

# PEOPLE WHO INJECT DRUGS



It is estimated that worldwide there are nearly 12.7 million people who inject drugs (1). Approximately 1.7 million, or 13%, are also living with HIV. Injecting drug use is found in nearly every country. Typically, when heroin injection reaches a new community, there is an exponential increase in HIV transmission (2).

People who inject drugs continue to face punitive legal environments, a variety of human rights abuses and have poor access to services; these and other factors combine to exacerbate their risks of acquiring HIV.

# { PEOPLE WHO INJECT DRUGS

**I am an injecting drug user.  
I face these issues.**



# WHY PEOPLE WHO INJECT DRUGS ARE BEING LEFT BEHIND

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## HIV burden

HIV prevalence among people who inject drugs is typically far greater than it is among the rest of the adult population, with people who inject drugs bearing a 28 times higher prevalence, ranging from 1.3 to more than 2 000 times higher HIV prevalence in 74 countries reporting such figures to UNAIDS (3). In eastern Europe and central Asia, a region where the number of people newly infected is rising, national HIV epidemics are typically driven by the use of contaminated injecting equipment and by further transmission to the sexual partners of people who use drugs.

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*People who inject drugs account for 30% of new HIV infections outside sub-Saharan Africa.*

*HIV prevalence among young people under 25 years old who inject drugs was 5.2%.*

*Approximately 13% of people who inject drugs are living with HIV.*

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Risk begins early. In 45 countries reporting youth data since 2009, HIV prevalence among young people under 25 years old who inject drugs was 5.2% (3).

People who inject drugs are severely affected by HIV. Preliminary analyses of 2013 Global AIDS Response Progress Reporting (GARPR) data estimate that people who inject drugs account for 30% of new HIV infections outside of sub-Saharan Africa (5).

HIV prevalence appears to be rising in the Asia and the Pacific and in eastern Europe and central Asia. The Russian Federation leads injecting drug use prevalence in eastern Europe and central Asia at 2.29%, where HIV prevalence among people who inject drugs ranges from 18 to 31%. Injecting drug use prevalence is 1.0% in the Republic of Moldova, 1.1% in Belarus and 0.9–1.2% in Ukraine (1).

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## THE TOP 4 REASONS

# 01

Criminalization and punitive laws

# 02

Absent or inadequate prevention services

# 03

Widespread societal stigma

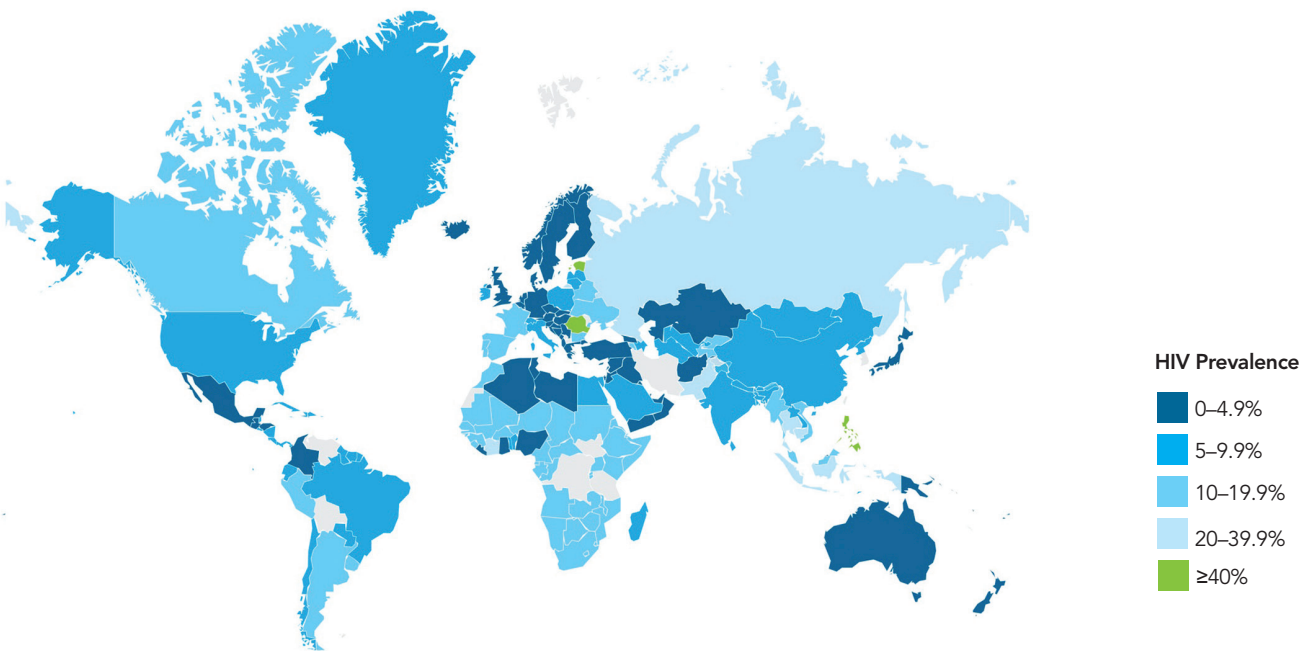
# 04

Lack of investment

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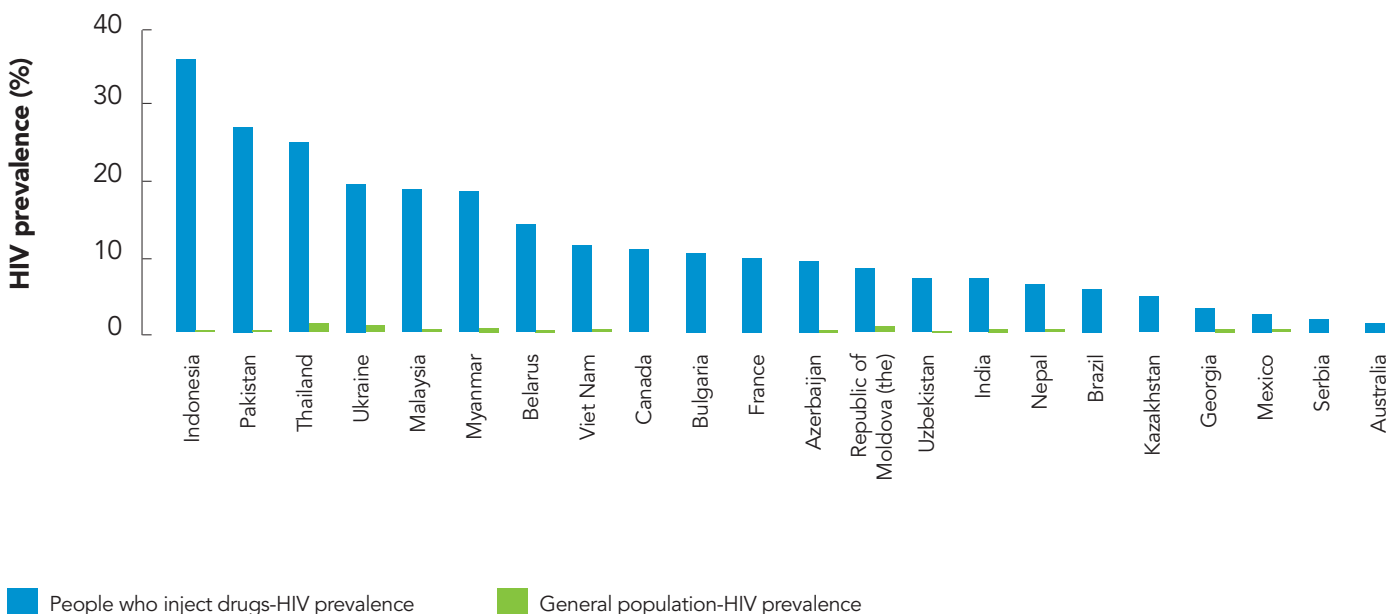
In countries with generalized epidemics, such as Kenya, Nigeria and United Republic of Tanzania, increases in injecting drug use and, subsequently, HIV prevalence among people who inject drugs have recently required AIDS programme responses.

### HIV prevalence among people who inject drugs



Source: Based on GARPR reporting from 79 countries since 2009, plus the UNODC World Drug Report 2014.

### HIV prevalence among people who inject drugs compared to the general population in countries reporting >30 000 people who inject drugs, 2009–2013



Source: Global AIDS Response Progress Reporting 2014.

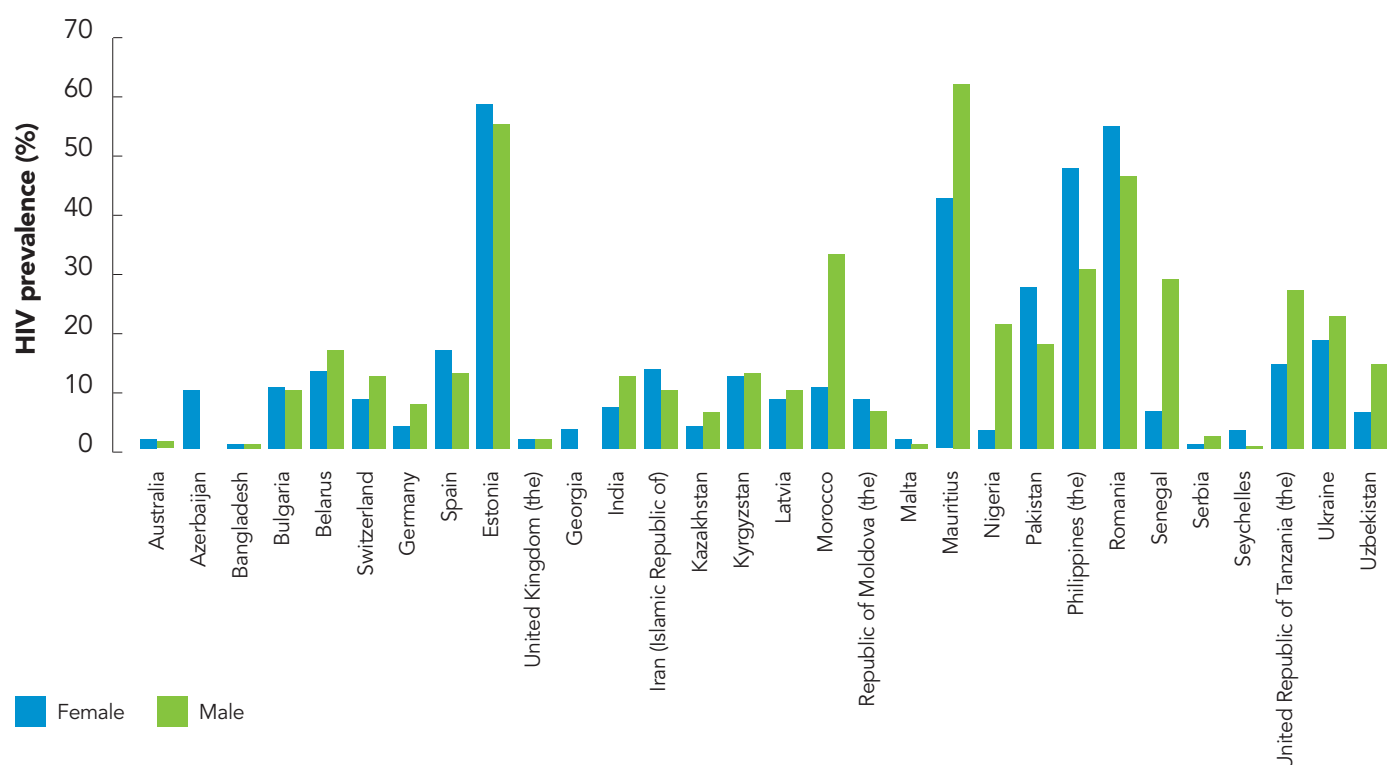
Compared with the general population, people who inject drugs have an elevated risk of death, although mortality rates vary across settings. A 2013 analysis showed higher mortality among people who inject drugs in low- and middle-income countries than in high-income countries, with an added risk among males and people who inject drugs who were also living with HIV. Drug overdose and AIDS-related illness were the primary causes of death (4).

## Women who inject drugs

Women who inject drugs are rarely the subject of surveys, and their injecting practices are poorly understood. However, 30 countries reported data on women who inject drugs. The pooled HIV prevalence among women was 13% compared to 9% among men from the same countries. Surveys from disparate sites such as Canada, Mauritius and the Republic of Moldova have found high rates of sex work among injecting respondents (6) and high rates of injecting drug use among sex-worker respondents (7,8).

Sex workers who inject drugs often have much higher HIV prevalence than non-injecting sex workers. In central Asia, Afghanistan and Mongolia, the odds of HIV were up to 20 times higher among female sex workers reporting injecting drug use (9). Sex workers along the United States–Mexico border were observed to play equal roles earning money, procuring drugs and assisting each other with injections (10). Transgender women who sell sex and inject drugs are at an even greater risk of acquiring HIV (11).

## HIV prevalence among people who inject drugs by sex since 2011



Source: Based on data submitted through GARPR reporting submitted since 2011. Geneva, UNAIDS.

## Criminalization and punitive laws

National responses to people who inject drugs range from the evidence-informed—that is, properly scaled up, community-led harm reduction services in much of western Europe and Australia—to the punitive—long prison sentences, so-called compulsory treatment and even the death penalty.

People who inject drugs are almost universally criminalized, either for their drug-use activity or through the lifestyle adopted in order to maintain their drug use. Many are in prison or held in detention at some point in their lives, often for long periods. Estimates suggest that 56–90% of people who inject drugs will be incarcerated at some stage during their life (12).

The criminalization strategy adopted by national drug control systems hinders the HIV response, as fear of arrest impedes people’s access to and the uptake of HIV services. Punitive laws can deter people from accessing the HIV testing and treatment services they need. In Bangkok, Thailand, 25% of respondents said they were avoiding health care out of fear of being referred to so-called compulsory treatment (13).

An evidence-informed combination prevention approach, including needle and syringe programmes, opioid substitution therapy, HIV testing and counselling and antiretroviral therapy, has the greatest and most cost-effective impact on the HIV epidemic among people who inject drugs. Unfortunately, in some countries, such programmes are illegal or simply unavailable (14).

The majority of national drug control policies focus on supply reduction and law enforcement against any drug use, and people who use drugs are often collateral victims of those interventions. This leads to the violation of people’s human rights in the name of drug control, including through forced drug testing, compulsory detention and the imposition of the death penalty for drug-related offences.

Compulsory detention centres and prisons often include forced labour and violence, in contravention of internationally recommended approaches and human rights. Compulsory detention centres remain common in Asia (15–17), particularly in Cambodia, China, the Lao People’s Democratic Republic, Malaysia, Myanmar, Thailand, Turkmenistan and Viet Nam. Some countries in Latin America use some form of so-called compulsory rehabilitation, while others are considering adopting such an approach (18), including, Brazil, Ecuador, Guatemala, Mexico, Peru and Uruguay.

A recent study of outcomes from compulsory detention in a Chinese city found that 90% of participants had on average 4.5 separate stays in detention. While HIV knowledge increased with more stays, overall condom use and needle sharing remained unchanged, and the sharing of cookers and cottons increased, as did HIV prevalence (19).

In various parts of the world, the possession of clean syringes can be used as evidence to prosecute people who inject drugs or provide grounds for police harassment, thereby deterring safe injecting practices. Regardless of the written

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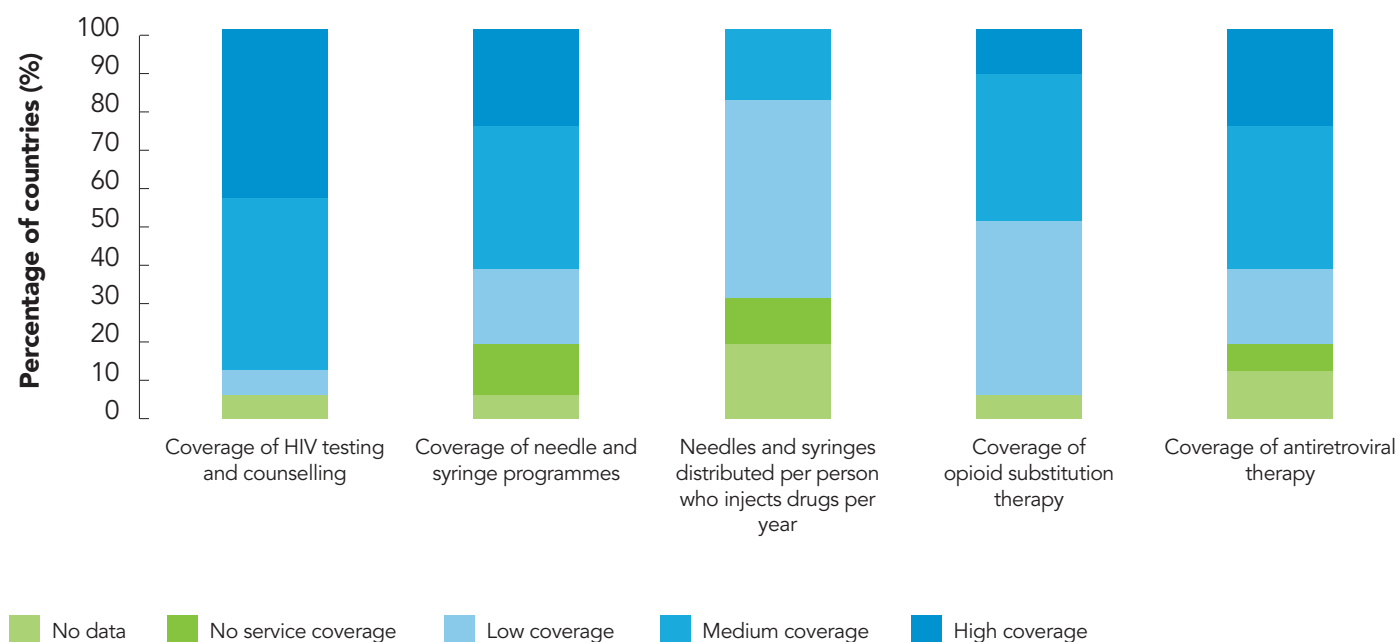
law, even in some countries where syringe possession is not criminalized—for example, Kyrgyzstan and Mexico—people who inject drugs report still being subject to police arrest due to the possession of syringes (20,21).

In 2010, an analysis highlighted the shortcomings of HIV strategies in the six countries with the greatest number of people who inject drugs (22). A 2014 review of the status of these countries shows that four—China, Malaysia, Ukraine and Viet Nam—have shifted their policies towards increased HIV service coverage. China and Viet Nam have expanded HIV treatment and opioid substitution therapy, and Malaysia has moved from a punitive to an evidence-informed HIV response. The policies of the fifth country, the United States of America, remain largely unchanged, with criminalization still the focus and evidence-informed harm reduction largely unsupported by the federal government. The Russian Federation, the sixth country mentioned, continues to steadfastly deny the evidence on the effectiveness of harm reduction, and the rates of HIV infection among people who inject drugs in the country are among the highest in the world (23).

### Absent or inadequate prevention services

In most countries, HIV service provision for people who inject drugs falls below even the lower-level targets outlined in the WHO, UNODC and UNAIDS technical guide to reduce HIV transmission among people who inject drugs (24).

### Percentage of countries reporting HIV prevention service coverage for people who inject drugs by level of coverage



Source: World drug report 2014. Vienna, UNODC, 2014.

Based on data submitted through GARPR reporting submitted since 2011 (only for the number of needles and syringes distributed per person who injects drugs). Geneva, UNAIDS.

Analysis of the latest data reported by countries for the 2014 GARPR shows important regional variations.

In western and central Europe, where overall incidence of HIV among people who inject drugs is low, 50–60% of reporting countries reported high access to services, particularly needle and syringe programmes and opioid substitution treatment.

On the other hand, in South-West Asia, the region that has the highest prevalence of HIV among people who inject drugs, no country reports a high level of coverage for any of the prevention services.

An estimated 45% of all people who inject drugs live in 16 countries. These countries are home to an estimated 66% of all people who inject drugs who are living with HIV. Despite the high disease burden, these countries nearly universally have low coverage with evidence-informed HIV and drug-use intervention prevention programmes (1).

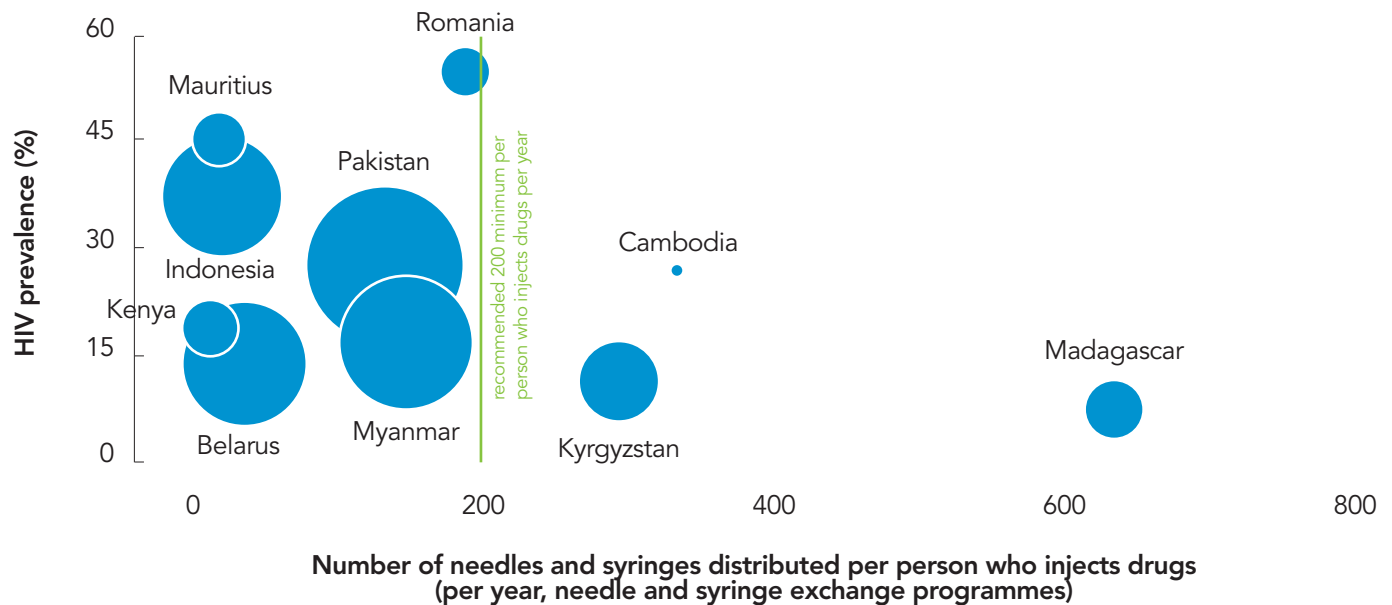
## Overview of the level of provision of harm reduction services

	Countries reporting low, medium or high coverage (percentage)			Number of countries reporting	Global median value	Low	Medium	High
	Low	Medium	High			Less than	From-to	More than
<b>Percentage of people who inject drugs who were tested for HIV in the last 12 months and who know the results</b>	31%	29%	40%	83	36% <sup>a</sup>	40%	40–75%	75%
<b>Percentage of all people who inject drugs who were reached by a needle and syringe programme over the last 12 months</b>	49%	25%	26%	85		20%	20–60%	60%
<b>Number of needles and syringes distributed per person who injects drugs per year</b>	62%	20%	18%	55	74	100	100–200	200
<b>Percentage of opioid-dependent people who inject drugs on opioid substitution therapy</b>	35%	32%	33%	79		20%	20–40%	40%
<b>Percentage of all HIV-positive people who inject drugs receiving antiretroviral therapy at a specified date</b>	32%	31%	37%	74		25%	25–75%	75%

<sup>a</sup> Based predominantly on behavioural survey data.



## Insufficient availability of needles and syringes, 2011-2013



● ● Relative sizes of the reported populations of people who inject drugs.

Source: Global AIDS Response Progress Reporting 2014.

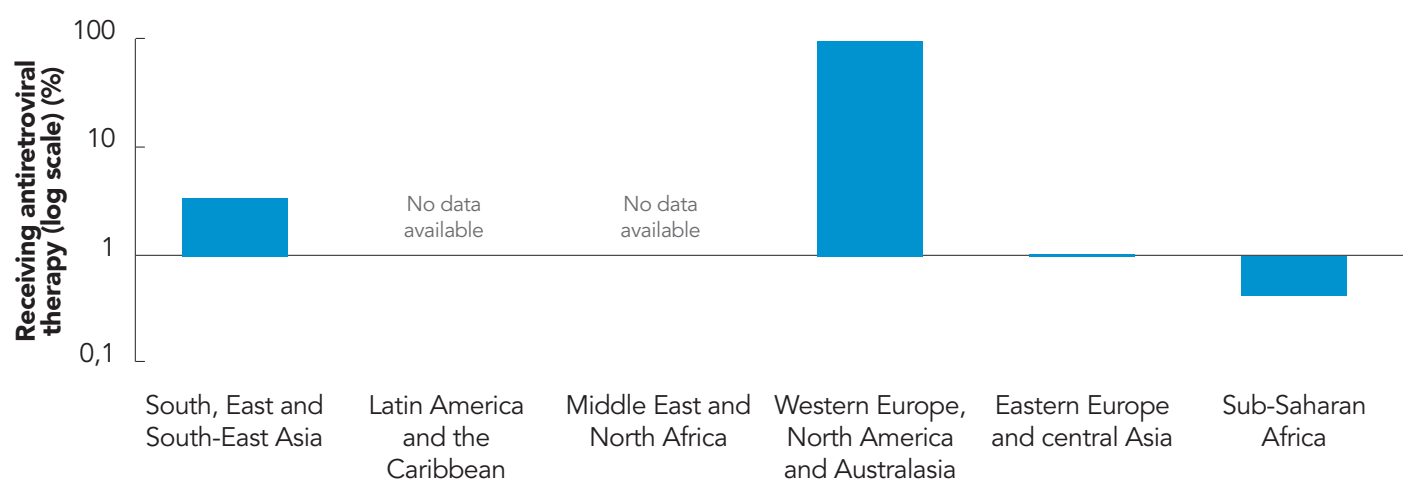
According to the World Drug Report 2014, only 79 of the 192 reporting countries offered opioid substitution therapy, and 55 countries provided needle and syringe programmes. Coverage of these critical services, along with HIV testing, is low across the majority of countries reporting: only 18% are meeting the target of distributing 200 clean needles per person injecting per year. Some 33% of the countries reporting opioid substitution therapy provision indicate good coverage (>40%) for opioid substitution therapy, and 40% of reporting countries have high coverage (>75%) for HIV testing (1).

The majority of people who use drugs living with HIV do not have access to HIV treatment. A World Bank analysis estimates that about one in ten people who inject drugs and is living with HIV is receiving antiretroviral therapy (25). Based on these estimates, people who inject drugs lag far behind other people living with HIV in accessing life-saving HIV treatment, particularly in low- and middle-income countries.

**In most countries, HIV service provision for people who inject drugs falls below even the lower-level targets outlined in the WHO, UNODC and UNAIDS technical guide to reduce HIV transmission among people who inject drugs.**

A 2010 review found that, in China, Malaysia, the Russian Federation, Ukraine and Viet Nam, people who inject drugs constituted 67% of all HIV cases, but only 25% of the people receiving antiretroviral therapy (26,27). The figures for treatment coverage vary from less than 1% (Chile, Kenya, Pakistan, the Russian Federation and Uzbekistan) to all HIV-positive drug users in six European countries. Countries in western Europe report the highest proportion of people living with HIV who inject drugs on antiretroviral therapy (89% coverage), while countries in eastern Europe report the lowest (less than 1% coverage for antiretroviral therapy) (28).

## Proportion of people who inject drugs living with HIV who receive antiretroviral therapy



Source: World Bank literature review and estimates, based on Mathers BM, et al. HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage. *Lancet*. 2010;375(9719):1014–1028. doi:10.1016/S0140-6736(10)60232-2.

## Widespread societal stigma

People who inject drugs are among the most marginalized and invisible people in all societies. Many governments find it politically unpalatable to provide adequate HIV and health services for people who inject drugs, who are a socially stigmatized and criminalized population.

Since they are readily ignored and left behind by politicians and policy makers, often their only support comes from each other through formal and informal peer networks. When people are socially marginalized, they are less likely to approach health authorities for their sexual and reproductive health, as well as other health services.

Stigma and discrimination in health- and social-care settings also keep people who use drugs away. Health services may even exclude people who inject drugs or treat them badly when they ask for help.

**Many governments find it politically unpalatable to provide adequate HIV and health services for people who inject drugs, who are a socially stigmatized and criminalized population.**

The Mauritius Stigma Index of 2013 shows that people living with HIV face layered stigma related to their perceived or actual belonging to one or more key population groups (29). The Stigma Index in Viet Nam found similar sentiments among respondents who reported that they felt more stigma from their behaviours—whether from injecting drug use or selling sex—than from their HIV status.

Of serious concern to people in Viet Nam who inject drugs and are living with HIV was the threat of disclosure of their status to their community by health officials (30). What is clear is that people who inject drugs frequently face multiple sources of stigma, making it very hard for them to demand and access the support they need.

Evidence indicates that, when women who inject drugs and are living with HIV become pregnant, they face substantial barriers to accessing services to prevent their infants from acquiring HIV infection—even more so than other women who are living with HIV. Female sex workers in the Russian Federation reported additional barriers that apply to women who inject drugs: poverty, lack of official documentation, lack of anonymity in testing and the official registration system. The availability of HIV services was not enough for them to access treatment successfully. To overcome the debilitating effects of stigma, service uptake was facilitated when there was support from family members, social connections within the health-care system and referral services from a nongovernmental organization (31).

To counter institutional stigma, discrimination and bias against people who inject drugs, successful advocacy for programme investments must be evidence-informed. Therefore, there is a need for valid programmatic monitoring data, with important disaggregation by sex and age (32) to support evidence-informed arguments for funding programmes based on actual need.

## Lack of investment

Funding for the vast majority of harm reduction programmes outside of western Europe and Australia comes from non-domestic sources, either through the Global Fund to Fight AIDS, Tuberculosis and Malaria or other donors, or arises from outside of specific HIV-earmarked budgets. This makes it difficult to scale up quality programmes sufficiently to have an impact, and the long-term prognosis for their sustainability is extremely precarious.

Most of the countries reporting high programme coverage are high-income countries. The vast majority of low- and middle-income countries are not adequately meeting their programmatic obligations to address HIV prevention among people who inject drugs (3).

Commitments to an effective response for people who inject drugs are uneven across countries. Seventy-eight countries reported that people who inject drugs are explicitly addressed in national HIV plans and policies, and only 44 of 141 countries reporting on the issue stated that they have a comprehensive package of interventions (33).

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**The vast majority of low- and middle-income countries are not adequately meeting their programmatic obligations to address HIV prevention among people who inject drugs.**

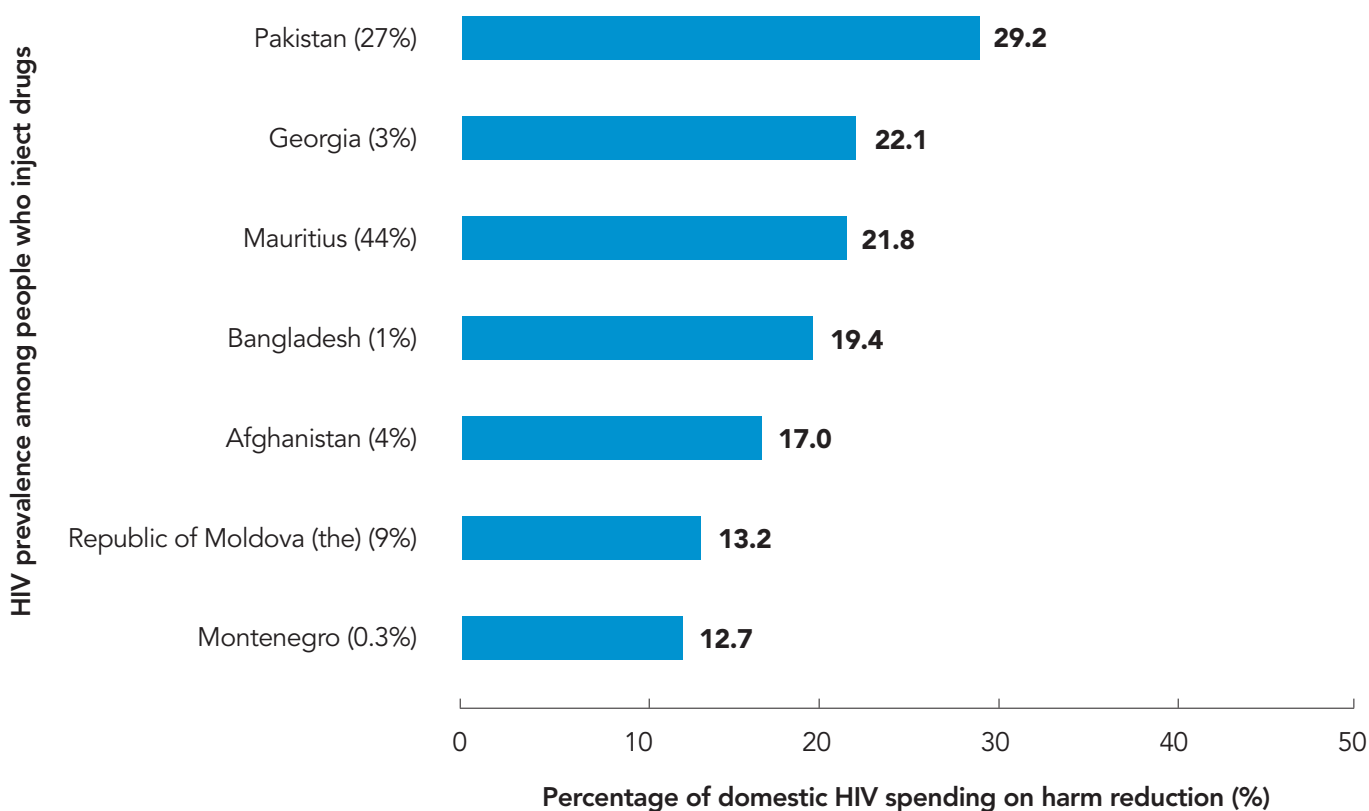
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Countries with large or growing HIV epidemics among this population include many newly middle-income countries. As international funding of their HIV response dries up, funding for services for people who inject drugs is not being replaced by domestic sources.

While many countries report expenditures on HIV, there has been a lack of political will to disaggregate spending by key populations. Thus the actual picture of where resources are being spent is not widely accessible (33). Even where spending for people who inject drugs looks reasonable, report funds might actually be used for interventions such as compulsory detention that have no evidence base.

Among those countries that do successfully report disaggregated spending, Pakistan is notable. HIV prevalence among people who inject drugs in Pakistan is 27%, and the share of spending on their prevention programmes is one third of total spending. Overall, only eight countries reported spending above 10% on programming for people who inject drugs (33).

### Countries reporting >10% of domestic HIV spending on harm reduction, with the HIV prevalence (%) among people who inject drugs



Source: Based on GARPR reporting since 2010. Geneva, UNAIDS.

# CLOSING THE GAP

WHO, UNODC and UNAIDS, along with international partners, have defined a comprehensive package of nine interventions that need to be implemented to address HIV among people who use drugs and their sexual partners.

They are: (1) needle and syringe programmes; (2) opioid substitution therapy and other evidence-informed drug dependence treatment; (3) HIV testing and counselling; (4) antiretroviral therapy; (5) prevention and treatment of sexually transmitted infections; (6) condom programmes for people who inject drugs and their sexual partners; (7) targeted information, education and communication for people who inject drugs and their sexual partners; (8) prevention, vaccination, diagnosis and treatment for viral hepatitis; and (9) prevention, diagnosis and treatment for tuberculosis.

Adopting a harm reduction approach is not only good for the health outcomes of people who use drugs, their families and the communities in which they live, it is also cost effective (34).

In order to close the programming gap for people who inject drugs, the following should be given priority.

Transform punitive laws that criminalize the use of drugs:

- End the criminalization of people who use drugs. Continued movement away from criminalization towards a humane and supportive approach to drug users and the problems they face will transform national strategies into the best public health outcomes.
- End arbitrary detention, so-called compulsory treatment, torture and other forms of ill-treatment.
- Increase access to justice for people who inject drugs whose rights have been violated.

Expand evidence-informed services:

- Integrate HIV services so that people who inject drugs can access what they need in a simple, coordinated and friendly fashion.
- Improve access to antiretroviral therapy among people who inject drugs living with HIV.
- Monitor and evaluate services and report to the community of people who use drugs.

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## HOW TO CLOSE THE GAP

# 01

Transform punitive laws that criminalize the use of drugs

# 02

Expand evidence-informed services

# 03

Address institutionalized stigma and discrimination

# 04

Increase domestic funding for harm reduction programmes

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- Design, plan and implement as many services in cooperation with the community of people who inject drugs and as close as possible to where they are located.
- Improve programme monitoring with data collection that is disaggregated by sex and age.

Address institutionalized stigma and discrimination:

- Develop legal literacy and legal services that will empower people who inject drugs to challenge discrimination and abuse.
- Sensitize law enforcement and health-care personnel to reduce stigma, discrimination and abuse and enhance the quality of life of people who inject drugs and initiate surveys to monitor stigma and its effects.
- Expand social support to manage drug dependence.
- Foster leadership so that people who inject drugs can support their peers and be active in the HIV response in their communities.

Increase domestic funding for harm reduction programmes:

- Commit to fully funding evidence-informed programmes.
- Report expenditures on HIV disaggregated by key populations.
- Strengthen civil society engagement in the planning and roll-out of HIV services.
- Include people who inject drugs in national HIV plans and policies.

Despite the challenges they face, which include social isolation and the risk of overdose and early death, people who inject drugs continue to care for themselves, their families and each other. They overcome huge hurdles on a daily basis, often at an enormous cost. A concerted effort to remove the obstacles that prevent them from accessing the range of services they want in a way that they can use them is required in order to support their HIV-related needs.

Harm reduction strategies—including opioid substitution therapy, needle and syringe distribution, condom promotion and distribution and peer outreach along with standard and free access antiretroviral therapy—were implemented in Xichang City, Sichuan Province, China in 2004. Two cohorts were followed before and after implementation. HIV incidence among people who inject drugs dropped from 2.5 to 0.6 cases per 100 person-years. In addition, the incidence of hepatitis B virus declined from 14.2 to 8.8 cases per 100 person-years (35).

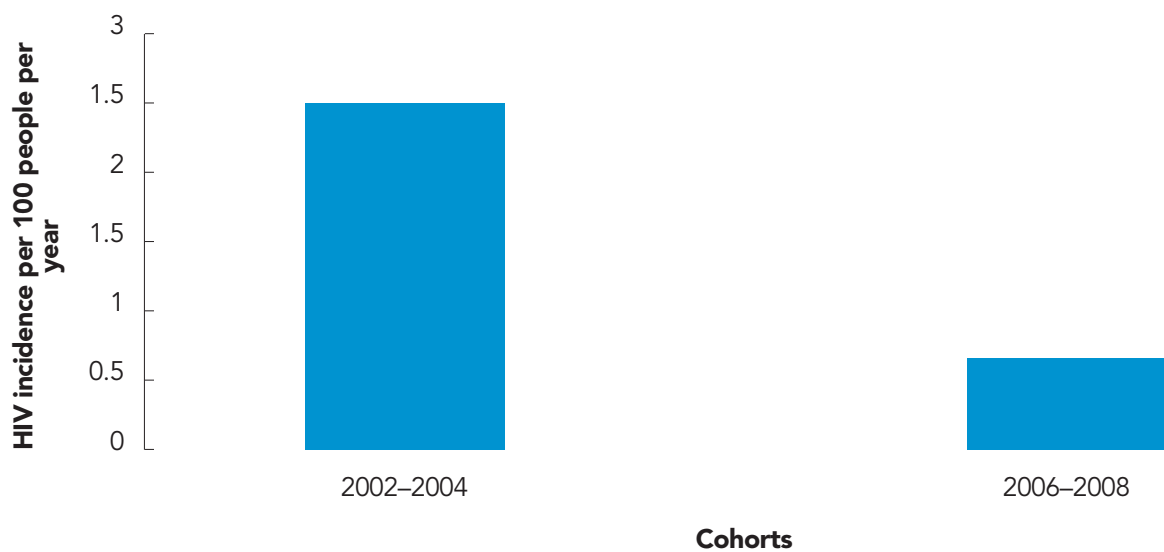
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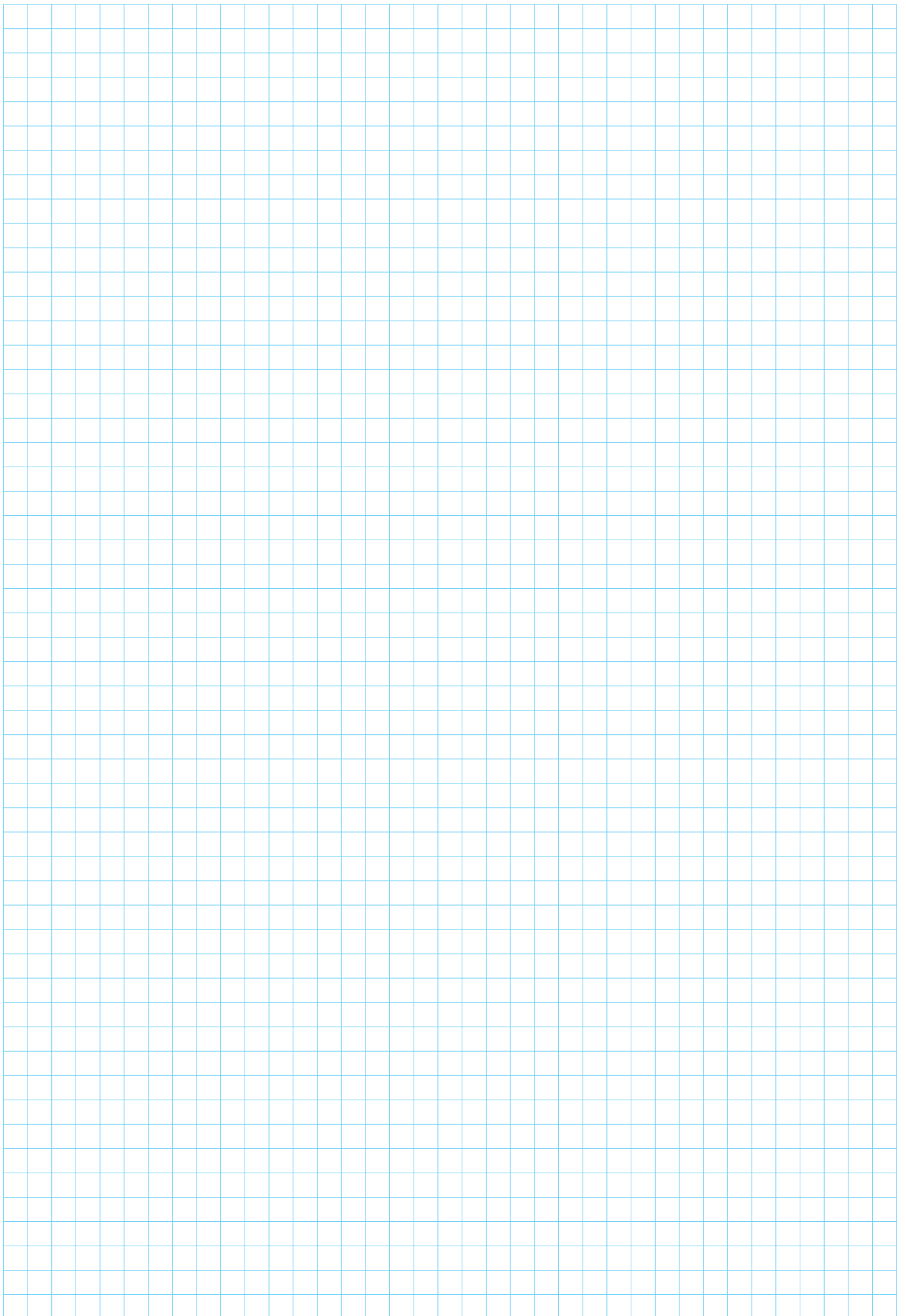
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## HIV incidence rate among people who inject drugs drops by 75% in one Chinese city with strong harm reduction programmes



Source: Ruan Y, et al. Evaluation of harm reduction programmes on seroincidence of HIV, hepatitis B and C, syphilis among intravenous drug users in southwest China. *Sex Transm Dis.* 2013;40(4):323-328. doi:10.1097/OLQ.0b013e31827fd4d4.

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