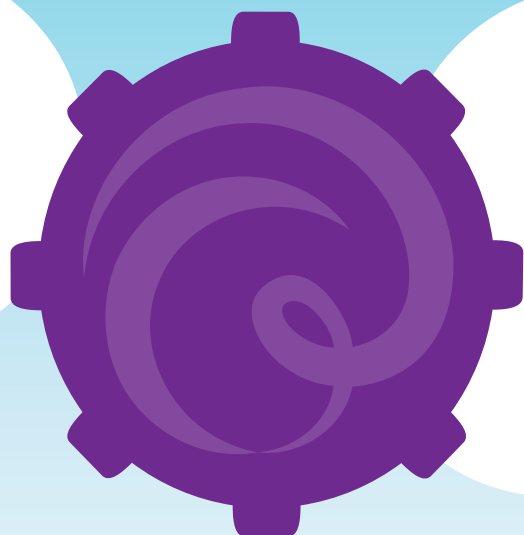
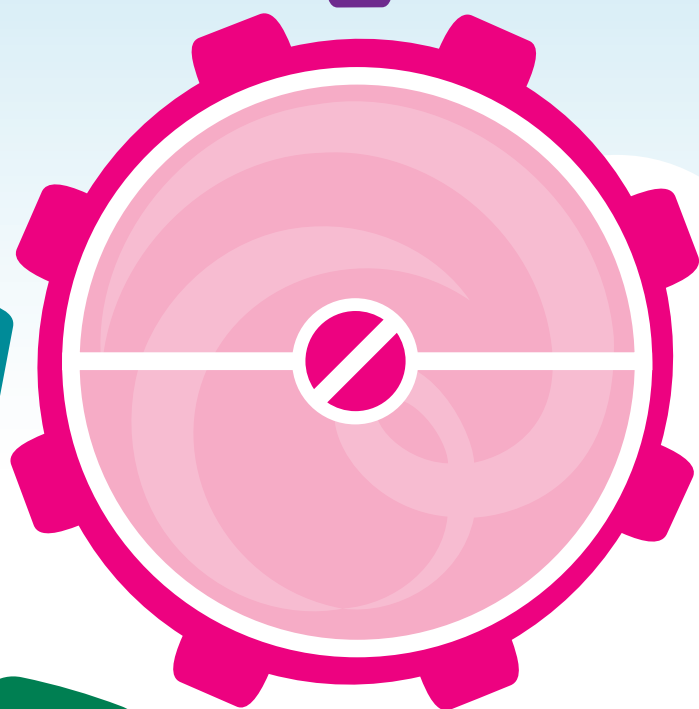
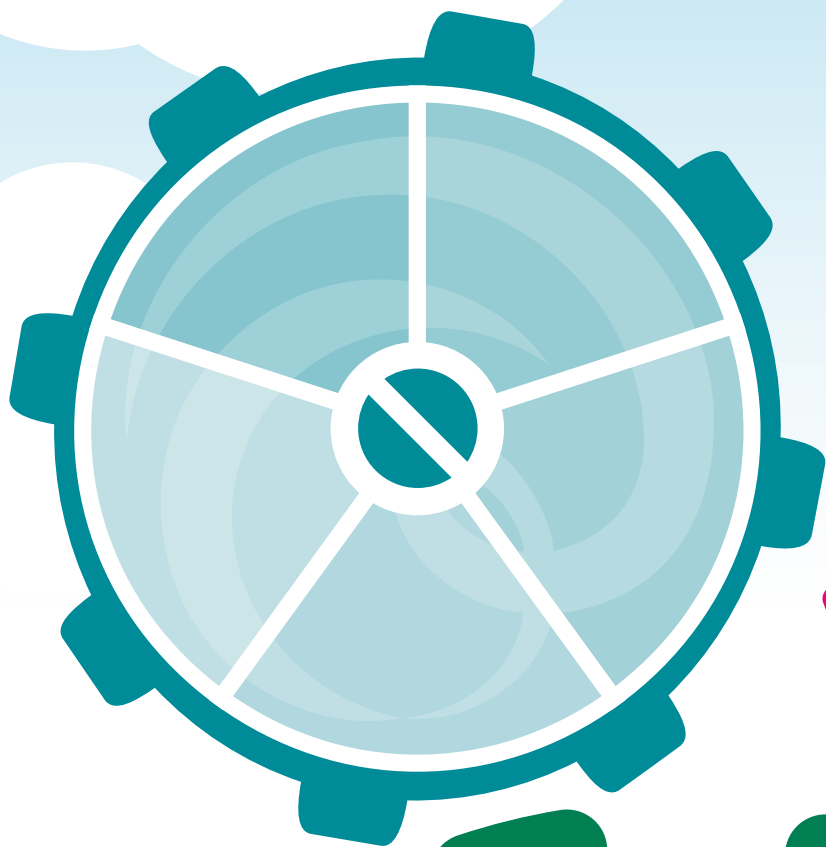




Ending AIDS among people who use drugs Our theory of change



About the International HIV/AIDS Alliance

We are an innovative alliance of nationally based, independent, civil society organisations united by our vision of a world without AIDS.

We are committed to joint action, working with communities through local, national and global action on HIV, health and human rights.

Our actions are guided by our values: the lives of all human beings are of equal value, and everyone has the right to access the HIV information and services they need for a healthy life.

Acknowledgements

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Designed by: Garry Robson

Unless otherwise stated, the appearance of individuals in this publication gives no indication of either sexuality or HIV status.

Cover illustration by Garry Robson

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Introduction

The International HIV/AIDS Alliance's (The Alliance) theory of change to end AIDS among people who use drugs guides the development of the Alliance's harm reduction programmes and advocacy over the remaining period of the **Alliance's 2016-2020 strategy, HIV, health and rights**. The long-term outcomes and some of the short-and medium-term outcomes in this theory of change will occur beyond this timeframe. This is a dynamic document that may change as new evidence emerges.

The document sets out the changes we want to achieve for people who use drugs, the responses we will make to achieve these changes, the desired outcomes, and the preconditions that need to be in place for the changes to occur.

This theory of change will help us better articulate and evaluate what we do in the area of harm reduction, and will provide a valuable tool for learning and reflection across the Alliance and beyond.

The context – a public health and human rights emergency

The HIV epidemic amongst people who inject drugs is both a significant threat to their health and a driver of the HIV wider epidemic.

Globally, there are an estimated 15.6 million people who inject drugs, of whom 3.2% are women. An estimated 2.8 million (17.8%) of people who inject drugs are living with HIV while over 50% are infected with Hepatitis C.¹

Alarmingly, new HIV infection among people who inject drugs increased by one third from 114,000 in 2011 to 152,000 in 2015.²

People who use drugs experience significant human rights violations and social marginalisation caused by the criminalisation of drug use and high rates of stigma related to both HIV and drug use. Their marginalisation and incarceration dramatically increase vulnerability to HIV infection.

Nearly 60% of people who inject drugs have experienced incarceration in prison and/or in prison-like compulsory detoxification centres.³ In prison people are more likely to share needles and have unprotected sex, which leads to further risk of HIV infection.

1. Degenhardt, L. et al (2017), 'Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: a multistage systematic review', *The Lancet*, **Volume 5**, (No. 12, e1192–e1207).
 2. https://www.unodc.org/wdr2017/field/WDR17_Fact_sheet.pdf
 3. Degenhardt, L. et al (2017), 'Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: a multistage systematic review', *The Lancet*, **Volume 5**, (No. 12, e1192–e1207).



People who use drugs are often isolated and poor, and are denied the means to protect themselves from HIV, Hepatitis, TB and other infectious diseases. 21.7% of people who inject drugs have experienced unstable housing or homelessness in the past year.⁴

The vicious cycle between drug use, crime and imprisonment is widely known and penalizing measures have been largely ineffective in reducing harmful drug use. Many drug users find themselves trapped in this punitive and hostile environment.

'People who use drugs' vs 'people who inject drugs'

Both people who inject drugs and people who use drugs through other means are vulnerable to HIV. Criminalisation, human rights abuses and stigma affect both these groups, hence our interventions, particularly at a structural level, are directed at people who use drugs rather than people who inject drugs alone.

However, people who inject drugs have additional risks and service needs, such as access to sterile injecting equipment and opioid replacement therapies, hence public health research and interventions tend to focus on this group. When referring to research targeting people who inject drugs, we use that term, whilst when we refer to our interventions we usually refer to people who use drugs.

The global response

Recent research shows that less than one percent of people who inject drugs live in countries providing comprehensive harm reduction services that include needle and syringes exchange programmes (NSP) and opioid substitution therapy (OST).⁵ In countries where services are available, they are often inadequate and under resourced, falling below WHO recommended minimum standards⁶.

Globally, people who inject drugs receive an average of 33 clean needles per year (the WHO recommends 200 needles per injecting drug user, per year) and only 16 out of every 100 people who inject drugs received OST (the WHO recommends 20 out of 100).⁷ The figures for sub-Saharan Africa are particularly low (two needles per person who injects drugs; only one percent receiving OST). The paucity of data on access to HIV testing and antiretroviral treatment (ART) for people who inject drugs is likely to reflect poor service provision in this area.

Financing for HIV and harm reduction programmes that target people who use drugs is inadequate.⁸ Many international donors and national governments fail to prioritise people who use drugs sufficiently in their HIV, health and development investments.

4. Degenhardt, L. et al (2017), 'Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: a multistage systematic review', *The Lancet*, **Volume 5**, (No. 12, e1192–e1207).
5. Larney, S. et al (2017), 'Global, regional, and country-level coverage of interventions to prevent and manage HIV and hepatitis C among people who inject drugs: a systematic review', *The Lancet*, **Volume 5**, (No. 12, e1208–e1220).
6. 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 http://www.who.int/hiv/pub/idu/targets_universal_access/en/
7. Larney, S. et al (2017), 'Global, regional, and country-level coverage of interventions to prevent and manage HIV and hepatitis C among people who inject drugs: a systematic review', *The Lancet*, **Volume 5**, (No. 12, e1208–e1220).
8. Harm Reduction International, International Drug Policy Consortium, International HIV/AIDS Alliance 2014 The funding crisis for harm reduction. http://www.aidsalliance.org/assets/000/001/821/Funding_HR_original.pdf?1443538837

GOAL

**END AIDS
AMONG
PEOPLE WHO
USE DRUGS**

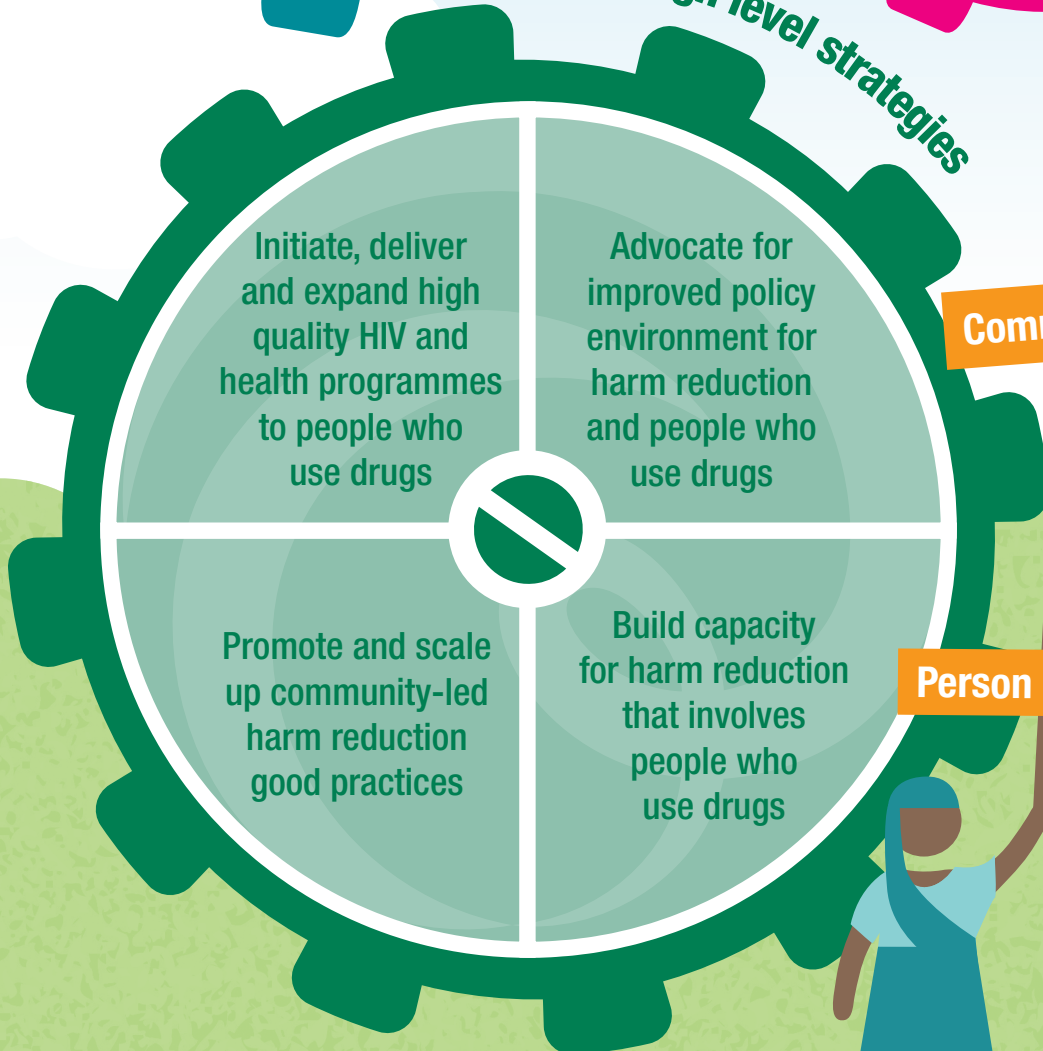
Short and medium-term outcomes



Long-term outcomes



High level strategies



Evidence based

Community led

Person centred

Human rights-based



The Alliance theory of change to end AIDS among people who use drugs

To address this global health and human rights emergency, the Alliance is accelerating its support to people who use drugs through programmes and advocacy.



High-level strategic responses

1. Initiate, deliver and expand high quality HIV and health programmes to people who use drugs

The Alliance works to improve access for people who use drugs and their partners and children to HIV prevention, treatment, sexual and reproductive health and other services. We do this mainly through outreach to increase the demand for existing services, and delivery of new services where gaps exist, for example NSP, OST and psychosocial services.

Our programmes focus on addressing geographic gaps in service coverage, reaching key or underserved population groups such as women and prisoners, and integrating harm reduction into other services such as sexual and reproductive health.

Innovative approaches to harm reduction

We use innovative approaches such as take-home methadone treatment; partnering with local and national law enforcement to promote community-based drug treatment models; promote community-based peer naloxone distribution; and use mobile of phone apps to enable health outreach workers to manage their clients more easily.

2. Advocate for improved policy environment for harm reduction and people who use drugs

Advocacy has always been a significant part of the Alliance's harm reduction efforts. This focuses on building an enabling policy environment for the delivery of harm reduction services, along with human rights advocacy to defend the rights of people who use drugs.

Our advocacy is firmly based on the evidence we gather from our community-based programmes. We advocate for a range of improvements including greater

resources for harm reduction, raising service standards, decriminalisation of drug use and alternatives to detention, expanding community-based treatment services, and reducing costs for medical treatments.

3. Build capacity for harm reduction that involves people who use drugs

The Alliance promotes the involvement of people who use drugs in decision-making and in the planning and delivery of services to this group. Our harm reduction programme is guided by the principle of ‘nothing about us without us’.

We support the development of networks of people who use drugs to ensure that people who use drugs are an essential part of service delivery: as programme managers, staff, advisors, key informants, peer educators and advocacy leaders as well as clients.

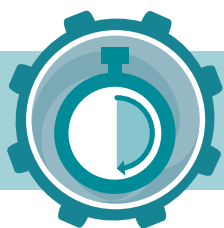
The Alliance also builds the capacity of NGOs, government authorities and institutions to work more effectively with the community of people who use drugs.

4. Promote and scale up community-led harm reduction good practices

The Alliance develops programme models to improve access and retention for a range of treatments: NSP, OST, HIV, Hepatitis C and TB. We create opportunities for civil society organisations to learn and share knowledge and good practices on harm reduction programming and advocacy. We invest in pilot programmes to scale up good practices in harm reduction so that they can be replicated across nations and regions. We document and share these good practices among our Linking Organisations and with other organisations involved in harm reduction.



Winnie Nyawira is a young woman who sells sex and who used to use drugs. She is now enrolled in the methadone program at Malindi general hospital. Here she walks through the compound of KANCO in Watamu where she visits daily for lunch, support and other services offered by the KANCO team for people who use drugs. Winnie has been on the methadone programme for over a year and continues to do well. © Corrie Wingate for the Alliance 2017



Short and medium-term outcomes

1. High quality services free from stigma and discrimination

People who use drugs have access to harm reduction services that are accessible, affordable, timely, and free from stigma and discrimination. These service providers have high quality knowledge and non-stigmatising attitudes, and provide commodities that meet recognised quality standards.

2. Comprehensive coverage of harm reduction services

Harm reduction services are widely available to all people who use drugs, and are provided where people who need them can easily access them, close to their communities. Services are comprehensive and comply with WHO, UNODC and UNAIDS guidelines for services to key populations.⁹

3. Harm reduction service delivery is led by communities of people who use drugs

Communities of people who use drugs are mobilised and have the capacity to engage in service delivery. Governments recognise and support the role of communities in leading, designing and delivering services. Service users have capacity to influence how services are delivered.

4. Community-based harm reduction services are sustainable

Community-based harm reduction services are maintained and scaled up to sufficient level, integrated with and provided as part of mainstream national health services, and funded by national governments.

5. Enabling environment for harm reduction services

Government laws, policies and their implementation promote and support harm reduction programmes and services, including decriminalisation of people who use drugs.

9. 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. http://www.who.int/hiv/pub/idu/targets_universal_access/en/



Long-term outcomes

1. People who use drugs are healthy

People who use drugs are prevented from contracting HIV and communicable diseases, and from dying from overdoses and other unsafe use of drugs.

2. People who use drugs enjoy equal and full rights

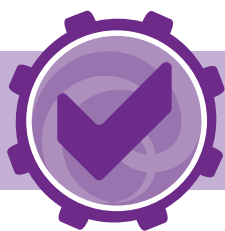
People who use drugs are treated as equal citizens with the same rights as those who do not use drugs: free from incarceration, and with access to education, employment opportunities and health services.



I heard about the Omari Project from my friends, many of whom use drugs and would go there to get information on harm reduction. Many of my peers engage in sex work but I did not want to do this. Through the project I received counselling support and information on family planning methods.

Mariam Yusuf

Mariam Yusuf is 22 and is from Malindi in Kenya. She is a mother to two children and has experienced gender based violence. She uses drugs and sometimes sells sex.
© Corrie Wingate for the Alliance 2017



Preconditions

This theory of change is based on the following preconditions and can only be successfully implemented if these are met:

 **Adequate resources are available for harm reduction programming at local and national level**

Many of the countries we work in are middle-income countries. Currently, most funding for harm reduction programmes is provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and other international donors. When donors leave, it is essential that governments step in to make resources available for community-led harm reduction programmes, and that the transition to government funding is done in a responsible manner, ensuring the continuity of services.

 **National governments permit community-led harm reduction services to be established and/or expanded**

Implementation of community-led harm reduction programmes requires national governments to allow them to operate in spite of drug use being illegal. Where drug use is illegal, governments can choose not to crack down on organisations providing harm reduction services, and allow them space to operate.

 **The ‘war on drugs’ approach that demonises and scapegoats drug users does not expand**

The ‘war on drugs’ approach is still prevalent in many countries. There is a risk of this hardened attitude to drug use spreading to other countries, making it difficult to provide harm reduction services, and protect the human rights of people who use drugs. The Alliance works with partners to counteract this risk by advocating for governments to take on board the UNGASS 2016 outcome document¹⁰, which promotes the protection of the health and human rights of people who use drugs.

The Alliance's work on harm reduction

We support a harm reduction approach that is both evidence- and rights-based, reducing the negative consequences of drug use, especially HIV transmission, and improving access to services. The key interventions we support are needle and syringe programmes (NSPs), drug substitution treatment, naloxone-based overdose management and HIV treatment.

As of March 2018, the Alliance works on harm reduction in 15 countries – Burundi, Cambodia, China, Ethiopia, India, Indonesia, Kenya, Mozambique, Myanmar, Nigeria, Senegal, Tanzania, Uganda, Ukraine, and Vietnam.

The Alliance's combined effort represents one of the largest community-led harm reduction programmes in the world.

The Alliance's three working models

As we work in countries that are at different stages in their harm reduction development, our responses need to be tailored to the specific needs of the community of people who use drugs. The roles and added values of the Alliance and community partners relate to the context they are working in.

Our responses range from being one of the main providers of services, to being a catalyst for the establishment of harm reduction programmes. In some countries, advocacy is our main contribution while in other contexts we innovate to make harm reduction services more cost effective and better integrated into existing health systems. The Alliance has developed three working models for its harm reduction work.



Methadone treatment centre, Vietnam. © Mr Thahn, SCDI 2013



Multiplier

This is our role in countries with a clear epidemic of drug use and large scale and/or mature harm reduction programmes (eg China, India, Indonesia and Ukraine).

Our support to harm reduction programmes in these countries is primarily to embed services in national health systems, leading to better quality, effective national programmes. These programmes are designed with sustainability in mind, aiming for governments to roll out service delivery country-wide.



CHINA

China has had a government-funded national harm reduction programme for more than a decade. Yet in many parts of the country not enough people who use drugs are using the services. With the support of the Alliance's Community Action on Harm Reduction project, **AIDS Care China** piloted a peer driven intervention model at three NSP and methadone maintenance treatment (MMT) sites to reach more people who use drugs. In 2015, the government adopted the model and has implemented it in more than 100 NSP and MMT sites. The model drew thousands of people who use drugs in to these services. It is now documented and recommended as national good practice.

Accelerator

This is our role in countries 'moving beyond pilot' where recently established programmes need to grow and develop further (eg Kenya and Senegal).

In these countries programme scale is the critical driver for impact, and support from the Alliance focuses on establishing the foundations for programme expansion. This is achieved primarily by replicating service provision models in new areas and reaching out to donors and governments to encourage their involvement in service provision.



KENYA

In 2011, the Alliance supported **Kenya AIDS NGO Consortium (KANCO)**, an Alliance Linking Organisation, to pilot the first harm reduction project in the country. This aimed to tackle a sub-epidemic of HIV among people who inject drugs. KANCO worked with the community of people who use drugs, the Ministry of Health and other stakeholders to establish a foundation for more donor-supported harm reduction projects in Kenya. By the end of 2016, 13,315 out of the estimated 18,000 people who inject drugs were reached by harm reduction services, including NSP and opioid substitution therapy (OST). The programme is now improving service quality by replicating best practice models from other countries and expanding services.

Kick-starter

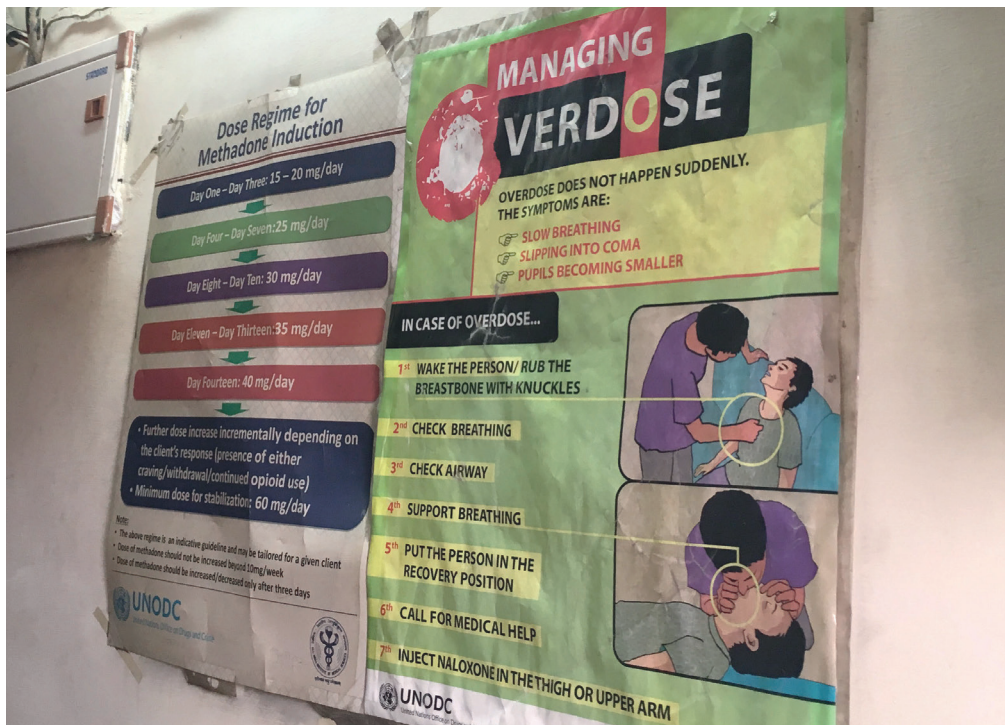
This is our role in ‘start up’ countries where the need for harm reduction is established but no harm reduction services are available (eg Mozambique, Nigeria and Uganda).

The Alliance’s role in these countries is to identify partners, establish groups of people who use drugs, build partnerships to support harm reduction, and pilot service delivery on a small scale.



UGANDA

Prior to 2017 there were no harm reduction services in Uganda. With support from the Global Fund regional programme led by KANCO and the **PITCH programme**, Alliance Linking Organisation **Community Health Alliance Uganda CHAU** advocated for permission from the government for piloting needle exchange services. The application was approved by the Ministry of Health and CHAU is now supporting local partners to pilot needle exchange services to people who use drugs. Results from the pilot will be used to advocate for scaling up such services nationally.



Drug dependence treatment centre, New Delhi, India.
© Alliance 2018



Annex 1: The Alliance harm reduction programme strategies

1. Initiate, deliver and expand high quality HIV and health programmes to people who use drugs

- 1.1. Ensure harm reduction services are available to people who use drugs across the countries and regions
- 1.2. Provide harm reduction services in prisons, or enable others to provide
- 1.3. Make sure harm reduction services adapt to the needs of women who use drugs
- 1.4. Strengthen linkages between harm reduction and sexual and reproductive health services
- 1.5. Identify countries, districts and/or sites where harm reduction services are needed and not covered
- 1.6. Mobilise drug users and investigate HIV and health needs
- 1.7. Identify best sites and best partners for the delivery of services.

2. Advocate for improved policy environment for harm reduction and people who use drugs

- 2.1. Advocate for national resources for harm reduction services
- 2.2. Educate decision makers and the media about harm reduction
- 2.3. Influence Country Coordinating Mechanisms of the Global Fund
- 2.4. Advocate for international donor funds for harm reduction programmes
- 2.5. Advocate for decriminalisation of drug use, and for alternatives to detention
- 2.6. Advocate for community-based drug treatment services
- 2.7. Advocate for the reduction in cost of HIV, Hepatitis B and Hepatitis C medicines
- 2.8. Work with national government to develop national standards for harm reduction services, adopted by government.

3. Build capacity for harm reduction that involves people who use drugs

- 3.1. Build capacity of government and community services to provide good practice, person-centred HIV and harm reduction services
- 3.2. Support the formation and build the capacity of drug user networks
- 3.3. Provide support and training to families and peers to support other people who use drugs to improve their health-seeking behaviour
- 3.4. Build capacity of communities in collecting, analysing and using strategic information to show the value of community-based harm reduction programmes.

4. Promote and scale up community-led harm reduction good practices

- 4.1. Develop strong programme models to improve access to and retention: in NSP, OST, HIV, Hepatitis C and TB treatment
- 4.2. Document and communicate examples of good practice and innovation
- 4.3. Support community action to monitor and improve the quality of services for people who use drugs and their families
- 4.4. Build advocacy messages about our piloted and tested models that can be scaled up to influence national policy and practices.

