations:

Community / Prisons and other closed settings

	Indicator:	Data sources:	Comments:
NSP.A.1a	Number of NSP sites	Programme data	NSPs may operate in a variety of locations and service models, including fixed sites, mobile services and outreach. For the purpose of reporting this indicator, it is recommended that, for a location to be considered a “site”, the following conditions must be met: • It is the location of a fixed site or site that is serviced by a mobile or outreach service. • If a fixed site, it must have frequent and regular hours of operation. • If a mobile service, the service must operate at the site on a frequent and regular basis. • If an outreach service, the specific site or defined area must be accessed on a frequent and regular basis by outreach workers. • This count includes pharmacy sites providing needles and syringes at no cost to the client but not those that only sell needles and syringes.
NSP.A.1b	Number of pharmacies or other outlets where needles and syringes are available for purchase	Programme data	In some countries injecting equipment may be available for purchase from any pharmacy, while in others the sale of injecting equipment may be more restricted; for example, only certain outlets provide needles and syringes.

	<i>Indicator:</i>	<i>Data sources:</i>	<i>Comments:</i>
NSP.A.1c	Number of <i>cities/states/provinces/oblasts</i> where NSPs are present	Programme data	See section 3.4, part 4, for more information on measuring and interpreting this indicator. Possible targets: Low ← 60% ← Mid → 80% → High
NSP.A.1d	Number of <i>cities/states/provinces/oblasts</i> where pharmacies or other outlets are present that offer needles and syringes for purchase	Programme data	
NSP.A.1e	Number of <i>cities/states/provinces/oblasts</i> where PWID are known to be present	Situational analysis, mapping exercise	
NSP.A.1f	Percentage of <i>cities/states/provinces/oblasts</i> where PWID are located and NSPs are present	$\frac{[\text{NSP.A.1c}]}{[\text{NSP.A.1e}]} \times 100$	
NSP.A.1g	Percentage of <i>cities/states/provinces/oblasts</i> where PWID are located and where pharmacies or other outlets are present that offer needles and syringes for purchase	$\frac{[\text{NSP.A.1d}]}{[\text{NSP.A.1e}]} \times 100$	

**

QUANTITY OF NEEDLES–SYRINGES DISTRIBUTED

This indicator looks at the total quantity of new/sterile needles–syringes that are distributed and, hence, estimates the total number of clean units of injecting equipment in circulation that might be used by the population of injecting drug users.

Level of application:

These indicators can be applied at the national, regional, city or service level. In each case the PWID population estimate used as the denominator should be relevant to the area examined.

Recommended disaggregations:

Gender (male/female/transgender)

Age (≤ 18 years; >18 years and <25 years; ≥ 25 years)

Drug injected (opioids/stimulants/other)

	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
NSP.C.1a	Total number of needles–syringes distributed by NSPs in the last 12 months	Programme data	NSPs may provide various types of needles and syringes, including separate needles and syringe or syringes with needles attached. For the purpose of counting the number of needles–syringes for this indicator, it is recommended to count the total number of equivalent single sterile injecting units distributed. For example: if 10 separate syringes and 20 separate needles are dispensed, a total of 10 sterile injecting units (each comprising 1 needle and 1 syringe) would be counted; similarly, if 12 separate syringes and 6 separate needles are dispensed, a total of 6 sterile injecting units would be counted. To allow for disaggregation by gender, age or drug injected, service-level data collection systems must record these client characteristics.
NSP.C.1b	Total number of needles–syringes sold to PWID by pharmacies or other outlets in the last 12 months	Retail data	In most countries it is unlikely that these data will be available. If such data are collected and collated, however, a more complete picture of the total number of needles and syringes in circulation and, hence, of coverage can be seen.

	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
NSP.C.1c	Number of needles–syringes distributed per PWID per year	$\frac{[\text{NSP.C.1a}] + [\text{NSP.C.1b}]}{[\text{Pop.1}]}$	Possible targets: Low ← 100 ← Mid → 200 → High These target levels are based upon studies in developed-country settings and mathematical modelling investigating the levels of syringe distribution and its impact on HIV transmission (124,134). Note that the levels required for the prevention of HCV are likely to be much higher than those proposed here. This indicator should still be calculated even if data on the number of needles–syringes sold by pharmacies is not available. This indicator is included in the Global AIDS Response progress reporting 2012 (12).

NSP.C.2	PWID REGULARLY REACHED BY NSPS <i>PWID who inject regularly require an ongoing supply of injecting equipment and, thus, continual access to NSPs.</i> <i>For the purpose of these indicators, “regular reach” is defined as once per month.</i> <i>If the quantity of injecting equipment that a client is able to obtain per visit is limited, it may be necessary for a PWID to access an NSP regularly more often than once per month to have a sufficient supply of clean injecting equipment and avoid used needles and syringes.</i> Level of application: <i>These indicators can be applied at the national, regional, city or service level. In each case the PWID population estimate used as the denominator should be relevant to the area examined.</i> Recommended disaggregations: <i>Gender (male/female/transgender)</i> <i>Age (≤18 years; >18 years and <25 years; ≥25 years)</i> <i>Drug injected (opioids/stimulants/other)</i>		
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	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
NSP.C.2a	Number of PWID who accessed an NSP once per month or more over the specified reporting period (e.g. last 12, 6 or 3 months)	Programme data	This indicator requires that service-level data collection systems use unique identifier codes (UIC; see page 37 for more detail) to allow the frequency of visits by each NSP client to be measured over a period of time.
NSP.C.2b	Percentage of PWID who were regularly reached by NSPs over the specified reporting period (e.g. last 12, 6 or 3 months)	$\frac{[\text{NSP.C.2a}]}{[\text{Pop.1}]} \times 100$	Possible targets: Low ← 20% ← Mid → 60% → High The <i>high</i> target level is based on a retrospective analysis of the coverage required to reverse the HIV/AIDS epidemic among PWID in an urban setting in a high-income country (135).

NSP.C.3	PWID REACHED BY NSPS <i>If NSP data collection systems are not able to determine clients' frequency of contact with NSPs but can record numbers of client contacts within reporting periods of different length, the following indicators investigating contacts within the last month and last 12 months can be used to give an indication of the level of NSP reach.</i> <i>These indicators may also be useful even when data on regular reach are available, as these more basic indicators may allow for comparison with other countries and with older data and thus make possible tracking of progress.</i> Level of application: <i>These indicators can be applied at the national, regional, city or service level. In each case the PWID population estimate used as the denominator should be relevant to the area examined.</i> Recommended disaggregations: <i>Gender (male/female/transgender)</i> <i>Age (<18 years; >18 years and <25 years; ≥25 years)</i> <i>Drug injected (opioids/stimulants/other)</i>		
	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
	NSP.C.3a Number of PWID who accessed an NSP over the specified reporting period (e.g. last 12, 6 or 3 months)	Programme data	This indicator requires services to have a data collection system using <i>unique identifier codes</i> (UIC, see page 37 for more detail) to allow determination of the total number of individual clients accessing the service within the reporting period and to avoid double-counting clients who access the service more than once.
	NSP.C.3b Percentage of all PWID who were reached by an NSP over the specified reporting period (e.g. last 12, 6 or 3 months)	$\frac{[\text{NSP.C.3a}]}{[\text{Pop.1}]} \times 100$	A 1-month reporting period can be used as a proxy for recent/current coverage. Possible targets: Low ← 20% ← Mid → 60% → High
	NSP.C.3c Number of PWID who accessed an NSP in the last 1 month	Programme data	These indicators requires services to have a data collection system using <i>unique identifier codes</i> (UIC, see page 37 for more detail) to allow determination of the total number of individual clients accessing the service within the reporting period and to avoid double-counting clients who access the service more than once.
	NSP.C.3d Number of PWID who accessed an NSP in the last 12 months	Programme data	
	NSP.C.3e Percentage of all PWID reached by an NSP in the last 12 months who were also reached in the last 1 month	$\frac{[\text{NSP.C.3c}]}{[\text{NSP.C.3d}]} \times 100$	If it is not possible to measure the frequency of access by PWID within a period of time, this indicator can be a proxy for estimating the frequency of contact, by comparing the number of PWID who have accessed an NSP recently, in the last 1 month, with the total number who have accessed an NSP in the last 12 months. Possible targets: Low ← 30% ← Mid → 70% → High

NSP.C.4	NSP OCCASIONS OF SERVICE (TOTAL CONTACTS)		
	Level of application: <i>These indicators can be applied at the national, regional, city or service level. In each case the PWID population estimate used as the denominator should be relevant to the area examined.</i> Recommended disaggregations: <i>Gender (male/female/transgender)</i> <i>Age (<18 years; >18 years and <25 years; ≥25 years)</i> <i>Drug injected (opioids/stimulants/other)</i>		
	Indicator:	Data source:	Comments:
NSP.C.4a	Number of NSP occasions of service (total contacts) in specified reporting period	Programme data	Total number of all NSP client service events, or occasions of service; this includes every visit to an NSP service in which needles and syringes were dispensed. Multiple visits by the same client are included in this count. The service data collection system does not require unique identifier codes.
NSP.C.4b	Ratio of the number of NSP occasions of service in specified reporting period per 100 PWID	$\frac{[\text{NSP.C.4a}]}{[\text{Pop.1}]} \times 100$	Possible targets: Low ← 30 ← Mid → 70 → High



NSP.Q.1	NATIONAL POLICY AND LEGISLATION RELATING TO NEEDLE AND SYRINGE PROGRAMMES		
	<i>Are the following standards and programme features included in national legislation, policy and guidance?</i>		
NSP.Q.1a	Legislation specifically supports the distribution of injecting equipment through NSPs The distribution and collection of injecting equipment and the operation of NSPs are authorized under the law. Legislation is not ambiguous on the legal status of NSPs or on the distribution and collection of injecting equipment.		
NSP.Q.1b	National police guidelines and policy specifically support the operation of NSPs Police guidelines stipulate that police activities do not deter or prevent PWID from accessing NSPs or from being in possession of new or used injecting equipment. Police routinely receive training and education relating to drug use, HIV and harm reduction principals and services.		
NSP.Q.1c	Legislation supports the provision of NSP services in closed settings In closed settings various delivery models for the distribution of injecting equipment have been implemented in different countries. These include distribution by prison health staff, by peer-educators, by NGO representatives and from dispensing machines.		
NSP.Q.1d	National strategy includes steps to secure long-term and sufficient levels of funding to ensure sustainability of NSPs and the achievement of other quality standards described here Long-term government funding should be committed to the ongoing operation of NSPs; if services are funded by external sources, sustainability of this funding should be assessed, and contingencies for funding gaps should be determined. Funding levels must be adequate to ensure high-quality NSP services, with high levels of access and coverage, including, for example, the distribution of a range of appropriate injecting equipment (NSP.Q.1o) and no restrictions on the quantity of equipment that can be distributed (NSP.Q.1m).		

NSP.Q.1e	National policy stipulates PWID be actively involved in the planning of NSP services This involves consultation with and meaningful involvement of PWID in the development of services to ensure that they are appropriate and acceptable to the target population.
NSP.Q.1f	National guidelines recommend PWID be actively involved in the delivery of NSP services PWID may be involved in the delivery of NSP services. This commonly entails training PWID to serve as peer-educators and outreach workers and involving them in the distribution of injecting equipment.
NSP.Q.1g	National guidelines stipulate that NSP services regularly seek anonymous feedback from clients Mechanisms are in place whereby clients can confidentially/anonymously provide feedback on the service. The service should be responsive to this information.
NSP.Q.1h	National guidelines outline training and supervision requirements for NSP workforce Services train staff in line with national training standards on staff knowledge and skills. Staff receives supervision in line with national standards. Funding is allocated for staff training and supervision. Staff members are respectful towards PWID, have credibility with the target population and are non-judgemental in their attitude towards drug users.
NSP.Q.1i	National guidelines stipulate that NSPs be located in areas known to be accessible to PWID Mapping of the target population may be required to determine the accessibility of locations for PWID. For example, sites should be easily and affordably accessible by public transport.
NSP.Q.1j	National guidelines recommend that a range of NSP service delivery models be employed to maximize reach. The mix of service delivery models should maximize the accessibility of injecting equipment, including at all times of the day and week; and may include: fixed-site services, mobile services, vending machines, outreach, home delivery and secondary distribution through other services such as sexual health clinics, drug treatment services and hospital emergency services.
NSP.Q.1k	National policy stipulates that NSPs maintain client confidentiality Services have systems in place to ensure that client records are kept securely and remain confidential. Clients are not required to show identification or provide personal details in order to utilize services or obtain injecting equipment. Client information is not shared with other services or law enforcement without client consent, unless required by law. Programme data collection systems do not contain clients' personal or identifiable information.
NSP.Q.1l	National policy stipulates that NSP services are "low-threshold" and do not require PWID to meet specific criteria in order to access services or receive injecting equipment Services do not restrict access on the basis of minimum age, proof of injecting status, proof of residence, gender or HIV status, citizenship status, residential status, incarceration or criminal history, nor should drug users be required to register in order to receive services.
NSP.Q.1m	National guidelines stipulate that there be no limit on the quantity of injecting equipment provided This distribution policy seeks to maximize the quantity of injecting equipment dispensed.
NSP.Q.1n	National guidelines stipulate that the return of used injecting equipment is <i>not</i> a prerequisite for clients to receive new injecting equipment While returning used injecting equipment should not be a prerequisite for receiving new injecting equipment, PWID should be encouraged and helped to dispose of injecting equipment safely.

NSP.Q.1o	National guidelines stipulates that NSPs provide a range of injecting equipment that is appropriate for local injecting practices and substances injected and that is acceptable to the target population Needles and syringes provided should be suited to the local drug market and context and acceptable to clients. PWID should be consulted to determine the most appropriate and acceptable equipment for distribution. Ideally, the smallest gauge needles should be provided in order to cause minimal tissue damage at the site of injection. Larger gauge needles may be required for the injection of some drugs, including those that are more viscous in solution and in some instances where drugs may be of poorer quality. Syringes should be of appropriate volume (larger for substances that are injected in greater volumes. Needles and syringes should have minimal dead-space, as larger syringe dead-space may retain greater quantity of infective particles, thus increasing risk of infection on reuse (28,29). Other, related materials should also be provided where appropriate, including sterile water, safe sharps disposal containers, filters, mixing vessels (e.g. spoons), disposable tourniquets, acidifiers (e.g. ascorbic or citric acid powders) and materials to encourage non-injecting routes of administration as a safer alternative to injecting, such as sterile pipes, papers or foil.
NSP.Q.1p	National guidelines stipulate that NSPs provide targeted information, education and communication (IEC), including overdose prevention, for PWID IEC material and messages, developed to suit the local context, should address the following: safe injecting technique; condom use and safer sex; drug effects and harms; blood-borne viruses risks, prevention, health impact and treatment; overdose risk, prevention and responses, which may including the provision of naloxone and training in its use for opioid users; drug treatment options; legal rights and responsibilities; safe disposal of injecting equipment; and access to medical, welfare and other services. PWID should be involved in the development and testing of these materials.
NSP.Q.1q	National guidelines stipulate that formalized referral pathways between NSPs and other relevant service providers are established, and NSP clients referred to these services as appropriate Relevant services include: drug dependence treatment; HIV, viral hepatitis, and TB testing, management, treatment and care; viral hepatitis vaccination; sexual health services (including STI testing and treatment); reproductive health services; mental health services; general medical services; welfare; accommodation services; legal services; education services; and primary health care. These services may be external to the NSP or may be within the same facility, if services are integrated. Established referral pathways should meet the following criteria: • The referring service has a roster of nominated services to which clients may be referred and has links with these services. • Services to which clients are referred are sensitive, supportive and responsive to the needs of PWID and are located close to the referring service or are easily accessible to the client. • Follow-up and continuity of care are strengthened through case management instituted by the referring service.
NSP.Q.1r	National guidance outlines systems to prevent NSP stock-outs NSPs need to store sufficient amounts of injecting equipment and to have reliable supply chains and robust procurement processes to ensure there is no interruption in the provision of injecting equipment.



QUALITY OF NSP SERVICE DELIVERY	
<i>These indicators examine the adherence to quality standards at the service level. These indicators can be used to assess service delivery of an individual service or NSP site. Results from multiple services may be aggregated to determine the proportion of all services adhering to each quality standard.</i>	
NSP.Q.2	
NSP.Q.2a	Long-term funding has been secured to ensure the sustainability of the NSP service (<i>see NSP.Q.1d</i>)
NSP.Q.2b	The programme has actively involved PWID in the planning of NSP services (<i>see NSP.Q.1e</i>)
NSP.Q.2c	PWID are actively involved in the delivery of NSP services (<i>see NSP.Q.1f</i>)
NSP.Q.2d	The service regularly seeks anonymous feedback from clients (<i>see NSP.Q.1g</i>)
NSP.Q.2e	The NSP workforce has received training and is supervised (<i>see NSP.Q.1h</i>)
NSP.Q.2f	The NSP is situated in a location known to be accessible to PWID (<i>see NSP.Q.1i</i>)
NSP.Q.2g	The programme employs a range of NSP service delivery models to maximize reach (<i>see NSP.Q.1j</i>)
NSP.Q.2h	The NSP service maintains client confidentiality (<i>see NSP.Q.1k</i>)
NSP.Q.2i	The NSP service is “low-threshold” and does not require PWID to meet specific criteria in order to access services or receive injecting equipment (<i>see NSP.Q.1l</i>)
NSP.Q.2j	There are no limits on the quantity of injecting equipment provided (<i>see NSP.Q.1m</i>)
NSP.Q.2k	The return of used injecting equipment is <i>not</i> a prerequisite for clients to receive new injecting equipment (<i>see NSP.Q.1n</i>)
NSP.Q.2l	The service provides a range of injecting equipment that is appropriate for local injecting practices and substances injected and that is acceptable to the target population (<i>see NSP.Q.1o</i>)
NSP.Q.2m	The NSP service provides targeted information, education and communication (IEC), including overdose prevention, for PWID (<i>see NSP.Q.1p</i>)
NSP.Q.2n	Formalized referral pathways between the NSP service and other relevant service providers have been established, and NSP clients are referred to these services as appropriate (<i>see NSP.Q.1q</i>)
NSP.Q.2o	A system to prevent stock-outs has been implemented (<i>see NSP.Q.1r</i>)

2 OPIOID SUBSTITUTION THERAPY AND OTHER DRUG DEPENDENCE TREATMENT

PRESENCE OF OPIOID SUBSTITUTION THERAPY (OST)			
OST.A.1 Recommended disaggregations: <i>Community / Prisons and other closed settings</i>			
	<i>Indicator:</i>	<i>Responses:</i>	<i>Comments:</i>
OST.A.1a	Availability of OST, involving the use of opioid agonists for maintenance treatment of opioid dependence	Present / Absent	Includes the use of opioid agonists for the purpose of maintenance substitution therapy; <i>does not</i> include short-term substitution therapy for detoxification.
OST.A.1b	Availability of methadone for maintenance treatment for opioid dependence	Present / Absent	Includes the use of methadone for the purpose of maintenance substitution therapy; <i>does not</i> include short-term substitution therapy for detoxification.
OST.A.1c	Availability of buprenorphine for maintenance treatment for opioid dependence	Present / Absent	Includes the use of buprenorphine for the purpose of maintenance substitution therapy; <i>does not</i> include short-term substitution therapy for detoxification.
OST.A.1d	Availability of other opioid agonists for maintenance treatment for opioid dependence	Present / Absent	Other opioid agonists that may be used in maintenance treatment include: • diamorphine (pharmaceutical heroin) • slow-release morphine preparations • tincture of opium • other; these should be specified when reported.

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NUMBER AND LOCATION OF MAINTENANCE OST SITES <i>These indicators look at the number of sites where OST is provided; because prescription and dispensing may take place at different locations, these are examined separately.</i> Recommended disaggregations: <i>Private / Public service providers</i> <i>Community / Prisons and other closed settings</i>			
	<i>Indicator:</i>	<i>Data sources:</i>	<i>Comments:</i>
OST.A.2a	Number of sites where OST is prescribed	Programme data	Sites where OST is prescribed may include: specialist services, general practitioner prescribers/office-based, and other primary care settings.
OST.A.2b	Number of sites where OST is dispensed	Programme data	Sites where OST is dispensed may include: pharmacies, specialist services, mobile dispensing services.
OST.A.2c	Number of cities/states/provinces/ oblasts where OST is available	Programme data	See section 3.4, part 4, for more information on measuring and interpreting this indicator.
OST.A.2d	Number of cities/states/provinces/oblasts where injecting drug users are known to be present	Situational analysis, mapping exercise	Possible targets: Low ← 60% ← Mid → 80% → High
OST.A.2e	Percentage of cities/states/provinces/oblasts where injecting drug users are located and where OST is available	$\frac{[\text{OST.A.2c}]}{[\text{OST.A.2d}]} \times 100$	

OST PROGRAMME CAPACITY <i>This indicator can provide a measure of the extent to which demand for OST is matched by the capacity of the programme.</i> Recommended disaggregations: <i>Private / Public service providers</i> <i>Community / Prisons and other closed settings</i>			
	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
OST.A.3a	Number of people on waiting list for OST on specified date	Programme data	

ODT.A.1	PRESENCE OF DRUG DEPENDENCE TREATMENT, OTHER THAN MAINTENANCE OST Recommended disaggregations: <i>Private / Public service providers</i> <i>Community / Prisons and other closed settings</i>		
	<i>Indicator:</i>	<i>Responses:</i>	<i>Comments:</i>
ODT.A.1a	Availability of inpatient detoxification	Present / Absent	Supported drug withdrawal in an inpatient setting, typically for a period lasting less than 10 days.
ODT.A.1b	Availability of outpatient drug dependence treatment	Present / Absent	Provision of drug dependence treatment services (other than OST) in an outpatient setting. May include such treatment modalities as group or individual counselling.
ODT.A.1c	Availability of inpatient short-term treatment for drug dependence	Present / Absent	Short-term inpatient treatment for drug dependence is defined as treatment lasting up to 4 months.
ODT.A.1d	Availability of inpatient long-term care or residential treatment	Present / Absent	Long-term inpatient or residential treatment for drug dependence is defined as treatment lasting 4 months or longer.
ODT.A.1e	Availability of peer-based support groups	Present / Absent	Also known as self-help groups. Describes groups in which participants support each other in recovering or maintaining recovery from drug dependence and related problems without professional therapy or guidance. Examples include Narcotics Anonymous (NA).
ODT.A.1f	Availability of NSPs, or other services targeting PWID, providing brief intervention for drug-dependent clients	Present / Absent	Brief interventions, based on motivational principles, may be offered for the treatment of substance use disorders in non-specialist settings (i.e. non-drug-dependence treatment settings) such as NSPs. Brief interventions are offered with a view to referral at later stages to specialized treatment services.

ODT.A.2 NUMBER OF DRUG DEPENDENCE TREATMENT SITES, OTHER THAN MAINTENANCE OST Recommended disaggregations: <i>Private / Public service providers</i> <i>Community / Prisons and other closed settings</i>			
	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
ODT.A.2a	Number of sites where inpatient detoxification is provided	Programme data	
ODT.A.2b	Number of sites where outpatient drug dependence treatment is provided	Programme data	
ODT.A.2c	Number of sites where inpatient short-term treatment for drug dependence is provided	Programme data	
ODT.A.2d	Number of sites where inpatient long-term residential treatment is provided	Programme data	
ODT.A.2e	Number of sites where peer-based support groups are available	Programme data	
ODT.A.2f	Number of NSP sites that provide brief intervention for drug-dependent clients	Programme data	
ODT.A.2g	Percentage of NSP sites that provide brief intervention for drug-dependent clients	$\frac{[\text{ODT.A.2f}]}{[\text{NSP.A.1a}]} \times 100$	

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INDIVIDUALS RECEIVING MAINTENANCE OST <i>Because the availability of data will likely vary in different settings, a variety of indicators to examine the scale of OST provision relative to the size of the target population are described. Where possible, however, efforts should be made to collect the data that most closely measure treatment delivery against need—ideally, using indicators OST.C.1c and OST.1C.d.</i> Level of application: <i>These indicators can be applied at the national, regional, city or service level. In each case, when measuring coverage, the population size estimate used as the denominator should be relevant to the area examined.</i> Recommended disaggregations: <i>Gender (male/female/transgender)</i> <i>Age (<18 years; >18 years and <25 years; ≥25 years)</i> <i>Community / Prisons and other closed settings</i>			
	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
OST.C.1a	Number of all individuals on OST at a specified date or over the specified reporting period (e.g. last 12, 6 or 3 months)	Programme data	This number includes all patients, regardless of injecting drug use history or status. If the number of patients in treatment at a specified date is not available, the number of patients who received OST at any time over a specified reporting period can be examined. It is important to ensure that there is no double-counting of individuals who may have dropped out of OST and then resumed treatment at a later date within the specified reporting period.
OST.C.1b	Number of PWID on OST at a specified date or over the specified reporting period (e.g. last 12, 6 or 3 months)	Programme data	This number includes patients who have a history of ever having injected drugs. If the number of patients in treatment at a specified date is not available, the number of patients who received OST at any time over a specified reporting period can be examined. It is important to ensure that there is no double-counting of individuals who may have dropped out of OST and then resumed treatment at a later date within the specified reporting period.
OST.C.1c	Percentage of opioid-dependent people on OST	$\frac{[\text{OST.C.1a}]}{[\text{Pop.2}]} \times 100$	Denominator is the estimated number of <i>all</i> opioid-dependent people [Pop.2]. Possible targets: Low ← 20% ← Mid → 40% → High The <i>high</i> target level is based on levels of coverage achieved in countries with well-established OST programmes.

	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
OST.C.1d	Percentage of opioid-dependent PWID on OST	$\frac{[\text{OST.C.1b}]}{[\text{Pop.3}]} \times 100$	Denominator is the estimated number of opioid-dependent <i>PWID</i> [Pop.3]. Possible targets: Low ← 20% ← Mid → 40% → High The <i>high</i> target level is based on levels of coverage achieved in countries with well-established OST programmes.
OST.C.1e	Ratio of the number of PWID on OST per 100 PWID	$\frac{[\text{OST.C.1b}]}{[\text{Pop.1}]} \times 100$	Denominator is the estimated number of all PWID [Pop.1]. Lacking OST programme data on clients' injecting drug use history or status and without estimates of the size of the opioid-dependent PWID population, this indicator may be the only measure of OST provision relative to PWID population size that can be reported. The very significant limitations of this indicator must be appreciated, however, it does not directly measure treatment need (demand). This indicator is most appropriate in settings where most PWID are opioid-dependent and where most OST recipients are PWID.

ODT.C.1	INDIVIDUALS RECEIVING DRUG DEPENDENCE TREATMENT, OTHER THAN MAINTENANCE OST <i>Drug dependence treatment providers may offer services for a wide range of patients in addition to those who may inject drugs, including, for example, those dependent on alcohol or cannabis.</i> <i>It is desirable, for the purpose of assessing drug dependence treatment as part of the response to HIV among PWID, to assess the coverage of drug dependence treatment for PWID specifically. To do this, however, requires data collection at the service level that identifies patients' injecting drug use status and allows for disaggregation accordingly. Many data collection systems may not allow this type of disaggregation; the indicators described here are for application where data collection systems do allow for reporting such disaggregated data.</i> Level of application: <i>These indicators can be applied at the national, regional, city or service level. In each case, when measuring coverage among PWID, the population size estimate used as the denominator should be relevant to the area examined.</i> Recommended disaggregations: <i>Gender (male/female/transgender)</i> <i>Age (<18 years; >18 years and <25 years; ≥25 years)</i> <i>Drug injected (opioids/stimulants/other)</i> <i>Community / Prisons and other closed settings</i>		
	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
	ODT.C.1a Number of <i>all individuals</i> receiving inpatient drug detoxification during the specified reporting period (e.g. last 12, 6 or 3 months)	Programme data	This number includes all patients, regardless of injecting drug use history or status.
	ODT.C.1b Number of <i>PWID</i> receiving inpatient drug detoxification during the specified reporting period	Programme data	These indicators can be reported only if patients' injecting drug use status is recorded in the data collection system.
	ODT.C.1c Percentage of PWID receiving inpatient drug detoxification during the specified reporting period	$\frac{[\text{ODT.C.1b}]}{[\text{Pop.1}]} \times 100$	
	ODT.C.1d Number of individuals receiving outpatient drug dependence treatment during the specified reporting period (e.g. last 12, 6 or 3 months)	Programme data	This number includes all patients, regardless of injecting drug use history or status.
	ODT.C.1e Number of PWID receiving outpatient drug dependence treatment during the specified reporting period	Programme data	These indicators can be reported only if patients' injecting drug use status is recorded in the data collection system.
	ODT.C.1f Percentage of PWID receiving outpatient drug dependence treatment during the specified reporting period	$\frac{[\text{ODT.C.1e}]}{[\text{Pop.1}]} \times 100$	

	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
ODT.C.1g	Number of individuals receiving inpatient short-term treatment for drug dependence during the specified reporting period (e.g. last 12, 6 or 3 months)	Programme data	This number includes all individuals, regardless of injecting drug use history or status.
ODT.C.1h	Number of PWID receiving inpatient short-term treatment for drug dependence during the specified reporting period	Programme data	These indicators can be reported only if individuals' injecting drug use status is recorded in the data collection system.
ODT.C.1i	Percentage of PWID receiving inpatient short-term treatment for drug dependence during the specified reporting period	$\frac{[\text{ODT.C.1h}]}{[\text{Pop.1}]} \times 100$	
ODT.C.1j	Number of individuals receiving inpatient long-term treatment for drug dependence during the specified reporting period (e.g. last 12, 6 or 3 months)	Programme data	This number includes all patients, regardless of injecting drug use history or status.
ODT.C.1k	Number of PWID receiving inpatient long-term treatment for drug dependence during the specified reporting period	Programme data	These indicators can be reported only if patients' injecting drug use status is recorded in the data collection system.
ODT.C.1l	Percentage of PWID receiving inpatient long-term treatment for drug dependence during the specified reporting period	$\frac{[\text{ODT.C.1k}]}{[\text{Pop.1}]} \times 100$	
ODT.C.1m	Number of individuals participating in peer-based support groups during the specified reporting period (e.g. last 12, 6 or 3 months)	Programme data	This number includes all patients, regardless of injecting drug use history or status.
ODT.C.1n	Number of PWID participating in peer-based support groups during the specified reporting period	Programme data	These indicators can be reported only if patients' injecting drug use status is recorded in the data collection system.
ODT.C.1o	Percentage of PWID participating in peer-based support groups during the specified reporting period	$\frac{[\text{ODT.C.1n}]}{[\text{Pop.1}]} \times 100$	



* OST.Q.1	NATIONAL POLICY AND LEGISLATION – OPIOID SUBSTITUTION PROGRAMMES <i>Are the following standards and programme features included in national legislation, policy and guidance?</i>
OST.Q.1a	Legislation explicitly supports the provision of OST The provision of opioid substitution therapy is authorized under the law, and legislation is not ambiguous on the legal status of OST programs.
OST.Q.1b	National police guidelines and policy specifically support the operation of OST programmes Police guidelines stipulate that police activities do not deter or prevent PWID from accessing OST programmes. Police routinely receive training and education relating to drug use, HIV and harm reduction principals and services.
OST.Q.1c	National OST guidelines are developed at the country level or lower These guidelines are detailed, comprehensive and evidence-based and reflect local laws, policies and conditions and are consistent with international guidance (e.g. relevant WHO guidelines).
OST.Q.1d	National strategy includes steps to secure long-term and sufficient levels of funding to ensure sustainability of OST programmes and the achievement of other quality standards described here Long-term government funding should be committed to the ongoing operation of OST programmes. If services are funded by external sources, sustainability of this funding should be assessed, and contingencies for funding gaps should be determined. Funding levels must be adequate to ensure high-quality NSP services, with high levels of access and coverage.
OST.Q.1e	National policy stipulates that PWID be actively involved in the planning of OST services This involves consultation with and meaningful involvement of PWID in the development of services to ensure that they are appropriate and acceptable to the target population.
OST.Q.1f	National guidelines stipulate that OST services regularly seek anonymous feedback from clients Mechanisms are in place whereby clients can confidentially/anonymously provide feedback on the service. The service should be responsive to this information.
OST.Q.1g	National policy stipulates a clear chain of accountability within OST services, and within the health system more broadly, to ensure that minimum standards for the provision of OST are met
OST.Q.1h	National policy requires OST prescribers to receive accredited training and to be registered OST prescribers are required to take accredited post-graduate training in OST, participate in continuing education, monitoring and evaluation, and be registered to prescribe OST. Prescribers are respectful towards PWID, have credibility with the target population and be non-judgemental in their attitude towards drug users.
OST.Q.1i	National policy requires that OST dispensing staff receive training in line with national guidelines Funding is allocated for staff training and supervision. Training includes responding to adverse events and assessment of patient pre-dosing.
OST.Q.1j	National policy stipulates that OST services be “low-threshold”, and access unrestricted Criteria for OST should be based on clinical indications for treatment. Access should not be restricted on the basis of non-clinical criteria such as minimum age, injecting status (both PWID and non-PWID who are opioid-dependent should be able to access treatment), gender, HIV status (either HIV-positive or negative), citizenship status, having a permanent address, incarceration or criminal history.
OST.Q.1k	National guidelines recommend that OST programmes operate through a range of service delivery models that allow for access to OST by all opioid-dependent people May include: general practitioner prescribers/office-based and prescription by specialist/ from specialist services; provision for “take home” medication; outreach or mobile services.
OST.Q.1l	National guidelines require OST prescribers and dispensing services to be located in areas known to be accessible to PWID Mapping of the target population may be required to determine the accessibility of locations for PWID. For example, sites should be easily and affordably accessible by public transport.

OST.Q.1m	National guidelines stipulate that dispensing of OST is available at various times of the day and beyond standard office hours if required Accessibility of OST is enhanced by the availability of dispensing at various times of the day, including outside regular business hours and on weekends to allow patients who are employed to access the service. Patients who work at night (e.g. sex workers) may require access outside of regular business hours.
OST.Q.1n	National policy includes provision to ensure that OST is affordable, so as to maximize access The cost of OST can be a significant barrier to treatment access for many opioid-dependent people. To increase accessibility, OST may be offered free of charge (this would be the best practice but likely not possible in the majority of resource-limited settings), the costs covered by health insurance provisions, the costs to patients partly subsidized, or provided free or at reduced cost especially for financially disadvantaged patients.
OST.Q.1o	National guidelines stipulate that patient identity must be confirmed and history of recent opioid use established for a patient to be eligible for OST
OST.Q.1p	National guidelines specify that comprehensive patient assessment protocols are consistently applied Patient assessment for OST includes the following: • drug use history • mental health history and current state • comorbid medical conditions • psychosocial assessment (including assessment of accommodation, employment, family, cultural issues, education status and legal issues including past incarceration) • clinical examination, including for physical signs of injecting-related complications • investigations: STI screen; HIV treatment and care; hepatitis screen; pregnancy test; and possibly a drug urine screen.
OST.Q.1q	National policy requires all patients to provide informed consent for OST
OST.Q.1r	National guidelines require all OST recipients to be registered on a national registration system This national registration system is secure and maintains client confidentiality. Client information is not shared with other services or law enforcement without client consent, unless required by law.
OST.Q.1s	National guidelines require complete medical records to be kept for all patients
OST.Q.1t	National policy stipulates that OST programmes maintain client confidentiality Services have systems in place to ensure that client records are kept securely and remain confidential. Client information is not shared with other services or law enforcement without client consent, unless required by law. Programme data collection systems do not contain clients' personal or identifiable information.
OST.Q.1u	National guidelines require patients to be provided information on potential risks and adverse events associated with OST OST patients receive information on adverse events, such as overdose, interactions with drugs and other medications and information on how to avoid these adverse events and how to respond should they occur.
OST.Q.1v	National guidelines stipulate that during OST induction patients are regularly reviewed by a clinician in accordance with protocol The following schedule is an example: • day 1 • day 3 or 4 • end of week 1 • weekly for month 1 or until stable dose achieved • every 2 weeks for first 3 months • monthly thereafter

OST.Q.1w	National guidelines stipulate the maximum initial dose for methadone maintenance treatment (MMT) and buprenorphine maintenance treatment (BMT) in line with international recommendations Initial dose: <30 mg for MMT; <8 mg for BMT.
OST.Q.1x	National guidelines stipulate the minimum maintenance doses for MMT and BMT Maintenance dose: >60 mg for MMT; >8 mg for BMT.
OST.Q.1y	National guidelines recommend duration of OST to be 6 months or longer, and no maximum duration of treatment is set
OST.Q.1z	National guidelines recommend that psychosocial assessment and support are offered to all patients Psychosocial support may include, as a minimum: • assessment of psychosocial needs • supportive counselling • links to existing family and community services. Where resources and capacity permit, a variety of structured psychosocial interventions are offered, according to the needs of the patient. These may include: • counselling and psychotherapy • assistance with social needs including accommodation, employment, education, welfare and legal issues • onsite psychosocial support and psychiatric treatment.
OST.Q.1aa	National guidelines outline circumstances necessitating involuntary discharge from OST Involuntary discharge occurs only when it is necessary for the safety of staff or other clients; drug use is not a reason for discharge from OST.
OST.Q.1ab	National guidelines require OST dispensing protocol to be followed The process for dispensing OST is clear and well-described in national guidelines and includes: • patient identification must be established • dose is checked • patient is assessed to ensure that it is safe to administer dose • dosing is supervised • records of dosing are kept • medication is stored safely.
OST.Q.1ac	National guidelines outline systems to prevent OST stock-outs OST dispensing services must store sufficient quantities of opioid substitution medication to avoid stock-outs and must have reliable supply chains and robust procurement processes.
OST.Q.1ad	National guidelines require formalized referral pathways to be established between OST programmes and other relevant service providers, and OST clients are referred to these services as appropriate Relevant services include: needle and syringe programmes; other drug dependence treatment; HIV, viral hepatitis, and TB testing, management, treatment and care; viral hepatitis vaccination; sexual health services (including STI testing and treatment); reproductive health services; mental health services; general medical services; welfare; accommodation services; legal services; education services; and primary health care. These services may be external to the NSP or may be within the same facility, if services are integrated. Established referral pathways should meet the following criteria: • The referring service has a roster of nominated services to which clients may be referred and has links with these services. • Services to which clients are referred are sensitive, supportive and responsive to the needs of PWID and are located close to the referring service or are easily accessible to the client. • Follow-up and continuity of care are strengthened through case management instituted by the referring service.
OST.Q.1ae	National guidelines require that OST patients who are detained in closed settings continue to receive OST while detained
OST.Q.1af	National guidelines require OST recipients in closed settings to be transferred to community-based programmes on release



QUALITY OF OST PROGRAMME SERVICE DELIVERY	
<i>These indicators examine the adherence to quality standards at the service level. These indicators can be used to assess service delivery of an individual OST programme. Results from multiple services may be aggregated to determine the proportion of all services adhering to each quality standard.</i>	
OST.Q.2a	Long-term funding has been secured to ensure the sustainability of the OST programme (<i>see OST.Q.1d</i>)
OST.Q.2b	The programme has actively involved PWID in the planning of OST services (<i>see OST.Q.1e</i>)
OST.Q.2c	The programme regularly seeks anonymous feedback from clients (<i>see OST.Q.1f</i>)
OST.Q.2d	The programme has a clear chain of accountability to ensure that minimum standards for OST provision are met (<i>see OST.Q.1g</i>)
OST.Q.2e	All OST prescribers have received accredited training and are registered (<i>see OST.Q.1h</i>)
OST.Q.2f	All OST dispensing staff has received training in line with national guidelines (<i>see OST.Q.1i</i>)
OST.Q.2g	The OST programme is “low-threshold”, and access is unrestricted (<i>see OST.Q.1j</i>)
OST.Q.2h	The OST programme employs a range of OST service delivery models to maximize reach (<i>see OST.Q.1k</i>)
OST.Q.2i	The service is situated in locations known to be accessible to PWID (<i>see OST.Q.1l</i>)
OST.Q.2j	The OST programme offers dispensing of OST at various times of the day (<i>see OST.Q.1m</i>)
OST.Q.2k	The programme provides OST at a cost that is affordable (<i>see OST.Q.1n</i>)
OST.Q.2l	The identity and history of recent opioid use of all patients is confirmed prior to initiation of OST (<i>see OST.Q.1o</i>)
OST.Q.2m	Comprehensive patient assessment protocols are consistently applied (<i>see OST.Q.1p</i>)
OST.Q.2n	All patients provide informed consent for OST (<i>see OST.Q.1q</i>)
OST.Q.2o	All OST recipients are registered on the national registration system (<i>see OST.Q.1r</i>)
OST.Q.2p	Complete medical records are kept for all patients (<i>see OST.Q.1s</i>)
OST.Q.2q	The programme maintains client confidentiality (<i>see OST.Q.1t</i>)
OST.Q.2r	All patients receive information on potential risks and adverse events associated with OST (<i>see OST.Q.1u</i>)
OST.Q.2s	During OST induction all patients are regularly reviewed by a clinician in accordance with protocol (<i>see OST.Q.1v</i>)
OST.Q.2t	Initial dose for all OST patients is less than the maximum recommended dose (<i>see OST.Q.1w</i>)
OST.Q.2u	No maximum duration of treatment is set (<i>see OST.Q.1y</i>)
OST.Q.2v	Psychosocial assessment and support are offered to all patients (<i>see OST.Q.1z</i>)
OST.Q.2w	Involuntary discharge from OST occurs only when conditions outlined in national guidelines are breached (<i>see OST.Q.1aa</i>)
OST.Q.2x	OST dispensing protocol is followed (<i>see OST.Q.1ab</i>)
OST.Q.2y	A system to prevent OST stock-outs has been implemented (<i>see OST.Q.1ac</i>)
OST.Q.2z	Formalized referral pathways between OST programmes and other relevant service providers have been established, and OST clients are referred to these services as appropriate (<i>see OST.Q.1ad</i>)



OST.Q.3

INDIVIDUALS RECEIVING MAINTENANCE OST CONTINUOUSLY FOR AT LEAST 6 MONTHS

This indicator examines the retention of patients in OST for a minimum period of 6 months; evidence demonstrates that maximum benefit from OST is gained when treatment lasts at least 6 months (39). Hence, this indicator can be understood as a measure both of how OST is prescribed and of patient retention.

This indicator makes use of OST register data, using a cohort study-type approach. This approach is similar to that used to monitor ART retention and survival and has been piloted in the monitoring of programmes funded by the Global Fund.

	Indicator:	Data source:	Comments:
OST.Q.3a	Number of people starting OST during time period defined as the cohort recruitment period	Programme data	OST register data can be used to determine the number of people starting OST in the defined period, as a cohort.
OST.Q.3b	Number of people from the cohort still in treatment 6 months after starting OST	Programme data	OST register data can be used to determine the number of people from the defined cohort (see above) who are still in treatment at 6 months after starting OST.
OST.Q.3c	Percentage of individuals receiving OST who received treatment for at least 6 months	$\frac{[\text{OST.Q.3b}]}{[\text{OST.Q.3a}]} \times 100$	Possible targets: Low ← 60% ← Mid → 80% → High



OST.Q.4

PATIENTS RECEIVING MAINTENANCE DOSE OF OST GREATER THAN OR EQUAL TO THE RECOMMENDED MINIMUM DOSE

	Indicator:	Data source:	Comments:
OST.Q.4a	Number of people, at a specified date, maintained on MMT receiving a dose ≥ 60 mg or currently maintained on BMT receiving a dose of ≥ 12 mg	Programme data	OST register data can be used if these registers record patients' OST dose received. Alternatively, service-level data can be used. If service-level data collection systems do not include patient dose, then audit of patient charts (medical records) can be undertaken; this could be limited to a random sample of patient records or could be a review of all patients, if resources allow.
OST.Q.4b	Number of people receiving maintenance dose of OST at a specified date	Programme data	This number does not include patients currently being inducted into OST and who are yet to reach the maintenance dose; also does not include patients on reducing doses of OST.
OST.Q.4c	Percentage of patients receiving maintenance dose of OST greater than or equal to the recommended minimum dose	$\frac{[\text{OST.Q.4a}]}{[\text{OST.Q.4b}]} \times 100$	Possible targets: Low ← 60% ← Mid → 90% → High

OST.Q.5 INDIVIDUALS ON MAINTENANCE OST RECEIVING PSYCHOSOCIAL SUPPORT			
	Indicator:	Data source:	Comments:
OST.Q.5a	Number of individuals on OST who have received psychosocial support in the last 12 months	Programme data	Psychosocial support may include, as a minimum: • <i>assessment of psychosocial needs</i> • <i>supportive counselling</i> • <i>links to existing family and community services.</i>
OST.Q.5b	Number of individuals receiving OST in the last 12 months	Programme data	
OST.Q.5c	Percentage of individuals on OST receiving psychosocial support	$\frac{[\text{OST.Q.5a}]}{[\text{OST.Q.5b}]} \times 100$	Possible targets: Low ← 50% ← Mid → 80% → High

3 HIV TESTING AND COUNSELLING



HTC.A.1 NUMBER OF PWID-TARGETED SITES WHERE HTC IS PROVIDED <i>For non-PWID-specific interventions, such as HTC, recommended indicators focus on the provision of HTC by PWID-targeted services such as NSPs and drug dependence treatment services, as well as integrated service provision and referral to other services.</i>			
	Indicator:	Data source / response:	Comments:
HTC.A.1a	Number of NSP sites that provide HIV testing and counselling	Programme data	Should include only sites where HIV testing is undertaken with informed consent, is confidential, and is accompanied by counselling.
HTC.A.1b	Percentage of NSP sites that provide HIV testing and counselling	$\frac{[\text{HTC.A.1a}]}{[\text{NSP.A.1a}]} \times 100$	
HTC.A.1c	Number of drug dependence treatment services that provide HIV testing and counselling	Programme data	Includes OST sites as well as other drug dependence treatment service providers. Should include only sites where HIV testing is undertaken with informed consent, is confidential, and is accompanied by counselling.
HTC.A.1d	Total number of drug dependence treatment sites	$[\text{OST.A.2a}] + [\text{OST.A.2b}] + [\text{ODT.A.2a}] + [\text{ODT.A.2b}] + [\text{ODT.A.2c}] + [\text{ODT.A.2d}]$	Some drug dependence treatment sites may offer more than one type of drug-treatment intervention. Each of these sites should be counted only once in the total for this indicator.
HTC.A.1e	Percentage of drug dependence treatment services that provide HIV testing and counselling	$\frac{[\text{HTC.A.1c}]}{[\text{NSP.A.1d}]} \times 100$	
HTC.A.1f	Are there mobile or outreach services targeting PWID that provide HIV testing and counselling in community settings?	Yes / No If yes, describe service.	Community-based testing can increase the reach of HTC. Rapid testing techniques are particularly useful in this context to make testing and results available during the same contact.



PWID TESTED FOR HIV IN THE LAST 12 MONTHS Level of application: <i>These indicators can be applied at the national, regional, city or service level. In each case, when measuring coverage among PWID, the population size estimate used as the denominator should be relevant to the area examined.</i> Recommended disaggregations: <i>Gender (male/female/transgender)</i> <i>Age (<18 years; >18 years and <25 years; ≥25 years)</i> <i>Drug injected (opioids/stimulants/other)</i>			
	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
HTC.C.1a	Number of PWID tested for HIV during the specified reporting period (e.g. last 12, 6 or 3 months) by NSPs, drug treatment services, or other services targeting PWID (including mobile or outreach services)	Programme data	To avoid double-counting, services contributing data to this indicator must share a common unique identifier code system. Clients tested on multiple occasions during the 12-month reporting period should be counted only once for this indicator. To be eligible to be counted in this indicator, clients tested should have received their results.
HTC.C.1b	Percentage of all PWID tested for HIV during the specified reporting period by NSPs, drug treatment services, or other services targeting PWID (including mobile or outreach services)	$\frac{[\text{HTC.C.1a}]}{[\text{Pop.1}]} \times 100$	Possible targets: Low ← 40% ← Mid → 75% → High
HTC.C.1c	Percentage of PWID who were tested for HIV in the last 12 months and who know the results.	Behavioural surveys	This indicator is included in the Global AIDS Response progress reporting 2012 (12) and in the FHI-BSS (127) as follows: • Q1114: "I don't want to know the result, but have you ever had an HIV test?" • Q1116: "Please do not tell me the result, but did you find out the result of your test?" • Q1117: "When did you have your most recent test?" Note that PWID living with HIV who became aware of their HIV status prior to the last 12 months will not have been tested in the last 12 months but would answer yes to question Q1114. If linked to HIV sero-surveillance (including anonymous surveillance), the percentage of those who are HIV-positive but unaware of their status can be determined. Potential sampling bias should be considered when interpreting results of this indicator. Possible targets: Low ← 40% ← Mid → 75% → High

4 ANTIRETROVIRAL THERAPY



ART.A.1 AVAILABILITY OF ANTIRETROVIRAL THERAPY FOR PWID

	Indicator:	Responses:	Comments:
ART.A.1a	Presence of restrictions that limit access to ART based on a history of injecting drug use or current injecting drug use status	Present / Absent	Restrictions limiting access may occur at various levels: • restrictions set out in national policy and guidelines • service-level restrictions on access • restrictions relating to prescriber practice/reluctance to provide treatment to PWID. If restrictions are present, their nature and extent should be described when reported.

ART.A.2

NUMBER OF PWID-TARGETED SITES WHERE ART IS PROVIDED

For non-PWID-specific interventions, such as ART, recommended indicators focus on the provision of ART by PWID-targeted services, such as NSPs and drug treatment services, as well as integrated service provision and referral to other services.

	Indicator:	Data source / responses:	Comments:
ART.A.2a	Number of drug treatment services that provide ART	Programme data	Sites provide assessment, monitoring, prescription and dispensing of ART.
ART.A.2b	Total number of drug dependence treatment sites	[OST. A. 2a]+[OST.A.2b]+ [ODT. A. 2b]+[ODT.A.2e]+ [ODT. A. 2h]+[ODT.A.2k]	Some drug treatment sites may offer more than one type of drug treatment intervention. These sites should be counted only once in the total for this indicator. Sites offering only peer-based support groups are not included in this total.
ART.A.2c	Percentage of drug treatment services that provide ART	$\frac{[\text{ART.A.2a}]}{[\text{ART.A.2b}]} \times 100$	
ART.A.2d	Availability of mobile or outreach services targeting PWID that provide ART	Present / Absent	
ART.A.2e	Number of other services targeting PWID that provide ART	Programme data	Other services that target PWID might include NSPs, other harm reduction services and drop-in centres targeting drug users. Sites provide assessment, monitoring, prescription and dispensing of ART.

PWID RECEIVING ART <i>These indicators may be difficult to report on due to the difficulties of identifying ART recipients who have a history of injecting drug use.</i> Level of application: <i>These indicators can be applied at the national, regional, city or service level. In each case, when measuring coverage among PWID, the population size estimate used as the denominator should be relevant to the area examined.</i> Recommended disaggregations: <i>Gender (male/female/transgender)</i> <i>Age (<18 years; >18 years and <25 years; ≥25 years)</i> <i>Drug type injected (opioids/stimulants/other)</i>			
	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
ART.C.1a	Number of PWID receiving ART at a specified date	Programme data	This number counts all ART recipients with a history of ever having engaged in injecting drug use, including those who are currently active PWID. It may be difficult to determine which ART recipients have a history of injecting drug use. Typically, ART and pre-ART registers do not record injecting drug use status or history. If these registers do include this information, it is critical that client confidentiality is maintained, that injecting drug use history or status is not shared with law enforcement agencies, and that drug use history or status does not prejudice access to treatment. ART registration systems may record only the probable transmission category. Some PWID may have a different transmission category recorded (other than injecting), hence underestimating the number of PWID receiving ART.
ART.C.1b	Percentage of all HIV-positive PWID receiving ART at a specified date	$\frac{[\text{ART.C.1a}]}{[\text{Pop.4}]} \times 100$	ART coverage of 100% of all HIV-positive PWID is generally not feasible or necessary; ART will not be indicated for all those living with HIV. Hence, since the denominator does is not an estimate of the number of PWID in need of ART, this indicator does not directly measure unmet need. Possible targets: Low ← 25% ← Mid → 75% → High

RELATIVE PWID ACCESS TO ART			
ART.C.2	<i>This indicator is a measure of the equity of access to ART for PWID who are HIV-positive compared with that for all HIV-positive people. Commonly, PWID have poorer access to ART than non-PWID, despite evidence that provision of ART to PWID has population-wide health benefits and that PWID can successfully undergo treatment and benefit from ART (55–57).</i>		
	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
ART.C.2a	Number of <i>all</i> ART recipients <i>at a specified date</i>	Programme data	This number includes all recipients (i.e. PWID and non-PWID).
ART.C.2b	Ratio of PWID receiving ART to general population ART coverage	$\frac{[\text{ART.C.1a}] / [\text{ART.C.2a}]}{[\text{Pop.4}] / [\text{Pop.5}]}$	Target: >1 is desirable



NATIONAL POLICY AND LEGISLATION – ART FOR PWID	
ART.Q.1	<i>Are the following standards and programme features included in national legislation, policy and guidance?</i>
ART.Q.1a	National policy supports the provision of ART to PWID living with HIV
ART.Q.1b	National ART guidelines are developed at the country level or lower and include the provision of ART to PWID These guidelines are detailed, comprehensive and evidence-based and reflect local laws, policies and conditions; they are consistent with international guidance (e.g. relevant WHO guidelines) and include the provision of ART to current and former PWID.
ART.Q.1c	National strategy includes steps to secure long-term funding to ensure sustainability of providing ART for PWID Long-term government funding should be committed to the ongoing operation of programmes providing ART for PWID; if services are funded by external sources, the sustainability of this funding should be assessed, and contingencies for funding gaps should be determined.
ART.Q.1d	National policy stipulates that PWID be actively involved in the planning of ART provision for PWID This involves consultation with and meaningful involvement of PWID in the development of services to ensure that they are appropriate and acceptable to the target population.
ART.Q.1e	National guidelines stipulate that ART services regularly seek anonymous feedback from clients Mechanisms are in place whereby clients can confidentially/anonymously provide feedback on the service. The service should be responsive to this information.
ART.Q.1f	National policy stipulates a clear chain of accountability within ART services, and within the health system more broadly, to ensure that minimum standards for the provision of ART are met.
ART.Q.1g	National policy requires that ART prescribers receive accredited training All ART prescribers are required to take accredited post-graduate training and encouraged/required to participate in continuing education, monitoring and evaluation. Prescribers are respectful towards PWID, have credibility with the target population and are non-judgemental in their attitude towards drug users.

ART.Q.1h	National policy stipulates that ART services are “low-threshold” and do not require PWID to meet specific criteria in order to access ART Only clinical criteria determine access to ART; access is not restricted on the basis of minimum age, injecting history or current status, gender, or citizenship or residency status, incarceration or criminal history.
ART.Q.1i	National guidelines require ART prescription to be provided via a range of service delivery models Includes: general practitioner prescribers/office-based and prescription by specialist/from specialist services.
ART.Q.1j	National guidelines require that ART prescribers and dispensing services are located in areas accessible to PWID Mapping of the target population may be required to determine accessibility of a location for PWID.
ART.Q.1k	National policy includes provision to ensure that ART is affordable The cost of ART can be a significant barrier to treatment access if patients are required to cover these costs themselves, particularly for PWID. To increase accessibility, ART may be offered free of charge (this would be the best practice but may not be possible in many resource-limited settings), the costs covered by health insurance provisions, the costs to patients partly subsidized, or provided free or at reduced costs especially for financially disadvantaged patients.
ART.Q.1l	National guidelines stipulate that ART service providers involve multidisciplinary teams in the provision of HIV treatment and care Multidisciplinary teams for the provision of HIV treatment and care may include physicians, nurses, counsellors/psychologists, social workers, peer educators/supporters.
ART.Q.1m	National guidelines specify comprehensive patient assessment protocols that include PWID-specific issues Issues particularly relating to PWID that should be addressed during assessment include: • drug use history—particularly current use; signs of drug use and related conditions and complications on examination (unless suspected drug use is denied by the client, drug urine testing is not necessarily indicated, as it is unlikely to change management); • experience with drug dependence treatment—past and present; • history of mental illness; current state assessed using standardized screening instruments, in particular depression and psychotic symptom scales; • signs and symptoms of opportunistic infections (bearing in mind that PWID may often present late, with advanced-stage disease); • detailed social assessment, including social stability and support (family, community); accommodation stability (homelessness); major life events/crises; employment status and financial security; legal issues, prior incarceration, pending criminal charges; and education status; • assessment of preparedness for treatment; • HBV, HCV exposure, infection, immunization (HBV), plus investigations—serology, liver function tests; • TB: exposure, infection, prevention, symptoms and signs.
ART.Q.1n	National guidelines recommend that ART be initiated for all people living with HIV, including PWID, when WHO-defined criteria are met Current WHO criteria (2010) recommend that ART be initiation in any of the following circumstances: • CD4 count ≤ 350 cells/mm³ • symptomatic and WHO clinical stage 3 or 4 • pregnant and WHO clinical stage 3 or 4 • Active TB • treatment for HBV required.

ART.Q.1o	National policy requires that all patients provide informed consent for ART
ART.Q.1p	National guidelines require complete medical records to be kept for all patients
ART.Q.1q	Nation policy stipulates that ART programmes maintain client confidentiality Services have systems in place to ensure that client records are kept securely and remain confidential. Client information is not shared with other services or law enforcement without client consent, unless required by law. Programme data collection systems do not contain clients' personal, or identifiable, information.
ART.Q.1r	National guidelines stipulate pre-treatment counselling be provided to all patients including PWID Issues that should be addressed when providing pre-treatment counselling for PWID living with HIV include: • implications of infection status • implications of disclosure • partners and other contacts • risk of super-infection • HIV risk reduction strategies • implications of drug use for ART treatment, including interactions • drug dependence treatment options, including interactions • need for ongoing monitoring • opportunistic infections • HCV, HBV and TB prevention, infection and implications • social supports: family, social/community contacts and intimate partnerships • preparedness for treatment.
ART.Q.1s	National guidelines require that ART recipients receive information on potential risks, side-effects and drug interactions associated with ART ART clients should receive information on adverse events and interactions with drugs and other medications. Clients should receive information on how to avoid these adverse events, what the warning signs are, how to respond should they occur, and when to seek medical assistance.
ART.Q.1t	National guidelines stipulate that all people living with HIV, including PWID, who do not meet criteria for ART receive regular monitoring of viral load and CD4 count per WHO guidelines WHO guidelines recommend measuring viral load and CD4 count every 6 months in persons living with HIV pre-ART.
ART.Q.1u	National guidelines stipulate that all ART recipients, including PWID, are reviewed regularly per WHO guidelines • The frequency and intervals for monitoring ART recipients differ among ART regimens. • Viral load and CD4 count help to gauge the success of treatment. • Additional tests include liver function tests, lipids and renal function. Patients should be assessed for toxicity and side-effects and these responded to, if detected.
ART.Q.1v	National guidelines recommend that all ART recipients, including PWID, are offered case management.

ART.Q.1w	National guidelines recommend protocols for adherence strategies and offering adherence support to all patients, including appropriate strategies for PWID Adherence support strategies for PWID include: • management of drug dependence • education and information on the need for ART • clear and accurate information addressing concerns and misconceptions • regular patient evaluation • peer support • strengthening/facilitating social and family support • addressing social issues such as accommodation, financial insecurity (provide social protection), legal and other issues • provide accurate and clear information on side-effects, alarm signals and when to see a doctor • information on interactions with other drugs, both prescribed and extra-medical • treating comorbid mental health conditions • directly observed ARV treatment, particularly when linked to drug dependence (e.g. OST) or other infectious disease (e.g. TB) treatment for which supervised treatment may already take place • dispensing medication in small amounts at frequent intervals to detect non-adherence.
ART.Q.1x	National guidelines recommend providing access to drug dependence treatment services for drug dependent ART recipients Adherence to drug dependence treatment is NOT a pre-requisite for access to ART. OST should be considered a first-line treatment for opioid dependence among persons living with HIV. Drug-dependent people on ART should have drug dependence addressed by their management plan.
ART.Q.1y	National guidelines recommend providing psychosocial support to all ART patients, including approaches appropriate for PWID Psychosocial support may include, as a minimum: • assessment of psychosocial needs • supportive counselling • links to existing family and community services. Best practice: Where resources and capacity permit, a variety of structured psychosocial interventions should be offered, according to the needs of the patient. These may include: • different forms of counselling and psychotherapy • assistance with social needs including finances, accommodation, employment, education, welfare and legal issues • onsite psychosocial support and psychiatric treatment.
ART.Q.1z	National guidelines recommend that ART recipients, including PWID, undergo a mental health assessment and receive counselling, treatment and support when indicated
ART.Q.1aa	National guidelines include protocols for providing prophylaxis for opportunistic infections in people living with HIV, including PWID, pre-ART and with ART, if indicated
ART.Q.1ab	National guidelines require ART programmes to ensure that patients who are co-infected with TB, HCV or HBV receive appropriate treatment for these infections See also indicators related to services for the prevention, diagnosis and treatment of viral hepatitis (Hep.A.1–Hep.A.4; Hep.C.1–Hep.C.3) and TB (TB.A.1–TB.A.3; TB.C.1, TB.C.2)
ART.Q.1ac	ART patients who are detained in closed settings continue to receive ART while detained, and treatment interruptions are prevented



ART.Q.2	QUALITY OF ART SERVICE DELIVERY FOR PWID <i>These indicators examine the adherence to quality standards at the service level. These indicators can be used to assess service delivery of an individual ART programme. Results from multiple services may be aggregated to determine the proportion of all services adhering to each quality standard.</i>
ART.Q.2a	Long-term funding has been secured to ensure the sustainability of providing ART for PWID (see ART.Q.1c)
ART.Q.2b	The programme has actively involved PWID in planning ART provision for PWID (see ART.Q.1d)
ART.Q.2c	The programme seeks regular anonymous feedback from clients (see ART.Q.1e)
ART.Q.2d	The programme has a clear chain of accountability to ensure that minimum standards for the provision of ART are met. (see ART.Q.1f)
ART.Q.2e	All ART prescribers receive accredited training (see ART.Q.1g)
ART.Q.2f	The ART provision is “low-threshold” and does not require PWID to meet specific criteria in order to access ART (see ART.Q.1h)
ART.Q.2g	The service is situated in a location known to be accessible to PWID (see ART.Q.1j)
ART.Q.2h	The programme provides ART at a cost that is affordable (see ART.Q.1k)
ART.Q.2i	A multidisciplinary team provides HIV treatment and care (see ART.Q.1l)
ART.Q.2j	Comprehensive patient assessment protocols that include PWID-specific issues are consistently applied (see ART.Q.1m)
ART.Q.2k	ART is initiated for all people living with HIV, including PWID, when WHO-defined criteria are met (see ART.Q.1n)
ART.Q.2l	All patients provide informed consent for ART (see ART.Q.1o)
ART.Q.2m	Complete medical records are kept for all patients (see ART.Q.1p)
ART.Q.2n	The programme maintains client confidentiality (see ART.Q.1q)
ART.Q.2o	Pre-treatment counselling is provided to all patients, including PWID (see ART.Q.1r)
ART.Q.2p	ART recipients receive information on potential risks, side-effects and drug interactions associated with ART (see ART.Q.1s)
ART.Q.2q	All patients living with HIV, including PWID, who do not meet criteria for ART receive regular monitoring of viral load and CD4 count, per WHO guidelines (see ART.Q.1t)
ART.Q.2r	All ART recipients, including PWID, are reviewed regularly, per WHO guidelines (see ART.Q.1u)
ART.Q.2s	All ART recipients, including PWID, are offered case management (see ART.Q.1v)
ART.Q.2t	Adherence support is offered to all patients, including appropriate strategies for PWID (see ART.Q.1w)
ART.Q.2u	Access to drug dependence treatment services is provided for drug dependent ART recipients (see ART.Q.1x)
ART.Q.2v	Psychosocial support is provided to all ART patients, including approaches appropriate for PWID (see ART.Q.1y)
ART.Q.2w	ART recipients, including PWID, undergo a mental health assessment and receive counselling, treatment and support when indicated (see ART.Q.1z)
ART.Q.2x	Protocols are followed for providing prophylaxis for opportunistic infections in people living with HIV, including PWID, pre-ART and with ART if indicated (see ART.Q.1aa)
ART.Q.2y	Patients who are co-infected with TB, HCV or HBV receive appropriate treatment for these infections (see ART.Q.1ab)

ART.Q.3 PWID ON ART RECEIVING ADHERENCE SUPPORT			
	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
ART.Q.3a	Number of PWID on ART who have received adherence support	Programme data	See ART.Q.1w for examples of adherence support.
ART.Q.3b	Number of PWID on ART	Programme data	
ART.Q.3c	Percentage of PWID on ART who also receive adherence support	$\frac{[\text{ART.Q.3a}]}{[\text{ART.Q.3b}]} \times 100$	Possible targets: Low ← 60% ← Mid → 80% → High

ART.Q.4 PWID ON ART RECEIVING CASE MANAGEMENT			
	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
ART.Q.4a	Number of PWID on ART who have received case management	Programme data	Requires ART registers to record injecting drug use status and whether or not patient has received case management.
ART.Q.4b	Number of PWID on ART	Programme data	
ART.Q.4c	Percentage of PWID on ART who have received case management	$\frac{[\text{ART.Q.4a}]}{[\text{ART.Q.4b}]} \times 100$	Possible targets: Low ← 60% ← Mid → 80% → High

5 SEXUALLY TRANSMITTED INFECTION PREVENTION, DIAGNOSIS AND TREATMENT

PWID SCREENED OR TREATED FOR STIS AT SERVICES TARGETING PWID			
STI.C.1	Level of application: <i>These indicators can be applied at the national, regional, city or service level. In each case, when measuring coverage among PWID, the population size estimate used as the denominator should be relevant to the area examined.</i>		
	Recommended disaggregations: <i>Gender (male/female/transgender)</i> <i>Age (<18 years; >18 years and <25 years; ≥25 years)</i> <i>Drug injected (opioids/stimulants/other)</i>		
	Indicator:	Data source:	Comments:
STI.C.1a	Total number of PWID screened or treated for STIs at NSP sites, drug treatment service sites (including OST) and other service targeting PWID during the specified reporting period (e.g. last 12, 6 or 3 months)	Programme data	
STI.C.1b	Percentage of PWID screened or treated for STIs at NSP sites, drug treatment service sites, and other services targeting PWID during the specified reporting period	$\frac{[\text{STI.C.1a}]}{[\text{Pop.1}]} \times 100$	

6 CONDOM DISTRIBUTION PROGRAMMES FOR PWID AND THEIR SEXUAL PARTNERS



QUANTITY OF CONDOMS DISTRIBUTED BY SERVICES TARGETING PWID			
* Cdm.C.1	Level of application: <i>These indicators can be applied at the national, regional, city or service level. In each case, when measuring coverage among PWID, the population size estimate used as the denominator should be relevant to the area examined.</i>		
	Recommended disaggregations: <i>Gender (male/female/transgender)</i> <i>Age (<18 years; >18 years and <25 years; ≥25 years)</i> <i>Drug injected (opioids/stimulants/other)</i>		
	Indicator:	Data source:	Comments:
Cdm.C.1a	Total number of condoms distributed by NSPs, drug treatment service sites (including OST) and other services targeting PWID during the specified reporting period (e.g. last 12, 6 or 3 months)	Programme data	This count includes both male and female condoms. Disaggregation by condom type (male/female) may be undertaken if desired.
Cdm.C.1b	Number of condoms distributed by PWID-targeted services per PWID during the specified reporting period	[Cdm.C.1a] [Pop.1]	Possible targets: Low ← 50 ← Mid → 100 → High

PWID RECEIVING CONDOMS IN THE LAST 12 MONTHS			
Cdm.C.2	Recommended disaggregations: <i>Gender (male/female/transgender)</i> <i>Age (<25 years of age/≥25 years of age)</i> <i>Drug injected (opioids/stimulants/other)</i>		
	Indicator:	Data source:	Comments:
	Cdm.C.2a	Behavioural surveys	This indicator is included in the Global AIDS Response progress reporting 2012 (12). It can be collected in a behavioural surveillance survey. It is important to consider issue of sample representativeness and bias. Possible targets: Low ← 40% ← Mid → 75% → High

7 TARGETED INFORMATION, EDUCATION AND COMMUNICATION FOR PWID AND THEIR SEXUAL PARTNERS



IEC.C.1

FREQUENCY OF NSP OCCASIONS OF SERVICE WHERE IEC IS PROVIDED

Level of application:

These indicators can be applied at the national, regional, city or service level. In each case, when measuring coverage among PWID, the population size estimate used as the denominator should be relevant to the area examined.

Recommended disaggregations:

Gender (male/female/transgender)

Age (<18 years; >18 years and <25 years; ≥25 years)

Drug injected (opioids/stimulants/other)

	Indicator:	Data source:	Comments:
IEC.C.1a	Number of NSP occasions of service in which PWID were provided with targeted IEC during the specified reporting period (e.g. last 12, 6 or 3 months)	Programme data	Data collection for this indicator requires services to record instances when a client receives IEC.
IEC.C.1b	Percentage of NSP occasions of service in which PWID were provided with targeted IEC during the specified reporting period	$\frac{[\text{IEC.C.1a}]}{[\text{NSP.C.4a}]} \times 100$	Possible targets: Low ← 25% ← Mid → 50% → High

IEC.C.2	PWID RECEIVING IEC Level of application: <i>These indicators can be applied at the national, regional, city or service level. In each case, when measuring coverage among PWID, the population size estimate used as the denominator should be relevant to the area examined.</i> Recommended disaggregations: <i>Gender (male/female/transgender)</i> <i>Age (<18 years; >18 years and <25 years; ≥25 years)</i> <i>Drug injected (opioids/stimulants/other)</i>		
	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
	IEC.C.2a Number of PWID receiving targeted IEC provided by NSPs, drug treatment service sites (including OST) and other services targeting PWID during the specified reporting period (e.g. last 12, 6 or 3 months)	Programme data	This indicator requires services to have a data collection system using <i>unique identifier codes</i> (UIC, see page 37 for more detail) to allow determination of the total number of individual clients accessing the service during the reporting period and avoid double-counting clients who access the service more than once. It also requires services to record instances when a client receives IEC. IEC and, hence, related data may come from multiple types of services; use of the same UIC system and linkage of data collection systems is required for this indicator.
	IEC.C.2b Percentage of PWID receiving targeted IEC provided by NSPs, drug treatment service sites (including OST) and other services targeting PWID during the reporting period	$\frac{[\text{IEC.C.2a}]}{[\text{Pop.1}]} \times 100$	Possible targets: Low ← 50% ← Mid → 90% → High

8 PREVENTION, VACCINATION, DIAGNOSIS AND TREATMENT FOR VIRAL HEPATITIS

Hep.A.1	NUMBER OF PWID TARGETED SERVICES PROVIDING HEPATITIS B VACCINATION <i>For non-PWID-specific interventions, such as HBV vaccination, recommended indicators focus on the provision of HBV vaccination by PWID-targeted services, such as NSPs and drug treatment services, as well as integrated service provision and referral to other services. The provision of HBV vaccination is of relevance in settings where childhood vaccination programmes are either absent or where these programmes are yet to result in coverage of the adult population.</i>		
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	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
Hep.A.1a	Number of NSP sites that provide HBV vaccination	Programme data	
Hep.A.1b	Percentage of NSP sites that provide HBV vaccination	$\frac{[\text{Hep.A.1a}]}{[\text{NSP.A.1a}]} \times 100$	
Hep.A.1c	Number of drug treatment sites (including OST) that provide HBV vaccination	Programme data	
Hep.A.1d	Total number of drug treatment sites	$[\text{OST.A.2a}] + [\text{OST.A.2b}] + [\text{ODT.A.2a}] + [\text{ODT.A.2b}] + [\text{ODT.A.2c}] + [\text{ODT.A.2d}]$	Some drug treatment sites may offer more than one type of drug treatment intervention. These sites should be counted only once in the total for this indicator. Sites offering only peer-based support groups are not included in this total.
Hep.A.1e	Percentage of drug treatment sites (including OST sites) that provide HBV vaccination	$\frac{[\text{Hep.A.1c}]}{[\text{Hep.A.1d}]} \times 100$	

Hep.A.2	NUMBER OF PWID-TARGETED SERVICES AND ART PROVISION SITES PROVIDING HBV TREATMENT <i>The presence of chronic active hepatitis B infection requiring treatment among those infected with HIV is an indication for the initiation of ART. ART services, therefore, have cause to manage hepatitis treatment among co-infected individuals.</i>		
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	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
Hep.A.2a	Number of ART provision sites that provide HBV treatment	Programme data	
Hep.A.2b	Number of ART provision sites	Programme data	
Hep.A.2c	Percentage of ART provision sites that provide HBV treatment	$\frac{[\text{Hep.A.2a}]}{[\text{Hep.A.2b}]} \times 100$	

	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
Hep.A.2d	Number of drug treatment sites (including OST) that provide HBV treatment	Programme data	
Hep.A.2e	Total number of drug treatment sites	[OST.A.2a]+[OST.A.2b]+[ODT.A.2a]+[ODT.A.2b]+[ODT.A.2c]+[ODT.A.2d]	Some drug treatment sites may offer more than one type of drug treatment intervention. These sites should be counted only once in the total for this indicator. Sites offering only peer-based support groups are not included in this total.
Hep.A.2f	Percentage of drug treatment sites (including OST sites) that provide HBV treatment	$\frac{[\text{Hep.A.2d}]}{[\text{Hep.A.2e}]} \times 100$	
Hep.A.2g	Number of other services targeting PWID that provide HBV treatment	Programme data	This number might include primary health care settings targeting PWID specifically.



Hep.A.3 AVAILABILITY OF HEPATITIS C TREATMENT FOR PWID

	<i>Indicator:</i>	<i>Responses:</i>	<i>Comments:</i>
Hep.A.3a	Presence of restrictions that limit access to HCV treatment based on a history of injecting drug use or current injecting drug use status	Present / Absent	Restrictions limiting access may occur at various levels including: restrictions set out in national policy and guidelines; service-level restrictions on access; and restrictions relating to prescriber practice. If restrictions are present, their nature and extent should be described when reported.

Hep.A.4 NUMBER OF PWID-TARGETED SERVICES AND ART PROVISION SITES PROVIDING HEP C MANAGEMENT AND TREATMENT			
	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
Hep.A.4a	Number of ART provision sites that provide HCV management and treatment	Programme data	
Hep.A.4b	Number of ART provision sites	Programme data	
Hep.A.4c	Percentage of ART provision sites that provide HCV management and treatment	$\frac{[\text{Hep.A.4a}]}{[\text{Hep.A.4b}]} \times 100$	
Hep.A.4d	Number of drug treatment sites (including OST) that provide HCV treatment	Programme data	
Hep.A.4e	Total number of drug treatment sites	$[\text{OST.A.2a}] + [\text{OST.A.2b}] + [\text{ODT.A.2b}] + [\text{ODT.A.2e}] + [\text{ODT.A.2h}] + [\text{ODT.A.2k}]$	Some drug treatment sites may offer more than one type of drug treatment intervention. These sites should be counted only once in the total for this indicator.
Hep.A.4f	Percentage of drug treatment sites (including OST sites) that provide HCV treatment	$\frac{[\text{Hep.A.4d}]}{[\text{Hep.A.4e}]} \times 100$	
Hep.A.4g	Number of other services targeting PWID that provide HCV treatment	Programme data	This might include primary health care settings that specifically target PWID.

PWID RECEIVING HBV VACCINATION FROM PWID-TARGETED SERVICES			
Level of application: <i>These indicators can be applied at the national, regional, city or service level. In each case, when measuring coverage among PWID, the population size estimate used as the denominator should be relevant to the area examined.</i>			
Recommended disaggregations: <i>Gender (male/female/transgender)</i> <i>Age (<18 years; >18 years and <25 years; ≥25 years)</i> <i>Drug injected (opioids/stimulants/other)</i>			
	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
Hep.C.1			
Hep.C.1a	Total number of PWID receiving HBV vaccination provided by NSPs, drug treatment services and other services targeting PWID, including mobile or outreach services, during the specified reporting period (e.g. last 12, 6 or 3 months)	Programme data	Reporting these data requires the data collection systems of all PWID-targeted services providing HBV vaccination to record the number of PWID receiving HBV vaccination.

Hep.C.2	PWID RECEIVING HBV TREATMENT FROM PWID-TARGETED SERVICES AND ART PROVISION SITES Level of application: <i>These indicators can be applied at the national, regional, city or service level. In each case, when measuring coverage among PWID, the population size estimate used as the denominator should be relevant to the area examined.</i> Recommended disaggregations: <i>Gender (male/female/transgender)</i> <i>Age (≤18 years; >18 years and <25 years; ≥25 years)</i> <i>Drug injected (opioids/stimulants/other)</i>		
	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
Hep.C.2a	Total number of PWID receiving treatment for HBV provided by drug treatment services and other services targeting PWID, including mobile or outreach services, during the specified reporting period (e.g. last 12, 6 or 3 months) or at a specified date	Programme data	Reporting these data requires the data collection systems of all PWID-targeted services providing HBV treatment to record the number of PWID receiving HBV treatment. If 12-month data are reported, the count includes the number of PWID receiving treatment at the start of the 12-month period and the total number of PWID started on HBV treatment during the 12-month period.
Hep.C.2b	Total number of PWID receiving treatment for HBV provided by ART service sites during the specified reporting period (e.g. last 12, 6 or 3 months) or at a specified date	Programme data	Reporting these data requires ART service-level data collection systems to record the number of patients receiving HBV treatment. If these data collection systems also record patient history of injecting drug use, then the number of PWID receiving treatment from these sites can be reported. If this information is not available, the number of all patients receiving HBV treatment provided by ART services can be reported. If 12-month data are reported, the count includes the number of patients receiving treatment at the start of the 12-month period and the total number of patients started on HBV treatment during the 12-month period. It is critical that client confidentiality is maintained, that injecting drug use history or status is not shared with law enforcement agencies, and that drug use history or status does not prejudice access to treatment.

**Hep.C.3****PWID RECEIVING HCV TREATMENT FROM PWID-TARGETED SERVICES AND ART PROVISION SITES****Level of application:**

These indicators can be applied at the national, regional, city or service level. In each case, when measuring coverage among PWID, the population size estimate used as the denominator should be relevant to the area examined.

Recommended disaggregations:

Gender (male/female/transgender)

Age (<18 years; >18 years and <25 years; ≥25 years)

Drug injected (opioids/stimulants/other)

	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
Hep.C.3a	Total number of PWID receiving HCV treatment provided by NSPs, drug treatment services and other services targeting PWID, including mobile or outreach services, during the specified reporting period (e.g. last 12, 6 or 3 months) or at a specified date	Programme data	Reporting these data requires the data collection systems of all PWID-targeted services providing HCV treatment to record the number of PWID receiving HCV treatment. If 12-month data are reported, the count includes the number of PWID receiving treatment at the start of the 12-month period and the total number of PWID started on HCV treatment during the 12-month period.
Hep.C.3b	Total number of PWID receiving HCV treatment provided by ART services during the specified reporting period (e.g. last 12, 6 or 3 months) or at a specified date	Programme data	Reporting these data requires ART service-level data collection systems to record the number of patients receiving HCV treatment. If these data collection systems also record patient history of injecting drug use, then the number of PWID receiving treatment from these sites can be reported. If this information is not available, the number of all patients receiving HCV treatment provided by ART services can be reported. If 12-month data are reported, the count includes the number of patients receiving treatment at the start of the 12-month period and the total number of patients started on HCV treatment during the 12-month period. It is critical that client confidentiality is maintained, that injecting drug use history or status is not shared with law enforcement agencies, and that drug use history or status does not prejudice access to treatment.

	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
Hep.C.3c	Total number of PWID receiving HCV treatment as recorded on HCV treatment registries	Programme data	As with ART and pre-ART registries, some countries may have developed HCV treatment registries. If this is the case, and if patients' injecting drug use history is recorded, the total number of PWID receiving HCV treatment can be reported. If these registers do include injecting drug use history, it is critical that client confidentiality is maintained, that injecting drug use history or status is not shared with law enforcement agencies, and that drug use history or status does not prejudice access to treatment.
Hep.C.3d	Percentage of HCV-infected PWID receiving HCV treatment during the specified reporting period or at a specified date	$\frac{[\text{Hep.C.3a}] + [\text{Hep.C.3b}]}{[\text{Pop.6}]} \times 100$ OR: $\frac{[\text{Hep.C.3c}]}{[\text{Pop.6}]} \times 100$	If a complete HCV treatment register exists and injecting drug use history is recorded, it may be possible to estimate coverage of treatment relative to the current PWID population infected with HCV. If registration data are not available, it may be possible to aggregate HCV treatment data across service providers if PWID on treatment can be counted in these systems. This aggregation may not, however, include all PWID currently receiving HCV treatment if treatment is also provided at other services. It is important to note that in either case this indicator measures the number of those in treatment with a history of injecting drug use against the number of current PWID who are HCV-infected. Those infected with HCV who have a history of injecting drug use but who have not injected in the last 12 months (as per the definition used in this guide and elsewhere) will not be included in the estimated number of past-year injectors with HCV, used as the denominator for this indicator.

9 PREVENTION, DIAGNOSIS AND TREATMENT OF TUBERCULOSIS

TB.A.1	TB INFECTION CONTROL AT PWID-TARGETED SERVICES <i>It is recommended that simple TB infection control measures be implemented by all health care settings where patients congregate, including drug services. TB infection control should include environmental and personal protection measures to reduce the risk of TB transmission, including the protection of personnel and any potential contacts of people with possible or confirmed TB. Environmental control measures include ventilation, air cleaners and ultraviolet germicidal irradiation (96,97).</i>		
	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
TB.A.1a	Number of drug treatment sites where demonstrable infection control practices include TB infection control	Programme data	For a service to be identified as having a TB infection control policy consistent with international guidelines, the following criteria must be met, and relevant documentation should be available: • The service has a written infection control plan, and a hard copy of this plan is available. • The service has a person responsible for implementing the TB infection control plan. • All areas where clients congregate—for example, waiting areas—are well-ventilated (e.g. windows and doors open). • Clients suspected of having TB are identified on arrival at the facility and separated from other clients. • TB cases reported among health care workers are routinely monitored and reported.

TB.A.2 NUMBER OF PWID-TARGETED SERVICES PROVIDING TB PREVENTIVE THERAPY <i>Isoniazid preventive therapy is recommended for injecting drug users living with HIV once active TB has been reasonable excluded (96,97).</i>			
	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
TB.A.2a	Number of NSP sites that provide TB preventive therapy	Programme data	
TB.A.2b	Percentage of NSP sites that provide TB preventive therapy	$\frac{[\text{TB.A.2a}]}{[\text{NSP.A.1a}]} \times 100$	
TB.A.2c	Number of drug treatment sites (including OST) that provide TB preventive therapy	Programme data	
TB.A.2d	Total number of drug treatment sites	$[\text{OST.A.2a}] + [\text{OST.A.2b}] + [\text{ODT.A.2b}] + [\text{ODT.A.2e}] + [\text{ODT.A.2h}] + [\text{ODT.A.2k}]$	Some drug treatment sites may offer more than one type of drug treatment intervention. These sites should be counted only once in the total for this indicator.
TB.A.2e	Percentage of drug treatment sites (including OST sites) that provide TB preventive therapy	$\frac{[\text{TB.A.2a}]}{[\text{TB.A.2d}]} \times 100$	
TB.A.2f	Number of other services targeting PWID that provide TB preventive therapy	Programme data	



TB.A.3 NUMBER OF PWID-TARGETED SERVICES PROVIDING TB DIAGNOSIS AND TREATMENT

	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
TB.A.3a	Number of NSP sites that provide TB diagnosis and treatment	Programme data	
TB.A.3b	Percentage of NSP sites that provide TB diagnosis and treatment	$\frac{[\text{TB.A.3a}]}{[\text{NSP.A.1a}]} \times 100$	
TB.A.3c	Number of drug treatment sites (including OST) that provide TB diagnosis and treatment	Programme data	
TB.A.3d	Total number of drug treatment sites	$[\text{OST.A.2a}] + [\text{OST.A.2b}] + [\text{ODT.A.2a}] + [\text{ODT.A.2b}] + [\text{ODT.A.2c}] + [\text{ODT.A.2d}]$	Some drug treatment sites may offer more than one type of drug treatment intervention. These sites should be counted only once in the total for this indicator. Sites offering only peer-based support groups are not included in this total.
TB.A.3e	Percentage of drug treatment sites (including OST sites) that provide TB diagnosis and treatment	$\frac{[\text{TB.A.3c}]}{[\text{TB.A.3d}]} \times 100$	

ASSESSMENT OF PWID TB STATUS BY HIV TREATMENT AND CARE SERVICES

TB.C.1

Level of application:

These indicators can be applied at the national, regional, city or service level. In each case, when measuring coverage among PWID living with HIV, the population size estimate used as the denominator should be relevant to the area examined.

Recommended disaggregations:

Gender (male/female/transgender)

Age (<18 years; >18 years and <25 years; ≥25 years)

	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
TB.C.1a	Number of PWID with HIV whose TB status was assessed and recorded at the last visit to an HIV treatment and care service during the reporting period	Programme data	It is recommended that HIV treatment and care services record the results of TB status assessments of HIV patients in ART and pre-ART registers. If these registers also record patients' injecting drug use status or history, it may be possible to report on this indicator. If these registers do record patients' injecting drug use history or status, it is critical that client confidentiality is maintained, that injecting drug use history or status is not shared with law enforcement agencies, and that injecting drug use history or status does not prejudice access to treatment.

TB.C.2	PWID LIVING WITH HIV STARTING ISONIAZID PREVENTIVE THERAPY (IPT) <i>Isoniazid preventive therapy is recommended for drug users living with HIV, once active TB has been excluded.</i> Level of application: <i>These indicators can be applied at the national, regional, city or service level. In each case, when measuring coverage among PWID living with HIV, the population size estimate used as the denominator should be relevant to the area examined.</i> Recommended disaggregations: <i>Gender (male/female/transgender)</i> <i>Age (<18 years; >18 years and <25 years; ≥25 years)</i>		
	<i>Indicator:</i>	<i>Data sources:</i>	<i>Comments:</i>
	TB.C.2a Number of PWID, diagnosed as HIV-positive, who were started on TB preventive therapy during the defined reporting period	Programme data ART and pre-ART registers	Provision of IPT to PLWHIV may be recorded in ART and pre-ART registers. If these registers also record patients' injecting drug use status or history, it may be possible to report on these indicators.
	TB.C.2b Number of PWID diagnosed as HIV-positive during the defined reporting period	ART and pre-ART registers	If these registers do record patients' injecting drug use history or status, it is critical that client confidentiality is maintained, that injecting drug use history or status is not shared with law enforcement agencies, and that injecting drug use history or status does not prejudice access to treatment.
TB.C.2b	Percentage of PWID, diagnosed as HIV-positive, who were started on TB preventive therapy during the defined reporting period	$\frac{[\text{TB.C.2a}]}{[\text{TB.C.2b}]} \times 100$	Possible targets: Low ← 30% ← Mid → 60% → High

4.4 OUTCOME/IMPACT INDICATORS

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OI.1

REDUCED HIV INCIDENCE AMONG PWID

Relevant to the following interventions:

Needle and syringe programmes
Opioid substitution therapy
Other drug dependence treatment
Antiretroviral therapy for HIV
Prevention and treatment of sexually transmitted infections
Condom distribution programmes
Targeted information, education and communication

Indicator:

Data sources:

Comments:

OI.1.a

Incidence of HIV among PWID

- HIV surveillance
- case reporting systems
- mathematical modelling exercises.

Limitations of various estimation techniques must be considered when interpreting results from these techniques; see section 3.6 (page 40) for more information.

*

OI.2

REDUCED HIV PREVALENCE AMONG PWID

Relevant to the following interventions:

Needle and syringe programmes
Opioid substitution therapy
Other drug dependence treatment
Antiretroviral therapy for HIV
Prevention and treatment of sexually transmitted infections
Condom distribution programmes
Targeted information, education and communication

Indicator:

Data source:

Comments:

OI.2.a

Prevalence of HIV among PWID

HIV sentinel surveillance

Sero-prevalence studies should be used, rather than self-reported HIV status.

As noted in section 3.4, limitations of sampling strategies, bias and likely representativeness should be considered.

Observed increases in prevalence may be due to improved surveillance or testing techniques or increased uptake of testing, rather than to actual increases in the number of infections.

Apparent decreases in prevalence may result from reduced testing; actual decreases in infections may be the result of out-migration or mortality rather than prevention of new infections.

Increased HIV treatment coverage can reduce mortality among persons living with HIV and thus increase prevalence even if incidence remains stable or decreases.



01.3	INCREASED USE OF STERILE INJECTING EQUIPMENT BY PWID Relevant to the following interventions: <i>Needle and syringe programmes</i> <i>Opioid substitution therapy</i> <i>Other drug dependence treatment</i> <i>Targeted information, education and communication</i>
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	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
01.3a	Percentage of PWID reporting the use of sterile injecting equipment the last time they injected drugs	Repeated behavioural surveys	This indicator is included in the Global AIDS Response progress reporting 2012 (12) as well as in the FHI-BSS (127) as follows: Q301: "Think about the last time you injected drugs. Did you use a needle or syringe that had previously been used by someone else?"
01.3b	Percentage of PWID who report always using sterile injecting equipment during the last one month	Repeated behavioural surveys	This indicator is included in the FHI-BSS (127) as follows: Q302: "Think about all the times you injected during the past <i>one month</i> . How often was it with a needle or syringe that had previously been used by someone else?" Responses: "Always; Most times; About half the time; Occasionally; Never."

01.4	REDUCTION IN FREQUENCY OF INJECTING Relevant to the following interventions: <i>Opioid substitution therapy</i> <i>Other drug dependence treatment</i>
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	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
01.4a	Percentage of PWID injecting once per day or more	Behavioural surveillance survey	This indicator is included in the FHI-BSS (127) as follows: Q205: "During the past one month, how often would you say you injected drugs?" Responses: "Only once; 2–3 times; about once a week; 2–3 times a week; 4–6 times a week; about once a day; 2–3 times a day; 4 or more times a day".

01.5 INCREASED AWARENESS OF HIV STATUS AMONG PWID Relevant to the following interventions: <i>HIV testing and counselling</i>			
	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
01.5a	Percentage of PWID who were tested for HIV in the last 12 months and who know the results	Repeated behavioural surveys	This indicator is included in the FHI-BSS (127) as follows: • Q1114: "I don't want to know the result, but have you ever had an HIV test?" • Q1116: "Please do not tell me the result, but did you find out the result of your test?" • Q1117: "When did you have your most recent test?" Note that PWID living with HIV who became aware of their HIV status prior to the last 12 months will not have been tested in the last 12 months but would answer yes to questions Q114.



01.6 DECREASED INCIDENCE OF AIDS CASES AMONG PWID Relevant to the following interventions: <i>Antiretroviral therapy</i> <i>HIV testing and counselling</i>			
	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
01.6a	Number of AIDS incident cases among PWID in the past 12 months	HIV/AIDS registration data	Available data may have significant limitations. AIDS registration data may not include details of injecting drug use history or status; in some cases injecting drug use may be included only when recorded as the likely exposure category. If these registers do include this information, it is critical that confidentiality is maintained, that injecting drug use history or status is not shared with law enforcement agencies, and that drug use history or status does not prejudice access to treatment.

01.7	DECREASED AIDS-RELATED MORTALITY AMONG PWID Relevant to the following interventions: <i>Antiretroviral therapy</i> <i>HIV testing and counselling</i>		
	<i>Indicator:</i>	<i>Data sources:</i>	<i>Comments:</i>
01.7a	Number of AIDS-related deaths among PWID in the past 12 months	• HIV/AIDS registration data • national mortality data • data from longitudinal PWID cohort studies	Available data may have significant limitations. National mortality data are unlikely to include information on injecting drug use history or status unless drug use was noted as associated with cause of death. This indicator is more easily reported if there is data linkage between HIV/AIDS registration and mortality records. If cohorts of PWID are followed, data from these studies may also be useful; representativeness and potential bias need to be considered.

01.8	DECREASED INCIDENCE OF SEXUALLY TRANSMITTED INFECTIONS AMONG PWID Relevant to the following interventions: <i>Sexually transmitted infection prevention, detection and treatment</i> <i>Condom distribution programmes</i> <i>Targeted information, education and communication</i>		
	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
01.8a	Percentage of PWID who report having had symptoms of an STI during the last 12 months	Repeated behavioural surveys	This indicator is included in the FHI-BSS (127) as follows: • Q1004: "Have you had a genital discharge during the past 12 months?" • Q1005: "Have you had a genital ulcer/sore during the past 12 months?"



01.9

INCREASED USE OF CONDOMS AMONG PWID

Relevant to the following interventions:

Condom distribution programmes

Targeted information, education and communication

	<i>Indicator:</i>	<i>Data source:</i>	<i>Comments:</i>
01.9a	Percentage of PWID who had sex in the last month who report using a condom the last time they had sexual intercourse	Repeated behavioural surveys	This indicator is included in the Global AIDS Response progress reporting 2012 (12). The FHI-BSS (127) includes questions regarding the use of condoms the last time a participant had sex but does so separately for each type of partner, as follows: • Q603: "The last time you had sex with your regular partner, did you and your partner use a condom?" • Q704: "The last time you had sex with a commercial partner, did you and your partner use a condom?" • Q804: "The last time you had sex with a non-regular partner, did you and your partner use a condom?"

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