Policy Analysis and Advocacy Decision Model for HIV-Related Services

People Who Inject Drugs

USAID FROM THE AMERICAN PEOPLE

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EURASIAN HARM REDUCTION NETWORK

HEALTH POLICY PROJECT

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Policy Analysis and Advocacy Decision Model for HIV-Related Services: People Who Inject Drugs

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Note that it is both a humbling and daunting effort to capture a policy environment as complex and dynamic as policies related to services for people who inject drugs. While we have made every attempt to capture the situation as of the date of this publication, we recognize the need to keep updating and improving the Decision Model. Before using it, please visit www.healthpolicyproject.com to check for an updated version.

All comments for clarification, expansion, and improvement are welcome. Please send comments to PolicyInfo@futuresgroup.com.

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Executive Summary

Primary Goal and Content of Decision Model

The Decision Model provides country stakeholders—such as advocates, policymakers, and service providers—with tools to inventory, assess, and advocate for policies that affect access to and sustainability of key services for people who inject drugs (PWID). The model maps service-specific policies to international human rights frameworks to identify needs and opportunities for policy advocacy that will help improve access to services, even while larger, long-term human rights policies may remain deficient.

The Decision Model addresses policies that specifically affect services related to PWID, including service coordination; data use and decisionmaking; participation of PWID in decisionmaking, service delivery and evaluation; consent; personal data; stigma and discrimination; criminal sanctions; gender-based violence; human rights; procurement and supply management; eligibility; funding; and service delivery protocols. These policies are assessed for services delivered in community, pre-trial detention, and prison settings and in settings and institutions that have custody of minors.

The Decision Model can address the following fundamental questions related to developing and implementing an incremental advocacy strategy for PWID or integrating PWID-specific policies into prevention and treatment strategies for hepatitis, tuberculosis (TB), and HIV:

1. What is the legal basis for injecting drug use (IDU)-related services as a component of national hepatitis, TB, HIV, and drug treatment and harm reduction strategies?
2. Do national policies conform to standards and guidelines developed by international, multilateral bodies and leading international, regional, and local organizations?
3. Are there national policies and guidance to support the establishment and access of services for PWID?
4. Are policies disseminated and implemented at the local level?
5. What are the feasible policy targets for advocacy?
6. Who are the in-country advocates for IDU service scale-up, and how can a scale-up strategy be developed?

Policy Barriers to PWID Services

The Decision Model specifically aims to address three types of policy barriers to services for PWID: restrictive, poorly written, and absent policies. The more easily detected of these are restrictive policies—policy document provisions that explicitly deny or rule out scientifically proven services (e.g., a drug policy that expressly outlaws the importation of buprenorphine entirely or restricts it for research purposes only). Policies that are poorly written, are unclear, or do not respond to current science or international best practices. For example, much legislation in Eastern Europe passed after the collapse of

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the Soviet Union has been marred by a lack of clarity, causing medical personnel to follow outdated Soviet regulations (OSI, 2009b).

The final type of policy barrier reflects the absence of explicit policy provisions to provide, sustain, and/or expand access to services. Often these barriers are more difficult to detect, yet they may be as important or even more important than restrictive policies—requiring a thorough assessment of the policy environment. The absence of explicit policy provisions can hamper the implementation and sustainability of services through mechanisms such as the following:

1. *Provider reluctance to offer potentially controversial services unless there are explicit policy documents that permit or even direct them to do so.* While providers in some countries may feel free to offer services not explicitly banned or prohibited, the culture and practices of other countries often discourage this practice.

2. *Reliance on decrees rather than legislation to establish a legal framework for services.* While this may be sufficient to set up pilot programs, there is no substitute for legislation to mandate the broad public policy and objectives in drug treatment and harm reduction programs. Policies established by the executive branch of government can be overturned more easily by subsequent administrations, while legislative provisions enacted by parliaments and legislatures establish a more sustainable public policy for services such as medication-assisted therapy (MAT) and sterile needle and syringe programs (NSP) (WHO, 1999a), (WHO, 1987).

3. *Ineffective or non-existent policies to coordinate national strategies and operational plans.* National coordinating bodies or advisory committees have a key role in ensuring a country's effective, coordinated, and holistic drug treatment programs. Their composition and powers must be specified in national legislation.

The Decision Model identifies the existence of restrictive, poorly written, or absent enabling policies that are required for hepatitis, TB, HIV, drug treatment, and harm reduction programs to provide sustained, accessible HIV counseling and testing (HCT), antiretroviral therapy (ART), hepatitis, TB, opioid substitution therapy, and sterile needle and syringe program services for PWID. These policies are mapped against established human rights guidelines in the areas of (1) framework, (2) community partnership, (3) legal environment, and (4) intervention design, access, and implementation.

Components of an Effective Policy Environment

Framework

The national framework for coordination of programs and ministries (e.g., health and justice) is particularly important to improve access to services for PWID. People who inject drugs often require services to address multiple and interrelated health concerns such as hepatitis, TB, HIV, drug treatment, and harm reduction in community, detention, and custodial settings. Designing national programs to ensure an integrated continuum of care among these health concerns and between governmental and nongovernmental providers increases entry points and retention in services that reduce harm to the individual and the community.

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The national framework also sets the policy guidance for data use in decisionmaking. The decisionmaking process for PWID services can be influenced by myriad political, social, and environmental factors. To be most effective at addressing the health concerns of PWID, policy must also define the scientific evidence base for decisions on funding levels, types of services needed, and coverage targets.

Community Partnership

Best practices for most sectors now recognize the value that commnuity partnership brings to program planning and implementation; PWID services will be more accessable and effective if they are designed, implemented, and evaluated with the input of individuals and organizations who have personal or professional experience with drug use. Moreover, partnership with some of the more underserved PWID, such as females and youth, is crucial in designing programs to address the specific needs of these populations.

Legal Environment

Public health law empowers public health authorities to provide a comprehensive range of HIV-related services and establishes standards for informed consent, confidentiality, and program implementation. Public health law is also the mechanism that can be used to protect individual rights and dignity (e.g., protection from stigma and discrimination) (UNAIDS, 2006, pp. 26-29).

Even where legislation may not criminalize drug use per se, in many countries, penalties for possession of minute amounts of drugs make virtually any drug user an offender and subject to large fines or imprisonment. As a result of repressive drug policies, people who use drugs are often turned into criminals even if they commit no crimes and inflict no harm to others. This legal construct contributes to stigmatization and discrimination of drug users by society, as well as additional vulnerability faced in prisons by PWID. In addition to being a violation of human rights, these policies grant power to the police for targeting drug users and may also facilitate the practice of abuse, violence, and extortion (HRC, 2010). As a recent shadow report from Russia to the UN Committee against Torture vocally suggests, "[r]epressive policy towards drug dependent people in Russia is primarily expressed not in laws on paper, but in ways how the authorities treat drug dependent people in reality, often violating the laws and saying that all methods can be used to combat 'this evil.' The daily life of drug users is full of fear and terror born from widespread illegal practices that are used by law enforcement" (Public Mechanism for Monitoring Drug Policy Reform in the Russian Federation , 2011).

Thus, even though policies criminalizing drug use usually do not formally prohibit or restrict access to harm reduction services, they directly create legal vulnerability of drug users to persecution and make them susceptible to illegal policing practices that prevent them from accessing services.

Intervention Design, Access, and Implementation

Policies that authorize, fund, and guide specific services for PWID are an essential piece of the policy environment. In some countries, government officials and program managers may be reluctant to take political risks by authorizing or initiating programs and services that can be perceived as controversial and are not directly required by the law (Reshevska, Foreit, Beardsley, & Porter, 2010). Policies that

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guide service implementation are also critical for establishing protocols to address the specific needs of PWID within larger service areas such as TB, HCT, and ART.

Conclusion

It is clear that human rights violations, stigma and discrimination, and restrictive (or absent) policies create barriers to high-quality services for PWID. This Decision Model provides local stakeholders and advocates a template to build a customized advocacy approach—specific to the needs and environment of each jurisdiction. The model provides valuable information on which level of government to target advocacy efforts and whether to target actual policy language or implementation. The customizable, in-depth, and standardized approach will build the capacity to identify incremental, feasible, near-term opportunities to improve the legal environment and the resulting quality of and access to services for PWID while long-term human rights strategies are implemented.

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Abbreviations

ART	antiretroviral therapy
CCM	Country Coordinating Mechanism
CEE	Central and Eastern Europe
CEECA	Central and Eastern Europe and Central Asia
CSAT	Center for Substance Abuse Treatment
EHRN	Eurasian Harm Reduction Network
FDA	Food and Drug Administration
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HAV	hepatitis A virus
HBV	hepatitis B virus
HCT	HIV counseling and testing
HCV	hepatitis C virus
HHS	U.S. Department of Health and Human Services
HIV	human immunodeficiency virus
IDU	injecting drug use
INCB	International Narcotics Control Board
IRB	Institutional Review Board
MAT	medication-assisted therapy
MOU	memoranda of understanding
MSM	men who have sex with men
NGO	nongovernmental organization
NIDA	National Institute on Drug Abuse
NSP	sterile needle and syringe program
OST	opioid substitution therapy (also referred to as medication-assisted therapy)
PEPFAR	United States President's Emergency Plan For AIDS Relief
PHRplus	Partners for Health Reformplus
PLHIV	people living with HIV
PSM	procurement and supply management
PWID	people who inject drugs
SAMHSA	Substance Abuse and Mental Health Services Administration
STI	sexually transmitted infection
SW/TG/MSM DM	Policy Analysis and Advocacy Decision Model for Services for Sex Workers, Transgender, and Men who have Sex with Men
TAC	Treatment Action Campaign
TB	tuberculosis
TIP	Treatment Improvement Protocols
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

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Introduction

Background

Biological, behavioral, and structural factors put people who inject drugs (PWID) at higher risk for HIV transmission than other individuals, even in generalized epidemics. HIV data are available for 128 of the 148 countries and territories reporting injecting drug use; the global estimate of HIV prevalence among injecting drug users is 19 percent, with prevalence of over 40 percent in nine countries (including Estonia and Ukraine) and between 20 and 40 percent in five countries (including Russia) (Mathers B. M., et al., 2008). Unsterile sharing of injection drug equipment is the major driver of the HIV epidemic in Eastern Europe and Central Asia, where 80 percent of cumulative HIV infections are registered among PWID (National Institute on Drug Abuse [NIDA] & International AIDS Society [IAS], 2010). Transmission of HIV also occurs from PWID to individuals who do not report the use of unsterile injection equipment. For example, in Russia, having sex with a person who injects drugs increased the odds of acquiring HIV by 3.6 times, with 66 percent of PWID reporting having sexual intercourse with a partner who had not injected drugs in the past year (USAID, 2011).

Additionally, marginalized and criminalized populations tend to experience, at disproportionate levels, specific environments that present higher risk of HIV transmission. For example, the correlation between drug use and pre-trial facilities and prison can present through a number of circumstances, including conviction for drug use that began before imprisonment, drug use that began during imprisonment, and the proximity of drug use and other criminal environments. Once placed in a pre-trial detention center or incarcerated, the lack of HIV prevention resources facilitates risk from sharing/re-using injecting equipment and drug solutions. Also, despite rules that prohibit sexual activity, consensual, coerced, and exchange sex, rape and sexual violence are well documented in prison settings. Finally, prisoners and staff alternate between prison and community environments, making prison health inseparable from the health of the broader population for not only HIV but also other communicable diseases such as hepatitis and tuberculosis (UNODC, pp. 11-17) (WHO, 2007d, pp. 8-11).

Other high-risk environments that marginalized and criminalized populations experience, especially children and youth, are living on the streets and in settings where minors are in state custody such as orphanages, foster care, or juvenile detention. Whether the result of or conducive to HIV-risk behavior, children living on the streets have documented HIV prevalence rates of 40 percent, injection drug use prevalence of over 50 percent, almost universal sexual activity, and high levels of compensated (16.5% boys, 56.7% girls) and forced (11.2% boys, 52.2% girls) sex (UNICEF, 2010, pp. 31-37). By 2009, only 8 percent of PWID per year had access to NSP services worldwide (10% in Eastern Europe and 36% in Central Asia), and the average number of needles and syringes distributed per PWID per year was 22 (9 in Eastern Europe and 92 in Central Asia). Opioid substitution therapy (OST) was implemented only in 70 countries out of 151 that reported injecting drug use (IDU), and only 8 percent of PWID were reported to receive OST (only 1% in Eastern Europe and Central Asia). Only 4 out of 100 PWID living with HIV worldwide received antiretroviral therapy (ART) (1 in Eastern Europe and 2 in Central Asia) (Mathers, et al., 2010).

Against this backdrop of increased risk and inadequate resources lie fundamental challenges in the policy legal environment. In 2010, 46 percent of government responses and 62 percent of civil society responses

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to the National Composite Policy Index acknowledged the existence of laws, regulations, and policies that obstruct access to prevention, treatment, care, and support services for populations at higher risk. In addition, almost one-third of reporting countries do not have laws and regulations that protect people living with or vulnerable to HIV from discrimination. And while the percentage of countries with protective legislation has increased from 32 percent in 2004 to 62 percent in 2010, little evidence exists to determine whether these laws are effectively enforced or whether individuals have access to justice or can seek redress for wrongs experienced (UNAIDS, 2010, pp. 126-128).

The Decision Model

Purpose and Target Audiences

This Decision Model is designed to help country stakeholders build a public policy foundation that supports the access to and implementation and scale-up of evidence-informed services for PWID. The model provides tools to help advocates, policymakers and decisionmakers, national committees and advisory boards, program developers, service providers, clients, nongovernmental organizations (NGOs), and other stakeholders identify and address the policy barriers to PWID services. Selection of the services covered in this model was based on recent guidance from the President's Emergency Plan for AIDS Relief (PEPFAR); scale-up priorities of the World Health Organization (WHO), United Nations Programme on HIV/AIDS (UNAIDS), and the United Nations Office on Drugs and Crime (UNODC); and feedback from the external advisory body at the International Harm Reduction Conference in 2011. The services covered are HIV counseling and testing (HCT); ART; hepatitis vaccination, diagnosis, and treatment; tuberculosis testing, diagnosis, and treatment; OST; and NSPs. The Decision Model is designed for global application but also addresses the specific policy environment in the Eastern European and Central Asian regions.

The model can be used to

- Compare the current policy environment in a particular country with international best practices and identify the extent to which current laws and policies enable or restrict implementation of services for PWID (this could also serve as a baseline for the design of advocacy programs);
- Identify policy barriers and the strategies and opportunities that could mitigate these barriers (this could form the basis of designing a policy advocacy strategy);
- Provide summary best-practice guidance for programmers and decisionmakers working with PWID in determining the content of programs and planning interventions; and
- Monitor the impact of policy advocacy and implementation (change in the country's policy/program environment could be measured by re-applying selected modules at a later date and comparing findings with the baseline)

The Decision Model is the second generation and expansion of the *Policy Advocacy Toolkit for Medication-Assisted Treatment (MAT) for Drug Dependence* (Reshevska, Foreit, Beardsley, & Porter, 2010) and the culmination of an initiative conducted by the Health Policy Project and funded by the U.S. Agency for International Development (USAID). Its design and content are the result of collaborations and consultations among international experts and regional organizations, including the

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Eurasian Harm Reduction Network, the Open Society Public Health/International Harm Reduction Development Program, United Nations Office on Drugs and Crime (UNODC), the AIDS Project Management Group, the Canadian HIV/AIDS Legal Network, the American Bar Association Rule of Law Initiative, USAID, the U.S. Centers for Disease Control, the Ukrainian Institute on Public Health Policy, the Clinton Health Access Initiative, and the International HIV/AIDS Alliance in Ukraine.

Organization and Design

The model is organized into two chapters. The first chapter provides background information on the overall policy framework, the Decision Model's components, and additional advocacy strategies. The second chapter includes four sets of tools that collect various quantitative (*inventory*) and qualitative (*interviews*) data on policy language and implementation, collate the quantitative data for easy comparison (*matrix*), and provide basic steps to create an advocacy strategy and set priorities (*worksheets*).

1. *Policy Inventory and Analysis.* Instruments and procedures to compile and analyze a reference library of country documents and an analytic framework to compare the collected documents against international best practices and assess the extent to which they enable or restrict implementation of hepatitis, TB, HIV, drug treatment, and harm reduction services.

2. *Policy Implementation Assessment Interviews.* Survey instruments to collect opinions and experiences of key informants, service providers, and clients regarding the implementation of policies.

3. *Policy Advocacy Planning Worksheets.* Guidance for advocates to identify and prioritize policy issues, engage stakeholders, and conduct advocacy campaigns.

In addition to the type of information collected, the Decision Model provides levels of detail appropriate to different kinds of stakeholders—from an inventory of detailed language that identifies specific clauses to change, to an assessment of policy implementation that identifies barriers to program access and implementation, to a high-level overview of policy documents that can identify gaps in the overall policy matrix (see Table 1).

Table 1. Levels of Detail Provided and Use

Tool/Instrument	Level of Detail	Uses
Policy Inventory and Analysis (Reference Library)	Highest	• Listing of citations to support policy arguments • Specification of policy clauses that should be changed
Policy Assessment Interviews	High	• Assessment of overall adequacy of policy environment • Identification of policy barriers, contradictory policies, and/or policy gaps
Quick Reference Matrix	Lowest	• Quick identification of relevant policy documents • Facilitation of use of reference library and inventory

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Implementation

Considerations

- *It is not necessary to implement the entire model.* While a complete implementation of the Decision Model will provide the most comprehensive analysis of policies impacting the access to and sustainability of services for PWID, a full implementation of the more than 1,300 points of policy analysis may not be feasible or necessary. Therefore, the document is designed so that it can be implemented in a modular fashion. For example, stakeholders may be most interested in policies for a specific intervention, such as NSPs, or specific contexts such as prison environments. When designing the policy analysis, simply identify the topics for consideration and complete the analysis for these policies.

- *As policy issues are being considered for inclusion, be sure to consult with implementers and PWID.* Policy analysis points that may not appear to be directly related to the interventions or contexts of interest may actually prove to be crucial policy barriers to services.

- *The policy inventory, analysis, and advocacy tools can be implemented at different levels of governmental jurisdiction.* Depending on the scope of the analysis, policies can be analyzed for national and subnational (e.g., regional, state, or local) governmental jurisdictions. If implementing at multiple levels of government, be sure to identify when there are policy contradictions among the different levels of government.

- *No country will score a perfect analysis.* The policy analysis standards used in this document are based on international standards that may or may not be relevant in a specific country. Advocates and stakeholders will need to consider the country context when incorporating the assessment findings into advocacy strategies.

- *Just because a policy does not align with international standards, it does not mean that it is inappropriate for the country context.* Again, local stakeholders and advocates will need to consider the local country context when interpreting the assessment findings. The assessment is meant to be the beginning of a conversation, not a declarative statement of absolute fact.

- *References for the assessment standards for policy language and implementation cannot always be specific to the intervention.* As much as possible, we identified specific international standards for assessing policies. However, when language specific to the intervention and context was not identified, we tried to apply and adapt the spirit and overarching concepts of related policies to specific policy analysis standards.

Model Implementation Challenges

- There are often *no national repositories of all policy documents* related to hepatitis, TB, HIV, and drug treatment and harm reduction services. Time will be needed to identify and collect policy documents, and some information may be totally lacking or inaccessible (e.g., for local estimates of coverage targets, many countries rely on international sources).

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- Application of the Decision Model will *probably require external assistance*—at least to train the data collectors and perhaps provide assistance with analysis. The inventory and analysis are best undertaken by individuals already familiar with policy documents.

- It is *unlikely that a single person will have the policy and content area expertise* to apply the entire model; thus, countries should assemble a team of knowledgeable individuals who collectively cover the policy content areas.

- Written policy documents set the stage for program implementation but cannot guarantee program success by themselves. The *policy assessment is only the first step* of a longer planning and implementation process; stakeholders will need additional resources to disseminate findings, train advocates and develop advocacy plans, support needed policy reform, train service providers, fund expanded treatment programs, and monitor progress.

Limitations to Findings

- *No policy or law is universally translatable* to all countries, and international standards must be implemented in a country context. The standards identified in the Decision Model are based on the language and context of international documents and best practices and are not meant to be either restrictive or comprehensive. The inventory and analysis of country documents outlined in the model serves to identify policies that require additional attention, as well as country-specific solutions.

- This model is designed to provide a high-level overview of the PWID-specific policies that most directly affect sustainability, access, utilization, and design of a defined list of services (HCT, ART, hepatitis, TB, OST, and NSP). It is *not designed to be a tool that measures implementation quality or effectiveness,* nor a detailed technical guide for these services. Stakeholders interested in a more in-depth analysis of the services are encouraged to consult service-specific documents—many of which are referred to in this document.

Technical/Administrative Capacity Requirements

Organizations implementing the Decision Model should have some level of expertise in the following areas—or partner with organizations that offer this expertise:

- *Project management.* Implementation will involve multiple collaborators, consultants, and potentially significant financial resources. Organizations should have administrative and organizational systems in place to facilitate financial management, project planning, and contracting.

- *Information analysis.* The model will generate a large volume of information that should be analyzed and presented in a manner that facilitates meaningful comment and feedback. Organizations should have experience identifying overarching issues, key themes, and priority actions.

- *Information dissemination and presentation.* Any analysis of policy and subsequent advocacy efforts must be a collaborative and participatory process to be seen as valid. Results will need to

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be validated with key stakeholders, and the priorities identified will need broad consensus and buy-in.

- *Policy environments.* Many policies identified in the Decision Model will not be contained in documents specific to PWID. Implementing organizations should have general knowledge of policies related to sectors such as health, family law, human rights, law enforcement, justice and correctional systems, gender-based violence, and procurement and supply management.
- *Coalition building.* Policy issues that impact services for PWID also impact services for other populations. Implementing organizations need to be creative in thinking about potential coalitions to engage in the analysis and advocacy effort.

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Chapter 1: Policy Environment and Requirements

Policy Framework

Fundamental human rights and policies of almost any sector impact the HIV epidemic among PWID and the quality of services for PWID. Human rights guidelines and principles create a framework to a "more comprehensive understanding of the complex relationship between the public health rationale and the human rights rationale of HIV/AIDS" (UNAIDS, 2006, p. 9). Implementing interventions within a combined public health and human rights framework increases the effectiveness of the overall country strategy. To align the value of a human rights approach with the policy environment required for program implementation, this Decision Model maps implementation policy to existing human rights frameworks developed by UNAIDS and the Office of the United Nations High Commissioner for Human Rights (UNAIDS, 2006). By mapping the structure to this well-established human rights framework, intervention-specific policy components are layered onto the broad foundation of human rights. The identification of the specific policy areas in each section were informed by the content of overarching human rights principles, published and grey literature, and the experience of program implementers and participants.

Detailed Technical Guidance

International Guidelines on HIV/AIDS and Human Rights
http://www.ohchr.org/EN/Issues/HIV/Pages/InternationalGuidelines.aspx

Legal Aspects of HIV/AIDS: A Guide for Policy and Law Reform
http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/LegalAspects OfHIVAIDS.pdf

Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS
http://www.aidslaw.ca/EN/modellaw/english.htm

Policy Components

Table 2 maps the structure of the Decision Model to the UNAIDS human rights framework. The policy areas included in this model are categorized into four components of an overall policy environment required for effective program implementation: (1) framework, (2) community partnership, (3) legal framework, and (4) intervention design, access, and implementation. These components will be found throughout country legislation, policies, regulations, guidelines, protocols, and operational plans.

Table 2. Mapping of UNAIDS Human Rights Framework to Decision Model Components

UNAIDS Human Rights Guidelines	Decision Model Component
Guideline 1: Framework Guideline 12: International Cooperation	**Framework** Multisectoral coordination Evidence-based planning and budgeting
Guideline 2: Community Partnerships	**Community Partnership** Community participation in policy design, program implementation, and evaluation Support for community organizations

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UNAIDS Human Rights Guidelines	Decision Model Component
Guideline 3: Public Health Legislation Guideline 4: Criminal Laws and Correction Systems Guideline 5: Anti-Discrimination and Protective Laws Guideline 7: Legal Support Services Guideline 9: Challenging Discriminatory Attitudes through Education, Training and the Media Guideline 11: State Monitoring and Enforcement of Human Rights	**Legal Environment** Public health legislation Authorization Consent Privacy and confidentiality Stigma and discrimination Criminal law Possession, penalties, aiding and abetting Gender-based violence Human and legal rights Legal services Correction systems integrated throughout Decision Model
Guideline 6: Access to Prevention, Treatment, Care, and Support Guideline 10: Development of Public and Private Sector Standards and Mechanisms for Implementing these Standards	**Intervention Design, Access, and Implementation** Procurement and supply management Service-specific policy Authorization/legality Eligibility/access Service protocols Referral mechanisms
Guideline 8: Women, Children, and Other Vulnerable Groups	Integrated throughout Decision Model

Priority Environments and Populations

Detention and Prison Settings

Overly strict drug legislation results in thousands of drug users being incarcerated for small drug offenses [e.g., see (IHRA & HRW, 2009)]. Imprisonment increases a person's risk of being exposed to TB, HIV, hepatitis C, and other blood borne infections, as the prevalence rates of HIV, HCV, and TB in prison populations by far exceed those among the general population (UNODC, 2006). Research has demonstrated that services like NSP and OST are effective for prevention of HIV and other health consequences of drug use in prison settings and do not compromise safety and security of staff and clients (UNODC, 2006). Nevertheless, only 10 countries worldwide were operating NSP in at least one prison and less than 40 countries introduced OST for inmates (IHRA, 2010a).

Detailed Technical Guidance

WHO HIV/AIDS in Prison Settings Resource Page
http://www.who.int/hiv/topics/prisons/en/index.html

In most cases, limited access to core services in prisons can be explained by national policy silence on the right of inmates to services for hepatitis, TB, HIV, and drug treatment and harm reduction. As a rule, national legislations do not strip the inmates of the right to the highest attainable state of health, as this would be in direct contradiction to international treaties signed by respective countries; however, they fail to explicitly authorize and mandate provision of evidence-based services like NSP or OST to inmates, as well as fail to secure funding for these services (UNODC & CHALN, 2010). In the absence of clear legislation

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requiring accessibility of services to inmates, high-level penitentiary officials remain reluctant to introduce services in prisons for various reasons. They may be unwilling to acknowledge the presence of drug use in prisons where policies mandate zero-tolerance of drug use, may see harm reduction services as undermining measures to prevent drug use among inmates, or may lack resources to support service provision (The Beckley Foundation Drug Policy Programme [BFDPP], 2007).

Female and Young PWID

Hepatitis, TB, and HIV risk for PWID is a function of physiological, cultural, structural, and environmental risk. While every effort to improve the policy environment for PWID will yield benefits across different populations and environments, female and young PWID deserve particular attention.

Detailed Technical Guidance

UNAIDS Gender Inequality Resource Page
http://www.unaids.org/en/targetsandcommitments/eliminatinggenderinequalities/

HIV/AIDS prevention and care for female injecting drug users
http://www.unodc.org/pdf/HIV-AIDS_femaleIDUs_Aug06.pdf

Female PWID. Gender and cultural norms have a particular impact on risk for female PWID; they are more likely to be initiated into drug use and injection by their male partners and will often be the last to use shared injection equipment. Societal marginalization and stigma compounded with stereotyped gender relationships present barriers to female PWID in asking for sterile injection equipment, seeking drug treatment services, and maintaining safer sex practices—and if accessed, harm reduction services are generally not designed for women. Women are also more likely to have partners who inject drugs than men. Additional risk factors include histories of physical and sexual abuse, high-risk sexual activities, and increased physical vulnerability to sexual transmission of HIV (UNODC, 2006b).

Detailed Technical Guidance

HIV Prevention among Young Injecting Drug Users
http://www.unodc.org/pdf/youthnet/handbook_hiv_english.pdf

Young PWID. The age of initiating drug use is declining and often connected with polysubstance use. The longer a person uses drugs, the more severe the long-term health, social, and economic consequences, as well as behavioral risk. Youth often use drugs in environments of peer pressure, limited awareness, and limited services. Youth have lower levels of economic stability, facilitating a more rapid initiation of criminal behavior and commercial sex work to get money for drugs and creating barriers to paying for services or medication. In addition, issues of stigma, eligibility, and confidentiality create barriers to testing and ongoing treatment services (UNODC, 2004).

Description of Policy Document Categories

Many kinds of policy documents guide and/or affect the overall public policy environment for effective HIV programs. The components identified above (framework, community partnership, legal environment, and intervention design and implementation) must work together across a variety of policy documents to create and sustain an enabling policy environment. When assessing the policy environment, the following categories of policy documents should be analyzed: legislation, national strategic plans and policies, regulations, legal precedent and judicial findings, guidelines and protocols, and operational plans.

Throughout this document, the term “policy” is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

Legislation

Laws (civil, criminal) and other documents are enacted or originated by the legislative branch of government, such as Parliament or the National Assembly. It is important that the legislation designates a body or agency to be responsible for the intent of the legislation and clearly and unambiguously empowers that agency to issue orders or regulations to put procedures into practice (see Regulations, below).

A common problem with national legislation is that the various program components required for interventions are rarely contained in a single piece of legislation. Usually, references are scattered across different pieces of legislation and different government sectors, with little attention given to linking goals of each sector to an overarching national strategy. Analysts and advocates need to have broad knowledge of legislation concerning topics such as authorization, criminal laws, medication and medical commodities procurement and supply chain, clinical practice and standards of care, and law enforcement, because relevant legislative provisions seldom have intervention-specific titles. Moreover, this lack of linkage among the different sectors that influence HIV-related services is often a major policy constraint at the national level. For this reason, advocates may decide to prioritize measures to establish or strengthen national coordinating bodies so that the legislative goals of different sectors are defined. Additional discussion of the components of legislation using the example of medication-assisted therapy (MAT) is included in the Annex.

Detailed Technical Guidance

Taking Action against HIV, Handbook for Parliamentarians
http://data.unaids.org/pub/Manual/2007/20071128_ipu_handbook_en.pdf

Handbook for Legislators on HIV/AIDS, Law and Human Rights
http://www.ipu.org/PDF/publications/aids_en.pdf

National Strategic Plans and Policies

High-level documents issued by the executive branch of government—such as the president, prime minister, and cabinet of ministers—include edicts, presidential or ministerial decrees, resolutions, national plans, and programs. National strategic plans and programs, established by the executive branch, are especially important for advocates to analyze. Strategic plans demonstrate the government's understanding of the overall picture for services for PWID (e.g., estimates of population size, where they are located, levels of current and optimal services, etc.) and lay out the government's vision underpinning demand reduction and other prevention and treatment efforts. In many countries, national advisory and coordinating bodies help governments formulate national strategic plans and policies. They are of special interest because they link policy development, program planning, and legislative enactments. Government authorities should collaborate with nongovernmental organizations in the establishment of a nationwide coordinating body to guide the development and maintenance of comprehensive services for PWID.

Regulations

Once legislation has been adopted, regulations are issued by line ministries and departments that specify how laws, decrees, and other high-level policies should be put into practice. Implementation issues, such as the details of day-to-day operations of a treatment service, are also handled best by regulations rather than by the primary legislation. Regulations are more flexible than legislation and can be altered more easily as circumstances change. Relevant regulations may be found in a variety of instruments, including

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ministerial orders, administrative rules, or departmental or board regulations. These instruments are generally drawn up and promulgated by the agency (e.g., line ministry, department) designated in the legislation.

Regulations flow from legislation in the following manner:

- Legislation authorizes the administrative agency through delegated authority.
- The delegated authority facilitates the ability of the administrative agency to carry out the legislative mandate.
- The administrative agency has the flexibility, within boundaries of delegated authority, to fulfill legislative goals in the face of changing public health, social, or workplace conditions.

In some legal systems, the drafts of regulations and other subsidiary instruments must be presented to Parliament or a parliamentary committee for approval or review, or must be approved by another public agency, such as the Ministry of Justice. In addition, regulations may be subject to a period of public comment prior to approval.

Legal Precedent and Judicial Findings

Otherwise known as case law, these findings include reported decisions of appeals courts and other courts that make new interpretations of the law and, therefore, can be cited as precedents. These interpretations are distinguished from "statutory law," which is the statutes and codes (laws) enacted by legislative bodies; and "regulatory law," which is regulations required by agencies based on statutes. The rulings in trials and hearings that are not appealed or reported are not case law and, therefore, not precedent or new interpretations (ALM).

Guidelines and Protocols

These include published documents prepared by organizations such as the WHO, UNODC, and professional associations/societies (e.g., medical, pharmacy, nursing, etc.) that specify the content of services and method of delivery. Guidelines and protocols can be prepared with the assistance of implementing agencies, such as the Ministry of Health or a specialized drug treatment unit. For example, in the United States, the Center for Substance Abuse Treatment (CSAT) has developed Treatment Improvement Protocols (TIPs). CSAT is part of the Substance Abuse and Mental Health Services Administration (SAMHSA), located within the U.S. Department of Health and Human Services (HHS).

Operational Plans

Operational plans are prepared by departments and programs, usually on an annual or biennial basis; they specify the type and number of program activities to be conducted, such as training events, supervision schedules, and commodities purchases. Operational plans are needed to set out activities across the spectrum of program dimensions, including, for example, activities to meet new requirements that may be imposed by ministerial orders or regulations, keep up with licensure and accreditation standards, and prepare plans for new advances in treatment and rehabilitation services.

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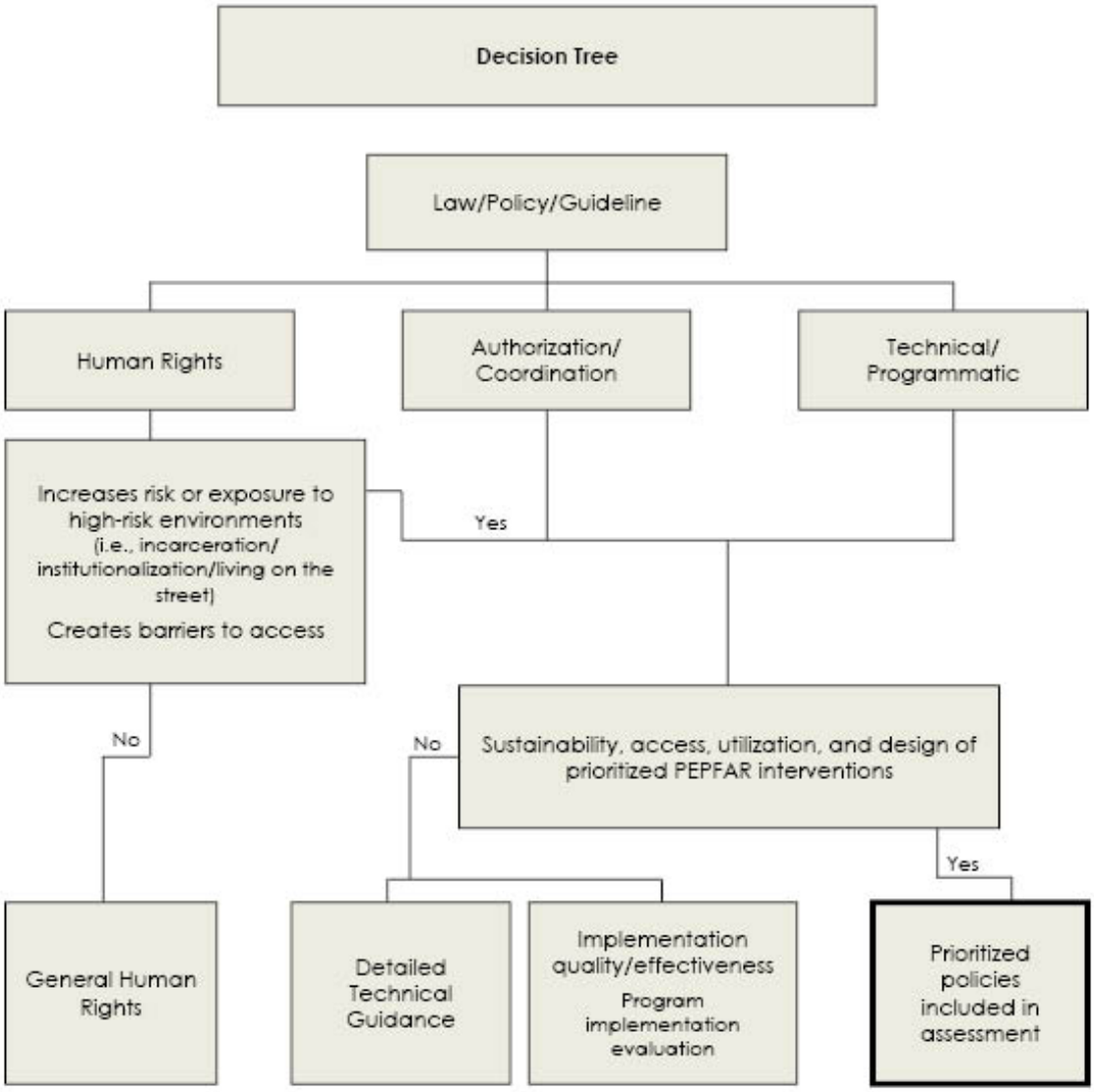
Policies that Directly Enable or Restrict Effective Access to IDU-related Services

As stated in the limitations section above, the purpose of this Decision Model is to provide a high-level overview of the PWID-specific policies that most directly affect sustainability, access, utilization, and design of a defined list of services (HCT, ART, hepatitis, TB, OST, and NSP). To identify policy areas for inclusion in this analysis, the following decision tree was developed; it categorizes policies as related to (1) human rights, (2) authorization and coordination, and (3) technical and programmatic implementation.



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Human rights policy issues are assessed to the degree that they directly increase risk or exposure to high-risk environments such as prisons, institutions, and living on the street; and the degree to which they create barriers to access. Human rights policies identified as directly affecting risk and access are then assessed—along with authorization, coordination, and technical and programmatic policy—for the degree to which they affect sustainability, access, utilization, and design of the interventions prioritized for this Decision Model.

Models for Policy Change

The earlier sections of this document describe the components of the policy framework for policies that enable or restrict access to PWID services. This section addresses the process of policy change to expand IDU-related services. It builds on the conceptual framework described in *The Policy Circle: A Framework for Analyzing the Components of Family Planning, Reproductive Health, Maternal Health, and HIV/AIDS Policies*, developed by the POLICY Project.

Policy Models

Many models have been developed to describe policy change. Some are linear (Lasswell, 1951), (Meier, 1991), others are iterative (Grindle & Thomas, 1991), and others describe change in terms of policy streams (Kingdon, 1984). They all share the common recognition that policies emerge from perceived problems and stress the importance of a wide range of stakeholders—not only policymakers, but also others in nonofficial roles—in proposing policies and acting on policy options.

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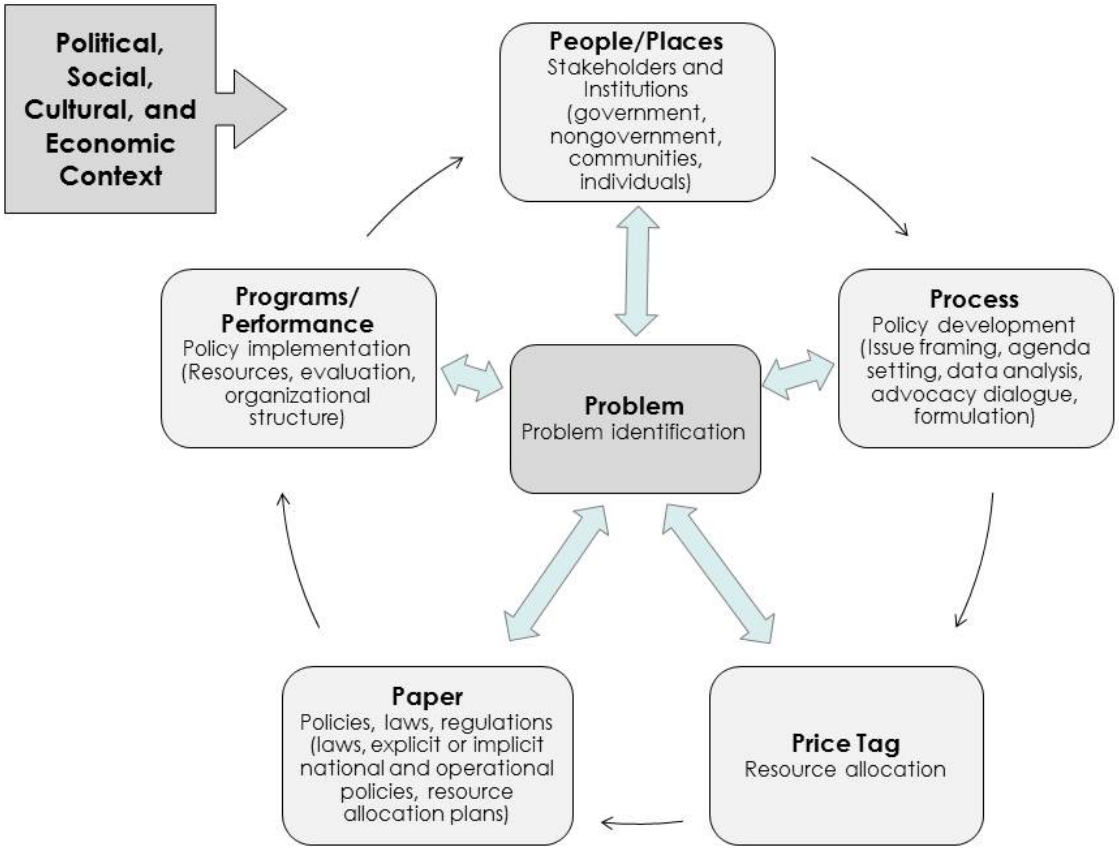
The Policy Circle Framework

The Policy Circle framework highlights six main components of policy, which play out against the backdrop of each country's unique political, cultural, social, and economic contexts: the *problems* that arise requiring policy attention, the *people* who participate in policy and the *places* they represent, the *process* of policymaking, the *price tag* of the policy (the cost of policy options and how resources are allocated), the *paper* produced (actual laws and policies), the *programs* that result from implementing policies, and their *performance* in achieving policy goals and objectives. This section will emphasize the identification of problems, the people who participate in policy and the places they represent, and the process of policymaking.



The political, social, cultural, and economic context. Policymaking does not take place in a vacuum. Different countries have their own political systems, forms of government, social and cultural traditions, and economic systems and levels of development. It is important to ascertain whether the political situation is stable or whether the government is working in a crisis mode. In addition to these general contextual issues that affect any policy change, IDU-related policy reform faces specific political, social, and economic barriers, including stigma against PWID, political and cultural alliances, policies of dominant countries in the region, lack of access to up-to-date scientific information, uneven or hostile mass media coverage, and fledgling design and implementation of both advocacy efforts and programs for PWID.

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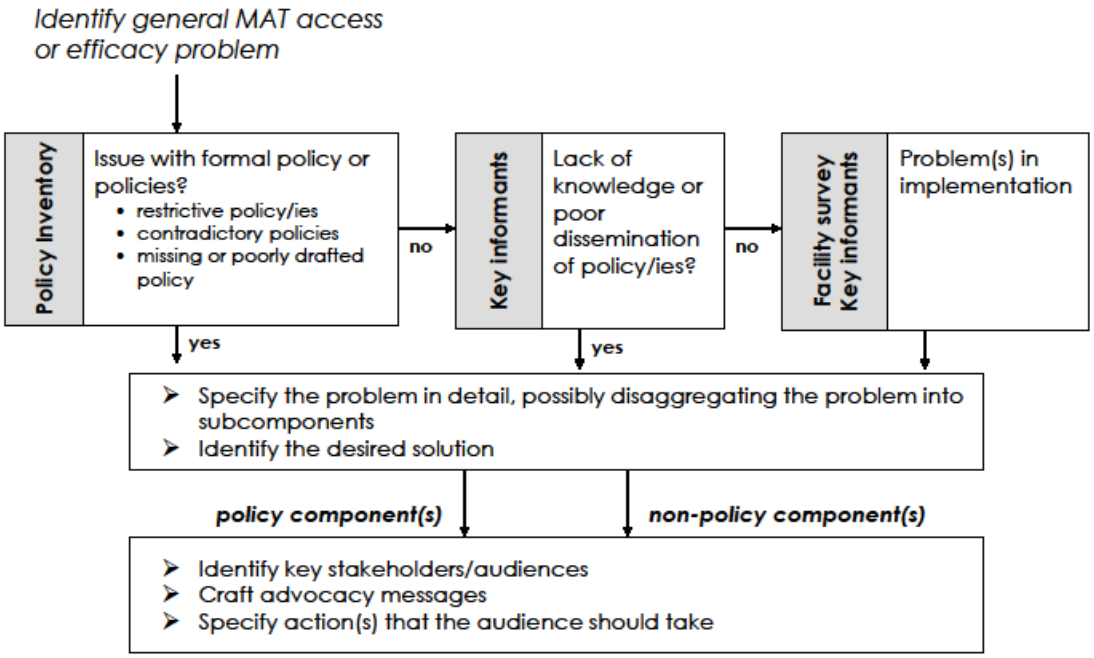

The problem. The Policy Circle begins with the problem that needs to be addressed through policy change. The general problem addressed by this Decision Model is access to high-quality services for PWID. To tackle such a broad issue, advocates must identify which specific problem or problems contributing to the overall lack of or access to services they wish to address first. Utilizing the policy inventory and assessment tools and methodologies presented here will provide analysis of the evidence that will underpin any effort to change policy; this evidence will help to measure the extent of the problem and suggest feasible and cost-effective policy responses.

People: individual stakeholders. Many people are affected by IDU-related policies and programs—legislators who enact laws, economists who design national budgets, law enforcement officials and the court systems responsible for maintaining public order, clinicians who set standards of care and provide services, people who need and use those services, and their families and the communities in which they live. Each has some interest or stake in services for PWID. These stakeholders (the people involved in and/or affected by policymaking) and the institutions (the places) they represent are central to policy change.

Individual stakeholders come both from within and outside the government. Public sector stakeholders can include politicians (heads of state and legislators); government officials and technicians from various sectors (e.g., health, education, finance, local government); and staff who implement public programs. Stakeholders from outside government can include members of civil society organizations; support groups (e.g., groups of people who inject drugs or people living with HIV, women's health advocacy groups) or networks of these groups; and faith-based organizations. They also may include researchers

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and opinion leaders, such as media personalities. Individual beneficiaries of policy can also be involved in calling for policy change.

Places: stakeholder institutions. Individual stakeholders not only have their own ideas and opinions, they also exercise responsibilities within their institutions. Various parts of government play key roles in formal policymaking, including the executive branch (the head of state and the ministerial or departmental agencies of government); the legislative branch (Parliament, congress, or equivalent); and the judicial branch. In some countries, local governments have their own policymaking structures. Program implementers also play important roles in policymaking—for example, the Ministry of Health or the Ministry of Justice. The strength of institutions involved in policymaking can have a direct impact on the success of the policies and programs.

Institutions outside the government play a role in policymaking by acting as advocates for policy change; providing data for decisionmaking; and providing funding for policy research, dialogue, formulation, and implementation. Finally, international organizations also play a role in supporting and influencing policymaking.

- *The expanded role of nongovernmental stakeholders in policy*: In the past, policymaking was concentrated in the hands of policymakers and a few influential people and organizations outside the government. Over the past decade, policymaking increasingly has included the participation of a wider range of stakeholders outside the government.

  It is not enough that nongovernmental stakeholders are kept informed as policies are developed. To be effective advocates, they should be included as contributing members of government bodies, consulted and engaged in policy dialogue with policymakers, and included as participants in multisectoral coordination mechanisms (UNFPA, 1999). For example, excluding PWID and others affected by drug use from MAT policy formulation runs the risk of developing an unresponsive or unsupported policy (both politically and socially). MAT advocates may find it useful to adapt the principle of Greater Involvement of People Living with HIV/AIDS in policymaking and program implementation, including application of the continuum of participation geared to ensuring the active involvement of people living with HIV (PLHIV) in decisionmaking and policymaking to participation of PWID (UNAIDS, 1999).

  International organizations and donors are also important stakeholders in policy development and implementation. Donor funds often drive policy agendas. Most notably, the Global Fund asks countries in which injecting drug use is a principal driver of HIV transmission to include harm reduction and substitution treatment in their HIV/AIDS grants applications and encourages applicants to consider interventions to ensure a more supportive policy environment (Global Fund, 2010).

- *The importance of policy champions:* High-level support within government is crucial for policy change to occur. While many stakeholders can and should be involved in advocacy, it is especially important to identify and support policy champions. A policy champion can be anyone committed to an enabling policy environment for IDU-related services and who will use his/her convictions to motivate others to act on or participate in policy development and reform. Being an effective policy champion requires not only positive personality characteristics to engage and communicate with others but also a solid understanding of the scientific and human rights

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arguments for services. Policy champions can come from any stakeholder group; what is important is that they have access to key decisionmakers. Generally, the higher level the policy champion, the more likely he or she will have a positive influence on the policy issue.

- *Analysis of people/places:* Stakeholder analysis is a useful tool for understanding the people and places (institutions) that can facilitate or block the desired policy reform. In its simplest form, a stakeholder matrix will list relevant individuals and organizations or groups; the reasons for their interest in IDU-related services; knowledge about drug use; resources they can bring to bear on behalf of or in opposition to services (including access to information, human and financial resources, legal or moral authority, etc.); their capacity to mobilize resources; and their position on services for PWID. The tool is best used when stakeholders from different sectors are brought together to conduct a comprehensive analysis that includes government, politicians, nongovernmental organizations, the commercial sector (including private medical practice), other civil society groups, and possibly international donors (POLICY Project).

The process: policy development. Once the specific problem requiring a policy solution has been identified, the process of policy development includes framing the problem (by various stakeholders), getting it onto the policymaking agenda, and formulating the policy document. Moving the process along requires advocacy and policy dialogue by stakeholders, as well as data analysis at each step.

- *Issue framing:* The way a problem is stated or an issue is framed influences the types of solutions proposed. Often, policy stakeholders take different sides of the drug use/dependency issue, with some advocating a law enforcement philosophy and others a medical condition and treatment philosophy. Issue framing—that is, describing the problem and its proposed solutions—sets the terms for policy debate and may influence the eventual outcome. Knowing likely arguments against services for PWID will help advocates frame the issue in the best possible way from the outset.

- *Agenda setting:* Stakeholders outside the government can advocate for policy reform related to PWID services, but government policymakers must be engaged in the process for the needed policy change to happen. Government policymaking bodies follow fixed calendars and terms of office. Health and welfare in general, and services for PWID in particular, are only a few myriad issues simultaneously clamoring for policymakers' attention. Clear issue framing, strong evidence to substantiate the problem, and effective policy champions are all needed to place services for PWID on the policy agenda.

- *Policy formulation:* Policy formulation is the part of a process in which proposed actions are articulated, debated, and drafted into language for a law or policy.

- *Advocacy and policy dialogue:* Both advocacy and policy dialogue are important for policy development. In advocacy, stakeholders promote issues and their positions on the issues. Advocacy is more likely to succeed if networks of organizations and individuals join forces (POLICY Project, 1999). The media also can play an influential role by highlighting issues that need to be addressed and stimulating public discourse—even deciding which issues will receive public attention and which will not.

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Policy dialogue involves discussions among stakeholders to raise issues, share perspectives, find common ground, and, if possible, reach agreement or consensus on policy solutions. Policy dialogue takes place among policymakers, advocates, other nongovernmental stakeholders, other politicians, and beneficiaries.

- *Data analysis:* Lack of information is a common barrier to IDU-related policy reform. Policymakers weigh their decisions on various criteria, including the technical merits of the issue; potential effects of the policy on political relationships within the bureaucracy and among groups in government and their beneficiaries; potential impact of the policy change on the regime's stability and support; perceived severity of the problem and whether the government is in crisis; and pressure, support, or opposition from international aid agencies (Thomas & Grindle, 1994). Data analysis expands from the technical aspects of IDU-related services to the political costs and benefits of policy reform.

The price tag. Price refers to the financial, physical, and human resources needed to implement policies, plans, and programs. It is crucial when developing or analyzing an IDU-related policy to consider the level of resources necessary for proper implementation, whether those resources already are available and allocated or need to be added, and any potential unintended consequences that funding decisions may have on program outcomes.

The paper: policies, laws, and regulations. Policy formulation culminates in the promulgation of formal policy documents that provide a broad framework for PWID services. These include legislation, policies, regulations, guidelines and protocols, and operational plans.

The programs and performance: policy implementation. Policies require strategic plans, operational policies, and, ultimately, programs to ensure that the policy is carried out as intended. Programs require organizational structure (including the lead implementing agency or body), resources, activities, and monitoring and evaluation of performance to assess the achievement of policy and implementation goals.

Policy implementation is political as well as technical and requires some of the same steps as policy development. The process of policy implementation is often left to technicians, including upper and mid-level managers. They may not be knowledgeable about services for PWID or even about established routines of the government, such as annual budget cycles.

Scaling-up programs (i.e., moving beyond pilot programs to broad access to treatment) face several implementation challenges (USAID, 2001):

- Generating and maintaining the support of community and government leaders
- Ensuring sufficient present and future budgets and human resources
- Adjusting the objectives, procedures, systems, and structures of agencies responsible for IDU-related service implementation
- Developing or reforming operational policies
- Monitoring progress and alerting decisionmakers and program managers to snags and intended and unintended consequences

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Summary

The *Policy Circle* presents a simple framework with easy-to-remember components. This simplicity is not intended to imply that formulating policy is simple—indeed, each component is complex and requires significant work. There will be many challenges. Perhaps the problem was not well articulated through adequate policy analysis. Perhaps there is strong opposition or differences of opinion on how to address the problem. There may have been insufficient efforts to consult those who will be affected by the policy change. Perhaps the policy document is vague or lacks an implementation strategy. Resources for implementation may be inadequate. Using the *Policy Circle* and related tools can help identify what aspects of policy or the policy process need to be addressed to solve an identified problem.

There is no rule as to how much time each component will take, because it depends on the context and the issue to be addressed. Small or lower-level policy changes may be resolved more quickly than more comprehensive changes. Finally, IDU-related service problems may need to be addressed by more than one policy. What is considered first as an adequate policy solution may not succeed, and the problem may need to be addressed through further policy reform—going back to the *problem* and beginning the cycle again.

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Additional Advocacy and Policy Reform Tools

The following tools listed may be also helpful in implementing advocacy and policy reform.

Tool Name	Description
Advocacy Tools and Guidelines: Promoting Policy Change Manual	This training guide familiarizes program managers with key advocacy concepts and techniques. It suggests a framework for identifying policy goals, creating a plan of action, and effectively building a case for change. http://www.care.org/getinvolved/advocacy/tools.asp
Networking for Policy Change: An Advocacy Training Manual	The Advocacy Training Manual describes the building blocks of advocacy and includes background notes, learning objectives, and handouts. It can easily be adapted to PWID advocacy efforts. http://www.policyproject.com/pubs/AdvocacyManual.cfm
Guidelines for Conducting a Stakeholder Analysis	The guidelines were developed by the PHRplus Project to provide users with a framework for assessing key actors and their interests, knowledge, positions, alliances, resources, power, and importance. http://www.phrplus.org/Pubs/hts3.pdf
HIV/AIDS Toolkit: Building Political Commitment for Effective HIV/AIDS Policies and Programs	The POLICY Project HIV/AIDS Toolkit contains five modules to assist activists interested in increasing political commitment for effective HIV/AIDS policies and programs. http://www.policyproject.com/pubs/toolkit.cfm
Implementing Policy Change	This is a series of documents based on a project to improve policy implementation and democratic governance in developing countries. It includes technical notes, research notes, working papers, case studies, and monographs. http://www.usaid.gov/our_work/democracy_and_governance/publications/ipcindex.html
Policy Characteristics Checklist	The Policy Characteristics Checklist assesses the various aspects of policy. It poses questions such as: Where did the impetus for policy change come from? What is the nature of the costs and benefits, and who bears them? How complex are the changes? http://www.policyproject.com/policycircle/content.cfm?a0=6c
Policy Stakeholder Analysis Matrix	The Policy Stakeholder Analysis Matrix is used to analyze the stakeholders related to a specific issue. It assesses the group or organization and their potential vested interest in the policy reform, level of knowledge about the issue, available resources, capacity for resource mobilization, and position on the issue. http://www.policyproject.com/policycircle/content.cfm?a0=3a
Political Mapping	PolicyMaker is a rapid assessment method for analyzing and managing the politics of public policy. PolicyMaker software is available at www.polimap.com.
Summary of Regulations and Policy Issues	The Summary of Regulations and Policy Issues provides a framework for assessing the population policy environment, including its legal, political, economic, demographic, ecological, cultural, and technological elements. The framework helps users identify the influences of obstacles and facilitators in each environmental element. It also provides a matrix to assess various issues and their impact and to propose strategies for change. http://www.policyproject.com/policycircle/content.cfm?a0=6b

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Chapter 2: Tools

Policy Inventory and Analysis

Background on inventory of documents pertaining to services for PWID

A combination of IDU-related services form a comprehensive harm reduction and treatment approach for individuals who are opioid dependent. The services covered by this inventory are those identified as eligible for PEPFAR funding or priorities for scale-up by the WHO; they include HCT, ART, hepatitis, TB, OST, and NSP. The focus of this inventory is to collect and analyze country policy documents that directly or indirectly affect the sustainability, access, utilization, and design of these services.

Written policy documents set the stage for program implementation but by themselves cannot guarantee program success. In other words, documents are necessary but not sufficient for effective policy and program implementation. The inventory is meant to be the first step in a comprehensive review that can help guide advocacy efforts to ultimately ensure widely accessible and high-quality IDU-related programs. Effective access to IDU-related services depends not only on a positive policy environment that enables programs to provide services but also on the absence of negative policies and practices that might keep otherwise motivated people from seeking therapy—such as the fear of being arrested or losing their job if seen at a treatment facility or identified as a person who uses drugs. Therefore, the inventory covers key documents that may not directly affect the availability of services and medications but could affect whether people in need of these services seek them out.

The inventory considers five types of documents: legislation, policies, legal precedent/judicial findings, regulations, guidelines, and operational plans.

Legislation: Laws and other documents enacted or originated by the *legislative branch* of government, such as Parliament and the National Assembly. Is broadly inclusive of legal codes in many sectors.

Policies: High-level documents issued by the *executive branch* of government, such as the president, prime minister, and other cabinet ministers. Includes edicts, presidential or ministerial decrees, national strategies, and programs.

Legal precedent/Judicial findings: The history of *court decisions and legal rationale* that guide interpretation and implementation of legislation.

Regulations: Documents issued by *line ministries and departments* that specify how laws, decrees, and other high-level policies should be put into practice. Includes orders, resolutions, rulings.

Guidelines, protocols: Published documents prepared by *professional associations* (e.g., medical, pharmacy, nursing, and dispensers) that specify the content and delivery of services.

Operational plans: Published documents prepared by *departments and programs* (e.g., National Treatment Program), usually on an annual or biennial basis, that specify the type and number of program activities to be conducted, such as training events, supervision schedules, commodities, and/or purchases.

Operational protocols: Specific guidance on day-to-day operations and standards.

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After the country policies have been collected, summary information can be put into a matrix that provides a snapshot of existing policies. The inventory and analysis of country polices can be used either as part of the model or independently to identify areas of strength and weakness in the country's policy/program environment and measure change in the environment over time. This allows users of the model to conduct a diagnosis, establish a baseline, advocate for specific changes, and evaluate the impact of advocacy efforts.

The purpose of the inventory is to compile and analyze a reference library of policy documents addressing specific policy areas that impact service implementation. As such, it does not assess the adequacy of the documents' provisions or the extent to which they have been put into practice—see example sidebar. Information on these aspects will be collected using the interview tools, following the inventory. While there is no single set of standards that encompasses all "best practices" for every situation and circumstance, the inventory identifies best practices based on the content and context of the source references cited for each policy standard.

For example, all services ask if policies allocate government funding for that service. If there is a budget-related document or authorization with a line item for the service, the data collector should check "yes," denoting that a line-item budget has been mandated, and should attach the relevant policy document(s), noting the section or clause. The data collector should not attempt to judge whether the amount of budget is sufficient to respond to the need or whether the allotted resources were spent effectively. These analyses will be conducted later, after the reference library of documents and other information have been compiled.

Profile of Team to Complete the Inventory Tools

The contents of the inventory are wide ranging—from administrative coordination and decisionmaking, to public health and criminal law statutes, to service-specific guidelines, and finally to legal precedent and judicial findings in legal systems where these are integral parts of the legal code. The policy documents to be collected range from national legislation (and in some cases, the Constitution itself) to clinical guidelines and operational plans. Because it is unlikely that a single person will have the policy and content area expertise to complete the entire inventory, countries should assemble a team of knowledgeable individuals who collectively cover the content areas. The country team will need a team leader to identify appropriate members for and ensure the balance and composition of the team.

Instructions for Filling Out the Inventory Tools

1. Engage stakeholders in deciding the scope and scale of the inventory. Identify the policy sections most relevant to the country context. Note that even if some policy areas are not analyzed, keep the numbering system the same, as it is designed to align with policy assessments in other countries and with policy assessments done with the Policy Analysis and Advocacy Decision Model for Services for Sex Workers, Transgender, and Men who have Sex with Men (SW/TG/MSM DM).

2. For each item in the inventory (1., 2., 3., 4., etc.), determine whether the country has enacted or issued pertinent policies.

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3. For every policy that is identified, decide whether it is a law, policy, regulation, guideline, and/or operational plan and identify components that address the best practices identified under each number (a., b., c., d., etc.).

4. Document the policy citation related to each best practice (name of policy and page/article/paragraph) and responsible agency in a separate document.

5. For every identified policy citation, assess whether it meets the criteria identified in the best practice language (a., b., c., d., etc.).

6. Note that you may find multiple citations from different sources that may conflict. Cite, assess, and document each policy individually.

Hints

Before starting to score, skim every policy document from the beginning to end. You may find a lot of useful information for multiple items.

Re-read each assessment question and the background information twice before you start to make sure you understand the context of what is being asked.

Do not forget to put the page number and section title of each source along with its citation.

Collect an electronic copy of all policy documents. If documents are not available electronically, collect paper copies.

Collect a copy (in English and electronic if possible) of the relevant document(s). Many documents may pertain to more than one item in the inventory. Each discrete document should be attached only once. If it is not possible to locate a physical copy of the policy document, describe it in detail—for example, exact name of the document, date of publication, registry number, etc. Use the description in lieu of the actual document only as a last resort.

Note that more often than not, the documents pertaining to the various subjects in the inventory will not be in a law, regulation, or policy that uses the terms "HIV" or "drug treatment" in its title. Rather, many of the relevant documents will be trade, procurement, or customs documents or may be part of a criminal or family law that uses a different title (see "Profile of team to complete the inventory tools" above).

Definition of Terms

Different countries may use different terms to describe substance use and related services, and even different documents from the same country may use different terms to refer to the same concept. The data collector should be mindful of these variations and not restrict the search to a single, precise term.

Drug dependence: This term usually refers to people who use psychoactive drugs and have reached the clinical stage of drug dependence as defined by the DSM-IV or ICD-10 codes. Other terms employed to refer to people who use drugs may include the following:

- Drug addiction
- Drug addicts; people who are addicted to drugs
- People who inject drugs

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

- People who use non-medical drugs; people who use drugs for non-medical purposes
- Illicit drug use; illegal drug use

Treatment for drug dependence: There are many forms of treatment for drug dependence, and not all of them follow international recommendations or best practices. The inventory team should collect all policy documents that refer to treatment for drug dependence, regardless of whether the content of that treatment is specified or follows international guidelines.

Medication-assisted treatment/Opioid substitution therapy: Primary medications for MAT/OST are either methadone or buprenorphine.

Mention: The purpose of the inventory is to collect all documents that expressly allow or prohibit specific practices as described in each item. The term "mention" includes both permission and prohibition. Pay attention to the entire phrase. For example, a document that states "public facilities may provide treatment" mentions governmental but not nongovernmental facilities; however, if the document states "only government facilities may provide treatment," it explicitly mentions public facilities and implicitly notes nongovernmental facilities would be prohibited because *only* public facilities are permitted.

Active participation: New policies, guidelines, and other procedures are usually developed by a group of people working together, rather than by a single individual. Often a governmental office decides who should participate in that group and ensures that the group meets and accomplishes the task. Other organizations or individuals may be invited to observe the meetings, comment on draft documents before they are officially approved, or receive the final documents before they are formally circulated. An organization is considered to be an *active* participant if it contributes directly to discussions, votes on the outcomes, or has another way of making its positions known and considered. An organization invited to observe the process would not be considered an active participant unless there was an additional mechanism to ensure that its opinions were considered in the debate; similarly, an organization receiving a pre-publication copy of an approved document would not be an active participant.

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

Framework (National, Regional, Local, etc.)

International guidelines identify the importance of a coordinated, participatory, transparent, and accountable approach that integrates program responsibilities across all branches of government, aligns with international standards, supports international initiatives, and shares knowledge and information (UNAIDS, 2006, p. 63). A framework identifies the value of (1) multisectoral coordination, roles, and responsibilities; (2) coordination among related health programs; (3) the importance of services within the prison system in achieving national goals; and (4) evidence-based decisionmaking in setting program priorities, budgets, and approaches for services for PWID.

The importance of coordination is illustrated by the effects of its absence; for example, the absence of effective coordination of national strategic policies and responses on OST undermines successful implementation of the program. Reshevska and others (Reshevska, Foreit, Beardsley, & Porter, 2010) recommend that the composition and power of national coordinating bodies be specified at the legislative level to ensure holistic and effective approaches to drug treatment. However, this is not always the case—in some countries, multiple institutions from the executive branch and ministries of interior and health oversee drug control and implementation of OST but with no clear division of responsibilities. (Latypov, Otiashvili, Aizberg, & Boltaev, 2010).

> "Strategic plans for TB, HIV, and substance misuse should clearly define the roles and responsibilities of all service providers delivering services for drug users and should ensure the monitoring and evaluation of TB and HIV activities for drug users, including treatment outcomes" (WHO, 2008a, p. 6).

Programs or strategies often

- Lack a clearly defined budget;
- Lack explicit provisions for allocating the funds necessary to implement the proposed programs and actions;
- Fail to ensure compliance of priorities and targets with available scientific evidence;
- Fail to provide specific coverage or scale-up targets for harm reduction services;
- Omit specific provisions ensuring access of drug users, including those in prisons, to the core harm reduction interventions; or state them in a vague, declarative manner not binding executive bodies to specific actions;
- Fail to get full commitment from all designated authorities across various sectors; and
- Fail to identify clear implementation mechanisms (UNODC & CHALN, 2010).

Programs may often be declarative in nature, amounting to simply statements of the government's policy intentions or desired outcomes. For example, a program may recognize PWID and inmates as priority groups but not guarantee specific access to evidence-based interventions like provision of OST or NSP or set service coverage targets for PWID in prisons. The program may call for ensuring access of most-at-risk populations to a comprehensive package of services; however, it does not clearly define who the

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most-at-risk populations are and the package of services to be delivered and makes no direct reference to UNODC/WHO/UNAIDS core PWID interventions.

Legal silence on evidence-based drug treatment and harm reduction services is probably one of the major reasons why, from the policy formulation point of view, HIV strategies and programs are unspecific, non-binding, and neglect scientific evidence. Since access to specific services is not required by the law, policymakers are reluctant to indicate specific actions and indicators in lower level policies and resort to broad or unclear statements. As a result, executive bodies are not held accountable to ensuring the availability and quality of services, and advocates cannot refer to national strategies and programs to demand access to core interventions.

Throughout this document, the term “policy” is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

Inventory and Analysis of Country Documents

Country: _____ Date completed: _____

Name of data collector:_____

Position: _____

Contact information for data collector:

Email address: _____

Telephone/fax: _____

Instructions to data collector:

Please fill out this page and indicate the best way to contact you (email, telephone, fax, etc.) should we need further information.

Refer to the instructions page for directions on how to fill out the inventory. Please provide information only on the areas you are familiar with or have been assigned to research and leave the others blank. Within these areas, please be sure to answer "yes" or "no" to each item. All data collectors should address the open-ended question at the end of the areas they are working on.

If you find a policy document that addresses areas you are not working on, send the document or citation to the team leader. They will share this information with the individual primarily responsible for that section.

When you have completed the inventory, please send all the pages and all the documents you have referenced to [*team leader should fill this in before distributing to team members*].

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

Framework (National, Regional, Local, etc.)

An effective framework for the response to HIV ensures a coordinated, participatory, transparent, and accountable approach, integrating HIV policy and program responsibilities across all branches of government (ABAROLI, 2011, p. 25).

I. Framework—Coordination of viral hepatitis, TB, HIV, drug treatment, harm reduction, and drug control programs in community, pre-trial detention, prison, or custody settings for minors	
A. Intentionally left blank to align with SW/TG/MSM DM	
B. Collect all policy documents that describe general development plans (UNAIDS, 2009a, p. 95)	
• The **National Development Plan** specifically identifies initiatives that address specific needs of PWID (Y) • The National Development Plan fails to specifically identify initiatives that address the needs of PWID (N)	1.
• The **Common Country Assessment/UN Development Assistance Framework** specifically identifies initiatives that address specific needs of PWID (Y) • The Common Country Assessment/UN Development Assistance Framework fails to specifically identify initiatives that address the needs of PWID (N)	2.
• The **Poverty Reduction Strategy** specifically identifies initiatives that address specific needs of PWID (Y) • The Poverty Reduction Strategy fails to specifically identify initiatives that address the needs of PWID (N)	3.
List other development plans that address the needs of PWID • • • • • •	4.

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

C. Collect all policy documents that describe **viral hepatitis, TB, HIV, drug treatment, harm reduction, and drug control programs in <u>community settings</u>** (UNODC, 2010, p. 40), (WHO, 2008a, pp. 6, 7), (WHO, 2010a, p. 10), (UNDP, 2009, pp. 10, 11)

For each affirmative citation (Y), make an additional assessment (#) on the level of coordination and alignment. Report on a scale of 1–5: one representing limited coordination, contradictory program goals and approaches, etc., and five representing complete alignment of program goals and approaches	Viral Hep	TB	HIV	Drug Treatment	Harm Reduction	Drug Control
Viral Hepatitis Activities mention coordination with 1. TB—(Y, #); no mention (N) 2. HIV—(Y, #); no mention (N) 3. Drug treatment—(Y,#); no mention (N) 4. Harm reduction—(Y,#); no mention (N) 5. Drug control—(Y, #); no mention (N)		1.	2.	3.	4.	5.
TB Activities mention coordination with 6. Viral hepatitis—(Y, #); no mention (N) 7. HIV—(Y, #); no mention (N) 8. Drug treatment—(Y,#); no mention (N) 9. Harm reduction—(Y,#); no mention (N) 10. Drug control—(Y, #); no mention (N)	6.		7.	8.	9.	10.
HIV Activities mention coordination with 11. Viral hepatitis—(Y,#); no mention (N) 12. TB—(Y, #); no mention (N) 13. Drug treatment—(Y,#); no mention (N) 14. Harm reduction—(Y,#); no mention (N) 15. Drug control—(Y, #); no mention (N)	11.	12.		13.	14.	15.

C. Collect all policy documents that describe **viral hepatitis, TB, HIV, drug treatment, harm reduction, and drug control programs in <u>community settings</u>** (UNODC, 2010, p. 40), (WHO, 2008a, pp. 6, 7), (WHO, 2010a, p. 10), (UNDP, 2009, pp. 10, 11)						
For each affirmative citation (Y), make an additional assessment (#) on the level of coordination and alignment. Report on a scale of 1–5: one representing limited coordination, contradictory program goals and approaches, etc., and five representing complete alignment of program goals and approaches	Viral Hep	TB	HIV	Drug Treatment	Harm Reduction	Drug Control
Drug Treatment Activities mention coordination with 16. Viral hepatitis—(Y, #); no mention (N) 17. TB—(Y, #); no mention (N) 18. HIV—(Y, #); no mention (N) 19. Harm reduction—(Y,#); no mention (N) 20. Drug control—(Y, #); no mention (N)	16.	17.	18.		19.	20.
Harm Reduction Activities mention coordination with 21. Viral hepatitis—(Y, #); no mention (N) 22. TB—(Y, #); no mention (N) 23. HIV—(Y, #); no mention (N) 24. Drug treatment—(Y,#); no mention (N) 25. Drug control—(Y, #); no mention (N)	21.	22.	23.	24.		25.
Drug Control Activities mention coordination with 26. Viral hepatitis—(Y, #); no mention (N) 27. TB—(Y, #); no mention (N) 28. HIV—(Y, #); no mention (N) 29. Drug treatment—(Y,#); no mention (N) 30. Harm reduction—(Y,#); no mention (N)	26.	27.	28.	29.	30.	

D. Collect all policy documents that describe **viral hepatitis, TB, HIV, drug treatment, harm reduction, and drug control programs <u>in pre-trial detention settings</u>** (UNODC, 2010, p. 40), (WHO, 2008a, pp. 6, 7), (WHO, 2010a, p. 10) (UNDP, 2009, pp. 10, 11)

For each affirmative citation (Y), make an additional assessment (#) on the level of coordination and alignment. Report on a scale of 1–5: one representing limited coordination, contradictory program goals and approaches, etc., and five representing complete alignment of program goals and approaches	Viral Hep	TB	HIV	Drug Treatment	Harm Reduction	Drug Control
Viral Hepatitis Activities mention coordination with 1. TB—(Y, #); no mention (N) 2. HIV—(Y, #); no mention (N) 3. Drug treatment—(Y,#); no mention (N) 4. Harm reduction—(Y,#); no mention (N) 5. Drug control—(Y, #); no mention (N)		1.	2.	3.	4.	5.
TB Activities mention coordination with 6. Viral hepatitis—(Y, #); no mention (N) 7. HIV—(Y, #); no mention (N) 8. Drug treatment—(Y,#); no mention (N) 9. Harm reduction—(Y,#); no mention (N) 10. Drug control—(Y, #); no mention (N)	6.		7.	8.	9.	10.
HIV Activities mention coordination with 11. Viral hepatitis—(Y,#); no mention (N) 12. TB—(Y, #); no mention (N) 13. Drug treatment—(Y,#); no mention (N) 14. Harm reduction—(Y,#); no mention (N) 15. Drug control—(Y, #); no mention (N)	11.	12.		13.	14.	15.
Drug Treatment Activities mention coordination with 16. Viral hepatitis —(Y, #); no mention (N) 17. TB—(Y, #); no mention (N) 18. HIV—(Y, #); no mention (N) 19. Harm reduction—(Y,#); no mention (N) 20. Drug control—(Y, #); no mention (N)	16.	17.	18.		19.	20.

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

D. Collect all policy documents that describe **viral hepatitis, TB, HIV, drug treatment, harm reduction, and drug control programs <u>in pre-trial detention settings</u>** (UNODC, 2010, p. 40), (WHO, 2008a, pp. 6, 7), (WHO, 2010a, p. 10) (UNDP, 2009, pp. 10, 11)						
For each affirmative citation (Y), make an additional assessment (#) on the level of coordination and alignment. Report on a scale of 1–5: one representing limited coordination, contradictory program goals and approaches, etc., and five representing complete alignment of program goals and approaches	Viral Hep	TB	HIV	Drug Treatment	Harm Reduction	Drug Control
Harm Reduction Activities mention coordination with 21. Viral hepatitis—(Y, #); no mention (N) 22. TB—(Y, #); no mention (N) 23. HIV—(Y, #); no mention (N) 24. Drug treatment—(Y,#); no mention (N) 25. Drug control—(Y, #); no mention (N)	21.	22.	23.	24.		25.
Drug Control Activities mention coordination with 26. Viral hepatitis—(Y, #); no mention (N) 27. TB—(Y, #); no mention (N) 28. HIV—(Y, #); no mention (N) 29. Drug treatment—(Y,#); no mention (N) 30. Harm reduction—(Y,#); no mention (N)	26.	27.	28.	29.	30.	

E. Collect all policy documents that describe **viral hepatitis, TB, HIV, drug treatment, harm reduction, and drug control programs <u>in prison settings</u>** (UNODC, 2010, p. 40), (WHO, 2008a, pp. 6, 7), (WHO, 2010a, p. 10) (UNDP, 2009, pp. 10, 11)

For each affirmative citation (Y), make an additional assessment (#) on the level of coordination and alignment. Report on a scale of 1–5: one representing limited coordination, contradictory program goals and approaches, etc., and five representing complete alignment of program goals and approaches	Viral Hep	TB	HIV	Drug Treatment	Harm Reduction	Drug Control
Viral Hepatitis Program mention coordination with 1. TB—(Y, #); no mention (N) 2. HIV—(Y, #); no mention (N) 3. Drug treatment—(Y,#); no mention (N) 4. Harm reduction—(Y,#); no mention (N) 5. Drug control—(Y, #); no mention (N)		1.	2.	3.	4.	5.
TB Program mention coordination with 6. Viral hepatitis—(Y, #); no mention (N) 7. HIV—(Y, #); no mention (N) 8. Drug treatment—(Y,#); no mention (N) 9. Harm reduction—(Y,#); no mention (N) 10. Drug control—(Y, #); no mention (N)	6.		7.	8.	9.	10.
HIV Program mention coordination with 11. Viral hepatitis—(Y,#); no mention (N) 12. TB—(Y, #); no mention (N) 13. Drug treatment—(Y,#); no mention (N) 14. Harm reduction—(Y,#); no mention (N) 15. Drug control—(Y, #); no mention (N)	11.	12.		13.	14.	15.
Drug Treatment Program mention coordination with 16. Viral hepatitis—(Y, #); no mention (N) 17. TB—(Y, #); no mention (N) 18. HIV—(Y, #); no mention (N) 19. Harm reduction—(Y,#); no mention (N) 20. Drug control—(Y, #); no mention (N)	16.	17.	18.		19.	20.

E. Collect all policy documents that describe **viral hepatitis, TB, HIV, drug treatment, harm reduction, and drug control programs <u>in prison settings</u>** (UNODC, 2010, p. 40), (WHO, 2008a, pp. 6, 7), (WHO, 2010a, p. 10) (UNDP, 2009, pp. 10, 11)						
For each affirmative citation (Y), make an additional assessment (#) on the level of coordination and alignment. Report on a scale of 1–5: one representing limited coordination, contradictory program goals and approaches, etc., and five representing complete alignment of program goals and approaches	Viral Hep	TB	HIV	Drug Treatment	Harm Reduction	Drug Control
Harm Reduction Program mention coordination with 21. Viral hepatitis—(Y, #); no mention (N) 22. TB—(Y, #); no mention (N) 23. HIV—(Y, #); no mention (N) 24. Drug treatment—(Y,#); no mention (N) 25. Drug control—(Y, #); no mention (N)	21.	22.	23.	24.		25.
Drug Control Program mention coordination with 26. Viral hepatitis—(Y, #); no mention (N) 27. TB—(Y, #); no mention (N) 28. HIV—(Y, #); no mention (N) 29. Drug treatment—(Y,#); no mention (N) 30. Harm reduction—(Y,#); no mention (N)	26.	27.	28.	29.	30.	

F. Collect all policy documents that describe **viral hepatitis, TB, HIV, drug treatment, harm reduction, and drug control programs <u>in settings of state custody or foster care of minors</u>** (UNODC, 2010, p. 40), (WHO, 2008a, pp. 6, 7), (WHO, 2010a, p. 10) (UNDP, 2009, pp. 10, 11)

For each affirmative citation (Y), make an additional assessment (#) on the level of coordination and alignment. Report on a scale of 1–5: one representing limited coordination, contradictory program goals and approaches, etc., and five representing complete alignment of program goals and approaches	Viral Hep	TB	HIV	Drug Treatment	Harm Reduction	Drug Control
Viral Hepatitis Activities mention coordination with 1. TB—(Y, #); no mention (N) 2. HIV—(Y, #); no mention (N) 3. Drug treatment—(Y,#); no mention (N) 4. Harm reduction—(Y,#); no mention (N) 5. Drug control—(Y, #); no mention (N)		1.	2.	3.	4.	5.
TB Activities mention coordination with 6. Viral hepatitis—(Y, #); no mention (N) 7. HIV—(Y, #); no mention (N) 8. Drug treatment—(Y,#); no mention (N) 9. Harm reduction—(Y,#); no mention (N) 10. Drug control—(Y, #); no mention (N)	6.		7.	8.	9.	10.
HIV Activities mention coordination with 11. Viral hepatitis—(Y,#); no mention (N) 12. TB—(Y, #); no mention (N) 13. Drug treatment—(Y,#); no mention (N) 14. Harm reduction—(Y,#); no mention (N) 15. Drug control—(Y, #); no mention (N)	11.	12.		13.	14.	15.
Drug Treatment Activities mention coordination with 16. Viral hepatitis—(Y, #); no mention (N) 17. TB—(Y, #); no mention (N) 18. HIV—(Y, #); no mention (N) 19. Harm reduction—(Y,#); no mention (N) 20. Drug control—(Y, #); no mention (N)	16.	17.	18.		19.	20.

F. Collect all policy documents that describe **viral hepatitis, TB, HIV, drug treatment, harm reduction, and drug control programs <u>in settings of state custody or foster care of minors</u>** (UNODC, 2010, p. 40), (WHO, 2008a, pp. 6, 7), (WHO, 2010a, p. 10) (UNDP, 2009, pp. 10, 11)

For each affirmative citation (Y), make an additional assessment (#) on the level of coordination and alignment. Report on a scale of 1–5: one representing limited coordination, contradictory program goals and approaches, etc., and five representing complete alignment of program goals and approaches	Viral Hep	TB	HIV	Drug Treatment	Harm Reduction	Drug Control
Harm Reduction Activities mention coordination with 21. Viral hepatitis—(Y, #); no mention (N) 22. TB—(Y, #); no mention (N) 23. HIV—(Y, #); no mention (N) 24. Drug treatment—(Y,#); no mention (N) 25. Drug control—(Y, #); no mention (N)	21.	22.	23.	24.		25.
Drug Control Activities mention coordination with 26. Viral hepatitis—(Y, #); no mention (N) 27. TB—(Y, #); no mention (N) 28. HIV—(Y, #); no mention (N) 29. Drug treatment—(Y,#); no mention (N) 30. Harm reduction—(Y,#); no mention (N)	26.	27.	28.	29.	30.	

G. Collect all policy documents that describe **viral hepatitis, TB, HIV, drug treatment, or harm reduction programs in community or pre-trial detention settings** (WHO, 1993, pp. 1-8), (UNODC, 2006, pp. 17, 22-26), (WHO, 2008a, p. 7), (WHO, 2007a, p. 11), (UNAIDS, 1999, p. 61) , (WHO, 2007c, p. 6), (UNODC, 2008a, p. 18), (UNODC, 2009a, pp. 42, 43), (UNODC, 2010, pp. 39, 41), (WHO, 2009a, p. 11), (CHALN, 2006e, pp. 30, 31)

• Policy defines or promotes **equitable levels** of access and resources among **community and pre-trial, prison, and minor-custody settings** (Y) • Policy is silent on equitability or describes different or conflicting levels of access and resources for community and non-community settings (N)	Pre-trial Detention	Prison Settings	Custody Settings for Minors
Viral Hepatitis Program	1.	2.	3.
TB Program	4.	5.	6.
HIV Program	7.	8.	9.
Drug Treatment Program	10.	11.	12.
Harm Reduction Program	13.	14.	15.

H. Collect all policy documents that describe **viral hepatitis, TB, HIV, drug treatment, or harm reduction programs in community, pre-trial detention, prison, or custody settings for minors** (WHO, 2008a, p. 6)

• Policy defines **roles and responsibilities** between governmental agencies and nongovernmental organizations for administration and provision of services for PWID (Y) • Policy makes no mention of roles and responsibilities between governmental agencies and nongovernmental organizations (N)	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
Viral Hepatitis Program	1.	2.	3.	4.
TB Program	5.	6.	7.	8.
HIV Program	9.	10.	11.	12.
Drug Treatment Program	13.	14.	15.	16.
Harm Reduction Program	17.	18.	19.	20.

Please include any additional remarks or observations about related policy areas for PWID not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

II. Framework—Data use and decisionmaking

A. Collect all policy documents that describe **viral hepatitis, TB, HIV, drug treatment, or harm reduction programs in community, pre-trial detention, prison, or custody settings for minors** (CESCR, 2000, p. 13), (UNAIDS, 2006, p. 23), (CESCR, 2000, p. 7), (WHO, 1993, p. 8), (UNODC, 2006, p. 28), (CHALN, 2006e, p. 34), (EHRN, 2011)

C—Community, PT—Pre-Trial Detention, P—Prison, MC—state custody or foster care of minors	Viral Hepatitis				TB				HIV				Drug Treatment				Harm Reduction			
Policy:	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC
• Identifies **services for PWID** (Y) • Fails to identify services for PWID (N)	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.				
• Requires **international recognized scientific basis for determining services** for PWID (Y) • Fails to state that services for PWID will be determined by scientific evidence, identifies another evidence base, or identifies services that do not fall within internationally recognized standards (N)	17.	18.	19.	20.	21.	22.	23.	24.	25.	26.	27.	28.	29.	30.	31.	32.	33.	34.	35.	36.
• **Overdose prevention and management** is included in list of program services (Y) • Overdose prevention and management is not mentioned or specifically excluded from program services (N)	37.	38.	39.	40.	41.	42.	43.	44.	45.	46.	47.	48.	49.	50.	51.	52.	53.	54.	55.	56.
• Identifies **coverage targets for PWID** (Y) • Fails to mention coverage targets for PWID (N)	57.	58.	59.	60.	61.	62.	63.	64.	65.	66.	67.	68.	69.	70.	71.	72.	73.	74.	75.	76.

II. Framework—Data use and decisionmaking

A. Collect all policy documents that describe **viral hepatitis, TB, HIV, drug treatment, or harm reduction programs in community, pre-trial detention, prison, or custody settings for minors** (CESCR, 2000, p. 13), (UNAIDS, 2006, p. 23), (CESCR, 2000, p. 7), (WHO, 1993, p. 8), (UNODC, 2006, p. 28), (CHALN, 2006e, p. 34), (EHRN, 2011)

C—Community, PT—Pre-Trial Detention, P—Prison, MC—state custody or foster care of minors	Viral Hepatitis				TB				HIV				Drug Treatment				Harm Reduction			
Policy:	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC
• Coverage targets for PWID **reference international coverage recommendations** (Y) • Coverage targets are made without reference or comparison to international coverage recommendations (N)	77.	78.	79.	80.	81.	82.	83.	84.	85.	86.	87.	88.	89.	90.	91.	92.	93.	94.	95.	96.
• Identifies **coverage targets for female PWID** (Y) • Fails to mention coverage targets for female PWID (N)	97.	98.	99.	100.	101.	102.	103.	104.	105.	106.	107.	108.	109.	110.	111.	112.	113.	114.	115.	116.
• Coverage targets for female PWID **reference international coverage recommendations** (Y) • Coverage targets are made without reference or comparison to international coverage recommendations (N)	117.	118.	119.	120.	121.	122.	123.	124.	125.	126.	127.	128.	129.	130.	131.	132.	133.	134.	135.	136.
• Identifies **coverage targets for young PWID** (Y) • Fails to mention coverage targets for young PWID (N)	137.	138.	139.	140.	141.	142.	143.	144.	145.	146.	147.	148.	149.	150.	151.	152.	153.	154.	155.	156.

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

II. Framework—Data use and decisionmaking

A. Collect all policy documents that describe **viral hepatitis, TB, HIV, drug treatment, or harm reduction programs in community, pre-trial detention, prison, or custody settings for minors** (CESCR, 2000, p. 13), (UNAIDS, 2006, p. 23), (CESCR, 2000, p. 7), (WHO, 1993, p. 8), (UNODC, 2006, p. 28), (CHALN, 2006e, p. 34), (EHRN, 2011)

C—Community, PT—Pre-Trial Detention, P—Prison, MC—state custody or foster care of minors	Viral Hepatitis				TB				HIV				Drug Treatment				Harm Reduction			
Policy:	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC
• Coverage targets for young PWID **reference international coverage recommendations** (Y) • Coverage targets are made without reference or comparison to international coverage recommendations (N)	157.	158.	159.	160.	161.	162.	163.	164.	165.	166.	167.	168.	169.	170.	171.	172.	173.	174.	175.	176.
• Requires **evidence basis for funding decisions** for PWID (Y) • Policy for making funding decisions for PWID services is not clear or not based on scientific and epidemiological evidence (N)	177.	178.	179.	180.	181.	182.	183.	184.	185.	186.	187.	188.	189.	190.	191.	192.	193.	194.	195.	196.
• Identifies **achievement of coverage targets** as a goal for funding allocations (Y) • Fails to tie funding decisions to achievement of coverage targets (N)	197.	198.	199.	200.	201.	202.	203.	204.	205.	206.	207.	208.	209.	210.	211.	212.	213.	214.	215.	216.
• Identifies **government commitment to scale up** services for PWID (Y) • Fails to identify government commitment to scaling up services for PWID (N)	217.	218.	219.	220.	221.	222.	223.	224.	225.	226.	227.	228.	229.	230.	231.	232.	233.	234.	235.	236.

II. Framework—Data use and decisionmaking

A. Collect all policy documents that describe **viral hepatitis, TB, HIV, drug treatment, or harm reduction programs in community, pre-trial detention, prison, or custody settings for minors** (CESCR, 2000, p. 13), (UNAIDS, 2006, p. 23), (CESCR, 2000, p. 7), (WHO, 1993, p. 8), (UNODC, 2006, p. 28), (CHALN, 2006e, p. 34), (EHRN, 2011)

C—Community, PT—Pre-Trial Detention, P—Prison, MC—state custody or foster care of minors	Viral Hepatitis				TB				HIV				Drug Treatment				Harm Reduction			
Policy:	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC
• Identifies **data-reporting requirements that disaggregate PWID from other participants** (Y) • Fails to identify data-reporting requirements specific to PWID (N)	237.	238.	239.	240.	241.	242.	243.	244.	245.	246.	247.	248.	249.	250.	251.	252.	253.	254.	255.	256.
• Identifies **data-reporting requirements that disaggregate female PWID** from other participants (Y) • Fails to identify data-reporting requirements for female PWID (N)	257.	258.	259.	260.	261.	262.	263.	264.	265.	266.	267.	268.	269.	270.	271.	272.	273.	274.	275.	276.
• Identifies **data-reporting requirements that disaggregate for young PWID** from other participants (Y) • Fails to identify data-reporting requirements for young PWID (N)	277.	278.	279.	280.	281.	282.	283.	284.	285.	286.	287.	288.	289.	290.	291.	292.	293.	294.	295.	296.
• Data-reporting requirements include **overdose** issues (Y) • Fails to identify data-reporting requirements for overdose (N)	297.	298.	299.	300.	301.	302.	303.	304.	305.	306.	307.	308.	309.	310.	311.	312.	313.	314.	315.	316.
Collect any available reports for these programs and analyze actual reporting against reporting requirements.																				

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B. Collect all policy documents that describe regular requirements for **estimating the population size** of PWID (UNAIDS/WHO, 2003, pp. 29-37)			
	Census/ capture-recapture	Multiplier	Population Behavioral Surveys
• Policy identifies **data and methodologies** for estimating PWID population size (Y) • Policy fails to mention data and methodologies for estimating PWID population size (N)	1.	2.	3.
• Policy identifies data and methodologies for **estimating female PWID** population size (Y) • Policy fails to mention data and methodologies for estimating female PWID population size (N)	4.	5.	6.
Please note whether the policy requires other size estimation methodologies for any of these populations. Collect the most recent size estimation reports, if available.			

C. Collect the most recent **UNGASS Indicator Report** (UNAIDS, 2009a)	
• Country reports on **Indicator #8** (percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results) (Y) • Country data is no more than 2 years old (Y) • Country does not report on Indicator #8 or uses data that is more than 2 years old (N)	1.
• Country reports on **Indicator #9** (percentage of most-at-risk populations reached with HIV prevention programs) (Y) • Country data is no more than 2 years old (Y) • Country does not report on Indicator #9 or uses data that is more than 2 years old (N)	2.
• Country reports on **Indicator #14** (percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission) (Y) • Country data is no more than 2 years old (Y) • Country does not report on Indicator #14 or uses data that is more than 2 years old (N)	3.
• Country reports on **Indicator #20** (percentage of injecting drug users who reported the use of a condom at last sexual intercourse) (Y) • Country data is no more than 2 years old (Y) • Country does not report on Indicator #20 or uses data that is more than 2 years old (N)	4.

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C. Collect the most recent **UNGASS Indicator Report** (UNAIDS, 2009a)	
• Country reports on **Indicator #21** (percentage of injecting drug users who reported using sterile injecting equipment the last time they injected) (Y) • Country data is no more than 2 years old (Y) • Country does not report on Indicator #21 or uses data that is more than 2 years old (N)	5.
• Country reports on **Indicator #23** (percentage of most-at-risk populations who are HIV positive) (Y) • Country data is no more than 1 year old (Y) • Country does not report on Indicator #23 or uses data that is more than 1 year old (N)	6.

D. Collect all policy documents that describe **regular data collection requirements for sexual violence in pre-trial detention, prison, and custody settings for minors**

	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Policy identifies **data collection requirements** of the incidence and context of sexual violence (Y) • Policy fails to identify data collection requirements or does not include data specific to sexual violence (N)	1.	2.	3.

If policy requires the collection of data on sexual violence, obtain a copy of the last report with this information and analyze actual reporting against reporting requirements.

E. Collect all policy documents that describe **viral hepatitis, TB, HIV, drug treatment, or harm reduction programs in community, pre-trial detention, prison, or custody settings for minors** (WHO, 2008a, p. 6)

	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Policy describes mechanisms for identifying, monitoring, and evaluating **program outcomes for PWID** (Y) • Policy makes no mention of PWID-specific outcomes (N)				
Viral Hepatitis Program	1.	2.	3.	4.
TB Program	5.	6.	7.	8.
HIV Program	9.	10.	11.	12.
Drug Treatment Program	13.	14.	15.	16.
Harm Reduction Program	17.	18.	19.	20.

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E. Collect all policy documents that describe **viral hepatitis, TB, HIV, drug treatment, or harm reduction programs in community, pre-trial detention, prison, or custody settings for minors** (WHO, 2008a, p. 6)

If the policy requires the collection of data on program outcomes for PWID, obtain a copy of the last report with this information and analyze actual reporting against reporting requirements.

• Policy describes mechanisms for identifying, monitoring, and evaluating **overdose prevention and management programs** (Y) • Policy makes no mention of overdose prevention and management-specific outcomes (N) (EHRN, 2011)				
Viral Hepatitis Program	21.	22.	23.	24.
TB Program	25.	26.	27.	28.
HIV Program	29.	30.	31.	32.
Drug Treatment Program	33.	34.	35.	36.
Harm Reduction Program	37.	38.	39.	40.

If the policy requires the collection of data on overdose prevention and management issues, obtain a copy of the last report with this information and analyze actual reporting against reporting requirements.

Please include any additional remarks or observations about related policy areas for PWID not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.

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Community Partnership

The value of including target populations in the design, implementation, and evaluation of programs and policies is well documented in both human rights and intervention-specific guidelines. This component identifies policy factors that affect partnerships of government and community organizations in the design, implementation, and monitoring of policy and services.

> "Programs or policies that are developed without the involvement and support of the people they are attempting to assist or serve are less likely to succeed" (WHO, 2005a, p. 47).
>
> "States should ensure, through political and financial support, that community consultation occurs in all phases of HIV/AIDS policy design and program implementation and evaluation and that community organizations are enabled to carry out their activities, including in the fields of ethics, law, and human rights, effectively. Community representation should comprise people living with HIV, community-based organizations, AIDS-service organizations, human rights NGOs, and representatives of vulnerable groups. Formal and regular mechanisms should be established to facilitate ongoing dialogue with and input from such community representatives into HIV-related government policies and programs" (UNAIDS, 1999, pp. 199-120).

Despite the recommendations of leading international technical agencies on meaningful involvement of representatives of key populations (e.g., drug users and PLHIV) in HIV and drug-related policymaking processes, vulnerable communities are often either excluded from decisionmaking or do not have the capacity to exercise sufficient influence in the process. There is often little country ownership or commitment to the involvement of drug users in policymaking, as this is often seen as a requirement externally imposed by donors and international agencies. This frequently results in limited or non-existent representation of PWID in decisionmaking bodies, such as national councils or country coordinating mechanisms, and a lack of transparent and clear mechanisms to ensure that the expertise of PWID is considered in formulating state policies and programs (Belyaeva & Aftandilyants, 2010).

Policy silence regarding the full involvement of drug users in the decisionmaking process deprives them of an important opportunity to voice their concerns and needs to government officials; advocate for availability, increased coverage, and better quality of services; and ensure that national responses address the specific needs of drug users. Finally, this situation hinders dialogue between the government and vulnerable communities and undermines efforts to remove criminalizing and stigmatizing approaches from national policies.

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III. Government/community partnerships and engagement of key populations in decisionmaking for hepatitis, TB, HIV, drug use, and/or drug treatment programs

A. Collect all policy documents that identify **decisionmaking processes for government policies and programs for viral hepatitis, TB, HIV, drug treatment, or harm reduction programs** (UNAIDS, 1999, pp. 119-120), (UNAIDS, 2006, pp. 24-26), (WHO, 2006, p. 6), (UNDP, 2009, pp. 10, 11)

- Policy identifies formal and regular mechanisms for **active participation in decisionmaking or policy design** (Y)
- Policy fails to provide specific mechanisms ensuring active participation or explicitly excludes participation (N)

	Viral Hepatitis Program	TB Program	HIV Program	Drug Treatment Program	Harm Reduction Program
• Individual or organizational representatives of **PWID**	1.	2.	3.	4.	5.
• Individual or organizational representatives of **female PWID**	6.	7.	8.	9.	10.

- Policy identifies formal and regular mechanisms for active participation in the **evaluation of policy implementation** (Y)
- Policy fails to provide specific mechanisms ensuring active participation or explicitly excludes participation (N)

	Viral Hepatitis Program	TB Program	HIV Program	Drug Treatment Program	Harm Reduction Program
• Individual or organizational representatives of **PWID** (Y)	11.	12.	13.	14.	15.
• Individual or organizational representatives of **female PWID** (Y)	16.	17.	18.	19.	20.

B. Collect all policy documents that describe the **Country Coordinating Mechanism** (CCM)

• Documents require membership of PWID or organizations serving PWID (Y) • Documents fail to require membership of PWID or organizations serving PWID (N)	1.
• Documents require membership of female PWID or organizations serving female PWID (Y) • Documents fail to require membership of female PWID or organizations serving female PWID (N)	2.

Collect the membership list of CCM and compare it to representation requirements.

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C. Collect all policy documents that describe **national multisectoral HIV/AIDS coordination bodies** (National AIDS Council or equivalent)

• Documents require membership of PWID or organizations serving PWID (Y) • Documents fail to require membership of PWID or organizations serving PWID (N)	1.
• Documents require membership of female PWID or organizations serving female PWID (Y) • Documents fail to require membership of female PWID or organizations serving female PWID (N)	2.

Collect the membership lists of national coordination bodies and compare them to representation requirements.

D. Collect all policy documents that identify the **role of nongovernmental organizations for service delivery of viral hepatitis, TB, HIV, drug treatment, or harm reduction programs** (UNAIDS, 1999a, p. 130), (UNDP, 2009, pp. 10, 11) (UNAIDS, 2008, pp. 215-217)

- Policy **supports the establishment and sustainability of nongovernmental organizations** (formal or informal) inclusive of but not limited to those comprised of PWID for peer education, empowerment, positive behavior change, and social support (Y)
- Policy **fails to mention** nongovernmental organizations or **explicitly restricts** funding to or service delivery by nongovernmental organizations (N)

	Viral Hepatitis Program	TB Program	HIV Program	Drug Treatment Program	Harm Reduction Program
Community settings	1.	2.	3.	4.	5.
Pre-trial detention settings	6.	7.	8.	9.	10.
Prison settings	11.	12.	13.	14.	15.
Custody settings for minors	16.	17.	18.	19.	20.

Please include any additional remarks or observations about related policy areas for PWID not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.

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Legal Environment—Authorization

It is of significant importance to identify the agency authorized to implement drug treatment and harm reduction strategies. In practice, national drug control structures are often granted power to oversee and coordinate countries' prevention and treatment responses, which promotes a law enforcement approach to drug issues. A review by Burnet Institute identified that in nine South and South East Asian countries, IDU-related interventions still remain the domain of law enforcement and judicial agencies (Burnet Institute, 2010). National drug control bodies in some Central Asian countries have mandates not only for combating drug trafficking but also for drug-demand reduction activities. Accordingly, their "...interpretation of the dynamics of the drug-related situation in the country and the perceived effectiveness of various preventive and treatment interventions may result in policy and legislative changes that can affect access of the population to evidence-based preventive and treatment measures" (UNODC & CHALN, 2010, p. 55).

> "Many countries with significant illegal drug use problems have introduced national drug strategies or policies to reduce illegal drug use. These are often coordinated by the police, public security and the justice departments. Many of the people involved in developing and implementing these strategies hold the view that harm reduction and public health strategies to reduce HIV infection work against the principles of the drug strategy and in fact encourage or condone illegal drug use" (WHO, 2005a, p. 37).

Entrusting law enforcement and drug control bodies with oversight, coordination, and direct provision of prevention, treatment, and care services is again the manifestation of an overall repressive approach to drug-related problems. These policies give the drug control and enforcement agencies staff larger weight in making decisions on drug-related issues compared with public health specialists and human right activists, thus making the policy environment less favorable for core HIV and drug-related, public health interventions.

Related to authorization of the agency responsible for the overall response to drug use is the authorization of the agency responsible for health in prison settings. A barrier to services may be posed by entrusting the healthcare of inmates, including drug dependency treatment and HIV prevention and treatment, to non-public health ministries such as the ministries of justice or internal affairs. National expert groups from Central Asian republics indicated that this situation affects quality and access to care for inmates and recommended shifting responsibilities to ministries of health. Organizations such as the UNODC, CHALN, and HRC have also suggested transferring responsibility for inmates' healthcare from the penitentiary system to the Ministry of Health, citing recommendations by the OSCE against healthcare providers working under the authority of the penitentiary system administration, as it may affect professional independence of the former (UNODC & CHALN, 2010), (HRC, 2010).

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IV. Authorization of hepatitis, TB, HIV, drug use, and/or drug treatment programs	
A. Collect all policy documents that describe **authority to provide** viral hepatitis, TB, HIV, and drug treatment or harm reduction services • Policy empowers public health **authorities to provide a comprehensive range of prevention and treatment services** for the following programs (Y) • Policy **fails to authorize** or **limits authority or services provided** for the following programs (N) (UNAIDS, 2006, pp. 26, 27)	
1. Viral Hepatitis (A/B vaccination and screening, Hep C testing, Hep C treatment/progression mitigation, etc.)	1.
If No—what service(s) are missing?	
2. TB (screening, diagnosis, directly observed therapy, contact tracing, etc.)	2.
If No—what service(s) are missing?	
3. HIV (testing, treatment, etc.)	3.
If No—what service(s) are missing?	
4. Drug Treatment (substitution maintenance therapy, overdose prevention, detox, etc.)	4.
If No—what service(s) are missing?	
5. Harm Reduction (needle/syringe distribution, STI screening, overdose prevention, etc.)	5.
If No—what service(s) are missing?	
B. Collect all policy documents that identify the **government sector with drug use prevention, treatment, and harm reduction oversight and coordination authority**	
• Policy authorizes **public health agencies** with oversight and coordination authority for drug use treatment and prevention (Y) • Policy authorizes **law enforcement and/or judicial agencies** with oversight and coordination authority for drug use treatment and prevention (N) Note: if both statements are true, indicate (Y/N) and comment.	1.

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C. Collect all policy documents that mention responsibility for the **management and provision of pre-trial detention, prison, and minor-custody health services** (UNODC, 2006, pp. 18, 22)

	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Policy assigns responsibility for **health services** to the same ministries, departments, and agencies providing **health services** to the general population (Y) • Policy does not explicitly mention responsibility for health services or assign prison health to **law enforcement, prison, or detention authorities** (N) Note: if both statements are true, indicate (Y/N) and comment.	1.	2.	3.
• Policy provides for independent **health provider decisions** (Y) • Policy places health provider treatment decisions under authority of law enforcement, prison, or detention authorities (N)	4.	5.	6.

Please include any additional remarks or observations about related policy areas for PWID not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.

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Legal Environment—Consent for Testing and Treatment

The declaration on the promotion of patients' rights in Europe, adopted by the European Meeting on Patient Rights, Amsterdam (WHO, 1994, p. 11), states that the informed consent of patients is a prerequisite of any medical intervention, including the right to refuse or to halt a medical intervention. Mandatory testing also drives people in need away from needed services, thus reducing access to prevention and treatment by PWID. However, abuses of this right were reported for many countries, particularly in Asia and Eastern Europe.

> "The same standards of ethical treatment should apply to the treatment of drug dependence as other healthcare conditions. These include the right to autonomy, self-determination on the part of the patient, and the obligation for beneficence and non-maleficence on behalf of treating staff" (UNODC, 2008, p. 8).
>
> "As any other medical procedure, in general conditions, drug dependence treatment, be it psychosocial or pharmacological, should not be forced on patients. Only in exceptional crisis situations of high risk to self or others should compulsory treatment be mandated for specific conditions and periods of time as specified by the law" (UNODC, 2008, p. 10).

The right to informed consent may be abused if policies do not set requirements or specify components and procedures for informed consent (e.g., the nature of testing or treatment, risks and benefits, the right to refuse intervention at any stage without punishment, etc.). For instance, laws may state that citizens and their legal representatives have the right to refuse testing and treatment at any stage, and refusal should be provided in written form. However, if the law lacks provisions requiring healthcare providers to obtain informed consent from patients, it may be interpreted to mean that the absence of written refusal of a patient counts as informed consent. Similarly, HIV legislation and policies stating the voluntary nature of testing for HIV often fail to specify the procedures for informed consent (for details, see the section on HIV testing and counseling).

The right to refuse medical testing or treatment may be undermined by contradictory policies such as fines for avoiding medical examination, including drug testing and treatment—often directed at individuals diagnosed with drug or alcohol dependence or in relation to whom there is 'adequate data' that they use drugs and psychotropic substances without prescription (UNODC & CHALN, 2010, p. 186).

Age Restrictions

> "States' parties need to introduce legislation or regulations to ensure that children have access to confidential medical counseling and advice without parental consent, irrespective of the child's age, where this is needed for the child's safety or well-being. Children may need such access, for example, where they are experiencing violence or abuse at home, or in need of reproductive health education or services, or in case of conflicts between parents and the child over access to health services. The right to counseling and advice is distinct from the right to give medical consent and should not be subject to any age limit" (UN, 2009, p. 23).
>
> "States must ensure that adolescents have access to appropriate health information and services regardless of parental consent, particularly those concerning sexual and reproductive health. Given sufficient maturity, adolescents may request confidential health services and information" (UNGA, 2009, p. 14).

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Young people in many countries are reported to have limited access to core health services due to age limitations posed by policy or healthcare providers. Even when there is no definitive restriction based on age, risk of prosecution due to harsh aiding and abetting legislation can result in needle and syringe exchange programs refusing to serve clients below age eighteen (EHRN, 2009a).

In many countries, minor drug users can receive core HIV and harm reduction services only upon official consent by parents or guardians. While parental consent is a key tool for ensuring protection of children's well-being, some authors and organizations argue that it poses a barrier to HIV-related services, as many young people may want to hide their drug use or sexual activity from their parents (Global Youth Coalition on HIV/AIDS & UNFPA , 2010); (EHRN & IHRA, 2010). As the age of initiation into drug use is decreasing in some areas, more young people experience barriers to testing, as policies contrary to the right of youth to consent for services are found in age restrictions for HIV or drug treatment and harm reduction services (EHRN & IHRA, 2010).

Policies restricting young drug users' access to services significantly undermine efforts to curb HIV and HCV epidemics, excluding the population in the highest need for such services and preventing early and comprehensive interventions where they would be most effective. Denying access to young drug users also contradicts conventions and laws protecting the right of children and youth for health, including the Convention on the Rights of the Child (Article 24), and violate key principles set in the Articles 2, 3, 6, and 12 of the Convention (EHRN, 2009a) by discriminating against young people; neglecting minors' best interest; hampering minors' optimal physical, social, and psychological development; and not consulting with minors and taking their views into account.

Mandatory/Compulsory Testing and Treatment

"UNAIDS/WHO supports mandatory screening for HIV and other blood borne viruses of all blood that is destined for transfusion or for manufacture of blood products. Mandatory screening of donors is required prior to all procedures involving transfer of bodily fluids or body parts, such as artificial insemination, corneal grafts and organ transplant. UNAIDS/WHO do not support mandatory testing of individuals on public health grounds" (WHO, 2005, p. 8).

"Mandatory or compulsory testing continues being a reality, particularly for members of most-at-risk and vulnerable populations. Sometimes it is done without the knowledge of the person being tested. The purpose of such testing is not to provide access to HIV prevention, treatment, care and support, but most often to exclude people with HIV from access to certain services, or otherwise impose restrictions on them. Such mandatory or compulsory forms of testing violate ethical principles and basic rights of consent, privacy and bodily integrity; they cannot be justified on public health grounds" (WHO, 2010c, p. 12).

"The vague and unelaborated language of laws and ministerial instructions regulating HIV testing and especially those related to testing of vulnerable groups opens the door for discrimination and other human rights violations" (UNODC & CHALN, 2010).

Despite WHO and UNODC recommendations, legislation in some countries requires mandatory HIV testing for reasons other than transplantation or blood transfusion procedures. Legislation may require mandatory HIV testing for drug users, pregnant women, persons diagnosed with STIs, and persons suspected by public health or law enforcement agencies to be HIV positive, which results in police raids targeting drug users and sex workers and in compulsory HIV testing (EHRN, 2011c). In other countries, the problem lies in legislation failing to explicitly prohibit broad application of mandatory HIV testing or requiring informed consent. In such cases, ministerial orders and guidelines tend to expand categories of

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people who should be tested based on "epidemiological indications" including, among other indications, injecting drug use.

Legal silence on the right to informed consent and related procedures may lead to vague policies lacking details on service providers' responsibilities. For example, policies may indicate that voluntary testing for HIV is done with the persons' informed consent; however, no specifics are given on how this consent should be obtained (oral or written) or what kind of information should be provided to the client. In this case, service providers may assume that consent is obtained if no objections are made by the patient, effectively violating the requirement for informed consent (UNODC & CHALN, 2010).

Mandatory treatment of drug users as well as forced detention in treatment facilities without a court order is a direct violation of human rights and is detrimental to public health. The use of drug treatment or "re-education" camps—where no harm reduction or other evidence-based healthcare services are available and treatment often is limited to forced labor (or "flogging therapy" and "bread and water therapy") and to the so-called psychological support consisting of military-style marching—has been classified by the UN Special Rapporteur on Torture as "a form of inhuman or degrading treatment or punishment, if not mental torture" (IHRA & HRW, 2009, p. 7).

Violating drug users' right to informed consent and refusal of testing and treatment, punishing them for evasion, and forcing them to undergo mandatory testing and treatment discriminate against drug users, generate additional stigma, make them subject to police abuse, and may drive them underground and away from the services.

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V. Consent for testing and treatment

A. Collect all policy documents that mention **consent for medical examination and drug testing, treatment, and detoxification** in prison and community settings (CHALN, 2006b, p. 19), (WHO, 2007e, pp. 36, 37), (UNGA, 2009), (WHO, 2009b, p. xiii), (UNODC, 2006, p. 25), (WHO, 2007a, p. 7), (WHO, 2007c, p. 6), (UNODC, 2009a, p. 39), (WHO, 1993, p. 7), (EHRN, 2011)

	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Policy **requires consent for medical examination and treatment** (Y) • Policy does not explicitly mention consent requirements or describe limitations on consent protections for medical examination and treatment (N)	1.	2.	3.	4.
• Policy **requires consent for drug testing, treatment, or detoxification** (Y) • Policy does not explicitly mention consent requirements or describe limitations on consent protections for drug testing, treatment, or detoxification (N)	5.	6.	7.	8.
• Policy identifies the **right to refuse or withdraw from medical examination and treatment** at any time (Y) • Policy does not explicitly mention the right to refuse or withdraw from medical examination and treatment (N)	9.	10.	11.	12.
• Policy identifies the **right to refuse or withdraw from drug testing, treatment, or detoxification** at any time (Y) • Policy does not explicitly mention the right to refuse or withdraw from drug testing, treatment or detoxification (N)	13.	14.	15.	16.
• Policy identifies the following **elements required** for consent to medical examination, drug testing, and treatment (Y) o the consent must relate specifically to the treatment administered o the consent must be fully informed o the consent must be given voluntarily o the consent is given individually, in private, and in the presence of a health-care provider o the consent may be verbal or written o the consent must not be obtained through misrepresentation, coercion, or fraud • Policy does not explicitly identify consent components listed above (N)	17.	18.	19.	20.

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B. Collect all policy documents mentioning access by **children**, in and out of state custody, to confidential medical counseling and advice about drug use, hepatitis, TB, and HIV (UNGA, 2009, pp. 5, 14), (WHO, 1993, p. 8)	Community Settings	Custody Settings for Minors
• Policy **guarantees access to information and counseling** regardless of parental/caregiver consent, irrespective of the child's age (Y) • Policy does not explicitly guarantee access to information or describe parental consent requirements or age restrictions (N)		
Hepatitis	1.	2.
TB	3.	4.
HIV	5.	6.
Harm reduction	7.	8.
Drug dependence treatment	9.	10.

C. Collect all policy documents mentioning access by **adolescents**, in and out of state custody, to information and medical services for hepatitis, TB, HIV, and drug dependence treatment (UNGA, 2009, pp. 5, 14), (WHO, 1993, p. 8)	Community Settings	Custody Settings for Minors
• Policy **guarantees access to information and medical services** regardless of parental consent (Y) • Policy does not explicitly guarantee access or describe parental consent requirements or age restrictions higher than adolescence (N)		
Hepatitis	1.	2.
TB	3.	4.
HIV	5.	6.
Harm reduction	7.	8.
Drug dependence treatment	9.	10.

D. Collect all policy documents that address **avoidance of drug testing and treatment**

	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Policy is silent on the issue of avoidance of drug testing, treatment, or detoxification (Y) • Policy identifies avoidance of drug testing, treatment, or detoxification as an offense (N)	1.	2.	3.	4.

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E. Policy that mentions **mandatory or compulsory testing or treatment** (WHO, 1993, p. 5), (UNODC, 2006, p. 18), (WHO, 2007a, p. 7), (UNODC, 2009a, p. 35), (UNODC, 2010, p. 38), (UNAIDS, 1999, pp. 124, 128), (UNAIDS, 2006, p. 37), (UNGA, 2009, pp. 8, 23, 24), (WHO, 2009a, pp. 9, 10), (CHALN, 2006a, pp. 24, 26), (WHO, 2002, p. 9) , (Inter-Parliamentary Unit [IPU], 2007, p. 79)

C—Community, PT—Pre-Trial Detention, P—Prison, MC—Minor Custody	Viral Hepatitis				TB				HIV				Drug Use			
Policy:	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC
• **Prohibits mandatory or compulsory medical testing** except for screening of donated blood prior to transfusion, occupational exposure, and before all procedures involving transfer of bodily fluids or body parts, such as artificial insemination, corneal grafts, and organ transplant (Y) • Fails to prohibit or allows mandatory or compulsory testing of PWID and prisoners (exception above notwithstanding) (N)	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.
• **Prohibits mandatory or compulsory drug testing** (Y) • Fails to prohibit or allows mandatory or compulsory drug testing (N)	17.	18.	19.	20.	21.	22.	23.	24.	25.	26.	27.	28.	29.	30.	31.	32.
• **Prohibits mandatory or compulsory medical treatment** (Y) • Fails to prohibit or allows mandatory medical treatment (N)	33.	34.	35.	36.	37.	38.	39.	40.	41.	42.	43.	44.	45.	46.	47.	48.
• **Prohibits mandatory or compulsory drug treatment and detoxification** (Y) • Fails to prohibit or allows mandatory drug treatment or detoxification (N)	49.	50.	51.	52.	53.	54.	55.	56.	57.	58.	59.	60.	61.	62.	63.	64.

Please include any additional remarks or observations about related policy areas for PWID not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.

Legal Environment—Privacy and Confidentiality

"Public health legislation should ensure that HIV and AIDS cases reported to public health authorities for epidemiological purposes are subject to strict rules of data protection and confidentiality.

"Public health legislation should ensure that information related to the HIV status of an individual is protected from unauthorized collection, use or disclosure in the healthcare and other settings, and that the use of HIV-related information requires informed consent" (UNAIDS, 1999, p. 122).

Disclosure of information on registered drug users by health service providers to law enforcement agencies is reported in many countries including, but not limited to, Thailand (HRW, 2007), (OSI, 2008a), Kyrgyzstan (HRC, 2010), Tajikistan, Kazakhstan, Uzbekistan (Latypov, Otiashvili, Aizberg, & Boltaev, 2010), Russia, Ukraine (OSI, 2009b) and Moldova (Curth, Hansson, Storm, & Lazarus, 2009). In most of these countries, healthcare legislation proclaims confidentiality of patients' information, but at the same time, this is contradicted by other provisions in health or law enforcement-related policies that grant access to health records and drug registers to prosecutors, police, and other agencies without court authorization. Laws may allow disclosure of personal health information without the consent of a patient or his/her legal representative or without court authorization for the purpose of initiating a criminal investigation or prosecution. Apart from being a clear violation of drug users' human rights, this policy has been reported to contribute to the avoidance of substitution treatment for fear of loss of job, drivers licenses, or other negative consequences of drug registration (Latypov, Otiashvili, Aizberg, & Boltaev, 2010), (OSI, 2009b).

In some countries, service providers are obliged to notify parents when minors are accessing core services for drug users such as NSPs and HIV and HCV testing, thus also compromising the confidentiality of services (Curth, Hansson, Storm, & Lazarus, 2009).

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VI. Privacy and confidentiality of personal medical and drug treatment/services utilization data

A. Collect all policy documents mentioning personalized **individual-level data** on hepatitis, TB, HIV, and drug treatment and harm reduction (UNAIDS, 1999, pp. 122, 124, 125), (UNAIDS, 2006, p. 28), (ABAROLI, 2011, p. 64), (CHALN, 2006b, p. 20), (CHALN, 2006c, p. 15), (WHO, 2009a, p. 16), (CHALN, 2006e, pp. 19, 20)

- Policy explicitly includes individual-level data on hepatitis, TB, HIV, and drug treatment and harm reduction within **definitions of personal/medical data subject to protection,** which prohibits its collection, use, disclosure, and/or publication without the individual's consent (Y)
- Policy fails to explicitly describe protections of individual-level data on hepatitis, TB, HIV, and drug treatment and harm reduction or identifies mechanisms for its collection, use, disclosure, and/or publication without the individual's consent (N)

	Viral Hepatitis Program	TB Program	HIV Program	Drug Treatment Program	Harm Reduction Program
• in **community settings**	1.	2.	3.	4.	5.
• In **pre-trial detention settings**	6.	7.	8.	9.	10.
• in **prison settings**	11.	12.	13.	14.	15.
• In **custody settings for minors**	16.	17.	18.	19.	20.

B. Collect all policy documents mentioning **disclosure of individual-level data on medical, psychological, and drug treatment or harm reduction service use** (WHO, 2009, pp. 9-11), (WHO, 2009a, p. 16), (WHO, 1993, p. 7), (UNODC, 2006, p. 18)

- Policy explicitly **prohibits routine disclosure** of individual-level data on medical, psychological, and drug treatment or harm reduction service use, including overdose, without the individual's consent (for example, to administrative and security personnel and law enforcement authorities) (Y)
- Policy fails to explicitly prohibit disclosure of individual-level data on medical, psychological, and drug treatment or harm reduction service use beyond direct service providers or identifies mechanisms for its routine disclosure without the individual's consent (for example, to administrative and security personnel and law enforcement authorities) (N)

	Medical Information	Psychological Information	Overdose Information	Drug Treatment Services Utilization Information	Harm Reduction Services Utilization Information
• in **community settings**	1.	2.	3.	4.	5.
• In **pre-trial detention settings**	6.	7.	8.	9.	10.
• in **prison settings**	11.	12.	13.	14.	15.
• In **custody settings for minors**	16.	17.	18.	19.	20.

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C. Collect all policy documents defining **parental/guardian** notification requirements (WHO, 1993, p. 8)	Y/N
• Policy requiring notifying parents or guardians of their children's medical or drug use status requires due regard for the principle that the **best interests of the child or adolescent are paramount** (Y) • Policy requiring notification of parents of a child's medical or drug use stats has no leeway or exceptions for the best interests of the child or adolescent (N)	1.
D. Collect all policy documents mentioning **individual access to personal drug treatment and medical records** (ABAROLI, 2011, p. 64)	Y/N
• Policy gives individuals **access to their personal drug treatment and medical records** (Y) • Policy fails to explicitly allow individuals access to their personal drug treatment and medical records (N)	1.
• Policy gives individuals the **ability to request amendments** to ensure that information is accurate, relevant, complete, and up-to-date (Y) • Policy fails to explicitly allow individuals the ability to request amendments to ensure that information is accurate, relevant, complete, and up-to-date or restricts such access (N)	2.
E. Collect all policy documents that identifies **recourse for the release of confidential information** (UNAIDS, 2006, p. 33), (Inter-Parliamentary Unit [IPU], 2007, p. 94), (ABAROLI, 2011, p. 64), (UNODC, 2006, p. 18), (UNODC, 2009a, p. 35)	Y/N
• Policy establishes an **independent agency to address breaches of confidentiality and related sanctions** for the unauthorized release of confidential information (Y) • Policy fails to identify mechanisms for recourse for the release of confidential information (N)	1.
F. Intentionally left blank to align with SW/TG/MSM DM	
G. Collect all policy documents mentioning **discovery and admissibility of drug treatment records for legal proceedings** (CHALN, 2006c, p. 16)	Y/N
• Policy explicitly states that **drug treatment records are not discoverable or admissible** during legal proceedings (Y) • Policy fails to explicitly protect drug treatment records from legal proceedings (N)	1.
• Policy explicitly states that **drug treatment records may not be used to initiate or substantiate any criminal charges** against a person who uses program services; or act as grounds for conducting any investigation of a person who uses program services (Y) • Policy identifies drug treatment records as admissible evidence to initiate or substantiate criminal charges or conduct investigations (N)	2.
• Policy explicitly states that **drug treatment program staff cannot be compelled to provide evidence** concerning the information that they received in that capacity (Y) • Policy explicitly states that drug treatment program staff can be compelled to provide evidence concerning the information that they received in that capacity (N)	3.
Please include any additional remarks or observations about related policy areas for PWID not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.	

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Legal Environment—Registries

"Requirements to register drug addicts in official records, if associated with the risk of sanctions, may discourage patients from attending treatment programs, thus reducing accessibility" (UNODC, 2008, p. 4).

"Under some laws in the region, inclusion on these registries is the basis for depriving parents of custody of a child. It is unjustifiable to equate drug and alcohol dependence with mistreatment of children, as it discriminates against people solely on the basis of their health condition. Deprivation of parental rights should not be carried out automatically, but rather on an individual basis, with reasonable grounds to believe children have been neglected or abused or are at real risk of such treatment" (EHRN, 2010, p. 3).

In many countries of Asia and Eastern Europe, policies require registration of drug users' personal information—including names, addresses, and pictures—in official registries maintained by drug treatment services and/or the police. Since registration of drug users entails limitation of numerous rights and freedoms and puts them under higher risk of police abuse, drug users try to avoid being registered, often at the cost of not using drug-related testing and treatment services. Young drug users are especially concerned about the consequences of being registered since it will affect their choice of future profession and subsequently decrease their chances to obtain a good job (EHRN, 2009a)—yet another impediment for young drug users seeking services.

In former Soviet countries, the reliance on registration of drug users is a legacy of Soviet-era repressive drug treatment policies. Official drug registries were also reported for countries outside of the former Soviet region, including China, Thailand, and Cambodia. Drug users, whose personal data was entered in such registries, suffer from sanctioned limitation of certain rights and opportunities—such as those related to parental rights, driving licenses, and employment in certain positions related to public safety and security (OSI, 2009a), (UNODC & CHALN, 2010), (OSI, 2009b). Another restriction is posed on the right to start a family when existing policies prevent people diagnosed with drug dependency, HIV, or TB from adopting children by listing these diseases and conditions as ineligibility criteria for adoption (UNODC & CHALN, 2010).

Once registered, drug users face serious obstacles to being removed from drug registers. In many former Soviet countries, drug users registered by narcological facilities can only be excluded from the registry through the decision of a special commission after a five-year, drug-free period. In many places, registration also comes with the requirement (now little enforced due to lack of resources) that people report for mandatory medical examinations to narcological dispensaries and triggers home visits from nurses who placard their doors with the public announcement that they are drug users. Drug users who test drug-free but are still in the registry continue to be legally discriminated against. In some cases, drug users are not removed from the existing police registries at all, even if they are drug-free for many years (OSI, 2009b).

Another consequence of disclosing drug registry information is increased vulnerability of drug users to abuse and harassment by law enforcement. People, whose names are entered into drug registries and shared with law enforcement, have been reported to suffer unjustified detention, extortion, set-ups, and physical abuse and torture by the police [Torban and Levinson, Tolopilo and Vlasenko cited in (OSI, 2009b)].

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Reviewed documents demonstrate that existing mechanisms of drug users' registration are not justified on the grounds of public safety and security. First of all, not everyone who uses drugs is registered, thus drug registries do not solve the problem of preventing accidents and other damage that can be inflicted by people under the influence of drugs and alcohol (therefore, in many countries, recruitment for safety-sensitive positions entails actual drug tests rather than a requirement for a certificate on not being formally registered as a drug user issued by a drug treatment center). Second, although people in drug registries may be drug-free, they remain registered for a long time and unfairly suffer from restrictions, which contradict laws protecting human rights in the countries. Third, restricting the civil rights of people solely on the basis of drug use without considering other circumstances is unjustified. Finally, since many countries with drug registries also suffer from widespread corruption, it may be relatively easy for people with access to financial resources to bribe their way out of registration and avoid limitations posed by the registries. Thus, registration of drug users for non-medical, control purposes does not have any benefit from the public health point of view, discourages drug users from accessing health services, and puts them at risk of police harassment.

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VII. Registries					
A. Collect all policy documents that authorize reporting individual-level data to public health authorities for **epidemiological purposes** (UNAIDS, 2006, p. 27), (ABAROLI, 2011, p. 65)					
	HIV	TB	Hepatitis	Drug Treatment	Harm Reduction
• Policy subjects individual-level data to strict rules of data protection and confidentiality (Y) • Policy fails to mention confidentiality protections or provides for regular disclosure of this data to non-health agencies (N)	1.	2.	3.	4.	5.
B. Collect all policy documents that authorize **registries of providers and clients** for HIV, TB, hepatitis, drug treatment, and harm reduction services (WHO, 2004b, p. 28), (CHALN, 2006b, p. 32)					
If Registries are authorized, assess the following. **If Registries are NOT authorized**, respond with a "N/R" in the appropriate box	HIV	TB	Hepatitis	Drug Treatment	Harm Reduction
• Policy focuses implementation of registry on **ensuring the quality of services** (Y) • Policy provides no mention of mechanisms for quality assurance (N)	1.	2.	3.	4.	5.
• Policy focuses implementation of registry on **minimizing the risk of prescribed medications being diverted into illicit channels** (Y) • Policy provides no mention of mechanisms for diversion prevention (N)	6.	7.	8.	9.	
• Policy guarantees **patient and provider confidentiality** (Y) • Policy makes no mention of patient or provider confidentiality or provides for regular disclosure of data (N)	10.	11.	12.	13.	14.
• Policy authorizes management of the monitoring system solely by **public health authorities** (Y) • Policy authorizes management of the monitoring system by non-health authorities (e.g., law enforcement) (N)	15.	16.	17.	18.	19.

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C. Collect all policy documents that mention **general drug user registries** (e.g., police registries or other non-medical registries) (OSI, 2009c, p. 55), (OSI, 2009c, pp. 57, 58), (EHRN, 2010, p. 9), (OSI, 2009b, pp. 13-15) -for employment/driver's license, (EHRN, 2011)	
	Y/N
• Policy **prohibits general drug user registries** (Y)—skip the rest of the analysis for registries • Policy allows general drug user registries (N)—continue analysis	1.
If policy authorizes general drug user registries • Policy **prohibits discriminatory actions** such as o loss of child custody, o registration as a requirement for drug treatment, o denial of state services such as education, housing, and financial assistance, or o denied eligibility for employment or driver's license solely on the basis of being registered as a drug user (Y) • Policy fails to prohibit discrimination or authorizes actions such as any of those listed above solely on the basis of being registered as a drug user (N). If No, describe discriminatory action	2.
• Policy prohibits **non-voluntary registration of overdose patients as drug users** (Y) • Policy allows for or requires non-voluntary registration of overdose patients as drug users (N)	3.
• Policy prohibits **non-voluntary registration of peer overdose witnesses as drug users** (Y) • Policy allows for or requires non-voluntary registration of peer overdose witnesses as drug users (N)	4.
If policy authorizes general drug user registries • Policy identifies clear and easy processes and timeline for **removal of a person's name** from the registry (Y) • Policy provides no clear mechanism or timeline for removal of a person's name from the registry (N)	5.
If policy authorizes general drug user registries • Policy requires **individual consent or court authorization** to disclose individual health and drug-use information (Y) • Policy grants access to health records and drug registers to prosecutors, police, and other agencies without court authorization (N)	6.
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Legal Environment—Stigma and Discrimination

"States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors" (UNAIDS, 2006, pp. 17-18).

"Very often, public debates, including Federal-level media coverage, position drug-dependent persons as "animals", "scum", "inhuman", "deadmen" or "zombies." This in spite of a law that prohibits propaganda that incites social hate." (Andrey Rylkov Foundation for Health and Social Justice, 2011, p. 11).

Stigma and Discrimination on the Grounds of Drug Use

Drug users experience stigma and discrimination throughout the world. Societies, communities, service providers, families, and friends view drug use as an immoral and wicked act that justifies harsh punishment and social exclusion of people who use drugs. In some if not many countries, existing policies directly stigmatize drug users—designating drugs as a "social evil" (AIDS Project Management Group [APMG], 2004).

Stigmatization of drug users by healthcare providers demonstrating non-friendly attitudes, expressing negative opinions, or denying or providing sub-standard services has been reported to affect access to services (Health Development Networks [HDN], 2004). At the same time, many countries lack legal provisions protecting the rights of PWID (CHALN, 2006g); this legal silence can be a major reason for the absence of policies prohibiting stigma and discrimination of drug users by healthcare providers and of mechanisms monitoring and responding to the cases of stigma and discrimination.

Detailed Technical Guidance

UNAIDS Stigma and Discrimination Resource Page
http://www.unaids.org/en/targetsandcommitments/eliminatingstigmaanddiscrimination/

Stigma Action Network
http://www.stigmaactionnetwork.org/web/guest/home

Discrimination Based on Nationality and Place of Residence

In many countries, policies discriminating against foreign nationals pose barriers for drug users to key healthcare and harm reduction services. Migrants, and particularly migrant sex workers and PWID, often lack health insurance in the host country and thus can only attend private clinics and personally pay for services received, placing medical service out of financial reach for these individuals (UNODC & CHALN, 2010) (Central and Eastern European Harm Reduction Network [CEEHN], 2005).

Some countries still have legal provisions requiring deportation of foreigners living with HIV, TB, and STIs. Foreign citizens face mandatory testing for conditions such as HIV, TB, syphilis, and drug dependency and face imminent cancelation of residency permits and deportation (UNODC & CHALN, 2010). The threat of deportation may cause migrants, including drug users, to avoid testing and treatment for HIV, TB, and STIs in the host country (International Organization on Migration [IOM], 2010).

Another barrier unique for the former Soviet countries is a requirement for local residency registration or the so-called "*propiska*." In some countries with the "*propiska*" system, state-guaranteed care may only be provided by facilities covering the patients' registered residence area, thus creating access barriers for

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people from other regions, homeless people, and people without passports. This provision particularly discriminates against drug users and sex workers, many of whom lack identification or residence registration (UNODC & CHALN, 2010), (Spicer, Bogdan, Brugha, Marmer, Murzalieva, & Semigina, 2011). To change place of registration, one often has to undergo several bureaucratic procedures, including changes in identification documents; removal from military registers for men; and for those in drug registers, transfer from local register in the old area of residence to that in the new one (Latypov, Otiashvili, Aizberg, & Boltaev, 2010).

> "The removal of passports as a result of imprisonment and the absence of a registered residency address upon release mean that ex-prisoners face difficulties to register for and continue TB or HIV treatment or any other medical services" (WHO, 2010a, p. 5).
>
> "...The institute of registration is a serious problem in Ukraine. For example, if I am registered in the city of Kyiv but have no official residence registration there, I have no universal access. Even if I am detected to be HIV-positive, I will have to go and get medical registration in the city of my residence registration" (Belyaeva & Aftandilyants, 2010, p. 12).

Denial of services based on nationality or residence registration, which is an example of restrictive policies, is unjustified in terms of public health, as it limits access to services to those who are most in need of them—including people who use drugs or live with hepatitis, HIV, or TB—and makes them hard to reach by service providers. Furthermore, policies envisaging provision of services based on "*propiska*" conflict with the right of citizens to mobility and free choice of place of residence, as well as the right to health, stated by the countries' constitutions.

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VIII. HIV and drug-use stigma and discrimination

A. Collect all policy documents describing national-level hepatitis, TB, HIV, and drug treatment and harm reduction programs (ABAROLI, 2011, p. 47), (UNAIDS, UNAIDS Reducing HIV stigma and discrimination: a critical part of national AIDS programs. A resource for national stakeholder in the HIV response, 2007, pp. 11-16), (Inter-Parliamentary Unit [IPU], 2007, p. 92), (UNDP, 2009, pp. 10, 11)

Policy	Viral Hepatitis Program	TB Program	HIV Program	Drug Treatment Program	Harm Reduction Program
• Identifies the **root causes of stigma and discrimination** against PWID (Y) • Fails to identify root causes of stigma and discrimination against (N)	1.	2.	3.	4.	5.
• Identifies **mechanisms to measure stigma and discrimination** against PWID (Y) • Fails to measure stigma and discrimination against PWID (N)	6.	7.	8.	9.	10.
• Implements and monitors a multifaceted national **approach to reduce stigma and discrimination** against PWID (Y) • Fails to implement and monitor activities to address stigma and discrimination against PWID (N)	11.	12.	13.	14.	15.

B. Collect all policy documents that describe the **general country-wide anti-discrimination policy** (e.g., prohibiting discrimination based on individual characteristics such as gender, race, etc.) (UNAIDS, 2006, p. 31), (CHALN, 2006g, p. 12) (CHALN, 2006g, p. 15), (UNODC, 2008, p. 36), (UNAIDS, 1999, p. 127), (Inter-Parliamentary Unit [IPU], 2007, p. 93), (WHO, 2011, p. 12)

• Policy mentions **prisoners** as individuals protected from discrimination (Y) • Policy fails to mention prisoners (N)	1.
• Policy mentions **relatives or associates of PWID and prisoners** as individuals protected from discrimination (Y) • Policy fails to mention relatives or associates of PWID and prisoners (N)	2.
• Policy mentions **individuals with actual or perceived health conditions** (including hepatitis, TB, or HIV) as individuals protected from discrimination (Y) • Policy fails to mention actual or perceived health conditions (N)	3.
• Policy mentions **individuals with actual or perceived drug use** as individuals protected from discrimination (Y) • Policy fails to mention actual or perceived drug use (N)	4.

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B. Collect all policy documents that describe the **general country-wide anti-discrimination policy** (e.g., prohibiting discrimination based on individual characteristics such as gender, race, etc.) (UNAIDS, 2006, p. 31), (CHALN, 2006g, p. 12) (CHALN, 2006g, p. 15), (UNODC, 2008, p. 36), (UNAIDS, 1999, p. 127), (Inter-Parliamentary Unit [IPU], 2007, p. 93), (WHO, 2011, p. 12)	
If traditional and **customary laws, teachings, or practices** affect the status and treatment of PWID (UNAIDS, 2006, p. 32) • Policy provides for **legal remedies** if such laws or practices are used against PWID (Y) • Policy fails to provide for legal remedies (N)	5.
• Policy authorizes and supports **information, education, or community mobilization** campaigns to change these customary laws and the attitudes associated with them (Y) • Policy fails to support activities to change laws and attitudes (N)	6.
C. Collect all policy documents that describe the **processes to file discrimination complaints**	
• Policy contains defined processes to file discrimination complaints (Y) • Policy fails identify process to file discrimination complaints (N)	1.
• Policy identifies protections against harassment and victimization for filing a discrimination complaint (Y) • Policy contains no protections for individuals filing discrimination complaints (N)	2.

D. Collect all policy documents that describe **anti-discrimination policy for healthcare access.** (WHO, 2006, p. 6), (CHALN, 2006b, p. 22), (UNAIDS, 2008, p. 187)

	Viral Hepatitis	TB	HIV	Drug Treatment	Harm Reduction
• Policy **prohibits discrimination based on past or present drug use** in access to all available services (Y) • Policy fails to prohibit discrimination based on past or present drug use (N)	1.	2.	3.	4.	5.
• Policy **prohibits discrimination based on residency/citizenship** to access to all available services (Y) • Policy fails to prohibit discrimination based on residency/citizenship (N)	6.	7.	8.	9.	10.

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E. Collect all policy documents that mention incitement of **hatred, contempt, or ridicule** (CHALN, 2006g, pp. 15, 16), (UNAIDS, 2006, p. 36)

	Viral Hepatitis	TB	HIV	Drug Dependency
• Policy states that it is **unlawful to incite hatred toward, serious contempt for, or severe ridicule** of a person or group of persons on the ground that they are, or are perceived to be, (1) living with hepatitis, (2) TB, (3) HIV, or (4) drug dependency (Y) • Policy does not mention incitement of hatred, contempt, or ridicule of people or promotes such actions (N)	1.	2.	3.	4.

Please include any additional remarks or observations about related policy areas for PWID not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.

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Legal Environment—Drug Dependence and Disability Definitions

"Attempts to treat and prevent drug use through tough penal sanctions for drug users fail because they do not take into account the neurological changes drug dependence has on motivation pathways in the brain" (UNODC, 2008, p. 1).

Detailed Technical Guidance

Neuroscience of psychoactive substance use and dependence http://www.who.int/substance_abuse/publications/en/Neuroscience.pdf

Policies criminalizing drug use imply that drug use is an act of free will by an individual who fully realizes the consequences of and is able to control his or her behavior; therefore, imposing punishment for drug use will deter people from using drugs. However, this line of reasoning is fundamentally flawed; the Global Commission on Drug Policy noted that countries imposing tough sanctions and arresting drug users and minor drug offenders have a higher rate of drug use compared with countries with a more liberal approach to drugs (Global Commission on Drug Policy, 2011). Research has demonstrated that drug dependency is a brain disease, affecting biological and behavioral mechanisms responsible for decisionmaking and self-control (NIDA, 2010). According to the disease model of drug dependency, punishment of drug users is no longer justified; instead, policies should ensure access to treatment and care services. Drug policies may contradict each other regarding definition of drug dependency, identifying it as a chronic disease while at the same time imposing administrative punishment for drug use (UNODC & CHALN, 2010). Thus, even though policymakers adopt legislation that acknowledges a disease model of addiction, their belief in a repressive approach to drug use may still be reflected in other conflicting policies.

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IX. Drug dependence and disability definitions

A. Collect all policy documents that describe or define substance use, misuse, and **dependence** (WHO, 2004, p. 248), (WHO, 2004b, p. 7)	Y/N
• Policy definition of drug use and/or misuse includes the concept of **occasional drug use** that has not resulted in drug dependence (Y) • Policy definition equates any drug use with drug dependence (N)	1.
• Policy describes drug dependence as a **medical disorder** that could affect any human being (Y) • Policy fails to describe drug dependence as a medical disorder or describes drug dependence as a **failure of will or of strength of character** (N)	2.
• Policy acknowledges that drug dependence is a chronic and relapsing disorder, often co-occurring with other physical and mental conditions (Y) • Policy fails to describe drug dependence as a chronic and relapsing disorder or describes drug dependence as a **failure of will or of strength of character** (N)	3.

B. Collect all policy documents that **describe or define disability** (UNAIDS, 2006, p. 31), (CHALN, 2006g, p. 12), (CHALN, 2006g, p. 14)

	Viral Hepatitis	TB	HIV	Drug Dependency
• Disability policy includes the **loss of physical or mental function/ability to earn a living** based on these conditions (Y) • Disability policy does not include condition in the definition of disability (N)	1.	2.	3.	4.
• **Disability determination** is not denied on the basis of drug dependency (Y) • Drug dependency is identified as a reason for denying disability (N)				5.

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Legal Environment—Criminalization

Criminal law establishes definitions and parameters of behavior that reflect a criminal justice perspective and identify options for enforcement and remedy. In this section, the Decision Model identifies criminal laws that affect access to services. Special attention is paid to criminal laws that increase HIV risk or exposure to high-risk environments such as prisons.

"Drug problems cannot be solved by criminal justice initiatives alone. A punitive approach may drive the people who most need prevention and care services underground" (WHO, 2004a, p. 8).

"Strict law enforcement practices may impede access to essential healthcare services among people who use drugs. Criminal sanctions may make it difficult for health professionals to reach people who use drugs with essential health information and services; may make people who use drugs afraid to seek health or social services on their own initiative... and may foster prejudicial attitudes towards people who use drugs, directing action toward punishment of the offender, rather than fostering understanding and assistance" (CHALN, 2006a, p. 6).

"The criminalization of drug use and dominance of a repressive approach over public health and human rights-based interventions is one of the most significant barriers to accessing core healthcare services for people using drugs" (IHRA, HRW, 2009).

Detailed Technical Guidance

Global Commission on Drug Policy
http://www.globalcommissionondrugs.org/

The Beckley Foundation
http://www.beckleyfoundation.org/policy/

International Drug Policy Consortium
http://www.idpc.net/

Criminalization of Consumption

Not only is drug trafficking criminalized, but punitive measures are directed at drug use itself. Almost all countries criminalize possession of drugs for personal use—some even punish consumption (OSI, 2009a) (EHRN, 2009) (HRC, 2010) (UNODC & CHALN, 2010, p. 228). Legislation and policies criminalizing drug use were reported to hamper drug overdose prevention. In countries where emergency healthcare providers have to inform police on overdose cases, people who witnessed the overdose are afraid to call emergency services, in particular if they are drug users themselves, since police may bring administrative or criminal charges for drug use against the person who had the overdose and the witnesses and put them into drug registries (Ataiants, Latypov, & Ocheret, 2011).

Liability for Possession of Drugs

Even in countries where drug use itself is not penalized, drug users remain vulnerable to administrative or criminal charges for possession, illegal manufacturing, production, processing, acquisition, transportation, or transfer of narcotics without an intention to sell for any amount of drugs below or over the official criminal threshold (UNODC & CHALN, 2010).

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Referral to Services Rather than Prosecution

> "In line with various United Nations instruments, legislative and policy reforms ... should be pursued in areas including... sentencing laws and practices, with the objective of developing alternatives to prison and non-custodial diversions for people convicted of offenses related to drug use so as to significantly reduce the number of drug users sent to prison, the overall prison population, and levels of prison overcrowding" (UNODC, 2006, p. 17).
>
> "When the use and possession of drugs results in state-imposed penal sanctions, the offer of treatment as an alternative to imprisonment or other penal sanction presents a choice to the patient/offender, and although it entails a degree of coercion to treatment, the patient is entitled to reject treatment and choose the penal sanction instead" (UNODC, 2008, p. 10).

Alternatives to incarceration of drug users can significantly contribute to reducing HIV transmission and other negative consequences of drug use. However, many countries do not have policies that include alternatives to prosecution, though UN Drug Conventions recommend such measures (EHRN, 2009). As a result, people who use drugs are often imprisoned for possessing minor amounts of drugs or other drug offenses committed to support their drug habit and deprived of access to essential health services. The cost to society, including prison expenses, productive years lost, and healthcare expenditures, is enormous.

Low Thresholds of Drugs Leading to Criminal Charges

> "In some countries... although governments have ostensibly sought to decriminalize minor drug offenses, they have set the personal use quantities so low that possession of virtually any quantity of an illegal drug exceeds the personal use cut-off" (CHALN, 2006a, p. 8)

Criminal threshold amounts are minimum amounts of confiscated drugs that trigger criminal liability. Set by national policies, they are one of the main mechanisms of enforcing drug criminalization. Often, thresholds are lower than the amount of drugs usually consumed by an average drug user in one or several days, and sometimes they are less than the amount needed for a single dose.

Policies regulating the calculation of the amount of seized drugs often envisage defining the weight of confiscated drugs inclusive of additives and impurities. In some cases, policies specify that for all mixtures containing any substance from the Schedule 1 (including heroin), threshold amounts are the same as for the pure substances regardless of the actual amount of the substance in the mixture. In other cases, policies may just omit the requirement to calculate the proportion of illicit substance in the confiscated mixture ("policy silence") with the same effect. Regardless of mechanisms, the result of these policies is that a person arrested with 5 grams of mixture of various substances containing 0.5 gram of heroin will face the same charges as someone detained with 5 grams of pure heroin. Given that drug users usually have access only to heavily adulterated drug mixtures, these policies significantly increase the risk of their criminal prosecution (UNODC & CHALN, 2010), (Levinson, 2008); (Magkoev, Marisoev, Odinaev, Sattorov, & Jamolov, 2010).

Thresholds set too low may also hamper harm reduction activities, since residues of heroin and other injectable drugs that can be found in used syringes may be sufficient to trigger criminal charges, thus putting needle and syringe program clients and staff at risk (Golichenko & Merkinaite, 2011). Furthermore, in many countries, decisions on criminal thresholds are made by executive bodies, so the

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issue is susceptible to changes in the political situation and governments may easily tighten the regulations (Golichenko & Merkinaite, 2011), (Levinson, 2008). Related to the issue of extremely low drug thresholds is a policy envisaging harsh penalties for a minor violation of the rules and procedures for the licit handling of drugs (or licit "turnover" of drugs). Under such policies, a very minor inadvertent technical mistake in filling in drug-related forms and other paperwork by pharmacists or medical personnel may lead to significant fines, withdrawal of license/permission to occupy certain positions or to engage in certain types of activities, or imprisonment. Such policies discourage medical professionals and pharmacists from prescribing controlled substances to patients and engaging in other types of activities related to the licit handling/"turnover" of drugs, ultimately limiting access to essential medicines and services.

Aiding and Abetting Legislation

"Educational material which may necessarily involve detailed information about transmission risks and may target groups engaged in illegal behavior, such as injecting drug use and sexual activity between the same sexes, where applicable, should not be wrongfully subject to censorship or obscenity laws or laws making those imparting the information liable for 'aiding and abetting' criminal offenses" (UNAIDS, 2006, p. 97).

"Criminal sanctions … may make service providers shy away from providing essential education on safer use of drugs or materials for the safer use of drugs (e.g., distributing sterile injection equipment), for fear of being seen to condone or promote drug use" (CHALN, 2006a, p. 6).

Laws criminalizing incitement of other persons to drug use and prohibiting "propaganda" and "promotion and advertisement" of drug use and drugs (also known as "aiding and abetting legislation") may put harm reduction programs at risk of prosecution. When put in such context, dissemination of information on drugs and drug-related activities is banned by legislation of some South Asian countries like Bangladesh, India, and Maldives; certain European countries like Albania, FYR Macedonia, Montenegro, Russia, Serbia, and Bosnia Herzegovina; as well as of most Central Asian countries including Kazakhstan, Uzbekistan, Tajikistan, Turkmenistan (Burnet Institute, 2010), (IDPC, 2011), (UNODC & CHALN, 2010). Experts emphasize that these provisions are usually defined in broad terms, which may allow law enforcement structures to prosecute staff of harm reduction programs if their activities are interpreted as illegal encouragement of drug use (UNODC & CHALN, 2010).

Legislation banning dissemination of information on narcotic drugs was reported to hamper information campaigns targeting drug users, their relatives, and healthcare professionals. Laws forbidding advertisement of narcotic and psychotropic substances restrict provision of information on narcotic medications, including those used for OST, to patients and healthcare professionals (Magkoev, Marisoev, Odinaev, Sattorov, & Jamolov, 2010). In India, drug-related education can be punished as obscenity under a penal code that prohibits the printing, sale, and distribution of "obscene" materials as well as the sale of obscene objects to young people (Burnet Institute, 2010).

A legal definition of incitement to drug use can also be broad, thus putting harm reduction services at risk—theoretically applied to the program that had provided clean syringes to a client who later died from a drug overdose (UNODC & CHALN, 2010).

Aiding and abetting legislation may limit access to services for young drug users. EHRN found that although these laws are adopted to protect minors from being initiated into drug use by adult drug dealers,

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these laws often lead to young drug users themselves being sentenced. Another implication of harsh penalties for "abetting" minors into drug use is avoidance of harm reduction programs to work with underage drug users (EHRN, 2009b).

> "... the ones who run the greatest risk of being charged for dealing or encouraging drug use are not unscrupulous older pushers but young users themselves, who frequently share or inject drugs with minors. The risk is greatly magnified in CEE [Central and Eastern Europe], particularly the former Soviet republics, where young drug users often get together to cook up injectable opioid and amphetamine concoctions themselves, using plant materials (poppy heads) or ephedrine-based medications as precursors. Legal paragraphs on aiding and abetting often assign the same penalties to dealing drugs to minors and providing drug paraphernalia and drug information to them. Such legislation has been used both inside and outside the CEE region to obstruct needle exchange, outreach to young IDUs, and the distribution of harm reduction information to IDUs with explicit or graphic information on safer drug use" (EHRN, 2009a, p. 63).

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X. Criminal/Administrative law (use, possession of drugs or harm reduction commodities, promotion/facilitation, aiding and abetting, etc.)	
A. Collect all policy documents that mention **personal use of controlled substances** (CHALN, 2006a, pp. 18-21), (UNODC, 2006, p. 16)	
• Policy **does not prohibit, criminalize, or penalize** personal non-medical use of controlled substances (Y) • Policy prohibits, criminalizes, or penalizes personal non-medical use of controlled substances (N)	1.
B. Collect all policy documents that mention **possession of controlled substances** (Golichenko & Merkinaite, 2011)	
• Policy **distinguishes between possession with intent and possession without intent** to distribute (Y) • Policy makes no distinction based on intent to distribute (N)	1.
• **Threshold amount of controlled substance that results in criminal offense** is not tied to the Defined Daily Dose identified by the International Narcotic Control Board, which is designed for statistical purposes, not as guidance for national policies (Y) • Policy ties threshold possession to the Defined Daily Dose identified by the International Narcotic Control Board (N)	2.
• **Threshold amount of controlled substance that results in criminal offense** is based on scientific evidence of average daily dosage in that country (Y) • Threshold amount is arbitrary or not based on scientific evidence of average daily dosage (N)	3.
C. Collect all policy documents that define **penalties for drug-related offenses** (UNODC, 2006, p. 17), (UN, 1990, p. 3) (EHRN, 2011)	
• Policy identifies **penalties that are significantly milder** for possession for personal use than for possession with intent to distribute (Y) • Policy provides for no difference in sanctions (N)	1.
• Possession for personal use is **not punished by imprisonment** (Y) • Possession for personal use is punished by imprisonment (N)	2.
• Policy identifies **alternatives to prison** and non-custodial diversions for people convicted of offenses related to drug use (Y) • Policy does not identify alternatives to prison or requires prison sentences for offenses related to drug use (N)	3.
• Policy guarantees **immunity from criminal prosecution and administrative sanction** to overdose patients (Y) • Policy fails to guarantee immunity or identifies criminal and administrative sanctions on overdose patients (N)	4.
• Policy guarantees immunity from criminal prosecution and administrative sanction to **individuals who witness and/or report overdose** (Y) • Policy fails to guarantee immunity or identifies criminal and administrative sanctions on	5.

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C. Collect all policy documents that define **penalties for drug-related offenses** (UNODC, 2006, p. 17), (UN, 1990, p. 3) (EHRN, 2011)	
witnesses (N)	
• Policy does **not identify escalating penalties for repeated possession** convictions (Y) • Policy identifies escalating penalties for repeated possession convictions (N)	6.
Collect any reports that document arrest and sentencing statistics for drug offenses	
D. Intentionally left blank to align with SW/TG/MSM DM	
E. Intentionally left blank to align with SW/TG/MSM DM	
F. Intentionally left blank to align with SW/TG/MSM DM	
G. Intentionally left blank to align with SW/TG/MSM DM	
H. Intentionally left blank to align with SW/TG/MSM DM	
I. Collect all policy documents that describe **restrictions on loitering, movement and association** (includes hooligan, rouge, vagabond, etc.) (UNAIDS, 2006)	
• Policy provides for **no restrictions on movement, association, and assembly** (Y) • Policy provides for restrictions on movement, association, and assembly (N)	1.
• If loitering policies exist, they **do not specifically mention drug users** (Y) • Loitering policies specifically mention drug users (N)	2.
J. Collect all policy documents that mention protection of **public morality and public scandal** (UNAIDS, 2009)**,** (Bradley)	
• Policy is restricted to oversight of **activities in public** (Y) • Policy fails to limit protection of public morality to public activities or authorizes authority over private activities (N)	1.
• Policy defines its purpose as the **protection of unsuspecting individuals to consent to engage in behaviors** (Y) • Policy fails to limit protection of public morality to the protection of consent of unsuspecting individuals or authorizes authority that undermines the ability of individuals to consent to behaviors (N) NOTE: For the purposes of our context, this would mean that public morality/scandal statutes focus on protecting someone who is simply walking down the street from being forced to watch or engage in illegal behavior without their consent (e.g., public drug use or aggressive solicitation for drug sales in areas where this would not be an expected occurrence). However, this must be balanced with protections of the ability of individuals to consent to legal behavior (e.g., accessing harm reduction information or services).	2.
• Policy defines its purpose as protection from crime or injury (Y) • Policy fails to limit the scope of protection of public morality to the protection from secondary injustices or authorizes authority that perpetuates secondary injustices (N)	3.

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K. Intentionally left blank to align with SW/TG/MSM DM

L. Collect all policy documents that **define admissible evidence of criminalized behaviors** for the purposes of determining criminal or administrative offense (CHALN, 2006e, p. 25), (UNAIDS, 2009)		
	Community	Prison
• Policy states that the **presence of disease or the mode of transmission** is not admissible as evidence of criminalized behavior (Y) • Policy fails to protect information regarding the presence of disease or the mode of transmission from admissibility in criminal or administrative proceedings (N)	1.	2.
• Policy states that **condoms and other safer sex materials** are not admissible as evidence of criminalized behavior for the purposes of determining any criminal or administrative offence (Y) • Policy fails to protect condoms and other safer sex materials from admissibility to criminal or administrative proceedings (N)	3.	4.
• Policy states that **needles, syringes, or other harm reduction materials** are not admissible as evidence of criminalized behavior for the purposes of determining any criminal or administrative offence (Y) • Policy fails to protect needles, syringes, or other harm reduction materials from admissibility to criminal or administrative proceedings (N)	5.	6.
• Policy states that **information provided in the process of reporting violence** is not admissible for the purposes of any criminal or administrative offence (Y) • Policy fails to disallow information from the report of violence or allows this information to serve as evidence in criminal or administrative proceedings (N)	7.	8.
• Policy states that **information provided in the process of reporting blackmail** is not admissible for the purposes of any criminal or administrative offense (Y) • Policy fails to disallow information from the report of blackmail or allows this information to serve as evidence in criminal or administrative proceedings (N)	9.	10.
• Policy states **that information provided in the process of filing a discrimination complaint** is not admissible for the purposes of any criminal or administrative offence related to criminalized identity or behavior (Y) • Policy fails to disallow information from the a discrimination complaint or allows this information to serve as evidence in criminal or administrative proceedings (N)	11.	12.

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M. Collect all policy documents that mention **promotion, facilitation, or aiding and abetting** of criminal offenses (EHRN, 2010, p. 10), (UNAIDS, 2006, p. 97), (UNAIDS, 2008, p. 203)	
• Policy states that **educational materials**—which include detailed information about disease transmission risks, drug treatment, and harm reduction information and may target groups engaged in illegal behavior, such as injecting drug use—are not subject to laws making those imparting the information liable for "aiding and abetting" criminal offenses (Y) • Policy fails to mention protection from criminal liability for HIV prevention and harm reduction information (N)	1.
• Policy states that **beneficiaries** of HIV prevention, drug treatment, and harm reduction activities are provided immunity from "aiding and abetting" prosecution (Y) • Policy fails to mention protection from criminal liability for beneficiaries of HIV prevention and harm reduction information and activities (N)	2.
• Policy states that **healthcare providers** of HIV prevention, drug treatment, harm reduction and general medical care activities are provided immunity from "aiding and abetting" prosecution (Y) • Policy fails to mention protection from criminal liability for healthcare providers for services provided to PWID (N)	3.
• Policy states that **non-medical service providers** of HIV prevention, drug treatment, and harm reduction activities are provided immunity from "aiding and abetting" prosecution (Y) • Policy fails to mention protection from criminal liability for non-medical service providers for services provided to PWID (N)	4.
N. Collect all policy documents that mention delivery of drug use-related information about hepatitis and HIV through **mass media** (UNAIDS, 1999, p. 128)	
• Policy enables widespread provision of how hepatitis and HIV are spread through injecting drug use and assures that this information is **not inappropriately subject to censorship** or other broadcasting standards (Y) • Policy does not explicitly mention protection of hepatitis and HIV drug-use specific transmission information from censorship or identifies inappropriate censorship barriers to its delivery (N)	1.
Please include any additional remarks or observations about related policy areas for PWID not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.	

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Legal Environment—Gender-based Violence

As a group, populations with criminalized behaviors such as PWID have more experience with the legal system and detention and prison settings. A key concern with any harm reduction program for PWID will be to address sexual violence in detention and prison settings, as this violence provides another mechanism for both human rights violations and disease transmission.

In addition, harm reduction programs in many countries serve mostly men and do not cater to the specific needs of female drug users. Programs often fail to ensure safe, non-threatening, and empowering environments, including women-only facilities, safe space, shelter, or transient housing for drug-using women who are at significantly higher risk of gender-based violence and sexual abuse. Lack of policies promoting the integration of harm reduction programs with services for survivors of gender-based violence prevents many female drug users from accessing both services, particularly when taking into account that women's shelters may deny services to active drug users, as was reported for Georgia, Russia, and Kyrgyzstan (EHRN, 2010), or the staff may lack knowledge and skills to deal with drug-using clients (also see assessment, referral, and training requirements in Section XV, Overarching Services Design).

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XI. Domestic, sexual, and gender-based violence

A. Collect all policy documents that **describe or define rape** (UNHCHR & McDougal, 1998)

The definition of rape	
• Identifies **any penetration without consent** or under conditions of force, coercion, or duress (Y) • Requires higher proof than "non-consent" such as physical resistance (N)	1.
• Includes **insertion of any body part or object** (Y) • Is limited to the insertion of a penis (N)	2.
• Includes **penetration of the mouth, anus, and vagina** (Y) • Penetration in rape is limited to the vagina (N)	3.
• Identifies **non-gender specific descriptions of the victim and perpetrator** (Y) • Victims are limited to females and/or perpetrators are limited to males (N)	4.

B. Intentionally left blank to align with SW/TG/MSM DM

C. Intentionally left blank to align with SW/TG/MSM DM

D. Collect all policy documents that mention services for individuals who **experience sexual violence or abuse** (UNDP, 2009, pp. 10, 11)

	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Policy provides for **access to medical assistance** for people who experience sexual abuse (Y) • Policy fails to provide for access to medical assistance (N)	1.	2.	3.	4.
• Policy authorizes **post-exposure prophylaxis (PEP)** for individuals who experience sexual abuse (Y) • Policy fails to authorize PEP for individuals who experience sexual abuse (N)	5.	6.	7.	8.
• Policy stipulates that **criminalized status, occupation, or behavior does NOT preclude an individual from legal recourse for sexual abuse** (Y) • Policy precludes individuals or circumstances that involve criminalized status, occupation, or behavior from legal recourse for sexual abuse (N)	9.	10.	11.	12.

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E. Collect all policy documents that mention **domestic violence reporting requirements** (OSI, 2009c, pp. 57-58)	
• Policy **does not require universal reporting of domestic violence incidents to police** as this may discourage drug users from seeking medical attention (Y) • Policy provides no leeway or judgment in domestic violence reporting requirements (N)	1.

F. Collect all policy documents that mention **access eligibility for domestic violence shelters** (OSI, 2009c, pp. 57-58)	
• Policy **does not restrict access of active drug users** to domestic violence shelters (Y) • Policy restricts access of active drug users to domestic violence shelters (N)	1.

G. Collect all policy documents that mention **housing of detainees** (WHO, 2009, p. 11)	
• Policy directs that **female detainees are housed separately from male detainees** (Y) • Policy does not provide for separate housing for female and male detainees (N)	1.
• Policy directs that **all transgender detainees are housed with female detainees** (Y) • Policy does not house transgender detainees with female detainees (N)	2.

H. Collect all policy documents that mention **non-consensual sex in prison** (WHO, 1993, pp. 5, 6), (UNODC, 2006, p. 19), (UNODC, 2010, p. 38), (UNAIDS, 1999, p. 124), (UNAIDS, 2006, pp. 30, 31), (CHALN, 2006e, p. 34)

	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Policy **prohibits non-consensual sex, coerced sex, bullying, and rape** (Y) • Policy fails to mention or prohibit non-consensual sex (N)	1.	2.	3.
• Policy outlines **structures and processes to punish** and/or segregate sexual predators (Y) • Policy fails to identify structures and processes to punish sexual predators (N)	4.	5.	6.
• Policy provides for comprehensive and compassionate **care and counseling** for survivors of sexual violence (Y) • Policy fails to provide for care and counseling for survivors of sexual violence (N)	7.	8.	9.

Please include any additional remarks or observations about related policy areas for PWID not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.

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Legal Environment—Cruel, Inhuman, or Degrading Treatment or Punishment

> "They had this system: if you are new, came by yourself or brought by others, they take you to a separate room. There is a couch… you lay down, get undressed to underwear… and there are two to three [staff of the fund], there were three people who beat me up at the same time. And beat me up until [my] butt was all black. And you cannot shield yourself with your hands, nothing like this. It'd be even worse if you tried to protect yourself with hands. That would be much worse. Then they hit you on the hands by shovels, clubs. You don't need this… It will be even more painful. They are kind of teaching you. Like teach drug users a lesson—so are you going to inject drugs again? Will you? Everyone shouts – 'No, I will not, I am not going to use drugs any more, stop, I swear, just stop flogging, don't flog me any more please.' Experience of 31-year-old man in a private rehabilitation center" (Andrey Rylkov Foundation for Health and Social Justice, 2011, p. 10).

Use of cruel, inhuman, and degrading treatment has been extensively documented both as punishment for drug use and treatment for addiction. Documented violations include flogging, beatings, starvation, long-term handcuffing to the bed frame, brain surgery, rape, and electrical shock (Andrey Rylkov Foundation for Health and Social Justice, 2011).

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Inventory and Analysis of Country Documents

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Name of data collector:_____

Position: _____

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Telephone/fax: _____

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XII. Cruel, inhuman, or degrading treatment or punishment

A. Collect all policy documents that mention **torture or cruel, inhuman, or degrading treatment or punishment** (CHALN, 2006b, p. 23)

	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Policy defines cruel, inhuman, or degrading treatment or punishment, or torture, as **illegal and liable for imprisonment** (Y) • Policy fails to mention or endorses torture or cruel, inhuman, or degrading treatment (N)	1.	2.	3.	4.

B. Collect all policy documents that mention **isolation, detention, or quarantine** (ABAROLI, 2011, p. 108)

• Policy **prohibits detention centers** for drug treatment, which impose arbitrary confinement and other human rights abuses (e.g., forced labor) on drug users (Y) • Policy endorses detention centers which impose arbitrary confinement (N)	1.

	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Policy prohibits isolation, detention, or quarantine **solely on the basis of drug use status** (Y) • Policy fails to mention or endorses isolation, detention, or quarantine on the basis of drug use status (N)	2.	3.	4.	5.
• Policy prohibits **withholding medical services** from PWID including treatment of drug withdrawal, ART, and TB treatment (Y) • Policy fails to provide for medical services or encourages withholding of these services for drug withdrawal, ART, and TB (N)	6.	7.	8.	9.
• Policy prohibits treatment protocols that are not internationally accepted as standard practice and **may cause harm to the patient** (Y) • Policy fails to cite international standards or identifies harmful protocols (N)	10.	11.	12.	13.

Please include any additional remarks or observations about related policy areas for PWID not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.

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Legal Environment—Monitoring and Enforcement of Human and Legal Rights

"States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV, their families and communities" (UNAIDS, 2006, p. 19).

Bribery, Coercion, and Extortion

Limitation of drug users' access to core harm reduction and HIV-related interventions due to criminalization of drugs and related police abuse of drug users has been documented for numerous countries. The war on drugs has been reported to restrict drug users' access to core health services, including drug treatment (BFDPP & IHRA, 2008), needle exchange, and antiretroviral therapy (OSI, 2009a). In addition, PWID are vulnerable to arrests while accessing harm reduction services, in particular needle and syringe programs, due to drug use criminalization (Burnet Institute, 2010) (Latypov, 2008), (Sarang, Rhodes, Sheon, & Page, 2010), (UNODC & CHALN, 2010).

Detailed Technical Guidance

The Global Programme against Corruption http://www.unodc.org/unodc/en/corruption/index.html

However, it should be noted that repressive drug policies are not the only cause of police abuse of drug users; in many developing countries, the problem is exacerbated by broader structural factors like a weak judicial system, the corruption and lack of accountability of law enforcement, and stigma and intolerance among the general population. So, if the broader issues are not addressed, police may continue to harass drug users and prevent them from accessing services even when drug use is decriminalized.

Police Arrest Quotas

"If the primary performance indicator of the police is volumes of arrests and seizures, little thought will be given to the impact of these arrests and seizures. Not surprisingly, these arrests and seizures are unlikely to have much positive impact" (UNODC, 2009).

"The evaluation of the police performance is based on fulfilling the arrest quotas. People who use drugs become easy prey for the police as arrests of drug users allow law enforcement agencies to achieve their target indicators and to report high performance scores" (EHRN, 2011b, p. 3).

Another implication of repressive drug policies is arrest quotas leading to unjustified detention and arrests of drug users by the police. This practice of targeting drug users is the result of policies related to law enforcement performance evaluation. For instance, key performance targets may include the number of detentions and arrests made, the number of criminal cases initiated, and the amount of illicit drugs seized. As a result, law enforcement officers tend to violate arrest and detention procedures or commit forgery (including planting evidence) to fulfill their performance targets by arresting drug users, who are much easier prey compared with drug traffickers. At the same time, high-ranking officers striving to reach their agencies' targets often turn a blind eye to these infringements (Magkoev, Marisoev, Odinaev, Sattorov, & Jamolov, 2010), (HRW, 2003), (Sarang, Rhodes, Sheon, & Page, 2010), (HRW, 2006), (HRW, 2007a).

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Arrest quotas are closely linked to policies related to the drug threshold amount. When the thresholds are set too low, it is much easier to fulfill the arrest and criminal case initiation plans by targeting drug users, since in almost all cases, the amount of confiscated drugs meant for personal use will be sufficient for detaining users and bringing criminal charges. In countries where "large" and "significantly large" drug quantities are equivalent to one to two doses, arresting ordinary users and petty drug "pushers" creates the illusion that law enforcement agencies are successfully combating drug trafficking.

Access to Legal Aid

Both stigma and discrimination, as well as widespread abuse at the hands of the police may create serious obstacles to access to services for drug users. Furthermore, absence of legislation to set effective mechanisms for monitoring and enforcement of the legal and human rights of people who use drugs and persons living with HIV hamper the elimination of stigma and discrimination. For example, though drug users and PLHIV often need legal aid, only 48 percent of low-income countries and 40 percent of lower-middle income countries reported to have mechanisms ensuring provision of legal aid to these groups (UNDP, 2011).

Inventory and Analysis of Country Documents

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XIII. Monitoring and enforcement of human and legal rights	
A. Collect all policy documents that mention **individual rights** (HRC, 2011, p. 17)	
• Policy describes the right of all individuals to the **highest attainable standard of physical and mental health** (Y) • Policy fails to mention or guarantee the right of all individuals to the highest attainable standard of physical and mental health (N)	1.
B. Intentionally left blank to align with SW/TG/MSM DM	
C. Intentionally left blank to align with SW/TG/MSM DM	
D. Intentionally left blank to align with SW/TG/MSM DM	
E. Intentionally left blank to align with SW/TG/MSM DM	
F. Collect all policy documents that mention **corruption** (UNODC, 2006a, p. 19)	
• Policy authorizes an **independent anti-corruption body or bodies** in charge of preventive measures and policies (Y) • Policy fails to mention or authorize an independent anti-corruption body (N)	1.
• Policy directs the **participation of civil society**, nongovernmental organizations, and community-based organizations in anti-corruption activities (Y) • Policy fails to mention or restricts nongovernmental and public participation in anti-corruption activities (N)	2.
• Policy identifies **activities to increase public awareness** of the threats, causes, and consequences of corruption (Y) • Policy does not explicitly mention anti-corruption measures (N)	3.
G. Collect all policy documents that mention or define **public servant codes of conduct** (UNODC, 2004a, p. 123), (UNODC, 2006a, p. 80), (UNODC, 2004a, p. 15)	
• Policy states that **bribery, coercion, and extortion by a public official is illegal** (Y) • Policy does not mention bribery, coercion, and extortion by public officials or endorses such behavior (N)	1.
• Policy identifies mechanisms to identify and **manage conflict of interest** that create barriers in access to services (Y) • Policy fails to mention or encourages conflicts of interest (N)	2.
• Policy identifies mechanisms to **limit ability of companies to incentivize particular diagnostic and treatment decisions** (Y) • Policy is silent on corporate incentives or encourages their use (N)	3.

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	Available to Public	Monitored	Enforced
• Policy identifies a **code of conduct for public servants** that is (1) available to the public, (2) monitored through a public complaints system, and (3) enforced through disciplinary boards (Y) • Policy fails to identify a **code of conduct for public servants** that is available to the public, monitored through a public complaints system and enforced through disciplinary boards (N)	4.	5.	6.
H. Collect all policy documents that guide **compensation of civil servants and political leaders** (UNODC, 2004a, p. 125)			
• Policy identifies the **goal of commensurate compensation** between civil servants and political leaders with those in positions in the private sector of similar responsibility (Y) • Policy makes no mention of commensurate compensation levels between private and public sectors (N)			1.
I. Collect all policy documents that identify **performance indicators for law enforcement** officials. (EHRN, 2011)			
• Policy provides financial and professional incentives for law enforcement **to respond to violence against PWID**(Y) • Policy provides no incentive or allows law enforcement to charge those who report violence with a crime (N)			1.
• Policy provides financial and professional incentives for law enforcement **to refer PWID to health and harm reduction resources** (Y) • Policy provides no incentive for referral (N)			2.
• Police performance indicators **prioritize cases of drug trafficking/selling** rather than drug possession (Y) • Police performance indicators make no distinction between trafficking/selling and possession (N)			3.
• Policy **discourages targeting and arresting drug users** for the purpose of police performance assessment (Y) • Police performance indicators make no distinction between arrest of drug dealers and drug users (N)			4.
• Policy prohibits targeting and **arresting individuals experiencing or reporting overdose** (Y) • Policy allows for or facilitates arrest of individuals experiencing or reporting overdose (N)			5.
• **Drug seizure reporting systems** report number of seizures stratified by amount of controlled substance in each seizure (Y) • Seizure reporting systems do not report number of seizures stratified by amount of drugs seized (N)			6.

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I. Collect all policy documents that identify **performance indicators for law enforcement** officials. (EHRN, 2011)	
Collect any available reports for these programs and analyze actual reporting against official reporting requirements	
J. Intentionally left blank to align with SW/TG/MSM DM	
K. Collect all policy documents that identify **processes to obtain identity papers** and other official documentation (UNDP, 2009a, p. 10)	
• Policy identifies clear and accessible process to obtain **identity papers** required for accessing services (Y) • Policy is unclear or creates unreasonable barriers to obtaining identity papers (N)	1.
• Policy guarantees the ability of transgender to obtain **gender-aligned identity papers** and other official documentation they need to access services (Y) • Policy restricts or fails to address changing gender on official identity papers (N)	2.

L. Collect all policy documents that mention **access to legal advice and representation** (UNAIDS, 2006, p. 48), (ABAROLI, 2011, p. 128)

	PWID	Young People Living on the Street	Prisoners
• Policy identifies **state funding to educate about legal rights** (Y) • Policy fails to provide funding for education on legal rights (N)	1.	2.	3.
• Policy **provides funding to overcome basic costs** associated with the legal system and access to free legal aid/consultation (Y) • Policy fails to provide access to free legal aid/consultation (N)	4.	5.	6.
• Policy **provides funding to overcome basic costs** associated with the legal system and access to free legal representation (Y) • Policy fails to provide access to **free legal representation** (N)	7.	8.	9.

M. Collect all policy documents that mention **international law** (ABAROLI, 2011, p. 124)	
Country has ratified the following **international conventions/treaties** (Y)/(N)	
1. Universal Declaration of Human Rights	1.
2. International Covenant on Civil and Political Rights	2.
3. Optional Protocol to the International Covenant on Civil and Political Rights	3.
4. Second Optional Protocol to the International Covenant on Civil and Political Rights, aiming at the abolition of the death penalty	4.

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M. Collect all policy documents that mention **international law** (ABAROLI, 2011, p. 124)	
5. The International Covenant on Economic, Social and Cultural Rights (ICESCR)	5.
6. The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)	6.
7. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	7.
8. Convention on Rights of the Child (CRC)	8.
Identify regional conventions/treaties that impact PWID and indicate whether there is country ratification (Y)/(N)	
9.	9.
10.	10.
11.	11.
12.	12.
• Policy recognizes the **supremacy of adopted international law** vis-a-vis national legislation (Y) • Policy fails to mention supremacy of adopted international law (N)	13.
• Policy recognizes the **competence of international human rights bodies** to receive complaints or communications from individual who claim that their rights have been violated (Y) • Policy fails to mention international human rights bodies or explicitly denies their jurisdiction (N)	14.
Please include any additional remarks or observations about related policy areas for PWID not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.	

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Intervention Design, Access, and Implementation—Procurement and Supply Management

A key element to the success of the services identified in this Decision Model is a functioning system for the procurement and supply management (PSM) of medicines and medical commodities. Central to PSM is the concept of "Approved Drugs and Essential Drugs."

Detailed Technical Guidance

Operational Principles for Good Pharmaceutical Procurement
http://apps.who.int/medicinedocs/en/d/Jwhozip49e/7.html

USAID/Deliver
http://deliver.jsi.com/dhome/

There are several documents a national government may use to control or specify which drugs and other medical commodities may be used in the country. The Decision Model inventory includes two of these: the *Approved Drug List*, and the *Essential Drug (or Medicine) List*. In addition, the government may specify which drugs are approved for local manufacture and which are approved for importation. Alternatively, the government may explicitly indicate by law or regulation the use of controlled medications.

Approved Drug List

The Approved Drug List is the largest, most extensive listing of medical pharmaceuticals permitted for use in the country. It typically is maintained by the equivalent of the U.S. Food and Drug Administration (FDA, part of HHS). The Approved Drug List usually includes generic formulations as well as brand-name drugs; it also covers drugs that are sold or distributed "over-the-counter" (i.e., without a physician's prescription) and those that require a physician's prescription. The list typically does not include drugs still being tested for safety and efficacy or those permitted only for research purposes.

For example, methadone is registered in the United States. It is available as a concentrate, powder, and tablet, or already in solution. But only the solution is dispensed in the treatment of opioid dependence by federal law; the tablet is used in pain management by prescription. The FDA lists its active ingredients (methadone hydrochloride) and several brand names (e.g., Methadose, Westadone) registered by different manufacturers.

If the consultant has difficulty locating the country's Approved Drug List, he/she might contact the local office of one of the large transnational pharmaceutical companies. Bayer-Schering, GlaxoSmithKline, and other companies often have local offices to ensure that their products can be imported, distributed, and sold. They would know who to contact for the Approved Drug List.

Essential Drug List

Many countries also maintain an Essential Drug List. Most are adapted from the *WHO Model Lists of Essential Medicines*, which is updated every two years. The WHO model list includes a *core list* of minimum medicines for a basic healthcare system to address public health concerns and a *complementary list* of essential medicines for priority diseases, for which specialized diagnostic or monitoring facilities, specialist medical care, and/or specialist training are needed.

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The Essential Drug List is usually smaller than the Approved Drug List—in other words, all of the drugs on the Essential Drug List should also be found on the Approved Drug List, but the reverse is not the case—not all drugs on the Approved Drug List will be found on the Essential Drug List.

Countries may use their Essential Drug List in different ways. Some countries may require that government health programs purchase only drugs included in the Essential Drug List; on the other hand, private sector organizations may purchase any drugs that are on the Approved Drug List, whether or not they are on the Essential List. Other countries may require that government programs stock *all* of the drugs on the Essential Drug List. And some countries may not specify their own Essential Drug List, but instead direct their government health programs to use the WHO model lists as reference. And finally, some countries may also have additional lists, such as the "List of drugs that are allowed to be purchased through state, municipal, or regional budget funding" that exists in Ukraine.

More than 150 countries have published an official essential drugs or medicines list. For example, Kyrgyzstan developed its first list of essential drugs in 1996, based on WHO guidelines, and revised the list in 1998, 2001, and 2003. Georgia developed an Essential Drugs List in 1995, which lists more than 250 generic drugs.

Local Manufacture and Importation

The drugs distributed and used in a country may include both locally manufactured and imported products. The decision to manufacture locally vs. import is based on many considerations, including the costs and type of laboratory installations required to manufacture the product. Government approvals to manufacture a drug locally (sometimes with imported raw materials) and/or to import the finished product may be found in different policy documents. In some cases, the approvals are indicated in the Approved Drug List and/or Essential Drug List. In other cases, approvals may be issued by special documents. Since methadone and buprenorphine are controlled substances, special approvals for their manufacture and/or importation are required to conform to international conventions. For example, the government of Kazakhstan issues an annual resolution, "On the requirement of the Republic of Kazakhstan in narcotic drugs, psychotropic substances and precursors," which specifies quotas limiting the amount of each controlled substance that may be imported during that year.

Registration and Procurement of ART Medications

Leonchuk and colleagues reported that, in many former Soviet countries, only registered ART medications (as well as any other medication or diagnostics) may be procured in the country; at the same time, a complicated, lengthy, costly, and non-transparent process of drug registration undermines competition in the ART market, resulting in high cost and a limited range of available ART medications. Countries also lack smooth and coherent management information systems for the forecasting, procurement, and stock management of ART medications. Often, all data collection and decisions are made by one specialist, which makes the system susceptible to serious errors (Leonchuk, De Lussigny, & Schonning, 2009). Problems with the procurement and supply of ART medications may result in stock-outs depriving patients of this life-saving treatment. In Russia, NGO Simona+ reported that 10 out of 20 researched regions experienced ART stock-outs in 2010, causing interruptions in treatment, unnecessary changes in treatment regimen, or a reduction in the number of drugs taken; interruptions of ART supply were also reported for Albania, Belarus, Georgia, Macedonia, and Ukraine (UNDP, 2011).

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In some countries, the cost of ART drugs was unreasonably high because governments either failed to register the generic versions of ART drugs (HRW, 2007a) to exempt them from taxes (Belyaeva & Aftandilyants, 2010) or failed to establish effective monitoring of the procurement process. Ineffective procurement policies and practices resulted in former Soviet countries spending USD31.9 million in excess of global median prices of ART drugs in 2002–2008, which comprised more than half of funds allocated for ART in the region and could provide first-line ART for an estimated 80,985 to 335,873 people per year depending on the regimen (UNDP, 2011).

Registration and Scheduling of OST Medications and Importing and Handling Procedures

> "Drug substitution and maintenance treatment … does not constitute any breach of treaty provisions, whatever substance may be used for such treatment in line with established national sound medical practice …. As is the case with the concept of medical use, treatment is not treaty defined" (INCB, 2003, p. 37).

Inclusion of methadone and buprenorphine into national schedules of narcotic and psychotropic substances with banned (Schedule I) or restricted (Schedule II) circulation following the UN 1961 Single Convention on Narcotic Drugs may pose a challenge for the introduction of OST. In countries where methadone is included in the Schedule I, it was not used for OST, as reported for Russia, Bangladesh, and India (Aizberg, 2008), (Burnet Institute, 2010). In the Maldives, buprenorphine is in the list of illegal drugs and therefore banned for OST, while methadone is on a less restricted list of medical drugs and is used for drug dependency treatment (WHO, 2010b).

Although methadone and buprenorphine are included in the *WHO Model List of Essential Medicines*, some countries implementing OST did not add them into their respective national lists (EHRN, 2011c). This creates additional bureaucratic hurdles for their purchase and import (Latypov, Otiashvili, Aizberg, & Boltaev, 2010).

In countries where methadone and buprenorphine are permitted for drug treatment purposes, cumbersome regulations related to importing, transportation, storage, and dispensing of OST medicines were reported to hamper effective implementation of the program. Fiellin and others wrote that unnecessary restrictions may reduce the feasibility of potentially effective treatment modalities like low-threshold, mobile, and prison transitional programs. At a basic level, according to International Narcotics Control Board (INCB) regulations, countries must get INCB approval for annual quotas of opioid medications to reduce the potential of a black-market diversion. The authors note that on top of that essential requirement to get an approval from INCB, many countries impose numerous additional restrictive procedures, including the need to (1) obtain approval from several ministries and agencies for importing and handling OST medication; (2) install alarm systems, safes, metal doors, and bars in storage rooms; (3) distribute medication with armed police escorts; and (4) implement complicated procedures for distributing and dispensing methadone and buprenorphine. As a result, the cost and complexity of logistics increases, and the supply of OST medications can be disrupted, as it happened in Moldova, where OST clients were left without medication for three months. In Ukraine and Kyrgyzstan, physicians experiencing or fearing shortage of OST medicines had to reduce doses to clients or exclude them from treatment, which made clients return to street drugs (Fiellin, Green, & Heimer, 2007). Complicated paperwork for methadone procurement and importation was reported as one of the key challenges in the introduction and scale-up of

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methadone programs in Eastern Europe and Central Asia countries (Aizberg, 2008). Complex import regulations also increase the price of OST medications (CHALN, IHRA, OSI & HRW, 2010).

Procurement Mechanisms

An OSI report found that procurement policies of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)-funded programs in Eastern Europe and Central Asia may limit clients' access to high-quality, safer injection commodities. The most significant barrier was the focus on the price of commodities as priority selection criteria, which often led to purchasing commodities of sub-standard quality. Another issue was the lack of flexibility of centralized procurement and supply mechanisms and the resulting inability to address timely changes in the type of commodities needed (since depending on the types of drugs available in the black market, clients may need syringes and needles of different size, length, and gauge) or increase in the number of clients participating in the programs. Another disadvantage of centralized procurement and supply was the delay in the supply of commodities, which resulted in months of commodity stock-outs that were exacerbated by restrictions on spending project funds for local, decentralized procurement.

Employing a centralized procurement system essentially suggests that regional health authorities cannot address the supply problems locally and have to rely on national authorities for handling the issue in cases when there is a serious risk of stock-outs. Pharmacies cannot procure the necessary drugs independently either. In Russia, this issue was solved by combining centralized procurement with a funding allocation for service providers to purchase small batches of commodities in the local market to address unexpected changes in clients' needs and ensure an uninterrupted supply of commodities. The report pointed out that, in general, the GFATM performance measurement heavily relied on quantitative indicators such as coverage and the number of commodities distributed, while overlooking quality issues and clients' satisfaction with services. Only recently did programs adopt the system of collecting clients' feedback on the commodities' quality and assortment to inform procurement-related decisions (OSI, 2009).

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XIV. Procurement and supply management of medicine and medical commodities

A. Collect all policy documents that identify bodies with **PSM oversight responsibility** (JSI/Deliver, 2005a, p. 29)

	Oversee, Coordinate, and Track Resources	Identify Gaps in Funding	Identify Technical Assistance Needs	Oversee Tendering
• Policy states that **oversight bodies** have responsibility to (1) oversee, coordinate, and track resources that have been promised and allocated; (2) identify gaps in funding, medicines, and medical commodity inventories; (3) identify technical assistance needs; and (4) oversee tendering (Y) • No mention of PSM oversight body or responsibilities (N)	1.	2.	3.	4.
• Policy identifies **representation of nongovernmental organizations** on oversight bodies (Y) • Policy fails to identify or restricts representation of nongovernmental organizations (N)				5.
• Policy guarantees that **procurement records are open to the public** (Y) • Policy restricts access to procurement records (N)				6.

B. Collect all policy documents that mention **quality standards for medicines and medical commodities**

• Procurement policy prioritizes utilization of **WHO Prequalified Drugs List** (Y) • Policy fails to mention use of WHO Prequalified Drugs List (N)	1.
• Policy identifies **quality assurance standards** for medicine and medical commodities (Y) • Policy fails to mention quality assurance standards (N)	2.
• Policy identifies **post-procurement quality control** medicine and medical commodities (Y) • Policy fails to mention post-procurement quality assurance standards (N)	3.

C. Collect all policy documents that mention the country **essential medicines** list (WHO, 2003, p. 4), (UNAIDS, 2008, p. 200)

• The country essential medicines list **includes all medications identified in the WHO Model List of Essential Medicines** for ART, overdose prevention, OST, TB, and hepatitis (Y) • The essential medicines list excludes some of the medications identified by WHO (N)	1.
• The country essential medicines list includes all medications identified in the WHO Model List of Essential Medicines for **post-exposure prophylaxis** (Y) • The essential medicines list excludes some of the medications identified by WHO (N	2.

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C. Collect all policy documents that mention the country **essential medicines** list (WHO, 2003, p. 4), (UNAIDS, 2008, p. 200)	
• Drugs that can be **procured through government funding** include medications for ART, overdose prevention, OST, TB, and hepatitis • Government funding is restricted for any medications for ART, overdose prevention, OST, TB, and hepatitis	3.
• Policy explicitly **allows importation or local manufacture for clinical use** of all medications identified in the WHO Model List of Essential Medicines for ART, overdose prevention, OST, TB, and hepatitis (Y) • Policy fails to explicitly allow importation or local manufacture of WHO medicines for clinical use (N)	4.
• Policy **removes or reduces taxes and tariffs** on essential medicines, controls distribution margins, and sets pricing parameters (Y) • Policy fails to mention reduction in taxes or tariffs, distribution margins or pricing parameters (N)	5.

D. Collect all policy documents that mention the process for **selection of harm reduction commodities** (WHO, 2010f, p. 85)	
• Policy identifies mechanisms for PWID to be involved in the product selection of harm reduction commodities (Y) • Policy fails to mention or excludes PWID from product selection process (N)	1.

E. Collect all policy documents that identify the process for **quantification and** forecasting of medicine and commodity need (WHO, 1999, pp. 12, 13), (JSI/Deliver, 2003, pp. 2, 8)			
	Reliable Estimate of Need	Review and Update Every Six Months	Monthly Reporting Cycle
1. Policy identifies mechanisms to calculate order quantities based on **reliable estimate of need** including all those who are eligible for prevention, diagnostics, and treatment based on internationally accepted guidelines (Y) 2. Policy requires **review and updating of forecasting** and quantification of medicines and medical commodities at least every six months (Y) 3. Policy requires implementation of a **monthly reporting** cycle (Y) • Policy fails to mention mechanisms for calculation or uses mechanisms that fail to consider current forecasts of need and reporting cycles (N)	1.	2.	3.

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E. Collect all policy documents that identify the process for **quantification and** forecasting of medicine and commodity need (WHO, 1999, pp. 12, 13), (JSI/Deliver, 2003, pp. 2, 8)	
• Policy allows for **participation of individuals or nongovernmental organizations** serving PWID in forecasting (Y) • Policy fails to support or restricts involvement of individuals or nongovernmental organizations (N)	4.
• Policy identifies guidelines that include **cost-effectiveness measures** for forecasting and procurement of appropriate quantities of both initial and advanced categories of medicines and commodities (Y) • Policy makes no mention of cost-effectiveness or encourages procurement of advanced categories of medicines and commodities (N)	5.

F. Collect all policy documents that establish **budgets** for medicines and medical commodities (JSI/Deliver, 2005a, p. 26), (WHO, 2007b, pp. 50-57)			
	Budget for Storage	Budget for Distribution	Budget for Logistics
• Budgets for medicines and medical commodities include a specific mechanism to finance (1) **storage**, (2) **distribution**, and (3) **logistics** (Y) • Budgets fail to fund storage, distribution, and logistics (N)	1.	2.	3.
• Policy assures budget for procurement of **infection control commodities** (gloves, sharps containers, etc.) for medical facilities (Y) • Policy fails to assure budget for procurement of infection control commodities			4.
• Policy allows for flexibility for **decentralized procurement** (Y) • Policy prohibits decentralized procurement (N)			5.
• Policy allows for **international tendering** (Y) • Policy prohibits international tendering (N)			6.

G. Collect all policy documents that mention **medicine and medical commodity distribution** (JSI/Deliver, 2005, p. 9)	
• Policy identifies systems **to redistribute medicines and medical commodities** to prevent stock-outs, overstock, and expiration (Y) • Policy fails to identify systems or prohibits redistribution (N)	1.

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Intervention Design, Access, and Implementation—Overarching Services Design

Lack of Integration of Healthcare Services

> "All services dealing with drug users should collaborate locally with key partners to ensure universal access to comprehensive TB and HIV prevention, treatment, and care as well as drug treatment services for drug users in a holistic person-centered way that maximizes access and adherence: in one setting, if possible" (WHO, 2008a, p. 7).

In many developing countries where sharing unsterile injecting equipment is the main driver of the HIV epidemic, drug treatment, HIV, TB, hepatitis and STI testing, and treatment services are provided via specialized vertical structures that are often not integrated (Wolfe, 2007). Some countries in Eastern Europe and Central Asia have no policies ensuring integration of HIV and TB-related services with OST programs or defining mechanisms of referrals and counter-referrals from OST facilities to other healthcare services and agencies (EHRN, 2011c).

Participants in the Yalta Scientific Leadership Summit recommended that specialists dealing with HIV treatment, including infectious disease specialists and family doctors, should be allowed to prescribe and deliver OST to their patients (International AIDS Society [IAS], 2008), as integrating delivery of ART with OST to PWID was suggested to be an efficient model for recruiting and retaining clients in ART programs (Bobrova, Sarang, Stuikyte, & Lezhentsev, 2007). Absence of integrated care facilities and weak interaction and referral mechanisms among vertically organized services limit access of drug users with one or several co-morbidities like HIV, TB, and HCV to a comprehensive package of treatment and care services. Lack of integration between community and prison healthcare systems may also lead to discontinuity of drug and HIV-related services for persons entering or leaving prisons (EHRN, 2011c).

Professional Education System

One reason for poor-quality healthcare services for drug users is the inadequacy of the professional health education system. In Eastern Europe and Central Asia, HIV personnel usually lack appropriate knowledge of drug dependency, case management, and the relationships between changing patterns of drug use in a local drug scene and HIV risk behavior, which hinders the provision of high-quality care and services and the ability to address patients' psychological and social needs. At the same time, narcology specialists often are unaware of the specifics of HIV treatment among drug users, including important interactions between some ART drugs and OST medications, which may result in withdrawal symptoms in patients (European AIDS Treatment Group [EATG], 2008). Healthcare providers also need education on human rights aspects of prevention, treatment, and care for drug users to address stigma and discrimination concerns (UNODC & CHALN, 2010). Therefore, professional education of healthcare specialists in countries where HIV prevalence among drug users is high should involve an integrated approach to drug dependency and HIV-related issues.

Access to high-quality services in prisons can be hampered, among other things, by the lack of awareness of prison staff about drug dependency, HIV, TB and HCV-related issues, as well as the human rights of

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inmates. To address this issue, training programs for prison staff should incorporate these issues into curricula (CHALN, 2006).

Lack of Legal Support for Harm Reduction

The International Drug Policy Consortium indicates that in South Eastern Europe, only a few countries included harm reduction in their national legislation (IDPC, 2011). Harm reduction is not explicitly supported by legislation in most Central Asia countries. In some Central Asian republics, the rights of most-at-risk populations to HIV prevention services endorsed in broad and non-binding terms and existing laws do not mention specific services such as NSP and OST. Only in Kyrgyzstan Article 5 of the Law on HIV guarantees "the right for participation in prevention programs and access to preventive materials (disinfectants, clean syringes, needles and condoms)." None of the HIV-related legislation for these countries specifies the right of inmates to OST or NSP services (EHRN, 2011c), (UNODC & CHALN, 2010).

At the same time, it should be noted that explicit legal endorsement is not necessarily a guarantee of access to services. References to harm reduction in HIV and drug legislation can be undermined by conflicting policies banning promotion of drugs and incitement into drug use, so unless comprehensive legal reforms are undertaken, programs will remain under legal threat. Even in countries, where the right to harm reduction services is recognized by the law, services may still be unavailable or at risk of closure.

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XV. Overall hepatitis, TB, HIV, drug treatment, and harm reduction services design

A. Collect all policy documents that guide **implementation** of hepatitis, TB, HIV, or drug treatment services (UNODC, 2009a, p. 43), (WHO, 1993, pp. 6, 8), (WHO, 2008a, p. 7), (UNODC, 2010, pp. 39, 41), (WHO, 2007c, p. 6), (UNODC, 2006, pp. 23, 26), (WHO, 2009a, p. 11), (CHALN, 2006e, pp. 30, 31), (UNODC, 2006b), (EHRN, 2011) (WHO, 2008a, p. 7), (WHO, 2010d, p. 18)

C—Community, PT—Pre-Trial Detention, P—Prison, MC—Minor Custody	Viral Hepatitis				TB				HIV				Drug Treatment				Harm Reduction			
Policy:	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC
• Policy directs all services for PWID to have protocols to **assess risk for HIV** (Y) • Policy fails to identify HIV risk assessment protocols (N)	1.	2.	3.	4.	5.	6.	7.	8.					9.	10.	11.	12.	13.	14.	15.	16.
• Policy directs all services for PWID to have protocols to **assess risk for hepatitis** (Y) • Policy fails to identify hepatitis risk assessment protocols (N)					17.	18.	19.	20.	21.	22.	23.	24.	25.	26.	27.	28.	29.	30.	31.	32.
• Policy directs all services dealing with drug users to have protocols to **assess risk for TB** (Y) • Policy fails to identify TB risk assessment protocols (N)	33.	34.	35.	36.					37.	38.	39.	40.	41.	42.	43.	44.	45.	46.	47.	48.
• Policy directs all services dealing with drug users to have protocols to **assess risk for sexual and domestic violence** (Y) • Policy fails to identify domestic and sexual violence risk assessment protocols (N)	49.	50.	51.	52.	53.	54.	55.	56.	57.	58.	59.	60.	61.	62.	63.	64.	65.	66.	67.	68.

A. Collect all policy documents that guide **implementation** of hepatitis, TB, HIV, or drug treatment services (UNODC, 2009a, p. 43), (WHO, 1993, pp. 6, 8), (WHO, 2008a, p. 7), (UNODC, 2010, pp. 39, 41), (WHO, 2007c, p. 6), (UNODC, 2006, pp. 23, 26), (WHO, 2009a, p. 11), (CHALN, 2006e, pp. 30, 31), (UNODC, 2006b), (EHRN, 2011) (WHO, 2008a, p. 7), (WHO, 2010d, p. 18)

C—Community, PT—Pre-Trial Detention, P—Prison, MC—Minor Custody	Viral Hepatitis				TB				HIV				Drug Treatment				Harm Reduction			
Policy:	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC
• Identifies **mechanisms of referral** to other services (Y) • Fails to identify mechanisms of referral (N)	69.	70.	71.	72.	73.	74.	75.	76.	77.	78.	79.	80.	81.	82.	83.	84.	85.	86.	87.	88.
• Identifies mechanisms to ensure **continuity of care between and within community and detention/prison/ custodial settings** (Y) • Fails to mention continuity of care between and within detention/prison/ custodial settings and community services (N)	89.	90.	91.	92.	93.	94.	95.	96.	97.	98.	99.	100.	101.	102.	103.	104.	105.	106.	107.	108.
• Policy directs all health services to ensure access to **isoniazid preventive therapy** for drug users living with HIV once active TB and hepatitis is reasonably excluded (Y) • Policy fails to provide preventive TB therapy (N)	109.	110.	111.	112.	113.	114.	115.	116.	117.	118.	119.	120.								

A. Collect all policy documents that guide **implementation** of hepatitis, TB, HIV, or drug treatment services (UNODC, 2009a, p. 43), (WHO, 1993, pp. 6, 8), (WHO, 2008a, p. 7), (UNODC, 2010, pp. 39, 41), (WHO, 2007c, p. 6), (UNODC, 2006, pp. 23, 26), (WHO, 2009a, p. 11), (CHALN, 2006e, pp. 30, 31), (UNODC, 2006b), (EHRN, 2011) (WHO, 2008a, p. 7), (WHO, 2010d, p. 18)

C—Community, PT—Pre-Trial Detention, P—Prison, MC—Minor Custody	Viral Hepatitis				TB				HIV				Drug Treatment				Harm Reduction			
Policy:	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC
• Policy directs **direct provision or provision of prescription for naloxone** to clients or people close to them as well as information on overdose prevention and management (Y) • Policy fails to provide for naloxone and overdose prevention and management information (N)	121.	122.	123.	124.	125.	126.	127.	128.	129.	130.	131.	132.	133.	134.	135.	136.	137.	138.	139.	140.
• **Prohibits mandatory use of family planning** as a condition for receiving services (Y) • Fails to prohibit or requires use of family planning to receive these services (N)	141.	142.	143.	144.	145.	146.	147.	148.	149.	150.	151.	152.	153.	154.	155.	156.	157.	158.	159.	160.
• **Guarantees access for female PWID who are pregnant or have children** (Y) • Policy fails to mention or denies access to female PWID (N)	161.	162.	163.	164.	165.	166.	167.	168.	169.	170.	171.	172.	173.	174.	175.	176.	177.	178.	179.	180.
• Guarantee services for PWID regardless of the status of **registration as a drug user** (Y) • Policies require registration of PWID as a drug user to receive services (N)	181.	182.	183.	184.	185.	186.	187.	188.	189.	190.	191.	192.	193.	194.	195.	196.	197.	198.	199.	200.
• Guarantee services for PWID regardless of the status of **registration with law enforcement** (Y) • Policies require registration of PWID with law enforcement to receive services (N)	201.	202.	203.	204.	205.	206.	207.	208.	209.	210.	211.	212.	213.	214.	215.	216.	217.	218.	219.	220.

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A. Collect all policy documents that guide **implementation** of hepatitis, TB, HIV, or drug treatment services (UNODC, 2009a, p. 43), (WHO, 1993, pp. 6, 8), (WHO, 2008a, p. 7), (UNODC, 2010, pp. 39, 41), (WHO, 2007c, p. 6), (UNODC, 2006, pp. 23, 26), (WHO, 2009a, p. 11), (CHALN, 2006e, pp. 30, 31), (UNODC, 2006b), (EHRN, 2011) (WHO, 2008a, p. 7), (WHO, 2010d, p. 18)

C—Community, PT—Pre-Trial Detention, P—Prison, MC—Minor Custody	Viral Hepatitis				TB				HIV				Drug Treatment				Harm Reduction			
Policy:	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC	C	PT	P	MC
• Directs that services be **available at times convenient to clients** (e.g., before/ after working hours/weekends) (Y) • Identifies restricted service hours (N)	221.	222.	223.	224.	225.	226.	227.	228.	229.	230.	231.	232.	233.	234.	235.	236.	237.	238.	239.	240.

B. Collect all policy documents that guide **implementation** of hospital, residential drug treatment, pre-trial detention, or prison discharge (EHRN, 2011)

	Hospital	Residential Drug Treatment	Pre-trial Detention	Prison
• Policy requires **mandatory counseling on overdose prevention** for anyone with a history of drug use who are being discharged from (1) hospitalization, (2) residential drug treatment, (3) pre-trial detention, and (4) prison (Y) • Policy fails to require counseling (N)	1.	2.	3.	4.

C. Collect all policy documents that **define training requirements** for prison, law enforcement, and healthcare providers (UNAIDS, 1999, p. 122), (UNAIDS, 2006, p. 29), (UNODC, 2009a, pp. 33, 34, 41) (EHRN, 2011)

• Policy require the following staff to undergo regular training (Y) • Policy fails to mention training requirement (N)	Ethics And Human Rights Including Consent and Confidentiality	Avoiding Stigma and Discrim-ination	Domestic and Sexual Violence	Overdose Prevention and Manage-ment	Referral Between Healthcare and Harm Reduction Services	Training on Drug Dependence	Specific needs of PWID	Training on hepatitis, TB, and HIV
• **Law enforcement staff**	1.	2.	3.	4.	5.	6.	7.	8.

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C. Collect all policy documents that **define training requirements** for prison, law enforcement, and healthcare providers (UNAIDS, 1999, p. 122), (UNAIDS, 2006, p. 29), (UNODC, 2009a, pp. 33, 34, 41) (EHRN, 2011)								
• **Judges and court staff**	9.	10.	11.	12.	13.	14.	15.	16.
• **Detention/prison workers**	17.	18.	19.	20.	21.	22.	23.	24.
• Staff working **in custody settings for minors**	25.	26.	27.	28.	29.	30.	31.	32.
• **Healthcare workers**	33.	34.	35.	36.	37.	38.	39.	40.
• **Drug treatment specialists (narcologists)**	41.	42.	43.	44.	45.	46.	47.	48.
Please include any additional remarks or observations about related policy areas for PWID not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.								

Intervention Design, Access, and Implementation—HCT

"HIV testing must always be done with informed consent, adequate pre-test information or counseling, post-test counseling, protection of confidentiality, and referral to services" (WHO, 2010c, p. 10).

Detailed Technical Guidance

WHO HIV Counseling and Testing Publications
http://www.who.int/hiv/pub/vct/en/

Scaling up HIV testing and counseling in the WHO European Region
http://www.euro.who.int/__data/assets/pdf_file/0007/85489/E93715.pdf

User Fees

In many countries, HIV testing is provided for free; however, in some cases, fees may be imposed, which may discourage vulnerable groups, including drug users, from testing. There are instances when HIV testing may be provided for free; however, if a client needs to obtain an official test certificate, a fee is charged (UNODC & CHALN, 2010), (Saidov, 2010).

Centralized HIV Testing

In many former Soviet countries, testing of blood for HIV and post-test counseling are mostly performed in AIDS centers. Even if pre-test counseling and drawing of blood specimens are done outside of AIDS centers, clients with positive or uncertain results are often referred to the centers for confirmatory tests. The problem is that drug users may often refuse to visit the centers due to fear of stigma and discrimination, lack of confidentiality, and/or unstable lifestyle, thus facing significant obstacles to HIV testing and counseling (Bobrova, Sarang, Stuikyte, & Lezhentsev, 2007).

"In countries with a limited laboratory infrastructure the use of HIV rapid testing algorithms has been more feasible and as effective as ELISA/Western Blot algorithms" (WHO, 2004d, p. 13).

HIV testing is commonly done in two stages: if the first test demonstrates a positive or uncertain result, another, confirmatory test is administered. In these cases, local HIV/AIDS authorities in some countries send blood samples to central province or national laboratories for immunoassay analysis, so receiving final results may take up to one month, while the clients are in suspense and endure significant psychological stress; some clients may also fail to come and receive the confirmatory test results (Bobrova, Sarang, Stuikyte, & Lezhentsev, 2007), (Ibragimov, Khasanova, Latypov, & Jamolov, 2011). This issue can be addressed, at least in some countries, by using rapid HIV tests for confirmation, as recommended by the WHO for resource-limited settings (WHO, 2004d).

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XVI. HIV counseling and testing (HCT)

A. Collect all policy documents **authorizing HCT services** (WHO, 2010a, p. 10), (UNAIDS, 2006, pp. 26, 27), (WHO, 2004d)

	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Policy **guarantees state funding** for HCT services (Y) • Policy fails to mention access or funding for HCT (N)	1.	2.	3.	4.
• Policy guarantees access to **free HCT** (Y) • Policy identifies fees for HCT testing or HIV-status certification (N)	5.	6.	7.	8.
• Policy authorizes HCT as part of an **integrated service model** (Y) • Policy identifies HCT as an isolated service (N)	9.	10.	11.	12.
• Policy allows use of **saliva-based rapid testing** (Y) • Policy fails to authorize or prohibits saliva-based rapid testing (N)	13.	14.	15.	16.
• Policy allows use of **rapid testing algorithms to diagnose HIV infection** (Y) • Policy fails to identify or prohibits diagnosis by rapid testing technologies (N)	17.	18.	19.	20.
• Policy guarantees that HCT services including receipt of test results, are available on an **anonymous basis** (Y) • Policy requires that names be provided for provision of HCT (N)	21.	22.	23.	24.
				Y/N
• Policy authorizes either **governmental or nongovernmental providers** to deliver HCT and provide HIV test results (Y) • Policy restricts either delivery of HCT or provision of test results to government bodies (N)				25.

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B. Collect all policy documents defining **required elements of HCT** (UNAIDS, 2006, p. 27), (CHALN, 2006e, p. 18), (Inter-Parliamentary Unit [IPU], 2007, p. 82), (UNODC, 2006, pp. 18, 25), (WHO, 2009, p. 10), (UNODC, 2010, p. 38), (WHO, 2007a, p. 7), (WHO, 2007c, p. 6), (UNODC, 2009a, p. 43), (OSI, UNAIDS & WHO, 2010b, pp. 9, 16, 17), (WHO, 2007e, p. 25)

Policy:	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Requires **pre-test counseling,** for all HIV testing (Y) • Fails to require pre-test counseling, for all HIV testing (N)	1.	2.	3.	4.
• Requires **informed consent**, for all HIV testing (Y) • Fails to require informed consent, for all HIV testing (N)	5.	6.	7.	8.
• Requires **post-test counseling**, for all HIV testing (Y) • Fails to require post-test counseling, for all HIV testing (N)	9.	10.	11.	12.
• Requires **referral** to medical and prevention services in for all HIV testing (Y) • Fails to require referral to medical and prevention services in for all HIV testing (N)	13.	14.	15.	16.
• Identifies mechanisms for **PWID to be involved in the development of HIV testing and counseling protocols** (Y) • Fails to mention PWID involvement in program design (N)	17.	18.	19.	20.
• Policy identifies **mechanisms to monitor** HCT programs for access, quality, informed consent, and linkages to HIV prevention and treatment, care, and support for PWID (Y) • Policy fails to mention monitoring and evaluation of HCT programs for PWID-specific outcomes (N)	21.	22.	23.	24.
• Policy identifies **mechanisms for PWID to be involved in the monitoring and evaluation** of HIV testing and counseling programs (Y) • Policy fails to mention PWID involvement in program monitoring (N)	25.	26.	27.	28.

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C. Collect all policy documents mentioning **access to HCT for prisoners** (WHO, 1993, p. 5), (UNODC, 2006, p. 25) (WHO, 2007a), (WHO, 2007c, p. 6), (UNODC, 2009a, pp. 36, 37, 39), (UNODC, 2010, p. 38), (WHO, 2006, p. 10), (CHALN, 2006e, p. 18)	
• Policy requires that prisoners are made aware of and offered or recommended voluntary, confidential HIV testing with counseling **upon entry and during imprisonment**—especially if a prisoner has signs, symptoms, or medical conditions that could indicate HIV infection (Y) • Policy fails to mention HCT access for prisoners (N)	1.
D. Collect all policy documents mentioning provision of **HCT in the healthcare setting** (WHO, 2007e, p. 5), (UNGA, 2009, p. 10)	
• Policy identifies an **opt-in approach to provider initiated HCT for PWID** (Y) • Policy identifies an opt-out approach to provider initiated HCT for PWID (N)	1.
Please include any additional remarks or observations about related policy areas for PWID not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.	

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Intervention Design, Access, and Implementation—ART

User Fees

Though in many developing countries ART medications are provided for free (sponsored by international donors), fees for laboratory monitoring may pose a significant barrier for patients (WHO, 2010b), (Wolfe, Carrieri, & Shepard, 2010), (Belyaeva & Aftandilyants, 2010).

Eligibility Criteria and Documentation and Testing Requirements

"The absence of the following desirable and optimal tests cannot be a barrier to starting ART:

- CD4 lymphocyte count to determine the severity of immunodeficiency (if available)
- Viral load testing (if available) to monitor the response to ART" (WHO, 2008, p. 14).

Requirements to undergo two weeks of various clinical tests were reported to restrict access to treatment for active drug users in Russia; most of these tests were not necessary for initiation of the ART course, such as examinations by a dentist or cardiologist. Visiting these specialists and passing additional tests takes up to three weeks and may become an insurmountable obstacle for PWID, many of whom live below the poverty level and fear stigma and discrimination by healthcare providers (Maron & Meylakhs, 2010).

Detailed Technical Guidance

WHO HIV Guidelines
http://www.who.int/hiv/pub/guidelines/en/

A requirement for proof of residency also limits drug users' access to treatment. This requirement was imposed by program managers in India to help track clients who do not report for treatment in time; however, it prevented some drug users, who were homeless or reluctant to give their address for fear of confidentiality breach by staff, from enrolling in the ART program (Chakrapani, Velayudham, Michael, & Shanmugam, 2008).

Clinical Protocols and Standards of Care

Until recently, many countries in Eastern Europe and Central Asia lacked clinical protocols guiding provision of ART to drug-using clients (Bobrova, Sarang, Stuikyte, & Lezhentsev, 2007). The lengthy process of updating and approving ART clinical protocols, which may take up to one year, limits clients' access to the most up-to-date treatment regimens (Leonchuk, De Lussigny, & Schonning, 2009). Absence of OST, mental healthcare, and peer support in standards of care for drug-using PLHIV significantly undermines the effectiveness of treatment (OSI, 2006). And protocols neglecting interactions between ART drugs and opioids, including OST medications and street drugs, deprive drug-using patients from high-quality care (HRW, 2007), (OSI, 2006), (Chakrapani, Velayudham, Michael, & Shanmugam, 2008).

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Exclusion of Drug Users from Treatment

> "Studies show that some clinicians may be reluctant to prescribe ART to HIV-infected people who inject drugs, due to the common belief that such people have lower levels of adherence which, in turn, may lead to elevated rates of antiretroviral (ARV) resistance. Studies show that adherence to ARVs is similar among people who inject drugs and those who do not" (WHO, 2008, p. ix).
>
> "... there is no need to wait for abstinence from opioids to commence either anti-TB medication, treatment for hepatitis, or antiretroviral medication" (WHO, 2009a, p. 21).

Drug users have been denied treatment by some AIDS centers that use social and behavioral eligibility criteria while administering ART. In Russia, for example, centers may tend to prioritize "socially stable" clients when making decisions on the admission to treatment (Maron & Meylakhs, 2010).

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XVII. Antiretroviral Therapy

A. Collect all policy documents **authorizing ART services** (WHO, 2006, p. 20), (WHO, 2009a, pp. 20, 21), (WHO, 2008a, p. 7), (WHO, 2010e, p. 20), (WHO, 2010e, p. 64), (WHO, 2010e, p. 21), (WHO, 2010e, p. 67), (WHO, 2008a, p. 7), (UNODC, 2010, p. 39)

Policy:	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• States that ART is provided **free of charge** (Y) • Fails to expressly prohibit fees or identifies fees for ART (N)	1.	2.	3.	4.
• States that any **related or required services are provided free** of charge (Y) • Fails to expressly prohibit fees or identifies fees for related services (N)	5.	6.	7.	8.

B. Collect all policy documents defining **ART eligibility** (WHO, 2006, p. 20), (WHO, 2009a, pp. 20, 21), (WHO, 2008a, p. 7), (WHO, 2010e, p. 20), (WHO, 2010e, p. 64), (WHO, 2010e, p. 21), (WHO, 2010e, p. 67), (WHO, 2008a, p. 7), (UNODC, 2010, p. 39)

Policy:	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Explicitly states that eligibility for ART includes those with **past or present drug use** as a prerequisite to access and initiate HIV treatment and care (Y) • Fails to mention PWID eligibility for ART	1.	2.	3.	4.
• Explicitly states that eligibility for ART **does not require detoxification** as a prerequisite to access and initiate HIV treatment and care (Y) • Places detoxification or "stability" requirements as a prerequisite to initiate HIV treatment and care (N)	5.	6.	7.	8.
• Identifies patients with **active TB** as eligible to initiate ART, irrespective of CD4 count (Y) • Fails to mention active TB or explicitly excludes or delays individuals with it from ART eligibility (N)	9.	10.	11.	12.
• Identifies patients who **require treatment for HBV** as eligible to initiate ART, irrespective of CD4 count (Y) • Fails to mention active HBV or explicitly excludes or delays individuals with it from ART eligibility (N)	13.	14.	15.	16.

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B. Collect all policy documents defining **ART eligibility** (WHO, 2006, p. 20), (WHO, 2009a, pp. 20, 21), (WHO, 2008a, p. 7), (WHO, 2010e, p. 20), (WHO, 2010e, p. 64), (WHO, 2010e, p. 21), (WHO, 2010e, p. 67), (WHO, 2008a, p. 7), (UNODC, 2010, p. 39)				
• Defines eligibility of patients **co-infected with HIV and HCV** as the same as those with only HIV infection (Y) • Fails to mention active HCV or explicitly excludes individuals with it from ART eligibility (N)	17.	18.	19.	20.
• Policy specifically states that **national guidelines** on care and treatment of HIV **apply to detention/prison/residential settings** (Y) • Policy is silent on inmate/resident eligibility for ART or identifies more restrictive eligibility guidelines for detention/prisons/residential custodial settings (N)		21.	22.	23.

C. Collect all policy documents defining **ART protocols**				
Policy:	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Identifies **protocols that mention delivery of ART to PWID** including interactions of ART with OST medications and street drugs (Y) • Policy fails to provide clinical protocols for ART that include PWID (N)	1.	2.	3.	4.
• Policy identifies **PWID-specific ART adherence support** protocols and services (Y) • Policy fails to provide PWID-specific adherence protocols for ART (N)	5.	6.	7.	8.
Please include any additional remarks or observations about related policy areas for PWID not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.				

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Intervention Design, Access, and Implementation—Hepatitis

Cost of Treatment and Testing

Extremely high cost of medications is the most significant impediment to universal access to hepatitis C treatment. The average cost of a treatment course in Eastern Europe was reported to be Euro 12,600; while in Kyrgyzstan and Russia, it cost more than USD20,000 and USD25,000, respectively (EHRN, 2011a). Many countries in Central and Eastern Europe do not fund treatment of hepatitis C, only allocate funds for treatment of a limited number of people, only pay for part of the treatment course, or only cover costs only for those who have health insurance, so PWID (who often lack health insurance) are left without treatment (CEEHRN, 2007).

Hepatitis C treatment for drug users can be funded by the GFATM; however, it is available only for those co-infected with HIV and only in countries that cover the cost of hepatitis C treatment for the general population (OSI, 2011). These policies restrict access to treatment for drug users in poor countries where the general population also has no access to treatment.

Access to HCV treatment can be impeded by the lack of free HCV testing. In Kyrgyzstan, the cost of some HCV testing reached USD100, making testing inaccessible for the majority of drug users (HRC, 2010). In some countries, though HCV testing is proclaimed free, user fees were nevertheless demanded by practitioners [Belarus, Georgia, Lithuania, Russian Federation, as reported by (Curth, Hansson, Storm, & Lazarus, 2009)], which can also be an indication of the lack of a proper regulatory framework ensuring access to free testing. No Central and Eastern European and Central Asian (CEECA) country appears to have made all HCV diagnostic tests (antibody test, viral load test, genotype test and liver biopsies) available for free and without restrictions (Hoover, 2009).

Clinical Protocols, Standards of Care, and Referral Mechanisms

Access to high-quality HCV treatment may also be impeded by the lack of national treatment protocols that specifically address the needs of PWID and people with HIV and HCV co-infection (Bobrova, Sarang, Stuikyte, & Lezhentsev, 2007). On some occasions, protocols also tend to disregard the needs for support and care for people with hepatitis C who are not ready for treatment or neglect the needs of people who complete a course of treatment and face a range of post-treatment problems, as was reported for Australia (AIVL, 2010).

No countries in the CEECA region had treatment guidelines specifically advising against denying HCV treatment to people who inject drugs ("policy silence"). In Belarus, Russia, Estonia, and Lithuania, official policies recommended abstinence from illicit drugs as a prerequisite for enrolling in HCV treatment. Proponents of excluding drug users from treatment argued that active drug users could not adhere to the treatment regimen or that the effectiveness of treatment was reduced by concurrent drug use; however, both claims have been refuted by research (Hoover, 2009).

Detailed Technical Guidance

WHO Hepatitis Resources
http://www.who.int/topics/hepatitis/en/

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XVIII. Hepatitis services

A. Collect all policy documents **authorizing hepatitis services** (WHO, 2010a, p. 10), (CEEHRN, 2007, p. 18), (OSI, 2006, p. 20)

Policy:	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Guarantees **access to free HCV testing** and counseling for all PWID (Y) • Fails to guarantee free access or identifies fees for HCV testing and counseling for PWID (N)	1.	2.	3.	4.
• Guarantees access to **free HAV and HBV vaccination** for all PWID (Y) • Fails to guarantee free access or identifies fees for HAV and HBV vaccination for PWID (N)	5.	6.	7.	8.
• Guarantees free **access to available resources and information** to reduce the likelihood of HCV-related liver disease progression for all PWID (Y) • Fails to guarantee free access or identifies fees to access resources and information to reduce the likelihood of HCV-related liver disease progression for PWID (N)	9.	10.	11.	12.

B. Collect all policy documents that set **eligibility criteria for hepatitis services** (WHO, 2009a, pp. 20, 21)

	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Policy specifically states that **abstinence from drug use is not a requirement** to provide hepatitis services, including treatment (Y) • Policy requires abstinence from drug use to provide hepatitis services, including treatment (N)	1.	2.	3.	4.

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C. Collect all policy documents that set clinical **protocols for hepatitis** (UNODC, 2010, p. 40)				
	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Policy specifically addresses the **needs of people with HIV and PWID** (Y) • Policy fails to address this issue (N)	1.	2.	3.	4.
• Policy specifically addresses **people who are not ready for treatment** (Y) • Policy fails to address this issue (N)	5.	6.	7.	8.
• Policy specifically addresses **people who have completed treatment** (Y) • Policy fails to address this issue (N)	9.	10.	11.	12.
• Policy directs that **detainees/residents and staff receive information** about the risks of HCV transmission and are educated about the ways to reduce that risk (Y) • Policy fails to identify requirements to provide information or actively restricts it (N)		13.	14.	15.
• Policy ensures **provision of personal shaving equipment and toothbrushes,** and replacements as necessary, to detainees/residents so that they do not have to share (Y) • Policy fails to require provision of personal hygiene equipment (N)		16.	17.	18.
• Policy **guarantees HAV and HBV vaccination** are available to all prison/custodial staff and detainees/residents (Y) • Policy fails to require availability of vaccination (N)		19.	20.	21.
• Policy **guarantees detainees/residents have voluntary and easy access** to testing for hepatitis B and hepatitis C, with proper follow-up of hepatitis patients and their treatment (Y) • Policy fails to require availability of testing and follow-up (N)		22.	23.	24.
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Intervention Design, Access, and Implementation—Tuberculosis

Detailed Technical Guidance

WHO TB Resources
http://www.who.int/tb/en/

Policy Guidelines for Collaborative TB and HIV Services for Injecting and Other Drug Users. An Integrated Approach
http://www.who.int/tb/publications/2008/tbhiv_policy_guidelines_injecting_drugusers/en/

User Fees

Though TB treatment is free in many countries, sometimes patients have to pay additional or hidden costs. Clients may have to pay for TB diagnostic tests or for non-TB services, such as testing for HIV and HCV.

In-patient Treatment of TB

Requirements for in-patient treatment of TB patients and long hospital durations pose an insurmountable barrier for TB treatment for active drug users, in particular in countries where no OST is available in TB facilities. In some cases, patients are required to be hospitalized for as long as one year, so patients with no access to OST are often expelled for illicit drug use. As a result, in many instances, no people who use drugs and live with HIV are able to adhere to the TB treatment regimen (Kurmanaevski, 2011). In-patient treatment, while no more effective for most patients than out-patient treatment, increases the treatment cost, fails to provide proper conditions for patients, and causes what colleagues have called the “treatment exhaustion” syndrome (Sarang, Meylakhs, Maron, Ivanova, & Torban, 2011), (WHO, 2010a).

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XIX. Tuberculosis (TB)

A. Collect all policy documents that **authorize TB services** (WHO, 2010a, p. 10)

	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Policy guarantees **free prevention, diagnosis, and treatment** of TB (Y) • Policy fails to mention free access or identifies fees for TB services (N)	1.	2.	3.	4.
• Policy allows for **integration of TB with other services for PWID** (Y) • Policy is silent on integration or isolates TB services from other medical, drug treatment, and harm reduction services (N)	5.	6.	7.	8.

B. Collect all policy documents identifying **eligibility for TB services** (WHO, 2008a, p. 7), (WHO, 2009a, pp. 20, 21)

	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Policy states that **comorbidity**, including viral hepatitis infection (such as hepatitis B and C), **does not necessarily contraindicate** TB treatment for drug users (Y) • Policy fails to mention TB service access for individuals with hepatitis comorbidity or identifies them as restricted from TB service eligibility (N)	1.	2.	3.	4.
• Policy states that **abstinence from drug use** is not a requirement to initiate anti-TB medication (Y) • Policy fails to mention TB service access for individuals with active drug use or identifies them as restricted from TB eligibility (N)	5.	6.	7.	8.

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C. Collect all policy documents that provide **clinical protocols for TB** (WHO, 2008a, p. 7), (WHO, 2010d, p. 18), (WHO, 2010, pp. 79, 80)	
• Policy authorizes out-patient **directly observed therapy** (DOTS) (Y) • Policy mandates routine, long-term hospitalization for non-complicated cases or identifies hospitalization as a requirement for PWID (N)	1.
• Policy identifies community-based DOTS treatment **adherence support for PWID** (Y) • Policy fails to identify community-based DOTS treatment adherence support for PWID (N)	2.

D. Collect all policy documents guiding **TB services in pre-trial detention, prison, and minor-custody settings** (WHO, 1993, p. 8), (UNODC, 2006, p. 23)			
	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Policy directs that **detainees/residents and staff are provided screening** for tuberculosis on entry and at regular intervals, **contact tracing, completion of effective treatment, and follow up** if medically indicated when released (Y) • Policy fails to mention or restrict access to TB services in pre-trial detention, prison, and minor-custody settings (N)	1.	2.	3.

E. Collect all policy documents that direct **environmental health or public health programs** (WHO, 2008a, p. 7), (UNODC, 2010, p. 40)	
• Policy that directs all congregate settings in the health, drug service, and criminal justice sectors have a **TB infection control plan** supported by all stakeholders that includes administrative, environmental, and personal protection measures to reduce the transmission of TB (Y) • Policy fails to mention TB infection control in congregate settings (N)	1.

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Intervention Design, Access, and Implementation—Opioid Substitution Therapy (OST)

Prohibition or Lack of Legal Endorsement of OST

"Substitution maintenance therapy has proven effective in terms of retention in treatment, reduction of drug use, improvement of psychological and social functioning, and reduction of high-risk injecting and sexual behaviors. As such, substitution maintenance therapy should be given serious consideration not only as an HIV prevention measure, but also for individuals with opioid dependence who are already infected with HIV, so as to minimize the risk of further transmission of the virus and to stabilize their underlying condition" (WHO, 2004b, p. 24).

"All types of evidence-based treatment available in the community should be accessible in prisons, especially OST for opiate-dependent people. In countries in which methadone or buprenorphine maintenance is available to opiate-dependent individuals in the community, this treatment should also be available in prisons. Prisoners on methadone or buprenorphine maintenance prior to imprisonment should be able to continue this treatment while in prisons and new treatments should be initiated for drug dependent inmates who may not have had access to treatment in the community" (UNODC, 2010).

Lack of legislative support of OST programs remains a significant barrier in many countries where the HIV epidemic is driven by shared use of unsterile drug injecting equipment. In Russia, OST is outright prohibited by legislation. In other countries, the problem is the lack of affirmative and comprehensive support of access to OST in the legislation ("policy silence"). In many countries, in particular in Asia and Eastern Europe, OST is implemented based on executive government decrees rather than legislation (Latypov, Otiashvili, Aizberg, & Boltaev, 2010), (Burnet Institute, 2010). Lack of clear guarantees of access to OST or an emphasis on abstinence-based drug dependency treatment in legislation also hampers scaling up OST programs from pilot stages or introducing OST in prisons (Latypov, Otiashvili, Aizberg, & Boltaev, 2010), (Reshevska, Foreit, Beardsley, & Porter, 2010), (UNODC & CHALN, 2010), (EHRN, 2011c).

Lack of State Funding

"At the time of commencement of treatment services, there should be a realistic prospect of the service being financially viable" (WHO, 2009a, p. 11).

In many developing countries of South, Southeast, and Central Asia and Eastern Europe, OST programs are almost exclusively funded by international donors. Lack of government funding for OST and the absence of transition plans ensuring funding of OST in case donor support discontinues undermine the sustainability of OST programs (IDPC, 2011), (Burnet Institute, 2010). Many countries in Eastern Europe and Central Asia lack explicit legislation or policies that allocate state funding to ensuring drug users' access to OST. Lack of state funding

Detailed Technical Guidance

WHO Drug Treatment Resources
http://www.who.int/substance_abuse/publications/treatment/en/index.html

Policy standards and information regarding pain management—The Center of Health Law, Policy and Practice
http://chlpp.org/project/access-opioid-medicines-pain-and-treatment-drug-dependency

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results in low coverage targets of OST programs, even in countries with higher incomes (EHRN, 2011c).

Lack of national funding for OST can be linked to the lack of explicit endorsement of OST in legislation. Legal silence makes the allocation of budget funds for OST non-mandatory. Such a situation serves as an obstacle to the scale-up and sustainability of OST programs, thus limiting many drug users' access to the service. Lack of government funding for OST cannot be solely explained by the limited state budget, since poor countries relying on international funding of OST have been reported to allocate significant budget resources for drug enforcement activities (Latypov, 2010).

> "Take-home doses [of OST medications] can be recommended when the dose and social situation are stable and when there is a low risk of diversion for illegitimate purposes" (WHO, 2009a, p. xv).

Restrictions on dispensing methadone and buprenorphine also limit clients' access to OST. In many developing countries, methadone is not dispensed via pharmacies or primary healthcare facilities, so clients have to pay daily visits to specialized drug treatment clinics or AIDS centers to receive OST, often travelling very long distances. Some programs provide treatment only to persons with local residence registration, thus excluding people without registration, people from other areas, or travelers (OSI, 2008). Policies banning take-home medications for fear of potential diversion and lack of regulatory mechanisms ensuring transfer of medication to another healthcare facility, where the OST program client is hospitalized, were similarly reported to limit access to treatment (OSI, 2008), (Aizberg, 2008), (Latypov, Otiashvili, Aizberg, & Boltaev, 2010), (Curtis, 2010).

In some countries, legislation and policies on take-home doses contradict each other. For example, in Albania, the Law on the Control of Narcotic Drugs and Psychotropic Substances envisages a seven-day, take-home dosage of narcotic substances for patients with special doctor's prescription, whereas the methadone therapy guidelines allow the provision of take-home methadone only to trusted relatives of the client (EHRN, 2011c).

Complicated procedures for handling OST medications are rooted in drug policies emphasizing control and enforcement. Overcautious policymakers often view OST medications as narcotic drugs in the first place and not as essential medications that are necessary for effective management of a chronic disorder. Above all, they fear diversion of methadone and buprenorphine into the black market, unwilling to acknowledge that street opiates are often more accessible than OST medications. As a result of this "opiatophobia," policymakers prefer to play it safe by adopting cumbersome regulations at the cost of limiting access of drug users to OST. Again, legal silence on OST facilitates this political risk-aversion strategy.

Intervention Design and Implementation Barriers

Individuals/Organizations Authorized to Deliver Services

> "Pharmacological treatment of opioid dependence should be widely accessible; this might include treatment delivery in primary care settings" (WHO, 2009a, p. 11).

Existing policies often limit the range of providers authorized to provide OST or establish complicated procedures to obtain permission. Countries may limit provision of OST to state-run facilities only, thus

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excluding private and nongovernmental service providers (EHRN, 2011c). In some countries, provision of OST is allowed only by certain types of government-run facilities, which then leads to the lack of availability of OST in AIDS or TB centers or primary care facilities. In other countries, legislation may not directly prohibit participation of non-state providers in OST service delivery, but onerous bureaucratic requirements make obtaining a license for the storage and dispensation of opiates by non-state providers practically impossible. Such restrictive and inadequate policies limit patients' choice of provider and may ultimately increase the cost of OST (Latypov, Otiashvili, Aizberg, & Boltaev, 2010).

Eligibility Criteria and Documentation Requirement

"Agonist maintenance treatment is indicated for all patients who are opioid dependent and are able to give informed consent, and for whom there are no specific contraindications" (WHO, 2009a, p. 29).

"Excessive restrictive regulations regarding criteria for placement in substitution maintenance therapy and its provision, which have no significant effect on quality of provided treatment, are counterproductive with regard to access to treatment and HIV prevention" (WHO, 2004b, p. 28).

Access to OST is significantly limited by excessive restrictive admission criteria imposed by governments. Many countries have age restrictions, require a long history of opiate use unsuccessful attempts at drug treatment, or give priority to clients with co-morbidities (for example, see the table below for eligibility and admission criteria that were either in place in some former Soviet countries until recently or are still in use).

Country	Eligibility criteria
Belarus	• At least 18 years of age • Diagnosed opioid dependency • Regular injecting opioid use for more than two years • Two or more unsuccessful attempts at abstinence-based treatment • HIV positive or diagnosed with AIDS
Ukraine	In addition to diagnosed opioid dependency, individual must meet the following criteria: • At least 18 years of age • Capable to provide informed consent • No medical contradictions • With approval from a multidisciplinary board
Lithuania	• Anyone with opioid dependence, regardless of duration qualifies • Minors 15 years of age and older may be treated with buprenorphine (to be admitted, a minor's medical history must show attempts at abstinence-based treatment) • The decision to admit is made by a panel of three psychiatrists

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Country	Eligibility criteria
Georgia	• At least 21 years of age • Total duration of opioid use for three years with at least one year injected drug use • At least one unsuccessful attempt at treatment • People living with HIV/AIDS are given priority
Kyrgyzstan	• Opioid use for at least two years • Two or more unsuccessful attempts at abstinence-based treatment • HIV positive, hepatitis B or C positive, seriously ill, or pregnant
Kazakhstan	• At least 18 years of age • Injection drug use for at least three years • At least two unsuccessful attempts at abstinence-based treatment (not required for people living with HIV/AIDS) • People living with HIV/AIDS will be given priority
Tajikistan	• At least 18 years of age • Diagnosis of opioid dependency • Injection drug use for at least two years • At least two unsuccessful attempts at abstinence-based treatment • HIV positive, TB, hepatitis B or C positive (patients with these conditions are given priority; requirements for injection history duration and/or age limits can be waived at discretion of medical panel, though written parental consent for minor clients is needed) • Serious medical conditions (diabetes, epilepsy) • Pregnancy
Uzbekistan *(prior to OST program closure)*	• At least 18 years of age • Opioid dependency for at least two years • Indicated for pregnant patients • Indicated for patients with HIV infection • History of failed treatment attempts

Sources: (Aizberg, 2008), (Ministry of Health of the Republic of Tajikistan , 2009).

While these additional criteria (on top of the two eligibility criteria recommended by the WHO—presence of opioid dependence and informed consent) are clearly not in line with the WHO guidelines, many reports document how they can serve as barriers to access to OST. The requirement to provide evidence of unsuccessful treatment attempts is hard to fulfill in countries where the only treatment that counts is provided by state-run facilities that run drug registries. To avoid such registration, clients often turn to private, NGO, or community-based treatment programs that are unable to provide official treatment certificates. Prioritization of clients with HIV, hepatitis C, or TB discriminates against those without co-morbidities, in particular in countries with limited uptake capacity of OST programs (Latypov, Otiashvili, Aizberg, & Boltaev, 2010), (Latypov, 2010). These additional criteria reduce the number of clients eligible for treatment. For instance, in Georgia, in 2007, of 250 clients in the waiting list for OST, only 42 fully met the eligibility criteria (Chirikashvili, Usharidze, Petriashvili, Bidzinashvili, & Tsurtsumia, 2007).

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Another hurdle is the assessment of potential clients by admission commissions, as reported for Azerbaijan, Estonia, Georgia, Kyrgyzstan, Moldova, Poland, Tajikistan, and Ukraine. In some cases, these commissions may include members who are not medical professionals; for instance, Georgia was reported to have journalists on the OST admission panel (OSI, 2008). In China, OST clients are required to have valid identification and obtain permission from the police, so people are afraid to enroll in the program for fear of harassment (Burnet Institute, 2010).

> "Central registration can facilitate breaches of privacy, and this may deter some patients from entering treatment. It can also delay the commencement of treatment. Safe and effective treatment of opioid dependence can be achieved without central registration. Because such registration could cause harm if privacy is breached, it should only be used if government agencies have effective systems for maintaining privacy" (WHO, 2009a, p. 147).

As described by many authors, OST clients who had not previously been registered as drug users by the authorities may be required to get registered in the official database (Latypov, Otiashvili, Aizberg, & Boltaev, 2010), (OSI, 2008), (OSI, 2009a). Negative consequences of such registration, including reluctance of clients to receive services, were described earlier.

Discharge Criteria

> "Constructive (non-punitive) clinic responses to client problems improve retention and treatment outcomes" (WHO, 2004b, p. 20).
>
> "The prescribing physician shall not discontinue services that are needed unless the patient requests the discontinuation, alternate services are arranged, or the patient is given a reasonable opportunity to arrange alternate services. Involuntary withdrawal from treatment shall be avoided except where compelling reasons exist. Regulations governing grounds for involuntary withdrawal shall be clearly communicated to patients at the outset of treatment" (CHALN, 2006b, p. 29).
>
> " The design and implementation of urine collection, testing and interpretation shall be carried out in a way that:
>
> (a) maximizes patient retention and other positive treatment outcomes and the safety of the patient;
>
> (b) respects the dignity of the patient;
>
> (c) minimizes the frequency of such screening, limiting it to tests needed to guide treatment;
>
> (d) recognizes the limitations of such screening, including false positives and false negatives; and
>
> (e) prohibits the use of results in a punitive manner" (CHALN, 2006b, p. 30).

The exclusion of patients from OST programs for non-clinical reasons contradicts WHO recommendations and hinders access to OST (WHO, 2004b). Nevertheless, many reports indicate that such contradictory exclusions of patients do occur in practice. For example, treatment may be discontinued if a criminal investigation is initiated against a patient (EHRN, 2011c) or if concurrent use of street drugs is detected via random urine testing (UNODC & CHALN, 2010), (Aizberg, 2008), (Chirikashvili, Usharidze, Petriashvili, Bidzinashvili, & Tsurtsumia, 2007). Clinical Protocols, Standards of Care, Accessibility, and Affordability

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> "Issues such as the maximum dose or maximum length of treatment should be left to the practitioner's clinical judgment, based on the assessment of the individual patient" (WHO, 2004b, p. 28).

Accessibility and quality of OST services can be compromised by service provision protocols and standards neglecting specific needs of drug users, imposing unjustified limitations or requiring payment for treatment.

In some countries, policies limit the maximum duration of client's participation in OST. For instance, in India, methadone is mostly provided on a short-term basis for detox purposes. A longer-term methadone maintenance program is limited to 1–2 years and is expected to lead to detoxification and rehabilitation (WHO, 2010b). Regulations may also cap maximum daily doses of OST medications; in Armenia, for instance, operational guidelines establish the maximum daily dose of methadone at 120 mg (EHRN, 2011c).

Clinical protocols and standards of care may disregard the needs of certain sub-groups of clients. Human Rights Watch reported that no national policies or guidance on provision of ART for OST clients were available in Thailand in 2007. As a result, interaction between some ART drugs and methadone, which can lead to decreasing methadone serum concentrations and withdrawal symptoms, was not addressed. In other countries, office hours of OST programs were also reported to be inconvenient for clients, in particular for those who work (Latypov, Otiashvili, Aizberg, & Boltaev, 2010).

> "To achieve optimal coverage and treatment outcomes, treatment of opioid dependence should be provided free of charge, or covered by public health-care insurance" (WHO, 2009a, p. 11).

In some countries, OST is provided on a paid basis. In China, the cost of methadone treatment for patients was around USD1.3 per day (Smith & Hayter, 2008). In Georgia, clients of government-subsidized OST programs have to co-pay around USD100 per month, which is equivalent to half of an average monthly income and thus unaffordable for many drug users (Aizberg, 2008), (OSI, 2008).

Inventory and Analysis of Country Documents

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XX. Opioid substitution therapy (OST)

A. Collect all policy documents **regulating or mentioning OST** (CHALN, 2006a, p. 21), (UNODC, 2006, pp. 17, 26), (WHO, 2009a, pp. 11, 13), (EHRN, 2010, p. 9), (WHO, 1993, p. 6), (UNODC, 2010, p. 39), (WHO, 2009a, p. 11), (CHALN, 2006e, pp. 30, 31)

	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Policy states that **methadone is legal** for medical use (Y) • Policy fails to mention legality of methadone or identifies it as illegal for medical use (N)	1.	2.	3.	4.
• Policy states that **buprenorphine is legal** for medical use (Y) • Policy fails to mention legality of buprenorphine or identifies it as illegal for medical use (N)	5.	6.	7.	8.
• Policy states that **opioid drugs are allowed for OST** (Y) • Policy fails to mention legality of opioid drugs or identifies them as illegal for OST (N)	9.	10.	11.	12.
• Policy provides specific mechanisms for OST to be **initiated** (Y) • Policy fails to allow or specifically disallows initiation of OST (N)		13.	14.	15.
• Policy provides specific mechanisms for OST to be **continued** (Y) • Policy fails to allow or specifically disallows continuation of OST (N)		16.	17.	18.
• Policy **guarantees government funding for OST** (Y) • Policy fails to guarantee government funding for OST (N)	19.	20.	21.	22.
				Y/N
• Policy authorizes the provision of OST in **private/nongovernmental clinics** (Y) • Policy fails to explicitly authorize private/nongovernmental providers or identifies restrictions on their implementation (N)				23.
• Policy provides specific mechanisms for OST to be initiated or continued in **outpatient and inpatient primary care settings (including maternity hospitals and TB hospitals)** (Y) • Policy fails to explicitly authorize or restricts delivery of OST in outpatient and inpatient primary care settings (N)				24.

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A. Collect all policy documents **regulating or mentioning OST** (CHALN, 2006a, p. 21), (UNODC, 2006, pp. 17, 26), (WHO, 2009a, pp. 11, 13), (EHRN, 2010, p. 9), (WHO, 1993, p. 6), (UNODC, 2010, p. 39), (WHO, 2009a, p. 11), (CHALN, 2006e, pp. 30, 31)	
• Policy authorizes specialists dealing with HIV treatment, **including licensed infectious disease specialists and family doctors** to prescribe and deliver OST to patients using drugs (Y) • Policy fails to explicitly authorize provision of OST by licensed infectious disease and family doctors or identifies restrictions on their implementation (N)	25.
• Policy provides specific mechanisms for OST to be provided in **pharmacy settings** (Y) • Policy fails to explicitly mention or restricts delivery of OST in pharmacy settings (N)	26.
• Policy **does not disproportionately punish OST providers** for minor infractions of drug-control regulations (Y) • Policy uses minor infractions of drug-control regulations to harass and/or punish providers of OST (N)	27.
• Policy **does not prohibit use of private, personal, or donor resources** to fund OST services (Y) • Policy fails to explicitly authorize or prohibits the use of private, personal, or donor resources to fund OST services (N)	28.

B. Collect all policy documents setting **eligibility criteria for OST** (CHALN, 2006b, pp. 22, 25), (WHO, 2009a, pp. 14, 15), (WHO, 2009, p. 81), (WHO, 2004b, p. 26), (Philipp, Merewood, & O'Brien, 2003)				
	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Policy identifies the **only eligibility criteria** for OST as (a) the **presence of opioid dependence** according to accepted medical definitions; and (b) the patient's **informed, voluntary consent** (Y) • Policy sets eligibility criteria that are more restrictive than opioid dependence and informed consent (including age, co-infection, registration as a drug user, proof of residency, length of drug use, unsuccessful attempts at drug treatment, and pregnancy) (N)	1.	2.	3.	4.
• Policy states that eligibility and initiation of OST is the **decision of the healthcare provider and client** (Y) • Policy requires review and approval by **panels including non-health members** to be eligible for OST (N)	5.	6.	7.	8.

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B. Collect all policy documents setting **eligibility criteria for OST** (CHALN, 2006b, pp. 22, 25), (WHO, 2009a, pp. 14, 15), (WHO, 2009, p. 81), (WHO, 2004b, p. 26), (Philipp, Merewood, & O'Brien, 2003)				
• Policy states that no health practitioner shall deny any person access to OST solely on the basis of **presence or absence of infection with blood-borne or other diseases** (including infection with HIV and diagnosis of AIDS) (Y) • Policy fails to explicitly prohibit discrimination based on presence or absence of infection or identifies this as a reason for denial of OST (N)	9.	10.	11.	12.
• Policy guarantees access to OST for **female PWID** who are pregnant and/or breastfeeding as effective pharmacotherapy treatment of opioid dependence can substantially improve obstetric, perinatal and neonatal outcomes (Y) • Policy fails to explicitly guarantee access for pregnant and/or breastfeeding female PWID or identifies restrictions in their participation in OST (N)	13.	14.	15.	16.

C. Collect all policy documents that guide **implementation of OST** (WHO, 2009a, p. 17) (CHALN, 2006b, p. 28) (WHO, 2004b, p. 28), (CHALN, 2006b, pp. 18, 19 26), (WHO, 2009a, p. 11), (CHALN, 2006b, p. 34)	
• Policy states that issues such as the maximum dose or maximum length of OST is left to the **practitioner's clinical judgment**, based on the assessment of and in collaboration with the individual patient, OR Policy is silent on maximum dose and length of treatment (Y) • Policy sets restrictive clinical parameters (N)	1.
• Policy allows **take-home doses** when the dose and social situation are stable, and when there is a low risk of diversion for illegitimate purposes (Y) • Policy fails to make provisions for take-home doses (N)	2.
• Policy guarantees that, for government funded OST, treatment is **provided free of charge** (Y) • Policy requires payment for government funded services (N)	3.
• Policy guarantees that OST is **covered by healthcare insurance** at the same level as other medical services and medications (Y) • Policy requires or allows higher or additional fees for OST compared with other health services (N)	4.

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D. Collect all policy documents that guide **management of OST clients** (UNODC, 2006, p. 19), (CHALN, 2006b, pp. 26, 30), (CHALN, 2006b, p. 29)

	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Policy prohibits the provision or denial of substitution treatment, or access to any other treatments, for **disciplinary or punitive reasons**, or as a reward for good behavior (Y) • Policies allow punitive actions in response to client non-compliance (N)	1.	2.	3.	4.
• Policy states that **drug screening** in the context of OST is done for the purpose of guiding treatment and is not used in a punitive manner (Y) • Policies allow punitive actions in response to client non-compliance (N)	5.	6.	7.	8.
• Policy directs that **involuntary withdrawal** from treatment shall be avoided except where compelling reasons exist (Y) • Policies allow punitive actions in response to client non-compliance (N)	9.	10.	11.	12.
• Policy directs that regulations **governing grounds for involuntary withdrawal** shall be clearly communicated to patients at the outset of treatment (Y) • Policy fails to direct communication of grounds for involuntary withdrawal (N)	13.	14.	15.	16.
• Policy guarantees patients the **right to voluntarily withdraw** from treatment at any time (Y) • Policy fails to mention voluntary nature of OST participation (N)	17.	18.	19.	20.

Please include any additional remarks or observations about related policy areas for PWID not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.

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Intervention Design, Access, and Implementation—Needle and Syringe Programs (NSPs)

Legislative Ban or Legal Ambiguity

"Legislation related to needles and syringes, e.g., paraphernalia laws that penalize injecting drug users and drug-dependent persons carrying their own clean injecting equipment, as well as penalizing health and outreach workers who make such equipment available, can be an important barrier to HIV control among injecting drug users" (WHO, 2004c, p. 2).

Detailed Technical Guidance

WHO Needle and Syringe Program Resource Page
http://www.who.int/hiv/topics/idu/needles/en/index.html

Drug users' access to clean needles and syringes is blocked in many countries by the so called "paraphernalia law" prohibiting the possession, carrying, and distribution of equipment and materials used for drug consumption. Paraphernalia laws banning possession of needles and syringes were reported for the United States, Kenya, Zambia, the Philippines, Sri Lanka, Thailand, Myanmar, Malaysia, PDR Laos, Bhutan, and Bangladesh. Paraphernalia laws restrict access to syringes, both via needle and syringe programs as well as pharmacies. If injecting equipment is seized in the course of police searches, it can be used as evidence for the prosecution of illegal drug use and possession of injecting paraphernalia [e.g., see (Cooper, Moore, Gruskin, & Krieger, 2005)]. Although in most of these countries the law is not aggressively enforced, legal barriers hamper more open and vigorous provision of services (IHRA, 2010a), (Gay Men's Health Crisis [GMHC], 2009). Strict enforcement of paraphernalia laws may have a significant negative public health impact. Studies in the United States demonstrated that fear of arrest for illegal possession of injecting equipment was associated with higher risk of sharing syringes and other injecting equipment [Bluthenthal et al., cited in (Csete, 2007)], while the street price of syringes as well as the prevalence of sharing syringes was higher in areas with strict paraphernalia laws compared with those where possession of injecting equipment was legal [Burris et al., Rich et al., cited in (Klein, 2007)].

In countries where possession of needles and syringes is not banned outright but legislation is either ambiguous or silent regarding the legality of injecting equipment distribution, NSP staff and clients may be at risk of criminal prosecution, as reported for Brazil (OSI, 2009a). The legal ambiguity of NSP in Russia was reported to impact scale-up of the program by allowing law enforcement to disrupt existing harm reduction programs, fostering insecurity of NSP personnel, and causing local officials and health professionals otherwise in favor of NSP to withdraw their support for expanding services (Tkatchenko-Schmidt, Renton, Gevorgyan, Davydenko, & Atun, 2008). Legislation in some countries imposes a strict one-for-one exchange rule, including several states in the U.S., Belgium, and New Zealand [Burris et al., De Ruyver, Kemp et al., cited in (Bluthenthal, Ridgeway, Schell, Anderson, Flynn, & Kral, 2007)].

Limits on Individuals and Organizations Permitted to Provide NSP

In Australia, local legislation of many states and territories permits the distribution of needles and syringes only by authorized persons, including medical personnel and staff of needle exchange programs,

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thus effectively prohibiting the distribution of injecting equipment by volunteers and peers. Unauthorized persons can also be prosecuted for delivering needles and syringes within aiding and abetting legislation (Australian Injecting and Illicit Drug Users League [AIVL], 2010a). In some areas in Canada, syringes and needles can be distributed only by pharmacies, health clinics, and public health authorities; however, clients in small communities were reluctant to ask for syringes in these facilities for fear of disclosing their drug use (Klein, 2007).

User Fees

In some countries, clients have to pay for safe injection commodities. In Australia, many pharmacies charge for the safe injection kit containing 3–5 syringes and some other equipment from USD3 to USD8, and many vending machines charge USD2–4. Some needle and syringe exchange points impose caps on the number of syringes a client can obtain for free per visit (usually around 30), charging for any additional syringes. These policies have been reported to restrict the ability of drug users, who often lack the money, to access harm reduction interventions (Australian Injecting and Illicit Drug Users League [AIVL], 2010a).

Exchange Policies

Some programs limit the number of syringes for distribution by the number of used syringes brought by clients for exchange (APMG), (Gay Men's Health Crisis [GMHC], 2009), (Klein, 2007). The rationale behind this one-for-one exchange policy is avoiding the creation of a market for new paraphernalia from NSPs, ensuring safe disposal of syringes, and bringing drug users into more regular contact with the program; in many cases, such limits were also a prerequisite for gaining political support for NSPs (Klein, 2007), (Gay Men's Health Crisis [GMHC], 2009). However, these policies were shown to limit clients' access to NSPs and decrease coverage by clean injecting equipment in the U.S. (Bluthenthal, Ridgeway, Schell, Anderson, Flynn, & Kral, 2007) and were associated with higher incidence of HIV among drug users in some cities of Canada [cited in (Sarang, Rhodes, & Platt, 2007)].

There are several ways in which one-for-one exchange policies limit clients' access. The one-for-one rule requires clients to keep the used equipment with them and carry it back to the NSP, which is risky in areas with strict paraphernalia laws or abusive policing practices. Clients living with families may be reluctant to store used syringes at home. Another issue is that the frequency of injections varies depending on the availability, type, and purity of drugs on the black market, which is hard to predict. Thus, clients may need more syringes than are provided by programs with exchange limits. This is particularly true in countries such as Russia, where desomorphine users tend to inject more frequently than heroin users. Clients may also lose used syringes or forget to bring them for exchange. Exchange limits also make secondary exchange of syringes via volunteers problematic. Finally, the one-for-one exchange rule is counterproductive to establishing trusting relationships between clients and staff (Sarang, Rhodes, & Platt, 2007), (APMG), (Klein, 2007).

Other Operational Barriers

Policies and program provision protocols that do not support a wide range of commodities in addition to needles and syringes (cookers, sterile water, filters, tourniquets) undermine the effectiveness of NSPs, since blood borne viruses, in particular HCV, can easily be transmitted via shared paraphernalia. Programs operating during regular business hours cannot be reached by clients who may need equipment at night (Sarang, Rhodes, & Platt, 2007), (Klein, 2007), (OSI, 2009a), (Australian Injecting and Illicit

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Drug Users League [AIVL], 2010a). These barriers may be caused by policy silence, omitting the explicit requirements for high-quality, accessible, and comprehensive services, as well as client involvement in the process of decisionmaking.

> "Prison authorities in countries experiencing or threatened by an epidemic of HIV infections among IDUs should introduce NSPs urgently and expand implementation to scale as soon as possible" (WHO, 2007, p. 5).
>
> "Since the first NSP started in 1992, there have been no reports of syringes ever having been used as weapons in any prison with an operating NSP" (WHO, 2007, p. 14).

Direct and indirect policies also limit the availability of NSP services in prisons. Policies impeding introduction of needles and syringes into prisons were reported in Central Asian countries (except for Kyrgyzstan and Azerbaijan), where inmates are not allowed to possess sharp and piercing objects for security reasons, though needles and syringes are not specifically mentioned (UNODC & CHALN, 2010). In countries where NSPs were introduced into prisons, distribution of injecting equipment exclusively from prison healthcare departments was reported as a barrier to obtaining syringes due to confidentiality concerns by inmates (e.g., in Moldova)—an obstacle that can be addressed by introducing peer-based syringe exchange (CHALN, 2006c).

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Inventory and Analysis of Country Documents

Country: _____ Date completed: _____

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XXI. Needle and syringe programs (NSPs)

A. Collect all policy documents **authorizing NSPs** (CHALN, 2006c, pp. 24, 25), (CHALN, 2006e, pp. 15, 29)

	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Policy states that possession, distribution, and dispensing of needles and syringes and other equipment used for drug consumption **is legal** (Y) • Policy states that possession, distribution, and dispensing of needles and syringes and other equipment used for drug consumption is illegal (N)	1.	2.	3.	4.
• Policy authorizes distribution of syringes and other equipment used for drug consumption by **dispensing machine** (Y) • Policy fails to authorize distribution by dispensing machines (N)	5.	6.	7.	8.
• Policy authorizes distribution of syringes and other equipment used for drug consumption by **pharmacies without prescription** (Y) • Policy fails to authorize distribution by pharmacies without prescription (N)	9.	10.	11.	12.
• Policy authorizes distribution of syringes and other equipment used for drug consumption by **health practitioners** (Y) • Policy fails to authorize distribution by health practitioners (N)	13.	14.	15.	16.
• Policy authorizes distribution of syringes and other equipment used for drug consumption by **nongovernmental organizations** (Y) • Policy fails to authorize distribution by nongovernmental organizations (N)	17.	18.	19.	20.
• Policy authorizes distribution of syringes and other equipment used for drug consumption by **non-medical staff, volunteers, or peer outreach workers** (Y) • Policy fails to authorize distribution by non-medical staff, volunteers, or peer outreach workers (N)	21.	22.	23.	24.

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• Policy establishes procedures for the confidential safe **collection and disposal** of used syringes and other equipment used for drug consumption (Y) • Policy fails to establish procedures for the confidential collection and disposal of used syringes and other equipment used for drug consumption (N)	25.	26.	27.	28.
• Policy guarantees **state funding** for NSPs (Y) • Policy fails to guarantee state funding for NSPs (N)	29.	30.	31.	32.

B. Collect all policy documents setting **eligibility criteria for NSPs** (WHO, 2011, p. 14) (CHALN, 2006c, p. 17)

	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Policy directs that there is **no minimum age** requirement that excludes younger groups from using sterile needle and syringe programs (Y) • Policy provides age restrictions on eligibility for NSP (N)	1.	2.	3.	4.
• Policy grants NSP access to **transgender people** who inject substances for gender enhancement to reduce the risk of infection with blood borne pathogens such as HIV, hepatitis B, and hepatitis C (Y) • Policy fails to guarantee access for transgender people (N)	5.	6.	7.	8.

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C. Collect all policy documents that guide **implementation of NSPs** (CHALN, 2006c, p. 13), (UNAIDS, 1999, p. 123), (UNAIDS, 2006, p. 30), (EHRN, 2011), (CHALN, 2006c, p. 14)

	Community Settings	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Policy allows NSPs to provide the following **services:** (Y) o sterile needles and syringes and other related material for safer injection drug use o material to enable safer smoking and inhalation of drugs o condoms, lubricants, and other safer sex materials o first aid in emergency situations, including overdose reversal • Policy restricts delivery of any of the services listed above (N)	1.	2.	3.	4.
• Policy allows NSPs to provide **information** including, but not limited to, the following: (Y) o drug dependence treatment services and other health services o means of protection against transmissible diseases, including blood-borne diseases such as HIV o the risks associated with the use of controlled substances o harm reduction information specific to the drug being used, including safe injecting and inhaling practices o overdose prevention o legal aid services o employment and vocational training services and centers o available support services for people with drug dependence and their families o addressing the specific needs of women and young people • Policy restricts delivery of any of the above information (N)	5.	6.	7.	8.
• Policy states that NSP services will be **provided free of charge** (Y) • Policy fails to prohibit fees for NSPs (N)	9.	10.	11.	12.
• Policy states that there are **no limitations on frequency, volume of distribution, or secondary exchange** by NSP clients to their networks (Y) • Policy identifies restrictions on the number of syringes exchanged or requires exchange of used syringes (N)	13.	14.	15.	16.

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

D. Collect all policy documents that guide **implementation of NSPs in pre-trial detention, prison, or minor-custody settings** (WHO, 1993, p. 6), (UNODC, 2006, pp. 24, 25), (WHO, 2007a, p. 7), (UNODC, 2010, p. 38), (CHALN, 2006e, p. 26)			
	Pre-trial Detention	Prison Settings	Custody Settings for Minors
• Policy directs that detainees/residents are **informed of the health consequences of drug use and** are explained **the risks of sharing injecting equipment compared with less dangerous methods of drug taking** (Y) • Policy fails to guarantee or restricts access to information on harm reduction (N)	1.	2.	3.
• Policy directs **confidential and non-discriminatory access to sterile needles and syringes** to be available throughout the period of detention/residency and prior to any form of leave or release where these measures are available in the outside community (Y) • Policy fails to guarantee or restricts access to sterile needles and syringes (N)	4.	5.	6.
• Policy **exempts needles and syringes from security restrictions on sharp and piercing objects** (Y) • Policy fails to exempt needles and syringes from security measures (N)	7.	8.	9.

E. Collect all policy documents that define **legality of possession, distribution, and dispensing of needles and syringes and other equipment used for drug consumption** (UNAIDS, 1999, p. 123), (UNAIDS, 2006, p. 30), (CHALN, 2006c, pp. 19, 20)	
• Policy states that possession, distribution, and dispensing of needles and syringes and other equipment used for drug consumption **cannot be used as sufficient reason for search, presumption of drug use, arrest, or testing** for use of a controlled substance (Y) • Policy fails to mention legality or states that possession, distribution, and dispensing of needles or paraphernalia is illegal (N)	1.
• Policy states that **syringes and other harm reduction material, is not admissible** as evidence in court for the purposes of establishing criminal or other liability for use, possession or trafficking of a controlled substance or other related offence (Y) • Policy does not prohibit use of syringes or other harm reduction material as evidence for establishing criminal or other liability (N)	2.
• Policy states that a person who is in **possession of any trace amount** of a controlled substance that is contained in a syringe or other related material is not, by the mere fact of that possession, taken to have committed an offence (Y) • Policy identifies such a small threshold for criminal liability that possession of used syringes or related material can result in prosecution (N)	3.

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E. Collect all policy documents that define **legality of possession, distribution, and dispensing of needles and syringes and other equipment used for drug consumption** (UNAIDS, 1999, p. 123), (UNAIDS, 2006, p. 30), (CHALN, 2006c, pp. 19, 20)	
• Policy states that any **trace amount** of a controlled substance that is contained in a syringe or other related material, is **not admissible** as evidence in court for the purposes of establishing criminal or other liability for use, possession or trafficking of a controlled substance or other related offence (Y) • Policy does not prohibit use of trace amounts of controlled substances as evidence in court (N)	4.
Please include any additional remarks or observations about related policy areas for PWID not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.	

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

Policy Quick Reference Matrix

The Quick Reference Matrix provides an easy way for policymakers, program managers, advocates, and other stakeholders to see which policy documents are especially important for content areas. This tool represents a snapshot of the information collected for the Inventory and can be used as an illustrative chart during the identification of advocacy strategies or the development of action plans for implementing advocacy strategies. It should be filled in only after the Inventory has been completed—after the reference library of documents has been compiled and the policy assessment tables have been completed.

Instructions

1. Identify which documents in the reference library are most relevant either because they enable effective treatment programs or because they pose significant obstacles or barriers to the design, implementation, and/or use of services for PWID.

   Each policy document should be listed only once in Column 1, even if it is relevant for more than one content area. Include its full title, official number, and the date that it was adopted or disseminated. Use one line per document.

2. The policy or content areas are listed in the vertical columns. Beginning with the first listed policy document, identify which policy area or areas it covers. Fill in that cell or cells with the page number and chapter/section number where the policy text can be found. (Do not fill in the actual text and do not specify which particular questions within the policy area are addressed.) When the line for the first listed policy document has been completed, go on to the second policy document and continue until the last line has been completed. Be sure to clearly indicate if a field is blank because there are no policies (n/p) or if it is because the policy area was not assessed (n/a).

3. Every listed policy document should be cross-referenced to at least one policy area. Some policy documents may be cross-referenced to more than one policy area. There may be some policy areas not covered by any document in the reference library.

Throughout this document, the term “policy” is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

Quick Reference Matrix

Key Documents: Title, Date, Official Number	Pretrial Detention	Prison	Minor Custody	Women	Youth	Multi-sectoral coordination	Data used in decisionmaking	Engaging PWID in decisionmaking	Partnerships with nongovernmental organizations	Authority to provide, oversee, or coordinate services	Consent	Mandatory or compulsory testing or treatment	Privacy and confidentiality of personal data	Registries	Stigma and discrimination	Dependence and disability definitions	Criminalized behaviors	Alternatives to incarceration	Aiding and abetting

Quick Reference Matrix

Key Documents: Title, Date, Official Number	Gender-based and sexual violence	Torture, cruel, inhuman, or degrading treatment or punishment	Bribery, coercion, and extortion	Police arrest quotas and performance indicators	Access to legal advice and representation	Status of international laws and conventions	Procurement of ART medications	Scheduling and procurement of OST medications	Medicine and medical commodity supply chain management	Service integration and referral	Training requirements	HCT funding	HCT protocols	HCT eligibility	ART funding	ART protocols	ART eligibility

Quick Reference Matrix

Key Documents: Title, Date, Official Number	Hepatitis funding	Hepatitis protocols	Hepatitis services eligibility	Tuberculosis funding	Tuberculosis protocols	Tuberculosis eligibility	OST legality	OST service providers	OST funding	OST protocols	OST eligibility	NSP legality	NSP funding	NSP protocols	NSP eligibility

Policy Implementation Assessment Interviews

The purpose of the conducting key informant interviews is to collect information on the perceptions and implementation of policies. This information will help advocates understand whether to direct advocacy efforts at changing policy language or policy dissemination/implementation.

A combination of client interviews—usually administered after, in, or around service sites—coupled with provider interviews, generally yield good overall information, within the shortest timeframe and at the lowest cost.

Instructions

Key Informant Interviews

The key informant interviews can be used to understand the opinions of the wide range of stakeholders involved in policies and programs for PWID. Respondents should come from within and outside the government. Public sector stakeholders can include legislators and other policymakers; government officials and technicians from various sectors; local government, law enforcement, and the courts; and treatment program staff. Respondents outside the government should include members of civil society organizations; support groups or networks (e.g., PWID, people living with HIV, women's health advocates); and faith-based organizations. Researchers and opinion leaders also may be included. Representatives of international organizations and donors are also important stakeholders in IDU-related policy and programs.

The team should form an advisory group to identify potential respondents and make introductions. At least 15 to a maximum of 25 respondents can be managed and should include a range of stakeholders, including those resistant to services for PWID.

If possible, a single interviewer should conduct all the interviews. He/she should have enough status to interview high-level officials and yet be sensitive to marginalized groups such as PWID. It is important that the interviewer not be seen as identifying with or advocating for a particular point of view.

The sample will be too small and too varied for statistical analysis. Analyses should look for areas of agreement and disagreement among respondents and seek to compare respondents' opinions and perceptions against objective measures, such as actual policy documents or clinic norms. The key informant questionnaire is designed to be administered as a standardized interview; if respondents are agreeable, it may be useful to audio-record the interviews and transcribe responses to open-ended questions later.

Preparing for the Facility-Based Survey

Simple preparations are essential to ensure that the right people are interviewed under proper conditions that safeguard privacy and do not impede patient flow or functioning of the facility. Clients should be interviewed immediately upon finishing their visit; providers should be interviewed after operating hours. To avoid interviewing the same client more than once, all client interviews should be completed during the same day if possible.

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The survey supervisor should visit the facility in advance of the fieldwork to meet with facility staff and explain the purpose of the survey and answer their questions. A normal workday should be chosen for the client interviews; it may be preferable to avoid the last day before the weekend or a major holiday and the first day after the weekend or holiday. Provider interviews should be conducted after all client interviews have been completed and may be scheduled over several days.

Criteria for selecting facilities to survey will depend on the policy issues of interest. If the purpose is to understand the typical facility and client experience, facilities would be selected proportional to size. If the purpose is to understand the range of facilities and client experience, purposive sampling would be more appropriate. In this case, it might be useful to compare facilities in the capital city to facilities in other locations, facilities that have been operating a longer time to those that started more recently, public sector facilities to private sector facilities, or larger facilities to smaller facilities.

Ethics Review

Client interviews will likely require approval by an Institutional Review Board (IRB) or comparable ethics review committee in the country where the survey will be conducted. If the survey is funded by U.S. government funds, IRB approval also will be required in the United States. Ethics review is required for any biomedical or behavioral research involving humans—particularly when vulnerable groups such as PWID are involved in the research—with the aim of protecting the rights and welfare of research participants.

Client Interviews

For statistical reliability, conducting at least 100 interviews per facility is recommended. If the facility serves fewer than 100 clients, all clients should be approached for an interview (a census). If the facility serves more than 100 clients, a quota sample should be interviewed, as follows. Different kinds of clients may have different experiences—for example women vs. men, ethnic minorities, or even clients who come in the early morning vs. those who come later in the day. To capture the typical client experience or the range of typical experiences, a minimum of 25 clients should be interviewed for each specific group (or all clients if there are fewer than 25 in that group) and interviews should be spaced out over the day more or less in the same proportion in which clients come in for treatment. This may require posting more interviewers during peak attendance hours than at other times of day. Assigning quotas will ensure that enough interviews of each type are conducted.

Illustration: Clinic A provides methadone treatment to 300 clients, including 30 ethnic minority men, 50 women (all ethnicities), and 220 non-minority men. Approximately 60 percent of all clients come for their doses in the early morning, with the remainder coming in late morning or afternoon. The following interview/quota schedule is proposed for a total of 100 interviews:

Group	Time	Quota	# Interviewers
Non-minority men	Early morning	30	3
Non-minority men	Late morning	10	2
Non-minority men	Afternoon	10	1
Minority men	All day	25	1
Women	All day	25	1

Interviewers should be instructed to approach the first client who passes their station and continue interviewing until they complete their assigned quota. Care should be taken to avoid interviewer selection bias (for example, not approaching clients who look to be in a hurry or who are poorly dressed, etc.).

Provider Interviews

It is important to interview the full range of facility staff who provide client services and/or supervise or manage those who provide services. In many facilities, there may be only one or two of each kind of service provider, and some providers may fill multiple roles (e.g., an attending physician also supervises non-clinicians). If there are three or fewer of any kind of service provider (e.g., physicians, nurses, counselors), all should be interviewed. If there is a large number (e.g., volunteers), a sample can be chosen, taking care to represent different sub-groups (e.g., men and women).

Data Entry and Analysis

Any standard computer package can be used for data entry (Excel, SPSS, STATA, etc.). Double data entry verification is recommended, along with range checks for accuracy. The survey is designed for analysis with simple descriptive statistics, such as frequencies and cross-tabulations by clinics and/or client characteristics. Responses to the last question that asks for additional open-ended comments should be transcribed into a separate text file. There probably will be too few provider interviews for meaningful statistical analysis. Provider responses should be compared to client responses.

Preliminary findings should be shared with clinic staff and patients for feedback and discussion before the final report is prepared. Care should be taken to ensure that responses cannot be traced back to specific respondents—for example, attributing a comment to the Social Worker at Clinic X will identify that staff person to anyone familiar with the system, even if names are not given.

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Key Informant Interview

Informed consent instructions

Good morning/afternoon/evening. My name is _____ and I work with _____. We are interviewing knowledgeable people such as yourself to learn about the availability of services for people who inject drugs in [country], the policies around drug dependence treatment and the groups that participated in developing the policies, and attitudes toward people who use drugs. The purpose of our work is to make recommendations to expand drug dependence treatment services and improve the quality of services provided in [country]. This work is funded by the U.S. Agency for International Development (USAID) [or other donor]. We invite you to take part in a survey about these topics.

- *All information will be kept confidential.* We will not ask for your name or for any other information that could identify you. We will not share your answers with anyone outside the project. Our report will combine all the interviews we collect and not single out any individual.
- *Taking part in this activity is entirely voluntary.* The interview should take no more than 30 minutes of your time. You are free to decline to answer any question or to terminate the interview at any time.
- *We anticipate no risk to you as a result of your participation in this survey* other than the inconvenience of the time to complete the questionnaire.
- Do you consent to participate in the survey?

  [ ] Consent to participate
  [ ] Decline to participate (Thank client and terminate interview.)

Identification number_____

Information

City/country: _____

Personal/professional affiliation(s) (Check at least one and all that apply)

[ ] National policymaker
[ ] Local policymaker
[ ] Service provider
[ ] Organization of people living with HIV
[ ] Organization of drug users
[ ] Organization of lawyers
[ ] Organization of families of drug users
[ ] Other advocacy group: specify _____
[ ] Professional organization: specify _____
[ ] Other: specify _____

Primary area of oversight, authority, or expertise—check all that apply:
□ Hepatitis □ TB □ HIV □ Drug Treatment □ Harm Reduction □ Human Rights
□ Drug Control □ Law Enforcement □ Courts/Justice □ Minor-custody
□ Other_____

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

I. Framework

A. **How would you describe the coordination of the following services with other services in the continuum of health services for people who inject drugs (hepatitis, TB, HIV, drug treatment, harm reduction)?**

	Aligned regulations and outcome targets	No coordination	Contradictory regulations and outcome targets
1. **HIV** coordination with the continuum of services	(a)	(b)	(c)
2. **Hepatitis** coordination with the continuum of services	(a)	(b)	(c)
3. **TB** coordination with the continuum of services	(a)	(b)	(c)
4. **Drug Treatment** coordination with the continuum of services	(a)	(b)	(c)
5. **Harm Reduction** coordination with the continuum of services	(a)	(b)	(c)

6. Please cite one example of good coordination

7. Please cite one example of poor coordination

8. Please specifically address initiatives to support (or barriers to) initiation or continuation of OST in long-term inpatient settings (e.g., maternity, TB treatment, etc.)

9. Notes:

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

B. **How would you describe the coordination between health services for people who inject drugs and drug control/law enforcement programs?**			
	Aligned regulations and outcome targets	No coordination	Contradictory regulations and outcome targets
1. At the national level	(a)	(b)	(c)
2. At regional/state/oblast levels	(a)	(b)	(c)
3. At the local level	(a)	(b)	(c)
4. Please cite one example of good coordination			
5. Please cite one example of poor coordination			
6. Notes:			

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

C. **What would you describe as your understanding of the differences between community and prison services for hepatitis, TB, HIV, drug treatment, and harm reduction programs?**			
1. National program guidelines and protocols apply equally between community settings and pre-trial detention, prison, and minor custody settings	Pre-trial detention	Prison	Minor-custody
Hepatitis (Y/N)	a)	b)	c)
TB (Y/N)	d)	e)	f)
HIV (Y/N)	g)	h)	i)
Drug control (Y/N)	j)	k)	l)
Drug treatment (Y/N)	m)	n)	o)
Harm reduction (Y/N)	p)	q)	r)
2. Identify any services that are available in the community that aren't available in the following settings			
a)Pre-trial detention			
b)Prison			
c)Minor-custody			
3. Identify any levels of financial resources that are different between community settings and the following settings			
a)Pre-trial detention			
b)Prison			
c)Minor-custody			

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

4. Please specifically address initiatives to support (or barriers to) initiation or continuation of OST in custodial settings (pre-trial, prison, and minor custody settings)
5. Notes

II. Data used in the decisionmaking processes
A. **Describe your perception of how the government sets funding-level and service delivery targets or performance targets** (select all that apply)
1. □ Historic funding levels/support for existing physical infrastructure and staffing levels
2. □ Data on utilization or need
3. □ Community-level epidemiological or census data
4. □ Don't know
5. □ Other, please describe:
6. Notes (especially if more than one of the above is selected):

B. **If applicable, describe how you use the following data in programming and funding decisions**

	Use it regularly	Would like to use it but not available	Don't need this level of data
1. Data specific to PWID	(a)	(b)	(c)
2. Data specific to female PWID	(a)	(b)	(c)

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B. **If applicable, describe how you use the following data in programming and funding decisions**			
3. Data specific to young PWID	(a)	(b)	(c)
4. Notes:			

III. Government/community partnerships and engagement of key populations in decisionmaking

A. **Please list any advisory bodies/processes for services for PWID and indicate (Y/N) if they have membership of individual PWIDs or organizations that serve PWIDs**

Viral Hepatitis	Individual PWID	PWID Org	Female PWID	Female PWID Org
1.				
2.				
TB Program				
3.				
4.				
HIV Program				
5.				
6.				
Drug Treatment Program				
7.				
8.				

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

A. **Please list any advisory bodies/processes for services for PWID and indicate (Y/N) if they have membership of individual PWIDs or organizations that serve PWIDs**				
Harm Reduction Program				
9.				
10.				
11. For areas above that have no participation from individuals or organizations, please describe barriers to engaging PWID in the decisionmaking process				
12. Notes:				

VI. Privacy and confidentiality of personal medical and drug treatment/services utilization data

A. **Describe your understanding of the protections given to individual-level medical data**

1. **Collection** of personal medical data is prohibited without the individuals consent Don't know (DK)

Community			Pre-trial Detention			Prison			Minor-custody		
a) □ Yes	b) □ No	c) DK	d) □ Yes	e) □ No	f) DK	g) □ Yes	h)□ No	i) DK	j) □ Yes	k)□ No	l) DK

2. **Disclosure** of personal medical data is prohibited without the individuals consent Don't know (DK)

Community			Pre-trial Detention			Prison			Minor-custody		
a)□ Yes	b) □ No	c) DK	d) □ Yes	e) □ No	f) DK	g) □ Yes	h)□ No	i) DK	j) □ Yes	k)□ No	l) DK

3. **Publication** of personal medical data is prohibited without the individuals consent Don't know (DK)

Community			Pre-trial Detention			Prison			Minor-custody		
a)□ Yes	b) □ No	c) DK	d) □ Yes	e) □ No	f) DK	g) □ Yes	h)□ No	i) DK	j) □ Yes	k)□ No	l) DK

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

A. **Describe your understanding of the protections given to individual-level medical data**												
4. Individual-level data on **drug treatment** is included in protections of medical data Don't know (DK)												
Community			Pre-trial Detention			Prison			Minor-custody			
a) □ Yes	b) □ No	c) DK	d) □ Yes	e) □ No	f) DK	g) □ Yes	h)□ No	i) DK	j) □ Yes	k)□ No	l) DK	
5. Individual-level data on **harm reduction** services is included in protections of medical data Don't know (DK)												
Community			Pre-trial Detention			Prison			Minor-custody			
a) □ Yes	b) □ No	c) DK	d) □ Yes	e) □ No	f) DK	g) □ Yes	h)□ No	i) DK	j) □ Yes	k)□ No	l) DK	
6. Identify any exceptions to the general answers you gave above:												

B. **Are there any circumstances where personal medical data on drug use, drug treatment, or accessing of harm reduction services are used for the initiation of criminal charges or investigations?**
1. □ Don't know 2. □ No 3. □ Yes, please describe
4. Notes:

VIII. HIV and drug-use stigma and discrimination

A. **Describe the mechanisms that the government uses to measure stigma and discrimination against people who inject drugs**

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B. **Describe any government supported activities that are being undertaken to reduce stigma and discrimination against people who inject drugs**

IX. Definitions of drug dependence and disability

A. **How would you describe drug dependence?**

Check all that apply

1. □ drug dependence is a medical disorder that could affect any human being
2. □ drug dependence is a chronic and relapsing disorder, often co-occurring with other physical and mental conditions
3. □ drug dependence is a failure of will or of strength of character
4. □ other_____

Notes (especially if more than one of the above is selected):

XIII. Human and legal rights

A. **Please describe the steps that the government is taking to address corruption**

1. □ We have independent anti-corruption bodies in charge of preventive measure and policies
2. □ Anti-corruption activities include the participation of civil society
3. □ We undertake public information campaigns on the threats, causes, and consequences of corruption
4. □ We undertake public information campaigns on the mechanisms to report corruption
5. □ other_____

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B. **Please describe your perception of compensation of civil servants and political leaders compared with similar positions in the private sector**
1. □ Compensation levels are about the same 2. □ Compensation levels are lower, but individuals are allowed to supplement their income through formal or informal supplemental fees collected from members of the public 3. □ Compensation levels are lower and individuals are forbidden to supplement their income through formal or informal supplemental fees collection from members of the public 4. □ other_____

C. **Please describe the role that adopted international conventions/treaties play in the legislative process**
1. □ Don't know 2. □ Adopted international conventions/treaties have overall supremacy over country legislation 3. □ Country legislation attempts to align with adopted international conventions/treaties 4. □ I'm not aware of any international conventions/treaties that we have adopted 5. □ There is no role for international conventions/treaties in country legislation 6. □ other_____

XXII. Those are all the questions I have. Before we finish, is there anything you would like to tell me about the services here, such as what could be done to make services better?

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

Facility-based Service Provider Interview

Informed consent instructions

Good morning/afternoon/evening. My name is _____ and I work with _____. We are visiting facilities like this one to learn about their practices from both clients and staff. The purpose of our work is to make recommendations to expand access to services for PWID throughout [country]. This work is funded by [name of funder—for example, the U.S. Agency for International Development (USAID)]. We would like to interview you about the services provided here.

- *All information will be kept confidential.* We will not ask for your name. We will not share your answers with other staff working at this facility or any other authorities. Our report will combine all the interviews we collect.
- *Taking part in this activity is entirely voluntary.* The interview should take no more than 20 minutes of your time. You are free to decline to answer any question or to terminate the interview at any time.
- *We anticipate no risk to you as a result of your participation in this survey* other than the inconvenience of the time to complete the questionnaire.
- Do you consent to participate in the survey?

[ ] Consent to participate

[ ] Decline to participate (Thank client and terminate interview.)

_____

Identification number_____

Facility Information

City / Country_____

Source of facility funding—check all that apply:

□ Government □ NGO/CSO □ Private

□ Other_____

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

Facility Type—check all that apply:

□ Clinic/Health Facility □ Health Promotion/Disease Prevention □ Pre-trial Detention

□ Prison □ Minor-custody □ Other_____

Identify services provided at this facility—check all that apply

□ Hepatitis □ TB □ HIV □ Harm Reduction □ Drug Treatment □ Other_____

Respondent position at facility

□ Attending physician

□ Drug treatment counselor

□ Facility manager

□ Nurse

□ Volunteer

□ Other: specify: _____

Length of time working at this facility

□ Less than 6 months

□ 7–12 months

□ 1–2 years

□ More than 2 years

I. Framework

A. **How would you describe the coordination of the following services with other services in the <u>continuum of health services</u> for people who inject drugs (hepatitis, TB, HIV, drug treatment, harm reduction)?**

	Aligned regulations and outcome targets	No coordination	Contradictory regulations and outcome targets
1. **HIV** coordination with the continuum of services	(a)	(b)	(c)
2. **Hepatitis** coordination with the continuum of services	(a)	(b)	(c)
3. **TB** coordination with the continuum of services	(a)	(b)	(c)
4. **Drug Treatment** coordination with the continuum of services	(a)	(b)	(c)
5. **Harm Reduction** coordination with the continuum of services	(a)	(b)	(c)

6. Please cite one example of good coordination

7. Please cite one example of poor coordination

8. Please specifically address initiatives to support (or barriers to) initiation or continuation of OST in long-term inpatient settings (example: maternity, TB treatment, etc.)

9. Notes:

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

B. **How would you describe the coordination between health services for people who inject drugs and <u>drug control/law enforcement</u> programs?**			
	Aligned regulations and outcome targets	No coordination	Contradictory regulations and outcome targets
1. At the national level	(a)	(b)	(c)
2. At regional/state/oblast levels	(a)	(b)	(c)
3. At the local level	(a)	(b)	(c)
4. Please cite one example of good coordination			
5. Please cite one example of poor coordination			
6. Notes:			

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

C. **What would you describe as your understanding of the differences between community and prison services for hepatitis, TB, HIV, drug treatment, and harm reduction programs?**			
1. National program guidelines and protocols apply equally between community settings and pre-trial detention, prison, and minor custody settings	Pre-trial detention	Prison	Minor-custody
Hepatitis (Y/N)	a)	b)	c)
TB (Y/N)	d)	e)	f)
HIV (Y/N)	g)	h)	i)
Drug control (Y/N)	j)	k)	l)
Drug treatment (Y/N)	m)	n)	o)
Harm reduction (Y/N)	p)	q)	r)
2. Identify any services that are available in the community that are not available in the following settings			
a. Pre-trial detention			
b. Prison			
c. Minor-custody			
3. Identify any levels of financial resources that are different between community settings and the following settings			
a. Pre-trial detention			
b. Prison			
c. Minor-custody			

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II.	Data used in decisionmaking processes
A.	**Describe your perception of how the government sets funding-level and service delivery targets for your facility** (select all that apply)
1.	□ Historic funding levels/support for existing physical infrastructure and staffing levels
2.	□ Utilization data
3.	□ Community-level epidemiological data
4.	□ Not applicable—this facility does not receive any government funding
5.	□ Other, please describe:
6.	Notes (especially if more than one of the above is selected):

B.	**Describe how you report the following disaggregated data**			
		It is required and my organization reports it regularly	We have access to this level of data, but it is not reported	The data are not collected in a disaggregated manner
1.	Services delivered to PWID	(a)	(b)	(c)
2.	Services delivered to female PWID	(a)	(b)	(c)
3.	Services delivered to young PWID	(a)	(b)	(c)
4.	Notes:			

III.	Government/community partnerships and engagement of key populations in decisionmaking
A.	**Have you or a representative of your facility ever been a part of discussions with government agencies about government policies and programs related to services for PWID?**
1.	If yes, please describe:

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

A. **Have you or a representative of your facility ever been a part of discussions with government agencies about government policies and programs related to services for PWID?**

2. If no, please describe barriers to participation:

3. Notes:

V. Consent for testing and treatment

A. **Describe the elements of consent for services at your facility**
(interviewer—check off each as it is mentioned and obtain any written protocols for consent if available)

1. □ the consent must relate specifically to the treatment administered
2. □ the consent must be fully informed
3. □ the consent must be given voluntarily
4. □ the consent is given individually, in private, in the presence of a healthcare provider
5. □ the consent may be verbal or written
6. □ the consent must not be obtained through misrepresentation, coercion, or fraud
7. □ other:

B. **Are there any restrictions on the ability of children or adolescents to access information or services without parental consent?**

1. □ No
2. □ Yes, please describe

C. **If a prison setting—are there any hepatitis, TB, or HIV services for which a prisoner cannot refuse testing or treatment (including detoxification)?**

1. □ There are no cases where a prisoner is required to accept medical testing or treatment
2. □ Yes, please describe

VI. Privacy and confidentiality of personal medical and drug treatment/services utilization data

A. **Does this facility routinely share medical, psychological, and drug treatment/service utilization information beyond the providers directly involved in the care of the client without the consent of the client?**

1. □ No, information is not shared

If yes, with whom is this information shared?

2. □ Government health agencies or personnel
3. □ Government administrative agencies or personnel
4. □ Law enforcement or security agencies or personnel
5. □ Employers
6. □ Family
7. □ Other

B. **Has this facility ever been forced to share HIV, drug use, or drug treatment information for the initiation of criminal charges or investigations?**

1. □ No
2. □ Yes, please describe

C. **Do the professional bodies that represent your staff (e.g., of healthcare workers) have codes of conduct and use them to discipline breaches of confidentiality and unreasonable invasion of privacy as professional misconduct?**

1. □ No
2. □ Yes, please describe

VIII. HIV and drug-use stigma and discrimination

A. **Please describe the availability of the following services in your facility to people who you know or suspect of being an active drug user?**

	Service provided to active drug users	Service provided at facility but not available to active drug users	Service not provided at facility
1. HCT	(a)	(b)	(c)
2. ART	(a)	(b)	(c)
3. Hepatitis services	(a)	(b)	(c)

A. **Please describe the availability of the following services in your facility to people who you know or suspect of being an active drug user?**			
4. TB services	(a)	(b)	(c)
5. OST	(a)	(b)	(c)
6. NSP	(a)	(b)	(c)

B. **Please describe the availability of the following services to people of a different or undocumented country residency or citizenship?**			
	Service provided regardless of residency/citizenship	Service provided at facility but not available to people without documentation of this country's residency/citizenship	Service not provided at facility
1. HCT	(a)	(b)	(c)
2. ART	(a)	(b)	(c)
3. Hepatitis services	(a)	(b)	(c)
4. TB services	(a)	(b)	(c)
5. OST	(a)	(b)	(c)
6. NSP	(a)	(b)	(c)

C. **Are any of the following services provided at a LOWER level in prisons in this area than in the community?**
1. □ HCT—if indicated, please describe
2. □ ART—if indicated, please describe
3. □ Hepatitis services—if indicated, please describe
4. □ TB services—if indicated, please describe

C. **Are any of the following services provided at a LOWER level in prisons in this area than in the community?**
5. □ OST—if indicated, please describe
6. □ NSP—if indicated, please describe

IX. **Definitions of drug dependence and disability**
A. How would you describe drug dependence? (check all that apply)
1. □ drug dependence as a medical disorder that could affect any human being 2. □ drug dependence is a chronic and relapsing disorder, often co-occurring with other physical and mental conditions 3. □ drug dependence is a failure of will or of strength of character 4. □ other_____
5. Notes (especially if more than one of the above is selected):

X. **Criminal law (use, possession of drugs or harm reduction commodities, promotion/facilitation, aiding and abetting, etc.)**
A. Has this facility ever had the information it provides on HIV or harm reduction censored?
1. □ No 2. □ Yes, please describe
B. **Has this facility or staff ever been accused formally or informally of promotion, facilitation, or aiding and abetting of criminal offenses?**
1. □ No 2. □ Yes, please describe

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XI. Monitoring and enforcement of human and legal rights

A. Does any of your staff or your organization receive incentive payments from the private sector for using particular products or procedures?

1. □ No
2. □ Yes, please describe

XII. Medicine and medical commodity procurement and supply management

A. Does your facility have access to all of the medicines or medical commodities required for the services you provide?

1. □ No—what do you not have access to?

2. □ Yes, do they come from the government or another donor?

B. In the last six months have you run out of medicines or medical commodities?

1. □ No
2. □ Yes, please describe

3. □ Yes, describe how you managed your clients (e.g., changed medications, restricted new clients, reduced medication dose, artificially increased forecast for future need, etc.)

C. Mechanisms that are used to forecast and distribute medicines or medical commodities

Forecasting

1. □ is based on historical use
2. □ is based on forecasted need
3. How often are forecasts reviewed and revised? Every _____ months

4. How often do you report on utilization? Every _____ months

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C. Mechanisms that are used to forecast and distribute medicines or medical commodities

Is there a system to redistribute inventory between facilities?

1. □ No
2. □ Yes, please describe

D. Mechanisms to include PWID in the selection of harm reduction commodities

Is there a mechanism to include PWID (or representative organizations) in the selection of harm reduction commodities?

1. □ No
2. □ Yes, please describe

XIII. Overall HIV and harm reduction intervention design

A. Please describe the services that are available at this location—identify all that apply

	Provided at this location	Coordinated clinical treatment plans and monitoring with another location	Referrals made to other locations	Client seeks independently at other locations	Unknown
1. HIV risk assessment/ screening	(a)	(b)	(c)	(d)	(e)
2. Client-initiated HCT	(a)	(b)	(c)	(d)	(e)
3. Provider-initiated HCT	(a)	(b)	(c)	(d)	(e)
4. ART	(a)	(b)	(c)	(d)	(e)
5. CD4/viral load testing	(a)	(b)	(c)	(d)	(e)
6. Testing for hepatitis A	(a)	(b)	(c)	(d)	(e)
7. Vaccination for hepatitis A	(a)	(b)	(c)	(d)	(e)
8. Treatment for hepatitis A infection	(a)	(b)	(c)	(d)	(e)
9. Testing for hepatitis B	(a)	(b)	(c)	(d)	(e)

A. Please describe the services that are available at this location—identify all that apply					
	Provided at this location	Coordinated clinical treatment plans and monitoring with another location	Referrals made to other locations	Client seeks independently at other locations	Unknown
10. Vaccination for hepatitis B	(a)	(b)	(c)	(d)	(e)
11. Treatment for hepatitis B infection	(a)	(b)	(c)	(d)	(e)
12. Testing for hepatitis C	(a)	(b)	(c)	(d)	(e)
13. Treatment for hepatitis C infection	(a)	(b)	(c)	(d)	(e)
14. Screening for TB	(a)	(b)	(c)	(d)	(e)
15. Diagnosis of TB	(a)	(b)	(c)	(d)	(e)
16. Treatment of TB	(a)	(b)	(c)	(d)	(e)
17. Information on prevention and management of drug overdose	(a)	(b)	(c)	(d)	(e)
18. Initiation of opioid substitution therapy using methadone and/or buprenorphine	(a)	(b)	(c)	(d)	(e)
19. Continuation of OST that was initiated at another location	(a)	(b)	(c)	(d)	(e)
20. Sterile needle/syringe distribution	(a)	(b)	(c)	(d)	(e)
21. Sterile injection equipment distribution	(a)	(b)	(c)	(d)	(e)
22. Needle/syringe/ equipment disposal	(a)	(b)	(c)	(d)	(e)

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B. Do you coordinate your services between community and prison settings?

1. □ No, please describe barriers to coordination

2. □ Yes, please describe

C. For the services you provide, please indicate if the following are reasons for denying, delaying, or interrupting the service

	HCT	ART	Hep	TB	OST	NSP	Not provided at this facility
1. Age less than 18 years	(a)	(b)	(c)	(d)	(e)	(f)	(g)
2. Current, active drug use	(a)	(b)	(c)	(d)	(e)	(f)	(g)
3. Active TB	(a)	(b)	(c)	(d)	(e)	(f)	(g)
4. Current treatment for hepatitis B	(a)	(b)	(c)	(d)	(e)	(f)	(g)
5. Hepatitis infection	(a)	(b)	(c)	(d)	(e)	(f)	(g)
6. Pregnant and/or breastfeeding	(a)	(b)	(c)	(d)	(e)	(f)	(g)
7. Non-use of contraception	(a)	(b)	(c)	(d)	(e)	(f)	(g)
8. HIV infection		(b)	(c)	(d)	(e)	(f)	(g)
9. Non-compliance with treatment	(a)	(b)	(c)	(d)	(e)	(f)	(g)
10. Inability to pay	(a)	(b)	(c)	(d)	(e)	(f)	(g)
11. Non-registration as a drug user	(a)	(b)	(c)	(d)	(e)	(f)	(g)

D. When was the last time that your staff received training in the following areas?				
	Within the last 6 months	6–12 months	More than 12 months	Never
1. Ethics and human rights	(a)	(b)	(c)	(d)
2. Domestic or sexual violence	(a)	(b)	(c)	(d)
3. Consent	(a)	(b)	(c)	(d)
4. Confidentiality of personal data	(a)	(b)	(c)	(d)
5. Stigma and discrimination	(a)	(b)	(c)	(d)
6. Overdose prevention and management	(a)	(b)	(c)	(d)
7. Referral between medical and harm reduction services	(a)	(b)	(c)	(d)
8. Drug dependency	(a)	(b)	(c)	(d)
9. Specific needs of PWID	(a)	(b)	(c)	(d)
10. Information on hepatitis, TB, or HIV	(a)	(b)	(c)	(d)

XIV. HIV counseling and testing (for facilities providing this service)

A. When HCT is offered to a PWID, please describe how it is presented

1. □ A healthcare worker presents it along with a list of other medical tests, and the client can ask to have it removed
2. □ A healthcare worker recommends that HCT be done, but the test is not done unless the client asks for it
3. □ We only offer HCT when the client asks us to
4. □ Other:

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XV.	ART (for facilities providing this service)
A.	**Does your facility provide adherence support measures for your ART patients who use drugs?**
1.	□ No
2.	□ Yes, please describe

XXIV.	TB services (for facilities providing this service)
A.	**Does your facility have a TB infection control plan?**
1.	□ No
2.	□ Yes, please describe
B.	**Does your facility provide adherence support measures for your TB patients who use drugs?**
1.	□ No
2.	□ Yes, please describe
C.	**For clients who require long-term inpatient care for TB who are active drug users or clients of OST services, please describe if and how OST is continued while the individual is in inpatient care.**
1.	□ OST is not provided, please describe barriers
2.	□ OST is provided, please describe process for providing this service

XX. OST services (for facilities providing this service)

A. Are there limits to dosing or length of treatment for OST services?

1. □ No, please describe how dosing and treatment length are decided
2. □ Yes, please describe

B. Do clients have to pay for OST?

1. □ No
2. □ Yes, how much? _____ per _____

C. Do you allow take-home doses?

1. □ No
2. □ Yes, how often and under what circumstances?

D. Please describe any protocols or practices that you use to manage clients who may not be complying with facility requirements and the associated violations

1. □ OST medications are reduced or withheld—used for the following types of violations
2. □ Individuals are suspended from the program for a short period of time—used for the following types of violations
3. □ Individuals are permanently removed from the program—used for the following types of violations
4. □ Other_____—used for the following types of violations

XXII.	Those are all the questions I have. Before we finish, is there anything you would like to tell me about the services here, such as what could be done to make services better?

Facility-based Client Intercept

Informed consent instructions

Good morning/afternoon/evening. My name is _____ and I work with _____. We are visiting facilities like this one to learn about their practices. The purpose of our work is to make recommendations to expand services for people who inject drugs throughout [country]. This work is funded by [name of funder—for example, the U.S. Agency for International Development (USAID)]. Information from clients such as yourself is critical to the work. We invite you to take part in a short survey to answer a few questions about yourself and the services you receive here.

- *All information will be kept confidential.* We will not ask for your name or for any other information that could identify you. We will not share your answers with the staff working at this facility or any other authorities. Our report will combine all the interviews we collect.
- *Taking part in this activity is entirely voluntary.* The interview should take no more than 15 minutes of your time. You are free to decline to answer any question or to terminate the interview at any time.
- *We anticipate no risk to you as a result of your participation in this survey* other than the inconvenience of the time to complete the questionnaire.
- Do you consent to participate in the survey? [If signed consent is required by local IRB: By signing/initialing this form, you indicate that you have been fully informed about the project and that you understand it, and you are voluntarily choosing to take part in this survey.]

  [ ] Consent to participate

  [ ] Decline to participate (Thank client and terminate interview.)

Identification number: _____

City: _____ Country: _____

Date (year/month/day): 20 __ __/ __ __/ __ __ Time interview started: __ __ : __ __

Gender: □ Male □ Female □ Transgender

How old are you? __ __ years

How long have you been coming to this facility services?

□ Less than one month (including first visit)

□ 1–6 months

□ 7–12 months

□ More than one year

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III. Government/community partnerships and engagement of key populations in decisionmaking

A. Have you ever been a part of discussions with government agencies about government policies and programs related to services for PWID?

1. □ No, please describe barriers to participation
2. □ Yes, please describe

V. Consent for testing and treatment

A. **Describe the information that was given to you about the services at this facility and the choice you made regarding accessing those services** (check all that apply)

1. □ I felt fully informed about the risks and benefits of the services
   a. This information was given □ verbally, or □ in writing
2. □ I was given the ability to decide to accept or decline the services voluntarily
3. □ I was informed that I had the ability to refuse or withdraw from treatment at any time
4. □ I didn't understand or receive information about the services at this facility
5. □ I felt forced to accept or decline the services at this facility
6. Notes:

VIII. HIV and drug-use stigma and discrimination

A. Have you ever been denied any of the following services because someone assumed or knew that you were using drugs?

1. □ HIV counseling and testing—if indicated, please describe
2. □ Medications to treat HIV (antiretroviral therapy)—if indicated, please describe
3. □ Hepatitis testing or treatment services—if indicated, please describe
4. □ TB services—if indicated, please describe
5. □ Substitution therapy (methadone, buprenorphine, etc.)—if indicated, please describe

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

A. Have you ever been denied any of the following services because someone assumed or knew that you were using drugs?
6. □ Needle and syringe distribution programs—if indicated, please describe

B. Have you ever been denied any of the following services because you did not have the correct residency documentation?
1. □ HIV counseling and testing—if indicated, please describe
2. □ Medications to treat HIV (antiretroviral therapy)—if indicated, please describe
3. □ Hepatitis testing or treatment services—if indicated, please describe
4. □ TB services—if indicated, please describe
5. □ Substitution therapy (methadone, buprenorphine, etc.)—if indicated, please describe
6. □ Needle and syringe distribution programs—if indicated, please describe

C. Are there traditional teachings or policies (religious/cultural) about drug use or people who use drugs that create a barrier to you seeking services?
1. □ No 2. □ Yes, please describe

IX. Definitions of drug dependence and disability

A. How would you describe drug dependence?
1. □ Drug dependence is a medical disorder that could affect any human being 2. □ Drug dependence is a chronic and relapsing disorder, often co-occurring with other physical and mental conditions 3. □ Drug dependence is a failure of will or of strength of character 4. □ Other_____

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

A. How would you describe drug dependence?
5. Notes:

XII. Cruel, inhuman, or degrading treatment or punishment

A. Do you feel like you have ever been treated in a way that was cruel, inhuman, or degrading in the healthcare sector?

1. □ No
2. □ Yes, please describe

B. Do you feel like you have ever been treated in a way that was cruel, inhuman or degrading by the police or criminal justice system?

1. □ No
2. □ Yes, please describe

C. Have you ever been denied medical treatment for withdrawal (have you ever been forced to go through withdrawal without any medications to make you feel better)?

1. □ No
2. □ Yes, please describe

XIII. Monitoring and enforcement of human and legal rights

A. Has anyone ever talked with you about your legal rights?

1. □ No
2. □ Yes, please describe

B. Do you know where to go if you feel like your rights have been violated?

1. □ No
2. □ Yes, please describe

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C. What might be the biggest barrier to you filing a complaint if you feel your rights have been violated?

1. Describe

D. Have you ever been asked or required to pay a police officer to keep from being arrested or receive more favorable treatment?

1. □ No
2. □ Yes, please describe

XIV. Medicine and medical commodity procurement and supply management

A. Have you ever been turned away from services because the facility had run out of medicine or supplies?

1. □ No
2. □ Yes, please describe (include how recent/how often)

B. Have you ever had your medication changed or reduced because the facility had run out of medicine or supplies?

1. □ No
2. □ Yes, please describe (include how recent/how often)

XV. Overall HIV, hepatitis, TB, drug treatment, and harm reduction intervention design

A. Please describe where you access the following services

	Provided at this location	I got information from staff at this facility about where this service is provided	I had to find this service on my own	I have never accessed this service
1. HIV risk assessment/screening	(a)	(b)	(c)	(d)
2. HCT that I asked for	(a)	(b)	(c)	(d)
3. HCT that my doctor ordered	(a)	(b)	(c)	(d)

A. Please describe where you access the following services				
	Provided at this location	I got information from staff at this facility about where this service is provided	I had to find this service on my own	I have never accessed this service
4. ART	(a)	(b)	(c)	(d)
5. CD4/viral load testing	(a)	(b)	(c)	(d)
6. Testing for hepatitis A	(a)	(b)	(c)	(d)
7. Vaccination for hepatitis A	(a)	(b)	(c)	(d)
8. Treatment for hepatitis A infection	(a)	(b)	(c)	(d)
9. Testing for hepatitis B	(a)	(b)	(c)	(d)
10. Vaccination for hepatitis B	(a)	(b)	(c)	(d)
11. Treatment for hepatitis B infection	(a)	(b)	(c)	(d)
12. Testing for hepatitis C	(a)	(b)	(c)	(d)
13. Treatment for hepatitis C infection	(a)	(b)	(c)	(d)
14. Screening/diagnosis for TB	(a)	(b)	(c)	(d)
15. Treatment of TB	(a)	(b)	(c)	(d)
16. Initiation of opioid substitution therapy using methadone and/or buprenorphine	(a)	(b)	(c)	(d)
17. Continuation of OST that was initiated at another location	(a)	(b)	(c)	(d)
18. Sterile needle/syringe distribution	(a)	(b)	(c)	(d)
19. Sterile injection equipment distribution	(a)	(b)	(c)	(d)
20. Needle/syringe/equipment disposal	(a)	(b)	(c)	(d)

B. Have you ever been told that you would not be able to access hepatitis, TB, or HIV services because of current or past drug use?

1. □ No
2. □ Yes, please describe

C. Are there any other reasons that you have been denied hepatitis, TB, or HIV services?

1. □ No
2. □ Yes, please describe

D. Has anyone ever talked to you about how to prevent or where to get medical care for a drug overdose?

1. □ No
2. □ Yes, please describe

E. Have you ever had to pay for medications or laboratory tests?

1. □ No
2. □ Yes, please describe

F. FOR WOMEN—were you ever denied drug treatment, harm reduction, hepatitis, TB, or HIV services because you were pregnant or breastfeeding?

1. □ No
2. □ Yes, please describe

G. FOR WOMEN—were you ever required to use contraception or family planning in order to receive drug treatment, harm reduction, hepatitis, TB, or HIV services?

1. □ No
2. □ Yes, please describe

XVI. HIV counseling and testing

A. The last time you received an HIV test, which of the following do you remember the healthcare provider doing? (check all that apply)

1. □ Talked to me about my potential risk for HIV
2. □ Explained what the HIV test was
3. □ Asked me if I wanted to have an HIV test
4. □ After the test results—explained to me what they meant
5. □ Gave me information about services that might be helpful for me
6. □ The healthcare provider didn't ask, they just did the test
7. □ I don't remember or I have not had an HIV test

XVIII. Hepatitis services

A. Have you ever been offered the following services?

1. Hepatitis C testing a) □ Yes b) □ No
2. Vaccination for hepatitis A or B a) □ Yes b) □ No
3. Information on the risks of hepatitis transmission and how to reduce that risk a) □ Yes b) □ No

XX. OST services

A. Have you ever had OST medications withheld or reduced as a punishment?

1. □ No
2. □ Yes, please describe

3. □ I've never been on OST medications

XXI. NSP

A. Have you ever had been restricted in the number or frequency of accessing needle and syringe services?

1. □ No
2. □ Yes, please describe

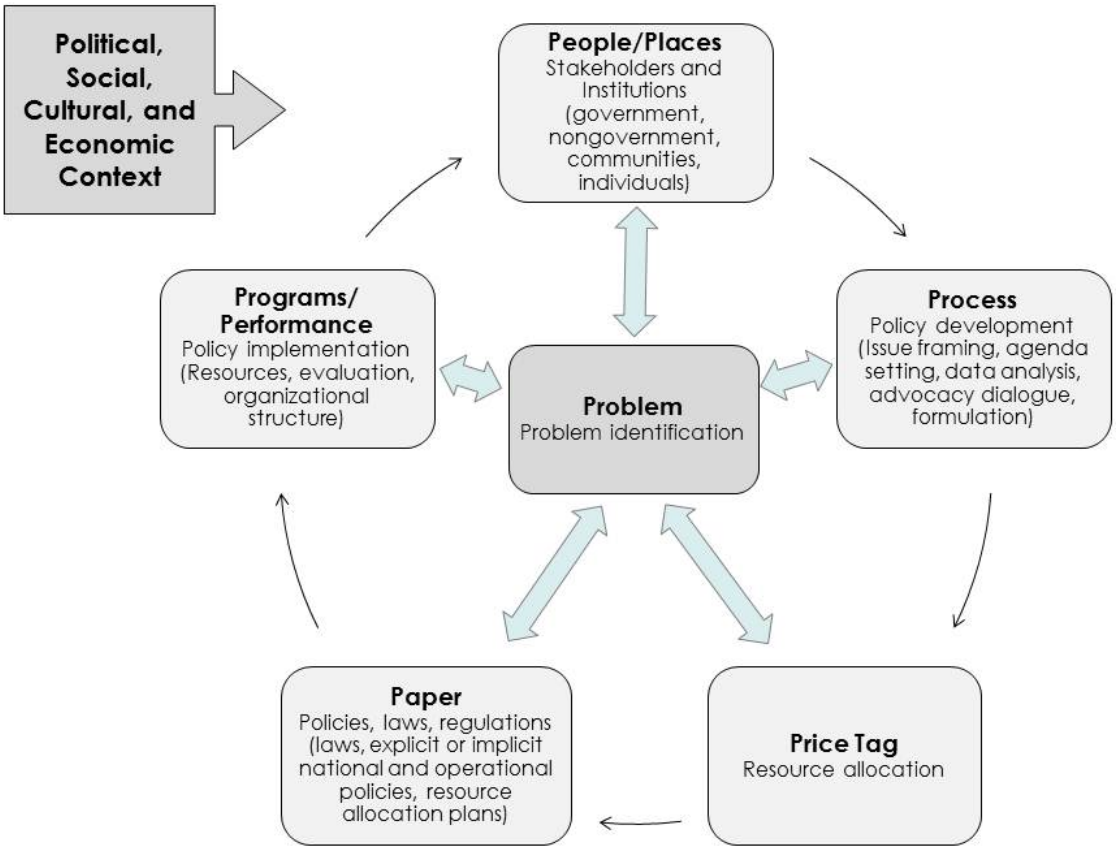
3. □ I've never accessed needle and syringe services

XXII.	Those are all the questions I have. Before we finish, is there anything you would like to tell me about the services here, such as what could be done to make the services better or what you especially like about your treatment here?

Policy Advocacy Planning Worksheets

Lessons learned from the field of policy advocacy have identified the importance of developing a coordinated, strategic, evidence-based advocacy strategy. This should be a strategy that has clear goals and objectives, addresses the needs of stakeholders, and is informed by a country's social, political, and economic contexts.

The following collection of worksheets is presented as a simple tool to help develop an advocacy strategy within the policy circle framework to incrementally increase access to services for PWID.



These worksheets are a highly summarized outline for developing an advocacy strategy. More in-depth information can be found in the following source documents.

Leading Voices in Securing Reproductive Health Supplies: An Advocacy Guide and Toolkit.
www.rhsupplies.org/fileadmin/user_upload/toolkit/Advocacy_Guide_and_Toolkit.pdf

Networking for Policy Change: An Advocacy Training Manual.
www.policyproject.com/pubs/advocacymanual.cfm

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People/Places: Stakeholder Engagement

Advocacy Steering Committee/Initiative Group of Stakeholders

The first step in policy advocacy will be to form or identify an advocacy committee or initiative group. Strategic engagement of stakeholders is critical to informing the design of an advocacy strategy. Look for individuals or organizations that have experience in policy development, advocacy, monitoring, and implementation; who understand the context of drug use (including opposition/opportunities); and who are providers and clients of services for PWID.

Composition of this committee/initiative group must strike a balance between a broad inclusion of stakeholders, including those resistant to some services such as OST, and establishment of a functional advisory body. While it is important to incorporate a range of expertise and opinion, try to include individuals who can work together constructively. Consider the different skills of individuals who design and implement policies; advocate for policy reform; and come from government agencies, nongovernmental groups, and international donors. Also consider the point at which law enforcement will be involved.

A decision also needs to be made on the role of the advocacy committee. Will the committee simply be convened to help develop an advocacy strategy or will it be involved more in implementation?

A decision will also need to be made on how—and if—other planning processes and groups are informed of the activities related to MAT advocacy. For example, will it be beneficial to keep the CCM/National AIDS Committee informed, or would these bodies try to block advocacy activities?

Keep this group at a reasonable size (12–15 maximum) and make sure that individuals who agree to participate have a clear understanding of the expectations for their roles and the time and resources that participation may require.

PWID Services Advocacy Committee Composition Worksheet

This worksheet is used to analyze the composition of the advocacy committee. It is helpful to get a picture of the range of experience and perspective of the committee. The goal is to have the participation of representatives of a broad range of experience and perspective in policy analysis and advocacy.[1]

Expand the tool as necessary.

Name of individual and the organization/group they represent	Identify reason or nature of group's/ individual's interest in services for PWID	Indicate the level of knowledge about services for PWID *(Enter low, medium, or high)*	Identify specific resources that the individual or group brings to advocacy efforts *(Resources include staff and volunteers, financial, technology, information, legal skills, religious/moral influence, etc.)*	Estimate how easily the individual or group can mobilize advocates *(Enter low, medium, or high)*	**Position on services for PWID** (Enter one rating only. If you do not know, enter DK for "Don't Know.")		
					Support *+3 Very strong support* *+2 Moderate support* *+1 Weak support*	**Neutral** *Enter 0*	**Oppose** *-3 Very strong opposition* *-2 Moderate opposition* *-1 Weak opposition*
Government Sector							
Political Sector							

[1] Adapted from Brinkerhoff, D. and B. Crosby, ―Managing Policy Reform: Concepts and Tools for Decision-makers in Developing and Transitioning Countries‖, Kumarian Press, CT, 2002 and POLICY, ―Networking for Policy Change: An Advocacy Training Manual, 1999.

Name of individual and the organization/group they represent	Identify reason or nature of group's/ individual's interest in services for PWID	Indicate the level of knowledge about services for PWID *(Enter low, medium, or high)*	Identify specific resources that the individual or group brings to advocacy efforts *(Resources include staff and volunteers, financial, technology, information, legal skills, religious/moral influence, etc.)*	Estimate how easily the individual or group can mobilize advocates *(Enter low, medium, or high)*	**Position on services for PWID** (Enter one rating only. If you do not know, enter DK for "Don't Know.")		
					Support *+3 Very strong support* *+2 Moderate support* *+1 Weak support*	**Neutral** *Enter 0*	**Oppose** *-3 Very strong opposition* *-2 Moderate opposition* *-1 Weak opposition*
Commercial/Private Sector							
Nongovernmental Sector							
International Donors							

Political, Social, Cultural, and Economic Contexts

It will be important for the steering committee to agree on a common understanding of the general context and issues affecting the provision of services for PWID and the specific context for the problems identified. Given the dynamic nature of policy related to drug use, this information should be assessed against current realities and will come from sources such as existing assessments, key informants, and official documents. In addition to the laws, policies, and regulations identified from the policy inventory, summarize

- Epidemiological data on HIV and drug use;
- Demand for services (official estimates, information from advocates, clients, providers); determine whether there is a difference in these estimates, and if so, why;
- Current state of services (primary providers, methods, coverage, quality, barriers to access); and
- Donor and government financing of drug treatment/HIV prevention for PWID.

Much of this information may seem obvious to local advocates, but documenting a common understanding will help identify positive and negative factors affecting access, assess strategic alternatives, and craft advocacy strategies to address barriers to access.

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

Political, Social, Cultural, and Economic Contexts Worksheet

Country/Jurisdiction:

Epidemiological data on HIV and injection drug use (e.g., estimate number of PWID, estimate HIV prevalence among PWID, types of drug used and HIV-risk behaviors):

Demand for services for PWID:

Current state of services for PWID (providers, methods, coverage, quality, barriers to access):

Donor and government financing of PWID services:

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Policymaking Process

A critical element in the success of any advocacy effort is a thorough understanding of the policy process. In-depth knowledge of the policy environment can help advocates identify and recognize advocacy opportunities and critical points of entry, so as to both influence the policy process and guide the selection of advocacy issues.

In many countries, government and political leaders remain skeptical, if not fearful, of NGOs and other representatives of civil society participating in the policy arena. There is a common perception among policymakers that civil society lacks the experience, skills, and knowledge required for policy analysis and formulation. This perception can lead to a reluctance or refusal to listen to or collaborate with networks in their advocacy efforts. Consequently, it is vital that advocates demonstrate a clear and accurate understanding of the process followed and the players involved in making policy decisions.

In addition, advocates should monitor the political, economic, sociocultural, and technological environment to keep abreast of emerging issues and the positions of government. Opportunities to influence policy and policymakers can arise or disappear at any time.

The advocacy committee should answer the following questions:

Issue Framing

1. How can we frame our problem/solution so it becomes a priority for policymakers to address?
2. How can the problem be framed to guide the terms of the policy debate in the direction that we want?

Agenda Setting

1. How are ideas or issues generated for new or revised policies?
2. How is a proposed issue introduced into the formal decisionmaking process?
3. Can the problem/solution be introduced at different levels of policymaking to increase pressure to address the issue?

Policy Formulation

1. What is the process for discussing, debating, and perhaps, altering the proposal? Who are the players involved?
2. How is the proposal approved or rejected?
3. If approved, what are the steps to move the proposal to the next level of decisionmaking?
4. Once the proposal is finalized, what are the implementation steps? Who are the players involved?
5. What is the process for identifying and addressing barriers or challenges to implementation?

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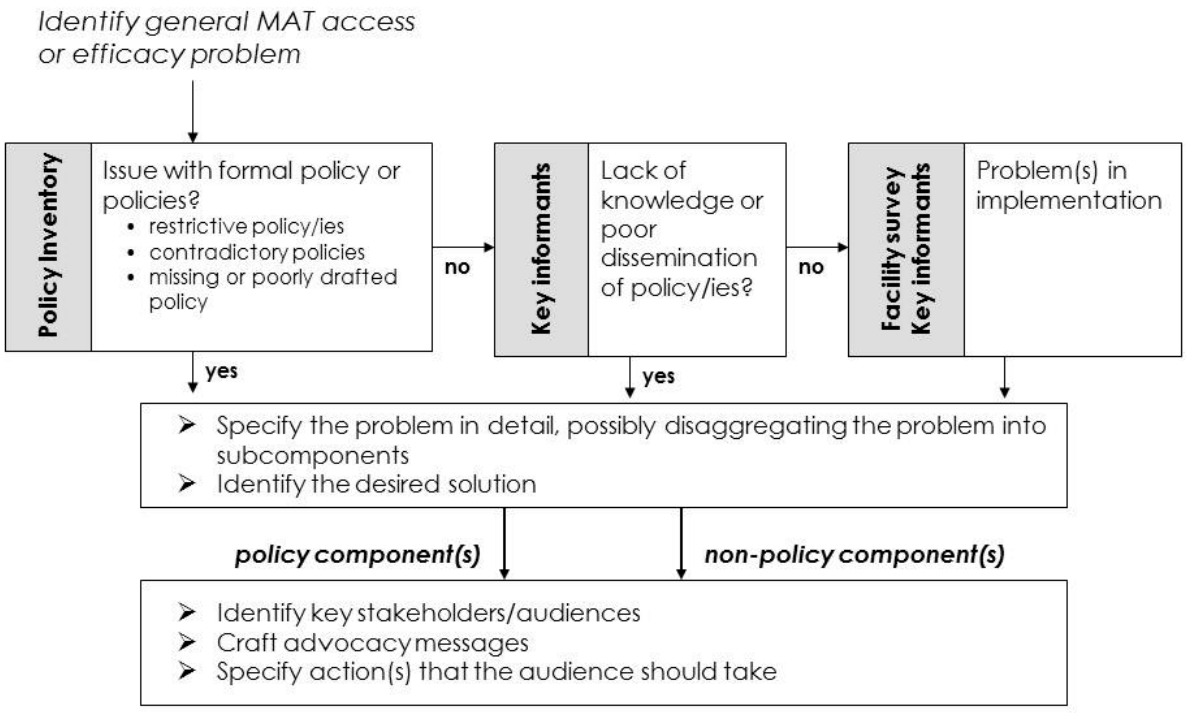
Advocacy Prioritization

There is no right or wrong way to prioritize advocacy efforts. Of real importance is keeping in mind the ultimate goal of increasing access to high-quality services and coming to agreement on an incremental strategy to achieve that goal.

This worksheet provides an example format to identify each advocacy need, consolidate information that has been gathered about the context, and undertake a process to weigh and prioritize advocacy activities.

Through a participatory process, the advocacy steering committee/initiative group should summarize and agree on a common list of the policy issues under problem identification.



Using the information gathered from policy inventories; policy assessment indexes; the political, social, and economic contexts; and relevant information from the policy process, members of the steering committee can assign numeric values to columns A through E and total their scores in column F.

By definition, the scoring will be subjective, which is why a membership of broad and diverse experience on the steering committee will be valuable. Scores can then be collected and averaged for the group to determine a final prioritization; the highest scores in column F will be the top priority issues to address.

Once the worksheet has been completed, it is important to assess whether it makes sense.

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Consider the following:

- Which advocacy issues rank highest (column F)? Does it make sense to address these issues first? Is there a logical sequencing of advocacy that either confirms this ranking or requires prioritizing issues with a lower score?

- For advocacy issues that rank lower but are really important, consider breaking the issues into smaller, incremental steps and score each step. Finally, revisit the issue priority-setting process regularly, especially if there is a significant change in political climate or resources available to implement policy advocacy.

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Problem Identification/Advocacy Prioritization Worksheet

Specific issue	What need to be changed?	A	B	C	D	E	F
List all barriers to PWID services	• Policy— good, bad, contradictory, nonexistent • Implementation of existing policy • Other	Potential that addressing this issue would improve access for PWID Scale of 10–1 *(strong-weak)*	Time needed to change Scale of 10–1 *(short-long)*	Financial and human resources required for change Scale of 10–1 *(low-high)*	Strength of opposition Scale of 10–1 (weak-strong)	Opportunities for engaging diverse coalitions Scale of 10–1 *(many/strong–few/weak)*	Priority ranking *(Add values of columns A, B, C, D, E and enter total)*

Use of International Law/Human Rights-Based Advocacy

In many cases, countries will have ratified international and/or regional human rights covenants or declarations. Depending on the status the individual country gives to these documents, advocates can use their language as a mechanism for advocacy (see analysis from question 13.m, p. 105 in the policy inventory). For example:

Document	Relevance to Services for PWID
International Covenant on Civil and Political Rights (ICCPR)	Examples of violations: arbitrary detention, due process violations, discrimination, forced labor, breaches of privacy, and other civil and political rights. Coerced treatment, forced labor in drug detention centers, and putting drug offenders on trial in military courts are all violations of the ICCPR. This committee has also stated that executing people for drug offenses is a violation of the right to life.
International Covenant on Economic, Social and Cultural Rights (ICESCR)	Examples of violations: Denial of antiretroviral drugs or refusal to provide substitution therapy could fall under this committee's mandate. This is a major resource for advocates in drug policy because of the attention this committee has devoted toward the right to the highest attainable standard of health.
Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)	Examples of violations: Cruel, inhuman, or degrading treatment or punishment or torture. This can include not only physical abuse, but also can also be interpreted to scenarios such as allowing someone to go into withdrawal without providing treatment or adequate pain medicine.
Convention on the Elimination of All Forms of Racial Discrimination (CERD) Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) Convention on the Rights of the Child (CRC)	All three committees are relevant to drug policy organizations. In many instances, drug policies have negative impacts on women, children, or particular racial groups. If a policy has a discriminatory effect or disproportionate impact on one of these groups, these committees are well placed to address the problem.
Source: A Brief Guide to the United Nations Human Rights System, Harm Reduction International http://www.ihra.net/files/2011/03/29/A_brief_guide_to_the_UN_human_rights_system.pdf	

Target Audience Identification

For each prioritized advocacy issue, there will be essential audiences to target with advocacy messages. Target audiences include decisionmakers and individuals or mechanisms that influence decisionmakers. Consider political leaders, legislators, officials of national and/or local government agencies, donors, national/local media, religious and traditional leaders, civic and non-profit organizations, and groups representing current and potential users of services for PWID.

As they are identified, document important information about each audience. This information will help to inform advocacy messages and strategies.

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- *Level of knowledge of services for PWID.* Is the audience well informed or does it lack accurate information? What are the sources of information the audience uses for learning about PWID services?
- *Level of demonstrated support for services for PWID.* Has the audience actively and/or publicly supported PWID services? Describe examples…
- *Level of demonstrated opposition toward services for PWID.* Has the audience actively and/or publicly opposed PWID services? Describe the reasons given for such opposition.

Detailed Technical Guidance

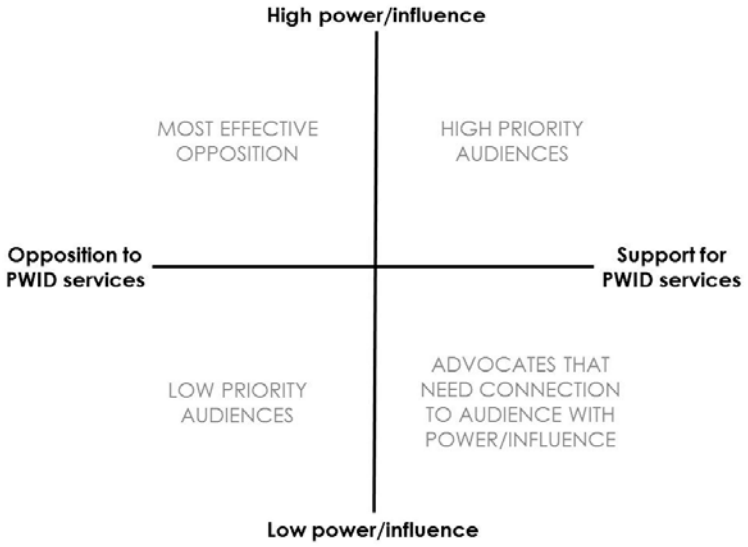
The UN Human Rights System and Harm Reduction Advocacy: A training package for civil society organizations http://www.ihra.net/human-rights-training

- *Undecided or unknown.* Has the audience failed to declare its position on services for PWID? What are the issues that remain unanswered?
- *Potential benefits to the audience.* How might the audience benefit on a personal, professional, or political level from supporting access to services for PWID?
- *Potential threats to the audience.* How might the audience's personal, professional or political position be threatened?
- *Find shared values.* Is there a "we" message possible? Might there be a way to frame the issue, drawing on the values that are important to both the audience and advocates for PWID?

As an exhaustive list of audiences is compiled, time and resources may require identifying priority audiences. Which ones are most critical to accomplishing the advocacy outcome identified? Consider:

- Audiences' influence on decisionmaking
- The relative "distance" they need to be moved to become advocates
- The strength of the benefit and shared value between PWID advocates and the audience
- The cost and time required to gain their support

It can be helpful to place audiences on a chart and draw lines between audiences linked with each other.



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Target Audience Identification Worksheet

Prioritized advocacy issue:

Final outcome desired:

Audience:
Role: (direct decisionmaker or influencer of decisionmaker—*if influencer*, identify decisionmaker and relationship between decisionmaker and audience)

Level of knowledge/ source of information on services for PWID	Support/opposition/ unknown	Benefit/danger to audience for supporting services for PWID	Shared value between PWID advocates and audience

Audience:
Role: (direct decisionmaker or influencer of decisionmaker—*if influencer*, identify decisionmaker and relationship between decisionmaker and audience)

Level of knowledge/ source of information on services for PWID	Support/opposition/ unknown	Benefit/danger to audience for supporting services for PWID	Shared value between PWID advocates and audience

Audience:
Role: (direct decisionmaker or influencer of decisionmaker—*if influencer*, identify decisionmaker and relationship between decisionmaker and audience)

Level of knowledge/ source of information on services for PWID	Support/opposition/ unknown	Benefit/danger to audience for supporting services for PWID	Shared value between PWID advocates and audience

Add additional audience assessments as necessary.
Repeat for each priority advocacy issue.

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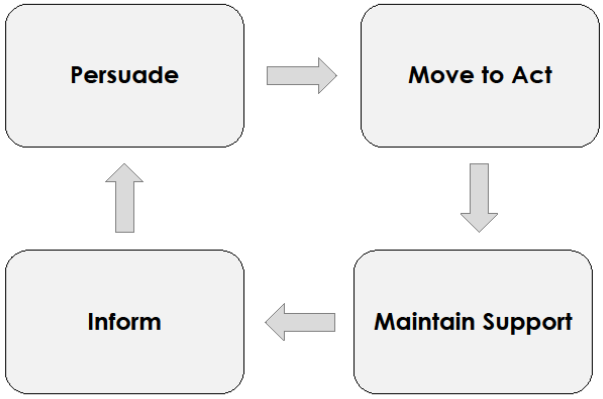
Stakeholder Mapping

As audiences are identified, carefully match the audience with stakeholder(s) that have credibility with that particular audience and message(s) that resonate with the audience's concerns.

To move an audience to action, stakeholders need information to develop a thorough understanding of the issue, the position of the audience, and the desired advocacy action. Once an audience is informed, the advocacy strategy seeks to persuade the audience to feel strongly about the issue, adopt the desired position, and move to action.



Successful Messages

Each message must inform the audience, persuade the audience to feel strongly about the issue, persuade it to adopt the desired position, and finally, persuade it to move to action. For each message developed, ask if it is tailored to the specific audience to accomplish these tasks (inform, persuade, move, maintain). Consider the following:

1. Have all of the key audiences been covered by a credible stakeholder and advocacy message? Have contextual issues been addressed or incorporated?

2. Are advocacy goals clear and attainable?

3. What is the timeline for achieving each advocacy goal? Are there specific events or processes that need to be taken into consideration when considering timelines (elections, parliamentary processes, holidays, opposition advocacy campaigns, etc.)?

4. How will achieving the listed advocacy goals move the group to its final advocacy outcome? (Clarify or describe the outcome.)

5. After these goals are achieved, what are the next steps?

Now that you have a basic advocacy strategy in place, make sure that individuals know their responsibilities and timelines; create a process for feedback, reporting, and adjusting the process based on successes or challenges; keep track of each incremental step; and keep planning for future advocacy.

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Annex: Components of Functioning Legislation

Note: The following example uses MAT as an illustrative example for legislative components. Original content was provided by Lane Porter (Reshevska, Foreit, Beardsley, & Porter, 2010).

Orientation

WHO guidelines (WHO, 1987) and other authoritative sources (UNODC, 2003) advise that legislation for the treatment of drug dependence should include the following components (some of which have been consolidated in this example):

1. Statement of purpose—what the law is to accomplish
2. Designation of agency—responsibility for treatment program
3. Coverage and client eligibility—who is eligible for treatment services
4. Budget—how the treatment program is funded
5. Operations—an adequate structure for operation of programs
6. Accountability and evaluation—proper system of accountability and evaluation
7. Delegation of regulatory powers—identification of agency or agencies to carry out day-to-day operations
8. Human rights—fulfillment of civil, economic, social, and cultural rights protects the individual and advances achievement of treatment goals
9. Reconciliation of legislative provisions—new or revised legislation provides for amendments, revision, or repeal of provisions necessary to reconcile them to new treatment law provisions.

These components are needed whether or not the legislation is broad reaching or addresses a narrower, specialized, aspect (e.g., MAT) of drug dependence. Obviously, the text will vary according to the purpose of the legislation and the country context. Government lawyers, especially in the Ministry of Health and the Ministry of Justice (attorney general's office), should be consulted to advise on the design, drafting, and interpretation of legislation regarding treatment of drug dependence.

This section presents selected legislative provisions illustrating the various components. Unless otherwise indicated, the source is Poland Law of 29 July 2005 on Counteracting Drug Addiction (UNODC, 2007).

Legislative Components

Component 1: Statement of Purpose

The WHO guidelines (WHO, 1987) note that a statement of purpose in legislation should include the following: (a) an indication of the problems that the legislation seeks to remedy and (b) the main purposes of the legislation.

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WHO also recommends that the statement of purpose should be prepared carefully, since it forms the basis of efforts to win support from interested groups and thus ensures that the proposed legislation becomes law (WHO, 1987). It should also emphasize that the treatment program will assist in the prevention and control of illicit drug use by preventing and repairing the damage done to the community and individuals.

Example:

Article 1. Purpose of this Part

The purpose of this part is to provide a legal framework for the provision of treatment programs for drug dependence, including opioid-agonist treatment, by

(a) encouraging the widespread availability and accessibility of said treatment;

(b) protecting the human rights of those who receive treatment;

(c) ensuring quality of care in the treatment provided; and

(d) improving the physical and mental health of those people who seek treatment.

(CHALN, 2006b)

Discussion: It is immediately clear what the law is supposed to accomplish—improve health by means of a human rights-based approach, focusing on the provision of high-quality services designed to improve physical and mental health. The words "availability" and "accessibility," in addition to their common-sense usage, carry special legal significance: they are terms used in the International Covenant on Economic Social and Cultural Rights. The countries of the Central Asian and Eastern European region are parties to this treaty. One of the fundamental obligations included in this Covenant is the "right to health." Using "availability" and "accessibility" in the statement of purpose of the new law creates several advantages for advocates and stakeholders. The government of a country can point to this provision in its required periodic reports to the Committee on Economic, Social and Cultural Rights to demonstrate the country's progress in fulfilling its obligations under the treaty. Advocates can point to these provisions when holding to account those obligated to achieve the legislative purpose.

Example: Establishing principles, rules of conduct, and performance duties for counteracting drug addiction.

Article 1.

This Act shall establish

1. principles and rules of conduct in counteracting drug addiction;
2. tasks and prerogatives of public administration bodies and local governments as well as other entities in the field of counteracting violations of law such as trade, manufacture, processing, conversion, and possession of addictive substances;
3. relevant bodies in performance thereof [……]; and
4. penalties for violating the provisions hereof and the regulations referred to in paragraph.

Article 2.

Counteracting drug addiction shall be performed through proper social, economic, educational, upbringing, and health policymaking and in particular through

1. upbringing, educational, informative, and preventive activities;
2. medical treatment, rehabilitation, and reintegration of addicted persons;
3. reduction of health and social harm;
4. control of addictive substances;
5. combating illicit trade, manufacture, processing, conversion, and possession of addictive substances; and
6. control of cultivation of plants containing addictive substances.

Discussion: Article 1 makes clear that principles and rules of conduct (to counter drug addiction) are purposes of the law. Article 2 reveals that the legislature intended a broad set of methods of performance ("proper social, economic, educational, upbringing and health policymaking"), which includes medical treatment.

Component 2: Designation of Agency Responsible for Treatment Program

WHO notes that it is essential that the legislation designate the agency or agencies responsible for carrying out the treatment program (WHO, 1987), (WHO, 1999a). The country will select the agency most appropriate to oversee the treatment program—e.g., the Ministry of Health or a newly established drug treatment board. The designated agency should be identified in the legislation itself. The agency should be directed in the legislation to coordinate the comprehensive program of treatment, rehabilitation, community and patient education, and epidemiological and other scientific research outlined in the preamble or statement of purpose. WHO guidelines state that, whatever agency is selected, the aim should be to centralize the leadership of the program and ensure effective coordination of treatment services.

Example: Legislation designates a range of institutions with assigned duties.

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Article 6.

1. Counteracting drug addiction shall be performed by the National Bureau for Drug Prevention, hereinafter referred to as the Bureau.
2. The Bureau shall be a state budget unit subordinate to the Minister competent for health matters.
    a. The Bureau's tasks shall comprise the following: [a list of enumerated tasks, assigned to different sectors].

Legislation in a number of countries establishes national coordinating bodies or boards responsible for advice or policymaking in connection with drug problems. These entities can be effective in bringing together the different stakeholder sectors that have duties of drug control, prevention, and treatment. Thus, law enforcement and public health sectors can find common ground to work out a memorandum of understanding (MOU) that reconcile police and treatment goals, to mutual benefit. The legislation serves to establish the duties and powers, both of which should be spelled out clearly (WHO, 1987).

Article 12.

1. The Council for Counteracting Drug Addiction, hereinafter referred to as the Council, is hereby established.
2. The Council shall operate by the Chairman of the Council of Ministers.
3. The Council shall operate as a coordinating and advisory body in the field of counteracting drug addiction.
4. The Chairman of the Council of Ministers shall prescribe, by way of a Regulation, the Council statutes, considering specific conditions and procedure for the operation thereof, including ways of operation of work teams referred to in Article 17.

Discussion: Legislation that fails to clearly assign responsibility to a particular agency creates a barrier to effective treatment. Effective drug treatment programs require services from different sectors, including social services, data collection and reporting, and education and training. The legislation should direct the designated authority to coordinate all of the services and coordinate activities with law enforcement agencies, as well, consistent with the protection of rights set out in the statement of purpose (WHO, 1987).

Component 3: Coverage and Client Eligibility

Example: Coverage means that treatment is permitted and funded under the legislation. Client eligibility to begin treatment refers to minimum requirements necessary to enter treatment for drug dependence. Legislation sets out how medical treatment is to be provided to an addicted person.

Article 26.

1. Medical treatment of an addicted person shall be provided by a healthcare center or a medical practitioner performing medical practice, including group medical practice.
2. Rehabilitation of an addicted person may be provided by
    a. medical practitioner specialized in psychiatry;
    b. person holding a certificate of addiction therapy specialist; and
    c. a person with certificate of addiction therapy instructor.
3. Reintegration of addicted persons may be provided by social integration centers established pursuant to social employment regulations as well as entities referred to in paragraphs 1 and 2 and Article 5(3).

The services referred to in paragraphs 1–4 provided to an addicted person, regardless of his or her place of residence in the country, shall be free of charge.

Example: Legislation sets out how an addicted person may be treated according to an opioid treatment program.

Article 28.

1. An addicted person may be treated according to the substitution treatment program.
2. Substitution treatment may be provided by a healthcare center upon license from the provincial governor (*wojewoda*) issued upon positive opinion of the Bureau Head in relation to meeting requirements set forth in regulations issued pursuant to paragraph 7.
3. The substitution treatment program license in healthcare centers for persons deprived of liberty shall be issued by the General Director of Prison Service upon opinion of the Bureau Head.
4. The substitution treatment license may be granted to the healthcare center, which has
    a. a hospital pharmacy or has entered into an agreement with a pharmacy to distribute a substitute substance;
    b. rooms adapted to:
        i. distributing a substitute substance,
        ii. provide group therapy,
        iii. the work of a medical practitioner, a therapist, or a social worker,
        iv. collect samples for analysis,
        v. store and prepare substitute substances in the way that prevents access of unauthorized persons thereto; and
        vi. proper personnel capacity adequate for the provision of outpatient treatment with particular reference to program head as well as program-trained nurses and auxiliary staff.
5. The licenses referred to in paragraphs 2 and 3 shall be issued by way of an administrative decision.
6. The substitution treatment license shall be revoked in the event that a healthcare center ceases to meet criteria for issuing the license.
7. The minister competent for health matters shall prescribe by way of a regulation specific rules of conduct in substitution treatment as well as specific conditions that the healthcare center providing substitution treatment must meet, considering the welfare of addicted persons.

Component 4: Budget

The legislation should set out a budgetary policy and provision of continuing fiscal support for the mandate.

Example: Legislation provides funding to the entities performing the tasks.

> **Chapter 1. General Provisions**
>
> **Articles 2. and 3.**
>
> 2. The tasks referred to in paragraph 1 (1–3) shall be financed through statutory funds of the entities performing tasks in counteracting drug addiction, funds allocated to the implementation of health programs co-financed by the state budget to be disbursed by the minister competent for health matters and the National Health Fund.
> 3. The tasks referred to in [section y] shall be financed through the state budget from the resources to be disposed of by relevant ministers.

Discussion: One of the identified barriers for drug treatment is a failure of the legislation (and other policy documents) to provide sufficient funds from government sources on a sustained basis. Financing provided by the Global Fund or other international donors does not provide the financial stability for the range of services needed for a successful MAT program. One strength of the above provisions is that they specify that "statutory funds" shall be used for prevention, treatment, and harm reduction activities. This suggests that public funds will be made available. However, advocates need to understand how health funds are raised and allocated in a country to be sure that appropriate financing is designated for treatment services ((WHO, 2006a) at Section 1.5), which may mean examining other legislation or policies that direct allocation and disbursement of funds.

Component 5: Operations

Legislation should set out a structure for program operations that administrators can follow and implement. Operational details should not be specified in the primary legislation but rather in regulations or other subsidiary legislation (see delegation of regulatory powers, below).

Other operational aspects of drug treatment should be covered in legislation, including the following:

- *Research, training, and education.* Legislation should provide for central planning (and financing to the extent determined) for research on the treatment of drug dependence and for the education and training of qualified personnel.
- *Minimum standards for staffing and resources.* Provision should be made for the establishment of a policy that sets out minimum standards (in such detail as may be deemed necessary and desirable) for treatment program staffing and resources, including regulation of professional competence and adequacy of treatment facilities.
- *Regulation of methods and procedures.* Provision should be made for the establishment of a policy for regulating the methods and procedures used in the treatment program, including clear legislative definitions of persons eligible for treatment, grounds (eligibility), and release.

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Legislation and national policies often are out of date and lag well behind health and technical scientific advances and guidance developed by researchers, investigators, and others working on drug treatment. Community advocates seeking to strengthen MAT and other drug treatment legislation, national policies/strategies, regulations, guidelines, protocols, and operational programs should ensure that they take into consideration the latest science-based guidance on drug treatment, such as that reported through WHO expert advisory committees on drug dependence.

Through its Technical Report Series, WHO makes available the findings of various international groups of experts that provide the latest scientific and technical advice on a broad range of medical and public health subjects (WHO, 2009a).

Component 6: Accountability and Evaluation

Example: The legislation should include a proper system of accountability and evaluation, which should be established in the basic law or implementing regulations.

Article 6.

1. Counteracting drug addiction shall be performed by the National Bureau for Drug Prevention, hereinafter referred to as the Bureau.
2. The Bureau shall be a state budget unit subordinate to the minister competent for health matters.
3. The Bureau's tasks shall comprise the following:

   ……..

7. conducting periodical evaluations of prevention, treatment, rehabilitation and reintegration programs in terms of their effectiveness in reducing use of narcotic drugs, psychotropic substances, or substitutes thereof;

   ……..

12. operating the national system of information on drugs and drug addiction as well as monitoring actions of counteracting drug addiction at national and international levels, including:

    a. collecting, gathering, exchanging information, and documentation on counteracting drug addiction that is covered by public statistical research as well as editing and processing collected data,

       ….

    k. evaluating the implementation of the National Programme for Counteracting Drug Addiction on a regular basis.

Discussion: WHO guidance (WHO, 1987) suggests that the only part of an overall treatment program that might not be placed formally under the authority of the designated agency (see component 2) is evaluation, especially when it comes under a National Drug Control or treatment board. This might be better located in a broadly oriented planning office of the board to ensure its independence.

Component 7: Delegation of Regulatory Powers

Legislation alone cannot make things happen. It requires administrative regulations, decrees, or other legal instruments for implementation of legislative policy, to apply technical detail to the program, and to

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adjust operations to respond to changing conditions, scientific advances, and other inevitable trends. The legislation must delegate specific authority to a specific administrative agency to adopt regulations in the area under consideration at that time. In the case of drug treatment programs, the legislation should delegate regulatory powers to the agency responsible for treatment program operations to ensure that they are modified and improved in line with demands and to consider technical and scientific advances in the field.

Example: Operational areas that may be covered in ministerial orders or regulations are as follows:

- Treatment programs
    - Procedures for the approval and registration/accreditation/certification of programs
    - Qualifications and duties of personnel
    - Powers of officers in charge
    - Treatment procedures and record keeping and reporting
    - Relations with courts and other referral centers
- Standards for professional personnel
    - Educational requirements
    - Experience requirements
    - Authority to prescribe therapeutic drugs

Component 8: Human Rights: The Fulfillment of Civil, Economic, Social, and Cultural Rights Protects the Individual and Advances Achievement of Treatment Goals

People who use drugs have equal rights with other people and should not be discriminated against based on their dependence. Legislation should make provision for equitable, non-discriminatory entry to MAT and other treatment programs for drug dependence. Protection of these rights is found, variously, in state constitutions and international and regional human rights treaties, such as the International Covenant on Economic, Social and Cultural Rights. WHO guidelines (WHO, 1987) emphasize that “drug-dependent persons should not lose their civil rights because they are undergoing treatment.”

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Example:

Article 4. Basic Rights of Patients

Every patient has the right

- to a full course of high-quality treatment and follow-up support to be provided in accordance with good clinical practice;
- to treatment without discrimination;
- to meaningful participation in determining his or her own treatment goals, which may include but are not limited to abstinence or changes in drug use that minimize the harms of dependence;
- to meaningful participation in all treatment decisions, including when and how treatment is initiated and withdrawal from treatment;
- to exercise his or her rights as a patient, including:
    - reporting, without retribution, any instances of suspected abuse, neglect, or exploitation of patients in the program;
    - a grievance and appeal process, in accordance with national laws and regulations;
    - input into the policies and services of drug dependence treatment programs; and
    - voluntary withdrawal from treatment at any time.
- to confidentiality of medical records and clinical test results; and
- to be fully informed, including but not limited to the right to receive information on
    - his or her state of health;
    - his or her rights and obligations as a patient, as specified in this Part and in applicable law;
    - the procedure for making a complaint about the services received through the program; and
    - cost and payment conditions and the availability of medical insurance and other possible subsidies.

(CHALN, 2006b)

Discussion: Legislation should declare it to be public policy to respect the rights of persons treated for drug dependence and establish mechanisms for the protection of their civil, political, economic, social, and cultural rights. In particular, legislation should provide for the protection by the law and through legal judicial institutions (courts, tribunals) of the rights, welfare, property, and dignity of drug-dependent persons (WHO, 1987).

The failure to keep the contents of patient records confidential is a major barrier to effective MAT and other types of treatment for drug dependence. WHO guidelines (WHO, 1987) state that "there are serious conflicts of public policy concerning the confidentiality of patient records in a treatment program that is part of an overall national campaign to combat drugs. Treatment personnel will wish to protect confidentiality to the same extent as in any other clinical setting. Yet, in the cases of diversion to treatment in criminal justice system, police often are allowed access to a person's treatment record, often kept in a central register, in order to determine eligibility for different types of treatment." However,

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police should not be permitted to use patient information to identify persons for arrest or surveillance. Except for circumstances involving child abuse and violence, confidentiality must be maintained.

Component 9: Amending, Aligning of Laws

When planning for legislative changes to achieve MAT access, it essential to assess the potential impact for all sectors of such changes on existing laws and policies. For example, when a public health law is modified to support MAT, are law enforcement laws and codes modified to harmonize with the revised public health law? A critical role of conducting an inventory is to identify other laws or policies that will need to be amended or deleted to ensure that new laws do not conflict with other laws. Refer to the policy inventory in this document to identify the full range of sectors.

Questions that will assist in this analysis include the following: What provisions in criminal law, without changes, would or might impede the purposes of the new law? What provisions in law concerning women or children, may be needed to bring such provisions in line with the new legislation? Do laws on confidentiality, informed consent, and other areas need revision?

Conclusion

Examination of existing legislation, gaps, and conflicts is an essential task for policy advocates. Advocates should seek out lawyers in local communities willing to give advice on laws already in the statute books. Attention to the legal basis for treatment should be given early priority—and not relegated to the end of the process.

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