2012

THE GLOBAL STATE OF HARM REDUCTION

TOWARDS AN INTEGRATED RESPONSE

HARM REDUCTION
INTERNATIONAL

CONTENTS

The Global State of Harm Reduction 2012
Towards an integrated response

Edited by Claudia Stoicescu

ISBN 978-0-9566116-6-6

This report was produced by the Public Health, Research and Policy Programme of Harm Reduction International.

Acknowledgements

This report was made possible by the collaborative input of numerous harm reduction networks, drug user organisations, research institutes and advocates. HRI would like to acknowledge the invaluable contribution of these individuals and organisations in providing information on their specific countries or regions:

Asia: Asian Harm Reduction Network; Pascal Tanguay, Population Services International, Thailand; Tasnim Azim, International Centre for Diarrhoeal Disease Research, Bangladesh; Ravindra Rao, United Nations Office on Drugs and Crime, India ***Caribbean:*** Caribbean Harm Reduction Coalition, Saint Lucia; ***Eurasia:*** Umed Ibragimov, Tajikistan; Larisa Abrickaja, Harm Reduction International, UK; ***Latin America:*** Pablo Cymerman, Agostina Chiodi, Intercambios Association Civil, Argentina; ***Middle East and North Africa:*** Middle East and North Africa Harm Reduction Association (MENAHRA), Lebanon; ***North America:*** Harm Reduction Coalition, US; Walter Cavalieri, Canadian Harm Reduction Network; Canadian Drug Policy Coalition, Canada; ***Oceania:*** Australian Injecting and Illicit Drug Users League, Australia; ***Sub-Saharan Africa:*** David Kuria Mbote, Kenya; Bronwyn Myers, Medical Research Council, South Africa ***Western Europe:*** European Monitoring Centre on Drug Use and Drug Addiction

Thanks also to the following people for reviewing sections of the report and for providing input and guidance:

Catherine Cook, Rick Lines, Maria Phelan, Annie Kuch, Damon Barrett, Pippa Gray, Eka Iakobishvili, Larisa Abrickaja, Susie McLean, Annette Verster, Joumana Hermez, Alexandra Ataya, Daniel Wolfe, Azzi Momenghalibaf, Roxanne Saucier, Ronny Waikhom, Elina Suzuki, Fabio Mesquita, Mukta Sharma, Tasnim Azim, Pascal Tanguay, Anna Bergenstrom, Dato Otiashvili, Alisher Latypov, Dasha Ocheret, Sergey Votyagov, Gerry Stimson, Gabriel Moshenska, Ann Fordham, André Noor, Dagmar Hedrich, Joanne Csete, Bronwyn Myers, Donald Macpherson, Connie Carter, Jamie Bridge, Steve Rolles, Gino Vumbaca, Eliot Albers.

Thanks finally to HRI's Scientific Review Committee for providing feedback on sections of the report.

Section 1 was written by Claudia Stoicescu
Section 2 was compiled by Claudia Stoicescu, Lucy Cullen, Elona Toska, Catherine Cook and Larisa Abrickaja
In Section 3, authors, contributors and reviewers are acknowledged at the beginning of each chapter.

Designed by Mark Joyce
Copy-edited by The Write Effect, Oxford

Published by
Harm Reduction International
Unit 2D12 South Bank Technopark
90 London Road London
United Kingdom SE1 6LN
E-mail: info@ihra.net
Website: www.ihra.net

Abbreviations and acronyms

AHRN	Asian Harm Reduction Network
AIVL	Australian Injecting and Illicit Drug Users' League
AIDS	Acquired immunodeficiency syndrome
ANPUD	Asian Network of People who use Drugs
ART	Antiretroviral therapy
ATS	Amphetamine-type stimulants
BMT	Buprenorphine maintenance treatment
CARICOM	Caribbean Community
CHRC	Caribbean Harm Reduction Coalition
CND	Commission on Narcotic Drugs
CPR	Cardiopulmonary resuscitation
CPT	Co-trimoxazole preventive treatment
CSO	Civil society organisation
DCR	Drug consumption room
DFID	Department for International Development (UK)
DOTS	Directly Observed Treatment Short-Course
ECOSOC	Economic and Social Council (UN)
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EMRO WHO	Eastern Mediterranean Regional Office
EC	European Commission
EU	European Union
EuroHRN	European Harm Reduction Network
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GP	General practitioner
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HAT	Heroin assisted treatment
HBV	Hepatitis B virus
HBsAG	Marker in the blood indicating active HBV infection
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HLS	High Level Segment
IDU	Injecting drug use
IHRA	International Harm Reduction Association
INCB	International Narcotics Control Board
INPUD	International Network of People who Use Drugs
MENA	Middle East and North Africa
MENAHRA	Middle East and North African Harm Reduction Network
MDT	Mandatory drug testing
MMT	Methadone maintenance treatment
MSM	Men who have sex with men
NASA	National AIDS Spending assessment
NGO	Non-governmental organisation
NIDU	Non-injecting drug use
NSP	Needle and syringe exchange programme
OST	Opioid substitution therapy
PAHO	Pan American Health Organization (WHO)
PEPFAR	President's Emergency Plan for AIDS Relief
PICTs	Pacific Island Countries and Territories
PNEP	Prison needle and syringe exchange programme
SAHRN	Sub-Saharan African Harm Reduction Network
SAMHSA	US Substance Abuse and Mental Health Services Administration
SIF	Supervised or safer injecting facility
STI	Sexually transmitted infection
SPC	Secretariat of the Pacific Community
TB	Tuberculosis
UAE	United Arab Emirates
UK	United Kingdom of Great Britain and Northern Ireland
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Economic, Social and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
MENARO UNODC	Middle East and North Africa Regional Office
US	United States of America
VCT	Voluntary HIV counselling and testing
WFP	World Food Programme (UN)
WHO	World Health Organization

Introductory comments from Michel Sidibé

Executive Director, UNAIDS

The third edition of the Global State of Harm Reduction report comes at a pivotal time in the HIV epidemic.

Thirty per cent of HIV infections outside sub-Saharan Africa, representing approximately 3 million people, are attributed to injecting drug use. New infections among people who use drugs account for an increasing share of global HIV incidence. In Eastern Europe and Central Asia, injecting drug use accounts for up to 80% of HIV infections, with the annual rate of new HIV infections in the region having increased by more than 250% between 2001 and 2010.[a] In several countries in sub-Saharan Africa including Kenya, Tanzania and South Africa a new wave of infections due to drug injecting has emerged in recent years.

This reality serves as an urgent reminder of the commitment made by all United Nations Member States in the 2011 Political Declaration on HIV/AIDS to reduce transmission of HIV among people who inject drugs by 50% by 2015. Achieving this target demands a cohesive response to HIV from UN agencies, states, civil society and affected communities alike based on the strongest available public health evidence and human rights principles.

UNAIDS is unequivocal in its message to Member States about what works to reduce HIV transmission among people who inject drugs. The evidence is clear and decisive: sufficient provision and coverage of needle and syringe programmes, opioid substitution therapy and antiretroviral therapy as part of the nine key interventions outlined in the WHO, UNODC, UNAIDS technical guide work to effectively reduce HIV transmission among people who inject drugs, as well as providing other measurable benefits to individuals' health and their communities.

Despite the existence of these evidence-based and cost-effective harm reduction interventions, their coverage remains shockingly low. As this report highlights, fewer than two clean needles per month are distributed globally per person who injects drugs, under 13% of people who use drugs are enrolled in opioid substitution therapy, and only 4% of people who inject drugs living with HIV are on antiretroviral treatment. [b]

Most alarming is that a significant number of countries with reported injecting drug use continue to restrict access to these services. Punitive laws and policies, whether via prohibiting the provision of sterile injecting equipment and opioid substitution therapy, criminalising drug use, possession of injecting paraphernalia, or denying HIV treatment to people who use drugs, violate people's right to health and harm the community. Such punitive policies not only fail to reduce HIV transmission but create unintended harms – for instance, by driving people who inject drugs away from prevention and care and resulting in prison overcrowding. Responses to HIV should transcend ideology and be based on scientific evidence and sound human rights principles; they should support, not punish, those affected.

UN Secretary-General Ban Ki-Moon stated that "No one should be stigmatised or discriminated against because of their dependence on drugs" and called on UN Member States to ensure that people who use drugs have equal access to health and social services. An important function of UNAIDS is to highlight the adverse human rights and public health impacts of restrictive laws and policies, and "to create protective social and legal environment that enable access to HIV programmes."[c] Further, in its 2011–2015 Strategy, Getting to Zero, UNAIDS is explicit about reducing by half the number of "countries with punitive laws and practices around HIV transmission, drug use or homosexuality that block effective responses".

The need for legal reform aligned with HIV prevention and treatment, complemented by the meaningful involvement of people who use drugs in service and policy formulation and implementation, has never been more imperative than it is now for achieving the goal of universal access.

On behalf of the UNAIDS Secretariat and our co-sponsors, I am proud to say that UNAIDS is committed to playing the leading role in a coordinated, unambiguous and bold UN response to HIV among people who inject drugs. In an increasingly hostile policy climate, we must replace dangerous complacency with decisive action when it comes to HIV-related harm reduction. Without firm global leadership, evidence and human rights-based national policies, bold resource replenishment for harm reduction and urgent scale-up of harm reduction interventions, there will be no "getting to zero".

The original Global State of Harm Reduction report, published in 2008, provided the first global snapshot of harm reduction service availability and coverage, reflecting the contributions of civil society organisations, multilateral agencies and researchers in the drug-related HIV response. Since then, the biennial reports have become an indispensable reference tool and authoritative resource for a wide range of agencies and individuals engaging in advocacy for harm reduction worldwide. The latest edition

a UNAIDS (2010) *Global Report. UNAIDS Report on the Global AIDS Epidemic.* Geneva: UNAIDS.

b Mathers BM et al. for the UN Reference Group on IDU (2010) The global epidemiology of injecting drug use and HIV among people who inject drugs: A systematic review, *Lancet*, 372 (9651): 1733–1745.

c UNAIDS (2010) *Strategy 2011–2015: Getting to Zero.* Geneva: UNAIDS

of the report includes important data on viral hepatitis, and a timely focus on intersections between drug use, HIV and harm reduction services among other key affected populations, including women, children and men who have sex with men. These sub-populations of people who inject drugs are often the most marginalised in the global AIDS response, requiring immediate services and a proportionate allocation of HIV prevention resources. The promotion of harm reduction as part of a bolder, more united and more comprehensive global effort will be essential to halving HIV infections among people who inject drugs by 2015.

Michel Sidibé
Executive Director, UNAIDS

Introductory comments from Michel Kazatchkine

Member of the Global Commission on Drug Policy

People who inject drugs remain a key population in global health, accounting for around 3 million HIV infections and 10 million hepatitis C infections. This is in addition to the numerous financial, social and public health burdens associated with overdose and drug dependence. But if you are reading this report, you probably know this all too well.

However, these issues – and the proven harm reduction interventions that can address them – are more important now than ever before. In a global economic downturn the burden of drug use is likely to increase, while the finances to deal with these problems become ever more limited. In 2011, United Nations Member States committed to reducing HIV transmission among people who inject drugs by 50% in the next four years, and yet we now face a major crossroads in the response. It is essential that people who use drugs are not forgotten or overlooked.

The Global State of Harm Reduction reports have fast become an integral tool in the ongoing advocacy for people who inject drugs. These biennial documents are helping us to track the progress that has been made. Grassroots projects to protect people who inject drugs in the 1980s have been developed, scaled up and integrated into mainstream healthcare in many diverse countries around the world. The evidence base has also grown, allowing harm reduction to become standard jargon for the key international bodies: including the United Nations General Assembly, the Office of the United Nations High Commissioner for Human Rights, the World Health Organization, the Joint United Nations Programme on HIV/AIDS, and the United Nations Office on Drugs and Crime.

I will always be proud to say that the Global Fund to Fight AIDS, Tuberculosis and Malaria explicitly supports harm reduction and is the leading international donor for this approach.[d] The Global Fund faces its own challenges in the current financial climate but remains committed to funding essential services including those for people who inject drugs. This report is a timely reminder of the urgent need for continued and reliable financing for harm reduction.

This report also highlights huge anomalies in the international response. In 2009, at the International Harm Reduction Conference in Bangkok, I stated that some countries "seem determined to swim against the tide with their wilful blindness to the evidence". This remains the case. For example, there are 120 countries that report HIV transmission among people who inject drugs, yet only 86 countries implement official needle and syringe programmes to some degree in order to prevent this transmission. In a majority of settings, coverage of such programmes is far below the level needed to have an impact. Too often we have seen inexpensive and cost-effective harm reduction approaches being overlooked, overshadowed or undermined by expensive and often ineffectual approaches with a 'war on drugs' rhetoric. The compulsory detention, forced treatment, execution, torture and corporal punishment of people who use drugs simply have to stop. They are violations of human rights and international law.

This is the third edition of this flagship publication, which provides the latest data on harm reduction, expanded regional updates and key thematic chapters. I would like to thank Harm Reduction International for giving me the opportunity to provide these introductory comments, and I wish you all the best in using this valuable resource to promote harm reduction in your own settings.

Professor Michel Kazatchkine
Former Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria
Member of the Global Commission on Drug Policy

d Bridge J et al. (2012) Global Fund Investments in Harm Reduction from 2002 to 2009, *International Journal of Drug Policy* (23): 279–285.

Introductory comments by Eliot Ross Albers

Executive Director, International Network of People who Use Drugs (INPUD)

On behalf of the International Network of People Who Use Drugs (INPUD), I welcome this third edition of the Global State of Harm Reduction, and thank Harm Reduction International for giving me the chance to add these opening remarks to what has become an essential tool used by INPUD and our members in their advocacy for the provision of essential harm reduction services for our community.

The evidence base for the efficacy of harm reduction programmes is irrefutable and widely supported by international agencies including UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Health Organization (WHO) and the Office of the United Nations High Commissioner for Human Rights.

Despite the overwhelming evidence in favour of harm reduction programmes, this report shows that there remains a significant discrepancy between what we know should be provided[e] and what actually is.

The publication of this report is especially timely, as not only are we in the grip of a global recession, but we are also seeing a political retreat from harm reduction on the domestic front by several states that have historically been strong supporters (e.g. the Netherlands and the United Kingdom); on the other hand, their international support for harm reduction remains strong. In many countries in Eastern Europe where the HIV and viral hepatitis epidemics are especially acute among people who inject drugs and largely driven by the sharing of syringes, harm reduction is scorned. For example, Russia, which has a population of 2 million injecting opiate users, of whom 37.2% are estimated to be living with HIV (in some regions prevalence reaches up to 75%),[f] refuses to provide needle and syringe exchange and prohibits the provision of methadone. The USA has also reinstated its ban on spending federal funds on needle and syringe programmes. This is a highly retrogressive step, as it applies not just to the USA but to all programmes, no matter where they are based, that receive federal funds.

Far from being provided with the services that we need, people who inject drugs remain criminalised, marginalised, repressed and discriminated against. We face human rights abuses including torture and corporal punishment, execution, arbitrary violence and abuse, compulsory detention and forced treatment in facilities that provide no medical services but that do subject their inmates to forced labour and often cruel and inhuman treatment.[g] [h] In spite of a recent call for their immediate closure sponsored by 12 UN bodies,[i] these facilities remain open and are often applauded, or simply ignored, by the guardians of the international system of punitive prohibition.

The Global State of Harm Reduction 2012 shows that where progress has taken place, it has often been at an insufficiently low level to have an impact on viral hepatitis and HIV epidemics among people who inject drugs, and the new programmes that have been implemented are generally small-scale pilots. The universal provision of harm reduction services is just the first step in righting the systematic human rights abuses to which people who use drugs are subjected. INPUD will continue to advocate and organise to make the voices of the illegal-drug-using community heard.

The Global State of Harm Reduction is an invaluable tool in INPUD's advocacy work and a strident wake-up call to anyone who believes that the work of harm reduction is done. We have known for more than 20 years what measures need to be taken to prevent HIV transmission among people who inject drugs, but we are facing a barrier of intransigent ignorance, prejudice and a refusal on the part of many governments around the world to accept the science. This is unacceptable and should be called what it is – wilful neglect and a breach of basic human rights, not least of all, the inalienable right to the highest standard of health to which all people, whether they use illegal drugs or not, are entitled.

Eliot Ross Albers
Executive Director, INPUD

e WHO, UNODC, UNAIDS (2009) *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users.* Geneva: World Health Organization.

f Federal Service on Customers' Rights and Human Well-being Surveillance of the Russian Federation (2010) *Country Progress Report on the progress of implementing the Declaration of Commitment on HIV/AIDS adopted at the 26th United Nations General Assembly Special Session on HIV/AIDS. Reporting period: January 2008 – December 2009.* Moscow: Federal Service on Customers' Rights and Human Well-being Surveillance of the Russian Federation.

g Stevens A (2012) The ethics and effectiveness of coerced treatment of people who use drugs, *Human Rights and Drugs*, 2(1) 7–16.

h Hall W et al. (2012) Compulsory detention, forced detoxification and enforced labour are not ethically acceptable or effective ways to treat addiction, *Addiction*, pp. 1-3. doi:10.1111/j.1360-0443.2012.03888.x, http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2012.03888.x/pdf Accessed 9 July 2012.

i United Nations (2012) Joint Statement: Compulsory drug detention and rehabilitation centres. New York: UN, http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/JC2310_Joint%20Statement6March12FINAL_en.pdf Accessed 20 May 2012.

Introduction

About the Global State of Harm Reduction 2012

In 2008 Harm Reduction International (HRI) released the *Global State of Harm Reduction,* a report that mapped responses to drug-related HIV and hepatitis C epidemics around the world for the first time.[j] The information gathered for the report provided a critical baseline against which progress could be measured in terms of the international, regional and national recognition of harm reduction in policy and practice. The second edition, *Global State of Harm Reduction 2010: Key Issues for Broadening the Response*, documented major developments in harm reduction policy adoption and programme implementation that had occurred since 2008, enabling some assessment of global progress. It also explored several key issues for harm reduction, such as the response to amphetamine-related harms; harm reduction in prisons; the reduction of various drug-related health harms including bacterial infections, tuberculosis, viral hepatitis and overdose; and the extent to which financial resources for harm reduction are available.[k]

The *Global State of Harm Reduction 2012* presents the major developments in harm reduction policy adoption and programme implementation that have occurred since 2010. It also explores several major topics for developing an integrated harm reduction response, such as effective harm reduction services for women who inject drugs; access to harm reduction services by young people; drug use among men who have sex with men and implications for harm reduction; global progress toward building an enabling policy environment for harm reduction implementation through drug decriminalisation and regulation; case studies on sustainability and scale-up of services; and promotion of harm reduction approaches in challenging environments.

This report, and other *Global State of Harm Reduction* resources[l] are designed to provide advocacy and reference tools for a wide range of audiences, such as international donor organisations, multilateral and bilateral agencies, civil society and non-governmental organisations (NGOs), including organisations of people who use drugs, as well as researchers and the media.

Methodology

The information in Sections 1 and 2 of this report was gathered using existing data sources, including research papers and reports from multilateral agencies, international NGOs, civil society and harm reduction networks, as well as expert opinion from organisations of people who use drugs and those working in the harm reduction field. Within each region, HRI enlisted support from regional harm reduction networks and researchers to gather qualitative information on key developments[m] and to review population size estimates, data on the epidemiology of HIV and viral hepatitis among people who inject drugs, and the extent of provision of needle and syringe exchange programmes (NSPs) and opioid substitution therapy (OST).

Quantitative data for the tables at the beginning of each regional update in Section 2 were obtained from a variety of sources. These data seek to reflect the most recent available estimates within each country at the time of the data collection exercise (January–April 2012). Sources used include global systematic reviews conducted by the Reference Group to the United Nations on HIV/ AIDS and Injecting Drug Use (UN Reference Group) on the epidemiology of injecting drug use and HIV and the coverage of key harm reduction interventions in 2008[n] and 2010,[o] updated reports since then by the UN Reference Group (including forthcoming articles),[p] national Global AIDS Progress reports submitted to UNAIDS in March 2012 and national surveillance studies conducted since 2010.[q] Where none of these sources were available, the data were unpublished or their reliability was questioned by civil society, researchers or other experts, expert opinion was sought to identify additional sources of information and verify their reliability. Unless HRI was able to identify newer data, prevalence estimates for viral hepatitis were sourced from the review of reviews published by Nelson and colleagues in the *Lancet* in 2011. Data for Western Europe and several countries in Eastern Europe were sourced from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2012 statistical bulletin, unless otherwise stated in the text.[r] Sources are provided for all of the estimates reported, and any discrepancies in data are noted in footnotes within the tables or in the text.

j Cook C and Kanaef N (2008) *Global State of Harm Reduction 2008: Mapping the Response to Drug-Related HIV and Hepatitis C Epidemics*. London: Harm Reduction International.

k Cook C (2010) *The Global State of Harm Reduction: Key Issues for Broadening the Response*. London: International Harm Reduction Association.

l See www.ihra.net for more details.

m A copy of the information collection questionnaire for the *Global State of Harm Reduction 2012* can be obtained by contacting info@ihra.net.

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

o Mathers B et al. (2010). HIV prevention, treatment, and care services for people who inject drugs: A systematic review of global, regional, and national coverage, *Lancet*, 375, DOI:10.1016/S0140-6736(10)60232-2.

p Petersen Z, Pluddemann A, van Hout MC, Dada S, Parry C & Myers B on behalf of the Secretariat to the United Nations Reference Group on Injecting Drug Use and HIV (2012) *The prevalence of HIV among people who inject drugs and availability of prevention and treatment services: findings from 21 countries. A brief report*. Parow: South African Medical Research Council.

q Nelson PK, Mathers BM, Cowie B, Hagan H, Des Jarlais D, Horyniak D & Degenhardt L (2011) Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews, *Lancet,* 378(9791): 571–583.

r See http://www.emcdda.europa.eu/stats12 for more details.

Figures published through international reporting systems, such as those undertaken by the World Health Organization and UNAIDS, may differ from those collated here due the different scope of monitoring surveys, varying reliability criteria and focus on regions that may include different country classifications.

Regions were largely identified using the coverage of the regional harm reduction networks. Therefore, this report examines the regions of Oceania, Asia, Eurasia (Central and Eastern Europe and Central Asia), Western Europe, Sub-Saharan Africa, Middle East and North Africa, Latin America, the Caribbean and North America.

Where possible, the regional updates were peer reviewed by the regional harm reduction networks and other experts in the field (see Acknowledgements).

This report also contains chapters on major topics for the harm reduction response, which were identified through feedback on the second report and consultation with HRI's Scientific Review Committee and key partners of the organisation. These chapters have been prepared by representatives from civil society, research and multilateral agencies with specific expertise in the area, and reviewed by peers in the field. Although some of the issues covered are fairly new areas with relatively little research to report on, these chapters aim to present what is currently known and raise issues for the international harm reduction community to consider.

Data quality

For global population size estimates of people who inject drugs and HIV epidemiology, this report draws heavily on global systematic reviews conducted by the UN Reference Group. These reviews present only data that fits with reliability criteria established by the UN Reference Group, resulting in data gaps for many countries with HIV epidemics among people who inject drugs.

Given that this remains the most reliable assessment of the state of the epidemic, HRI has presented the UN Reference Group data where these data were the most recent available estimates, and provided data from other sources for those countries and territories for which other reliable sources were available. These included bio-behavioural surveillance reports, academic studies and, for information on the most recent number of NSP and OST sites, expert opinion was also consulted. The data collection process involved regional harm reduction networks and other regional experts reviewing the regional data gathered, including the figures reported in the tables. The data tables were additionally shared for review with researchers and members of the UN Reference Group from around the world. Where the accuracy of data was questioned but no alternate, reliable figures were provided, this is noted in footnotes or within the text.

Although population size estimates for people who inject drugs have become available at the national level for several countries since 2008 (for instance, through UNAIDS Global AIDS Progress reports), a systematic calculation of global population size estimates was not conducted in the context of this report.

The significant data gaps are an important reminder of the need for improved monitoring systems and data reporting on HIV and drug use around the world.

In reporting on the existence and coverage of harm reduction, this report sought input from harm reduction networks, researchers and other experts in the field. Where no updates were available, 2010 data was reported.

The data presented here on epidemiology and coverage represent the most recent, verifiable estimates currently available; however, lack of uniformity in measures, data collection methodologies and definitions for the estimates provided renders cross-national and regional comparisons challenging.

Limitations

This report attempts to provide a global snapshot of harm reduction policies and programmes and, as such, has several limitations. It does not provide an extensive evaluation of the services or policies in place. It must be recognised that the existence of a service does not necessarily denote adequate quality and coverage to have an impact on drug-related harms.

While this report aims to cover some important areas for harm reduction, it focuses largely on the public health aspects of the response and does not document the full spectrum of social and legal harms faced by people who use drugs. Neither does it cover the full spectrum of health harms related to substance use, including, for example, those related to alcohol and tobacco use.

A significant gap in the current edition of the report is the omission of a thematic focus on the intersection between sex work and drug use. HRI is presently in the process of developing a separate publication and web resources addressing drug use among sex workers and broader implications for harm reduction.

Report structure

Section 1 provides a global overview of harm reduction policy and programming.

Section 2 contains nine brief regional updates – Asia, Eurasia, Western Europe, the Caribbean, Latin America, North America, Oceania, Middle East and North Africa, and Sub-Saharan Africa – that examine the developments for harm reduction since 2010.

Section 3 comprises six chapters that explore themes relevant to developing an integrated harm reduction response, including specific barriers to service access faced by women and young people who inject drugs, drug use among men who have sex with men and implications for harm reduction, a global overview of drug decriminalisation policies around the world, and an exploration of sustaining and scaling up services in challenging social and political environments.

1.1 | Harm Reduction
A Global Update

Harm Reduction: A Global Update

Harm reduction is increasing in recognition around the world. This is demonstrated by several significant developments in policy, implementation and research in the last two years. Among these are increases in the number of countries addressing harm reduction in national policies and strategic plans, as well as those gathering epidemiology and coverage monitoring data among people who inject drugs (PWID) and implementing harm reduction programmes. However, the availability and coverage of harm reduction programmes remains uneven among and within regions, and is particularly limited in low- and middle- income countries. In many parts of the world, harm reduction programmes face widespread challenges in the context of economic and donor uncertainty (see below for more details).

Injecting drug use (IDU) has been documented in at least 158 countries and territories globally.[1] The latest available global population size estimates indicate that 15.9 million (range 11–21 million) people inject drugs around the world.[2] The most significant numbers of PWID reside in China, the USA and Russia. Reports of HIV among PWID are documented in 120 countries.[3] In 2010, nearly half (47%) of people who inject drugs living with HIV in low- and middle-income countries came from five nations – China, Vietnam, Malaysia, Russia and Ukraine.[32] Specific sub-populations of PWID, including young people and women who inject drugs, experience elevated barriers to service access (see Sections 2 and 3 for more details).

PWID also face elevated rates of viral hepatitis and tuberculosis. Recent estimates indicate that approximately 10 million PWID worldwide may have hepatitis C, a figure that surpasses HIV infection among this population.[3] China is home to more than half (1.6 million, range 1.1–2.2 million) of PWID living with hepatitis C worldwide, followed by the USA (1.5 million) and Russia (1.3 million).[3] Asia has the largest populations of PWID with active hepatitis B (HbsAg)[a] (300,000, range 100,000–700,000). People living with HIV who also inject drugs have a two- to six-fold increased risk of developing TB compared to non-injectors, and commonly have co-infection with hepatitis B (HBV) and C (HCV) viral infection.[4] This risk is on average twenty-three times higher in prisons than in the general population[5] (see Section 2 for more details).

a HbsAg indicates active (either acute or chronic) infection. Approximately 95% of adults with acute HBV infection clear the virus and develop anti-HBc and hepatitis B surface antibodies (anti-HBs). People who inject drugs may have lower clearance rates for HBV than the general population because more PWID may become chronically infected. For more information, see Nelson PK et al (2011) Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews, *Lancet*, 378(9791): 571–583.

The global harm reduction response

International policy developments for harm reduction

In the past two years since 2010, several developments in international policy have occurred, with important implications for harm reduction:

» On 16 December 2011 the US Congress reinstated the ban on federal funding for needle and syringe exchange programmes (NSPs).[6] The decision comes just two years after the 21-year-old ban was repealed and signed into law by President Barack Obama in December 2009, thereby allowing states and local public health officials to use federal funds for sterile syringe access. The decision includes reinstatements of bans on both domestic and international use of US federal funds for NSPs as part of the 2012 omnibus spending bill.

» At the UN High Level Meeting on AIDS in June 2011, states adopted a new declaration with revised targets for measuring progress in the global response, the *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS*.[7] The text of the final outcome document reflects ongoing tensions between evidence and human rights-based approaches, and relativist stances by some states, which emphasise 'local circumstances, ethics and cultural values' at the expense of public health-based strategies.[8] However, the document also reflected negotiation successes, including the explicit mention of the WHO/UNAIDS/UNODC comprehensive harm reduction package, a pledge to reduce HIV among PWID by 50% by 2015 and concrete, time-bound coverage and funding targets.

» Countries submitted their first reports to monitor progress against commitments in the 2011 Political Declaration on HIV/AIDS to UNAIDS in March 2012, which will form the basis of an end-of-year report on the state of the global HIV epidemic. The core indicators for country progress reporting have been revised to reflect the new targets set out in the 2011 Political Declaration, and represent one of the most comprehensive tools to date for monitoring the epidemiology of HIV and service coverage among PWID by multilateral agencies.[9]

» In March 2012, twelve UN agencies called on states to close compulsory drug detention and rehabilitation centres and implement voluntary, evidence-informed and rights-based health and social services in the community.[10] This is a particularly relevant development for countries in Asia, where the continued commitment to compulsory detention by some countries remains a serious human rights concern.[11-12] During a meeting with civil society at the 55th Session of the Commission on Narcotic Drugs (CND), however, the International Narcotics Control Board (INCB) refused to denounce such

centres, or 'any atrocity' committed in the name of drug control.[13] The INCB President also refused to refrain from referring to people who use drugs (PWUD) as 'abusers' and 'drug abusing offenders' when asked to do so by the International Network of People who Use Drugs (INPUD), who explained the terms were seen as stigmatising and offensive.

» The role of naloxone in addressing opioid overdose was recognised for the first time in a high-level international resolution in March 2012. Members at the 55th CND unanimously endorsed a resolution promoting evidence-based strategies to address opioid overdose.[14] Introduced by the Czech Republic and co-sponsored by Israel and Denmark (the latter on behalf of the European Union), the resolution calls on UNODC, WHO and other international organisations to work with member states to address the global overdose epidemic.

» Also at the 54th session of the CND in March 2011, a resolution was adopted, co-sponsored by the USA, entitled 'Achieving zero new infections of HIV among injecting and other drug users.'[15] Following tense debates, with Russia in particular being resistant to the resolution, member states finally endorsed the WHO, UNAIDS, UNODC comprehensive package on HIV and IDU – a first at the CND.

» The emerging issue of new psychoactive substances, commonly known as 'legal highs', and the need to explore considered, evidence-informed approaches other than criminal justice, was recognised in a progressive resolution adopted at the 55th CND.[16] Originally proposed by Australia, the resolution did not call for 'legal highs' to be banned or criminalised, but rather urged countries 'to consider a wide variety of evidence-based control measures to tackle the emergence of new psychoactive substances, including the use of consumer protection, legislation regarding medicine and legislation regarding hazardous substances.' Advocates welcomed the resolution, noting that an acknowledgement of alternative means of regulating illicit substances is an important step forward for member states at the CND.[17]

» The World Health Organization (WHO) has developed new guidance[b] on prevention strategies for viral hepatitis B and C in PWID planned for release at the 19th International AIDS Conference Washington, DC, in July 2012. Recommendations will comprise three distinct but interlinked areas: surveillance, screening and antiretroviral therapy (ART) management in people with HIV and viral Hepatitis B and C co-infections. Recommendations include strengthening hepatitis monitoring systems through standardising case definitions of viral hepatitis, integrating hepatitis with HIV, TB and STI surveillance, and considering sentinel surveillance for acute hepatitis among key populations at higher risk, including PWID.

» Since 2010 the leadership of the UN Office on Drugs and Crime (UNODC) on HIV-related harm reduction has deteriorated. As UNODC is the lead UNAIDS co-sponsor with responsibility for HIV and IDU, this is a considerable concern. Since taking the office of Executive Director, Mr Yury Fedotov has failed to endorse basic HIV prevention measures related to IDU and has questioned whether his agency has a harm reduction mandate[18] or an official position on OST.[19] HIV/AIDS organisations took the occasion of World AIDS Day in 2011 to write to Mr Fedotov to seek clarification on these issues. They received no reply from Mr Fedotov, rather an ambiguous reply from another senior member of staff.

» During the 55th session of the CND, the UNODC Executive Director's report to member states on HIV and IDU reworded the agreed WHO, UNAIDS, UNODC comprehensive package to give prominence to abstinence-based drug treatment and to downplay opioid substitution therapy (OST).[20] Throughout the report, HIV prevention was seen as a subset of drug treatment, while the phrases 'opioid substitution therapy' and 'needle and syringe programmes' were avoided. Following an intervention by the European Union, UNODC had to correct the actual wording of the comprehensive package at the plenary of the Commission. To date the document remains unchanged.

» Within the European Union, Sweden and Italy continued to play negative roles on harm reduction. As a group, the European Union has weakened in its harm reduction position. This was evident at the High Level Meeting on HIV at the UN, and despite some important progress, also at the 55th CND. This is due in part to harm reduction being seen as a less important diplomatic issue for countries that previously adopted leadership roles internationally, including the United Kingdom and the Netherlands. This is despite strong, ongoing harm reduction programming nationally and funding for harm reduction internationally from those same countries.

An enabling environment for harm reduction

In 2012 there are 97 countries and territories that support a harm reduction approach, four more[c] than reported in 2010 (see Table 1.1.1).[21d] This support is explicit either in national policy documents (eighty-three countries – four more than in 2010), and/or through the implementation or tolerance of harm reduction interventions such as NSPs (eighty-six countries – four more than in 2010)[e] or OST (seventy-seven countries – seven more than in 2010).[f]

b The new guidance can be downloaded from http://www.who.int/hiv/pub/guidelines/hepatitis/en/.

c Macau, Jordan, Syria, Tunisia.
d Inclusion in this list refers both to countries or territories that have newly supported a harm reduction approach in policy and/or practice since 2010, and to countries or territories for which 'not known' was reported in 2010 (i.e. Macau).
e South Africa, Tanzania, Macau and Laos PDR.
f Cambodia, Bangladesh, Tajikistan, Kenya, Tanzania, Macau and Kosovo.

There is a trend towards less punitive responses toward PWID in some countries and regions, with between 25 and 30 countries adopting some form of decriminalisation of possession of drugs for personal use.[g] Although significant variations in such reforms and how they are implemented and evaluated makes generalisations difficult, emerging evidence indicates that decriminalisation provides an enabling environment supporting implementation and take-up of harm reduction programmes proven to reduce HIV and viral hepatitis transmission.

Table 1.1.1: Countries or territories employing a harm reduction approach in policy or practice[h]

Country or territory	Explicit supportive reference to harm reduction in national policy documents	Needle exchange programmes operational	Opioid substitution programmes operational	Drug consumption room(s)
ASIA				
Afghanistan	✓	✓	✓	x
Bangladesh	✓	✓	✓	x
Cambodia	✓	✓	x	x
China	✓	✓	✓	x
Hong Kong	✓	x	✓	x
India	✓	✓	✓	x
Indonesia	✓	✓	✓	x
Macau	✓	✓	✓	x
Malaysia	✓	✓	✓	x
Maldives	x	x	✓	x
Mongolia	x	✓	x	x
Myanmar	✓	✓	✓	x
Nepal	✓	✓	✓	x
Pakistan	✓	✓	x	x
PDR Laos	✓	x	x	x
Philippines	✓	✓	x	x
Taiwan	✓	✓	✓	x
Thailand	✓	✓	✓	x
Vietnam	✓	✓	✓	x
CARIBBEAN				
Puerto Rico	x	✓	✓	x
Trinidad and Tobago	✓	x	x	x
EURASIA				
Albania	✓	✓	✓	x
Armenia	✓	✓	✓	x
Azerbaijan	x	✓	✓	x
Belarus	✓	✓	✓	x
Bosnia & Herzegovina	✓	✓	✓	x
Bulgaria	✓	✓	✓	x
Croatia	✓	✓	✓	x
Czech Republic	✓	✓	✓	x
Estonia	✓	✓	✓	x
Georgia	✓	✓	✓	x
Hungary	✓	✓	✓	x
Kazakhstan	✓	✓	✓	x
Kosovo	✓	✓	✓	x
Kyrgyzstan	✓	✓	✓	x
Latvia	✓	✓	✓	x
Lithuania	✓	✓	✓	x
Macedonia	✓	✓	✓	x
Moldova	✓	✓	✓	x
Montenegro	✓	✓	✓	x
Poland	✓	✓	✓	x
Romania	✓	✓	✓	x
Russia	x	✓	x	x
Serbia	✓	✓	✓	x
Slovakia	✓	✓	✓	x
Slovenia	✓	✓	✓	x
Tajikistan	✓	✓	✓	x
Turkmenistan	x	✓	x	x
Ukraine	✓	✓	✓	x
Uzbekistan	✓	✓	x	x
LATIN AMERICA				
Argentina	✓	✓	x	x
Brazil	✓	✓	x	x
Colombia	✓	x	✓	x
Mexico	✓	✓	✓	x
Paraguay	✓	✓	x	x
Uruguay	✓	✓	x	x
MIDDLE EAST and NORTH AFRICA				
Egypt	x	✓	x	x
Iran	✓	✓	✓	x
Israel	✓	✓	✓	x
Jordan	✓	x	x	x
Lebanon	✓	✓	✓	x
Morocco	✓	✓	x	x
Oman	x	✓	x	x
Palestine	x	✓	x	x
Syria	✓	x	x	x
Tunisia	✓	✓	x	x
NORTH AMERICA				
Canada	✓	✓	✓	✓
United States	✓	✓	✓	x
OCEANIA				
Australia	✓	✓	✓	✓
New Zealand	✓	✓	✓	x
SUB-SAHARAN AFRICA				
Kenya	✓	x	✓	x
Mauritius	✓	✓	✓	x
Senegal	x	x	✓	x
Seychelles	x	x	x	x
South Africa	x	✓	✓	x

g See Chapter 3.4 of this publication for a global summary of drug decriminalisation policies.

h This includes countries that have harm reduction in their national policies or strategy documents on HIV, viral hepatitis and/or drug use. In many countries, harm reduction may appear in one or more of such policies, but not all. Inclusion in this table of NSP, OST and DCRs indicates only the availability of these interventions, rather than their scope or coverage.

Country or territory	Explicit supportive reference to harm reduction in national policy documents	Needle exchange programmes operational	Opioid substitution programmes operational	Drug consumption room(s)
Tanzania	✓	✓	✓	x
Zanzibar	✓	x	x	x
WESTERN EUROPE				
Austria	✓	✓	✓	x
Belgium	✓	✓	✓	x
Cyprus	✓	✓	✓	x
Denmark	✓	✓	✓	x
Finland	✓	✓	✓	x
France	✓	✓	✓	x
Germany	✓	✓	✓	✓
Greece	✓	✓	✓	x
Iceland	nk	x	✓	x
Ireland	✓	✓	✓	x
Italy	✓	✓	✓	x
Luxembourg	✓	✓	✓	✓
Malta	✓	✓	✓	x
Netherlands	✓	✓	✓	✓
Norway	✓	✓	✓	✓
Portugal	✓	✓	✓	x
Spain	✓	✓	✓	✓
Sweden	✓	✓	✓	x
Switzerland	✓	✓	✓	✓
United Kingdom	✓	✓	✓	x

Civil society and networks

Harm reduction networks continue to operate in every region of the world, and are making important contributions at national, regional and international levels. Regional networks include the AHRN Federation, Caribbean Harm Reduction Coalition (CHRC), Eurasian Harm Reduction Network (EHRN), European Harm Reduction Network (EuroHRN), Middle East and North Africa Harm Reduction Association (MENAHRA), Intercambios Asociación Civil (Latin America) and a nascent Sub-Saharan Africa Network. There are also numerous national and local level networks that continue to advocate for harm reduction at these levels.

In recent years, there have been a number of notable developments among regional harm reduction networks. These include the expansion of EuroHRN, which was formed in 2009. The major outputs of the network have been the publication of the first civil society audit in Europe and a report detailing a mapping of drug user organisations throughout the region.[22] The research into drug user organisations was particularly significant as it led to the formation of the first pan-European network of PWUD. EuroHRN held its first European Harm Reduction Meeting in Marseille in 2011.

The Asian Harm Reduction Network has gone through significant modifications including a name change to the AHRN Federation. It has undergone organisational restructuring to develop a federation model, which aims to allow national harm reduction organisations and networks to have a key role in determining the future and priorities of the network. The federation consists of national and sub-national harm reduction networks, as well as key focal organisations, and focuses its efforts in India, Indonesia, Thailand, Cambodia, Myanmar, China, Malaysia and Nepal.

MENAHRA has been a significant catalyst for increasing attention to harm reduction in the MENA region since its founding in 2007.[23] In January 2012, MENAHRA began implementation of its round 10 Global Fund grant to expand harm reduction in twelve countries[i] across the region through capacity building, training, advocacy and networking activities. The overall aim of this project is to create a conducive environment for the scale-up and implementation of HIV and harm reduction programmes across the region.

Global networks that include harm reduction as a key component of their work continue to operate at the international level. These include YouthRISE, International Network of People Who Use Drugs (INPUD), International Nursing Harm Reduction Network (INHRN), International Doctors for Healthy Drug Policies (IDHDP), International Centre for Science in Drug Policy (ICSDP), Law Enforcement and HIV Network (LEAHN), Women's Harm Reduction Network (WHRIN) and the International Drug Policy Consortium (IDPC).

IDPC has developed a strong membership base and produced several publications since 2010, including the Second Edition of the IDPC Drug Policy Guide and over twenty drug policy briefings. IDPC facilitates strong civil society involvement and engagement with policy makers at regional and international forums, particularly at the CND, and works at national and international levels to promote open dialogue around a human rights and public health approach to drug policy.

There has been some progress in the engagement of civil society in international policy-making. During the 54th CND session, a resolution was adopted on improving civil society engagement at the Commission. During informal negotiations it was one of the most contested resolutions, reflecting many member states' ongoing discomfort with civil society engagement. The following year, however, the first official civil society hearing was held at the CND: an important and positive development. Despite this improvement, the 2012 session of the CND was marred by the secretariat's censorship of civil society statements. Two oral statements – one criticising the UNODC's Executive Director for a lack of leadership on HIV, and the other on human rights concerns about the International Narcotics Control Board's annual report – were not permitted and had to be amended.

i Iran, Pakistan, Libya, Lebanon, Syria, Jordan, Bahrain, Morocco, Egypt, Afghanistan, Oman and Palestine.

Civil society launched a number of significant declarations that sought to mobilise international support for key international forums in 2010 and 2011. The Vienna Declaration,[24] a global initiative supported by the Open Society Foundations, was launched at the 18th International AIDS conference in July 2010. Calling for drug policy to be based on scientific evidence, the Declaration received over 17,000 endorsements in less than three months. Notable signatories include three former Latin American presidents, as well as cities, Nobel laureates, scientists, lawyers, academics, researchers, and activists from around the world.

In advance of the UN High Level Meeting (HLM) on AIDS held in June 2011, Harm Reduction International (HRI) launched the Beirut Declaration on HIV and Injecting Drug Use: A Global Call for Action, an initiative aimed at increasing support for harm reduction and related drug policy reform within the proceedings and outputs of the HLM, and raising awareness of the limited international support for harm reduction and the drug policy reforms necessary for its optimal implementation. The Declaration was endorsed by over 200 organisations in the broader HIV/AIDS and development fields[j] and was featured in prominent forums. For example, the 9 April 2011 edition of the scientific journal the *Lancet* featured the Beirut Declaration in its editorial, calling for increased attention to harm reduction, IDU and drug policy reform within the proceedings of the HLM.[25]

The visibility of regional networks of PWUD has also increased in recent years; new networks have been established in Eurasia, Europe and the MENA regions. The Eurasian[k] and MENA networks were established in 2010, and the European[l] network in 2011.

INPUD has undergone significant changes since 2010 with the selection of a new executive director, a full-time staff team and a newly elected board. INPUD's increased capacity has allowed its staff and members to engage actively in international forums such as the CND and the UNAIDS Programme Coordinating Board (PCB), and at the community level in Afghanistan, Kenya, Tanzania, Eastern Europe, and Central Asia through the delivery of capacity-building workshops and technical assistance. Since 2010, INPUD has become an increasingly important partner representing the perspective of drug using and injecting populations to civil society and multilateral agencies.

The harm reduction 'network of networks' continues to work collectively and share information. It is made up of regional and global networks as well as national harm reduction networks, which include the Canadian Harm Reduction Network (CHRN), Colectivo por Una Politicia Integral Hacia las Drogues (CUPIHD, based in Mexico) and the Harm Reduction Coalition (HRC, based in the USA).

Community Action on Harm Reduction

Community Action on Harm Reduction (CAHR) is a new and ambitious five-year project led by the International HIV/AIDS Alliance and made possible by a grant from the Dutch Ministry of Internal Affairs (BUZA). It aims to significantly improve HIV and harm reduction services for people who inject drugs, their partners and children, in China, India, Indonesia, Kenya and Malaysia. The project works to introduce essential harm reduction interventions in Kenya, improve access to community-based support services in China, increase the quality of behavioural change programming in India and Malaysia, and expand quality harm reduction services to new communities within PWID populations in Indonesia. Overall, it aims to reach more than 180,000 people who inject drugs, their partners and children. There is a strong focus on building the capacity of community-based organisations as well as the meaningful engagement of people who use drugs in the development, implementation and evaluation of services within each country.

Global coverage of harm reduction services

The lack of reliable population size estimates for PWID in several countries, and inconsistencies in the quality of available data, make accurate assessments of progress since 2010 challenging. Generally, where data is available, harm reduction service provision has increased in countries where it was already being implemented. Several countries in sub-Saharan Africa, Asia and parts of Eastern Europe and Central Asia have NSPs and/or OST. Despite these improvements, expansion of programmes has been slow and many new programmes are small-scale pilots. The last two years have also witnessed significant scale-down of services in countries with some of the highest HIV burdens among PWID. In most low- and middle-income countries, coverage remains insufficient to stabilise and reverse HIV and viral hepatitis epidemics among PWID.

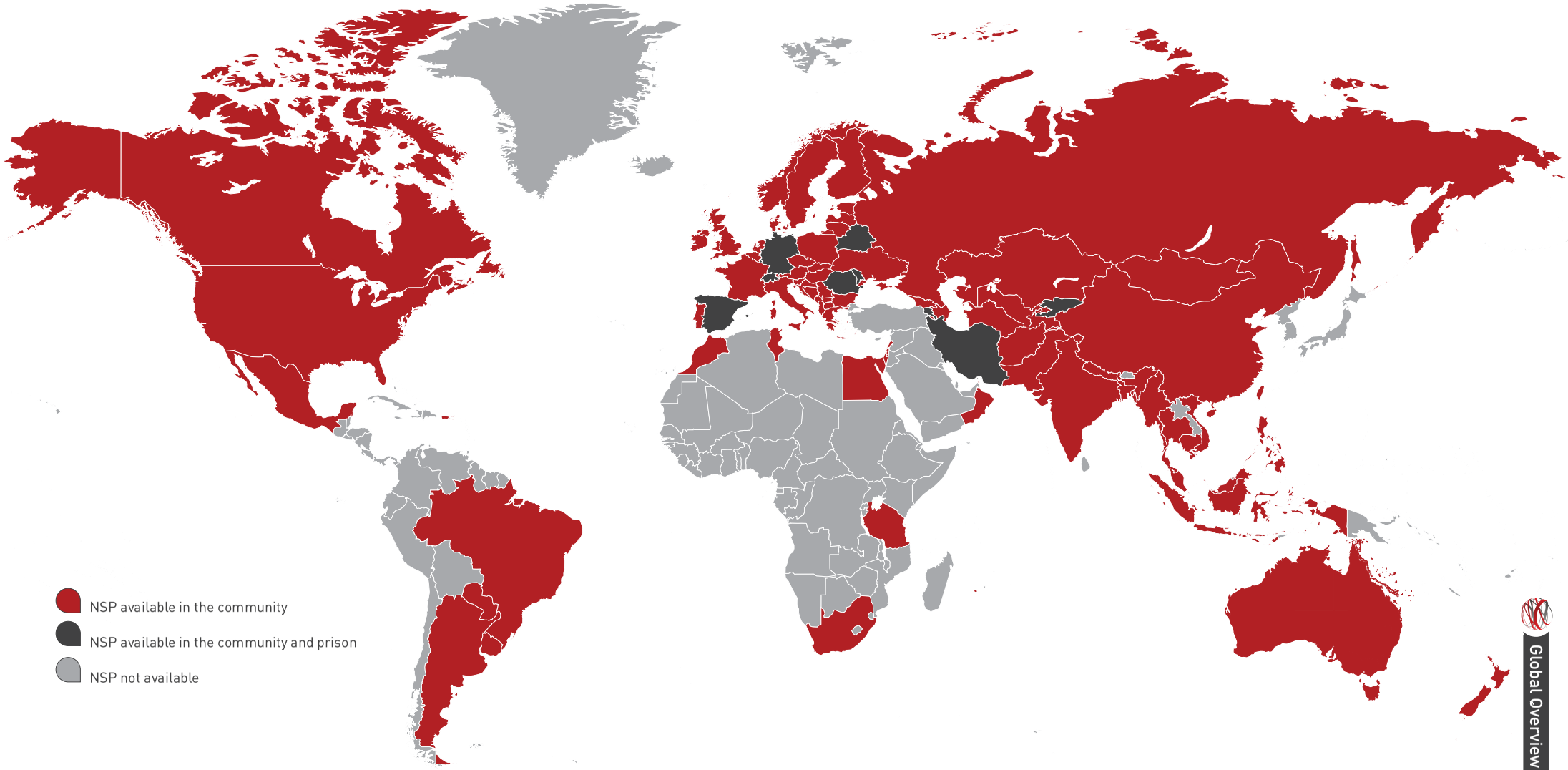
Needle and syringe exchange programmes

In 2012 there are eighty-six countries and territories that implement NSPs to varying degrees. Models of provision include fixed and specialist NSP sites, community-based outreach, pharmacy provision and vending machines. Three countries have newly implemented NSPs since 2010 -- South Africa, Tanzania and Laos PDR.[m]

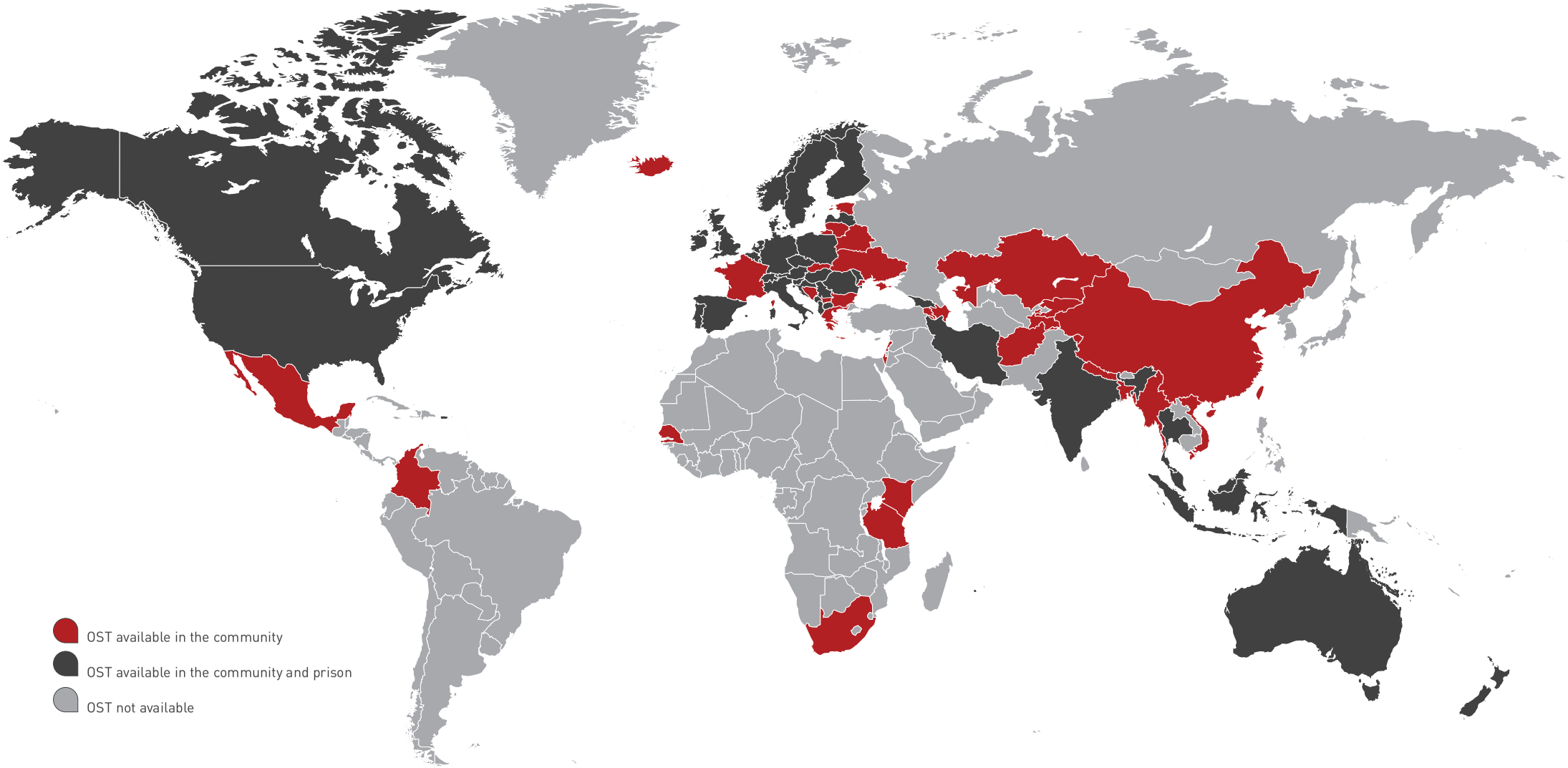
j For a complete list of endorsements visit www.ihra.net/endorsements.
k Refer to Chapter 2.2 of this publication for further information on the development of this network.
l Refer to Chapter 2.3 of this publication for further information of the development of this network.

m Macau is not included, although it is newly reported to provide NSP and OST in this report. Provision of harm reduction services in Macau started prior to 2010. However, in past reports, information on Macau was not known/not reported.

Map 1.1: Global availability of needle and syringe programmes in the community and in prisons



Map 1.2: Global availability of opioid substitution therapy in the community and in prisons



The number of operational NSP sites, and the coverage provided through existing services, varies widely among countries and regions. According to internationally recommended targets,[n] coverage is high in only a few countries such as Australia, several Western European countries, as well as in Bangladesh, where over 200 needle/syringes per PWID are reached per year.

Generally coverage is lower in low- and middle-income countries, with few changes in provision since 2010 in Latin America and the Caribbean, which distribute less than one needle per person per year.[26] An increasing number of sites provide sterile injecting equipment around the world, including in countries that have high HIV and viral hepatitis prevalence among PWID such as the Ukraine and several countries in Asia. Despite increases in provision, existing services in most low and middle-income countries do not reach coverage levels sufficient to stabilise and reverse HIV epidemics among this population. For instance, just an estimated 10% of PWID in Eastern Europe, and 36% in Central Asia, access NSPs.[27]

Since 2010, NSP provision was scaled back in several countries in Asia[o] and Eurasia.[p] Seventy-two countries and territories with reported IDU (thirty-eight of them with HIV reported among this population) remain without any NSP provision.

Drug consumption rooms

In 2012 there are fifty-eight cities around the world that operate at least one drug consumption room (DCR). DCRs form a vital part of harm reduction services in some parts of Western Europe, allowing PWUD to inject in a safe space and under medical supervision. They are eighty-six operational DCRs implemented across seven European countries (Denmark, Germany, Luxembourg, the Netherlands, Norway, Spain, and Switzerland), as well as one in Sydney, Australia and one in Vancouver, Canada. Denmark is the latest country to implement the intervention. In 2011, an NGO in Copenhagen began operating a mobile DCR without explicit permission or interference from authorities. Ten months later, in June 2012, the Danish parliament officially gave municipalities the legal mandate to operate DCRs, making Denmark the first country globally to implement legally regulated DCRs.[28]

Opioid substitution therapy

OST is provided in seventy-seven countries worldwide – seven more than reported in 2010.[q] Methadone and buprenorphine are the substances of choice for substitution, but in some countries other formulations are also provided, including slow-release morphine and codeine, and heroin-assisted treatment (HAT).

The number of sites providing OST and the proportion of people that receive substitution therapy, is substantially higher in high-income countries. For example, an estimated 61% of PWID are receiving OST in Western Europe.[26] Among low and middle-income countries, high coverage has also been reported in Iran, where 42.6% of PWID are receiving OST,[27] and in the Czech Republic, with 40% OST coverage.[30] Provision of OST has been scaled up in several countries in Asia, Eurasia and the Middle East and North Africa. Since 2010, OST provision has been newly introduced in Tajikistan, Kosovo, Kenya, Tanzania, Cambodia, and Bangladesh. However, the coverage of existing programmes remains substantially below minimum levels recommended by international guidance, and improvements in scale and quality are urgently needed to ensure that interventions achieve the greatest impact.[r]

The latest global estimates of OST coverage, from 2010, indicate that 6–12% of PWID are receiving OST, with wide variations among regions.[26] OST coverage remains very limited in parts of sub-Saharan Africa, Latin America and Asia. Available data suggest that less than 3% of PWID receive OST in countries such as Cambodia, Indonesia, Myanmar and Vietnam, where IDU has contributed significantly to HIV epidemics.[31]

OST remains unavailable in eighty-one countries with reported IDU (fifty of them with reports of HIV among PWID).

Integrated HIV, viral hepatitis and TB services for people who inject drugs

Data on the extent to which interventions other than NSP and OST, such as treatment for HIV, viral hepatitis and tuberculosis, reach PWID around the world is less available on a global basis. Comprehensive estimates of HIV, viral hepatitis and tuberculosis needs and access among PWID are not available. Existing research suggests that access to ART by people who inject drugs and live with HIV remains disproportionately low compared with other key populations at higher risk of HIV, particularly in low- and middle-income countries.[32-33] For example, PWID comprise 67% of cumulative HIV cases in China, Vietnam, Russia, Ukraine, Malaysia, but only 25% of ART recipients.[32]

Critical barriers affecting the delivery of and access to TB and HIV services for PWID include separate management of TB, HIV, viral hepatitis and drug use, high levels of stigma and discrimination and the criminalisation of drug use in many countries around the world.[4, 34] Increased research and surveillance efforts are also critical to better understand the true burden of HIV, viral hepatitis and TB among PWID in communities and prisons and the scale of services required.

n The 2009 WHO, UNAIDS, UNODC Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users categorises NSP coverage levels as follows: low (<100 needles/syringes per injector per year), medium (>100–<200 needles/syringes per injector per year) and high (≥200 needles/syringes per injector per year).

o For example, Pakistan, Nepal and Cambodia.

p For example, Belarus, Hungary, Kazakhstan, Lithuania and Russia.

q Cambodia, Bangladesh, Tajikistan, Kenya, Tanzania, Macau and Kosovo.

r The 2009 WHO, UNAIDS, UNODC Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users categorises OST coverage levels as follows: low: <20% of opioid dependent PWID on OST; medium: 20–40% of opioid dependent PWID on OST; and high: >40% of opioid dependent PWID on OST.

There is an urgent need for greater integration of ART provision with harm reduction services, including OST, as well as with TB and viral hepatitis treatment.[32, 35] The provision of coordinated and tailored service delivery models, along with peer involvement in treatment delivery, are key to achieving sufficient coverage of these interventions among PWID.[33]

Overdose

Overdose remains a leading cause of death globally among PWUD, particularly those who inject. Research from an increasing number of countries has examined overdose-related mortality among people who use opioids, including among PWID.[36] However, estimates on the occurrence of overdose mortality and non-fatal overdose outside of high-income countries remains very limited, and usually requires consultation of qualitative data sources and expert opinion.[37-38] A recent global meta-analysis of prospective studies on mortality associated with heroin and other opioid use found that Asia had the highest crude mortality rate (CMR) at 5.23 deaths per 100 person-years, and Australasia had the lowest (1.08), with overdose most commonly cited as the cause of death.[38] Research since 2010 has also shown that PWUD have a 74% greater risk of overdose if they are HIV-positive compared to their HIV-negative counterparts.[39] There is a clear need to conduct more research and to improve standardised reporting to obtain an accurate picture of overdose among this population in low and middle-income countries.

The urgent need to address overdose among PWUD was recognised in 2011 by the Global Fund to Fight AIDS, Tuberculosis and Malaria, which has encouraged grant applicants to include overdose services in national proposals since 2010.[40] The US President's Emergency Plan for AIDS Relief (PEPFAR) has also recently included naloxone provision as part of their revised guidance on PWID.[41]

Naloxone, an effective opioid antagonist used to reverse the effects of opiate overdose, remains limited for distribution by peers and family members of PWUD, especially in low- and middle-income countries. As of 2012, community-based naloxone distribution programmes are present to varying degrees in at least sixteen countries, including Afghanistan, Australia, Canada, China, Germany, Georgia, India, Kazakhstan, Kyrgyzstan, Tajikistan, Thailand, the UK, USA, Ukraine, Russia and Vietnam.

Harm reduction in prisons

The provision of harm reduction interventions including NSPs and OST in prisons and other closed settings, remains extremely limited compared with responses in the community. As of 2012, ten countries[s] around the world implement NSPs in prison, including Iran and countries in Eastern Europe, Central Asia and Western Europe. Forty-one countries[t] provide OST in prisons. Among these, sixteen are countries in Western Europe, twelve in Eurasia and four in Asia, in addition to Canada, the USA, Puerto Rico, Australia, New Zealand, Iran and Mauritius.

Considering the high rates of IDU and the complex interaction of HIV, viral hepatitis and tuberculosis in prison settings worldwide,[42-43] there is an urgent need to implement and expand the provision of harm reduction services in these settings. This is especially urgent for Eastern Europe and Central Asia where this interaction in prison settings is most marked.[4]

Resourcing the harm reduction response

The funding landscape has changed drastically since the first comprehensive analysis of harm reduction funding and resourcing gaps was published by HRI in 2010.[44] The international financial crisis, combined with a shift in aid priorities toward low-income countries and resource constraints at the Global Fund to Fight AIDS, Tuberculosis and Malaria, pose a major threat to the future and sustainability of harm reduction.

HRI previously estimated that approximately US$160 million (or US$0.03 per PWID per day) was invested in HIV-related harm reduction in low and middle-income countries in 2007, of which US$136 million (90%) was from international donors.[45] This amounted to 7% of the US$2.13 billion in 2009 and 5% of the US$3.29 billion in 2010 estimated by UNAIDS to meet the basic HIV prevention needs of PWID.[46]

In June 2011 a group of international experts, including from UNAIDS, the Global Fund, PEPFAR, WHO, the Bill and Melinda Gates Foundation, and the World Bank, launched a new framework for investment in the global HIV response, which has since been endorsed widely by multilateral agencies and researchers.[47] The investment framework argues for setting priorities based on country-specific epidemiology and calls for the scale-up of investments in evidence-based, high-impact interventions, including NSP and OST for PWID. Modelling of the framework's potential impact indicates that, to avert 12.2 million new infections and 7.4 million AIDS-related deaths between 2011 and 2020, annual resource needs must increase from US$16.6 billion in 2011 to US$22–24 billion in 2015.[48] To achieve the proposed reduction in transmission and AIDS-related deaths among PWID, US$2.3 billion is required by 2015 (falling to US$1.5 billion by 2020 through savings in treatment and economies of scale) compared to the US$0.5 billion estimated to be available in 2011.[47]

During the past decade, and particularly in recent years, the

s Armenia, Belarus, Kyrgyzstan, Moldova, Romania, Iran, Germany, Luxembourg, Spain and Switzerland.

t India, Indonesia, Malaysia, Thailand, Albania, Croatia, Czech Republic, Georgia, Hungary, Macedonia, Moldova, Montenegro, Poland, Romania, Serbia, Slovenia, Iran, Canada, USA, Puerto Rico, Australia, New Zealand, Mauritius, Austria, Belgium, Denmark, Finland, Germany, Ireland, Italy, Luxembourg, Malta, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, UK and Latvia.

Global Fund has emerged as the largest funder for harm reduction programmes targeting PWID. Between Round 1 in 2002 and Round 9 in 2009, an estimated US$430 million was approved for this population.[49] Two-thirds of the budgeted funds were allocated to the core package of harm reduction interventions as defined by WHO, UNODC and UNAIDS,[50] including needle and syringe distribution and OST. More than half of the funds (US$236 million) were granted to countries in Eastern Europe and Central Asia. Global Fund support for harm reduction has grown steadily since 2009, and has particularly risen in Round 10, when it introduced a funding reserve for grants targeting most-at-risk populations[51] and released the first harm reduction guidance note for applicants.[40] Subsequent analysis indicates that an additional estimated investment of US$152 million for PWID was committed in Round 10, taking the ten-year total to nearly US$580 million (see Table 1.1.2). Although the need for harm reduction services still far outweighs current provision, and hostile policy environments in some countries continue to prevent effective programmes from scaling up,[26] commitment to harm reduction improved significantly during this period, both in national level HIV and drug strategies and internationally.

Table 1.1.2: Approved Global Fund investments targeting people who inject drugs, Round 1 (2002) to Round 10 (2010)[52]

COUNTRY / TERRITORY	TOTAL (US$)	
ASIA	166,700,000	
Afghanistan	1,300,000	
Bangladesh	10,800,000	*
Bhutan	<100,000	
Cambodia	5,800,000	*
China	23,400,000	
India	20,800,000	*
Indonesia	14,000,000	*
Malaysia	6,100,000	*
Mongolia	100,000	
Maldives	500,000	
Myanmar	7,700,000	*
Nepal	7,600,000	*
Pakistan	13,800,000	*
Philippines	1,500,000	
Sri Lanka	200,000	*
Thailand	28,000,000	*
Timor Leste	<100,000	*
Viet Nam	25,100,000	*
EASTERN EUROPE AND CENTRAL ASIA	366,100,000	
Albania	1,400,000	
Armenia	3,100,000	*
Azerbaijan	6,000,000	*
Belarus	17,500,000	*
Bosnia & Herzegovina	9,800,000	*
Bulgaria	9,500,000	
Croatia	600,000	
Estonia	2,700,000	
Georgia	12,700,000	*
Kazakhstan	29,800,000	*
Kosovo	2,000,000	
Kyrgyzstan	25,800,000	*
Macedonia	15,600,000	*
Moldova	7,200,000	*
Montenegro	1,600,000	*
Romania	4,200,000	
Russian Federation	38,400,000	
Serbia	6,500,000	*
Tajikistan	15,600,000	
Ukraine	143,900,000	*
Uzbekistan	12,200,000	*
LATIN AMERICA	10,200,000	
Argentina	1,600,000	
Mexico	7,000,000	*
Paraguay	1,600,000	*
MIDDLE EAST AND NORTH AFRICA	24,000,000	
Algeria	500,000	
Egypt	800,000	
Iran	8,200,000	*
Jordan	300,000	
MENAHRA	6,200,000	* †
Morocco	4,600,000	*
Syrian Arab Republic	1,200,000	*
Tunisia	1,400,000	
West Bank and Gaza	800,000	
SUB-SAHARAN AFRICA	7,800,000	
Burundi	600,000	*
Cape Verde	700,000	*
Kenya	1,900,000	*
Madagascar	1,300,000	*
Mauritius	1,500,000	*
Nigeria	1,300,000	*
Zanzibar	500,000	‡
Western Europe	900,000	
Turkey	900,000	
Total (all regions)	575,900,000	

Notes
Figures are rounded. Data are correct as of March 2012. Data are based on detailed grant budgets submitted to the Global Fund and may not reflect actual expenditures.
* Figure includes projections for future years of grants that have not yet been formally committed.
† The Middle East and North Africa Harm Reduction Association (MENAHRA) received a multi-country grant that covers Afghanistan, Bahrain, Egypt, Iran, Jordan, Lebanon, Libya, Morocco, Oman, Pakistan, Syrian Arab Republic, Tunisia, and the West Bank and Gaza.
‡ Zanzibar, a semi-autonomous part of Tanzania, receives separate grants from the Global Fund.

In November 2011, however, the Global Fund announced the cancellation of its next funding round (Round 11) along with

the imposition of additional cost-cutting measures. These structural changes at the Global Fund have severe short and long-term implications for harm reduction programme start-up, sustainability and expansion.[u] The Transitional Funding Mechanism (TFM) was established by the Global Fund to support the continuation of existing, essential[v] programmes, but does not allow for further scale-up or start-up of services. This affected several countries in Asia, Eastern Europe and Central Asia with significant HIV and IDU burdens or emerging epidemics among PWID.[27] In addition, several countries that may have planned to submit grant proposals in 2012 and 2013 cannot now do so until 2014.

In November 2011, the Global Fund board also passed the '55% rule', requiring that total funding approved for grant renewals for low-income countries be no less than 55% of any annual funding window.[53] As an interim measure, it placed a 75% ceiling on grant renewals funding for lower-middle income countries, further limiting available funds. The new rules, based solely on income status, affected many states with prominent injecting-driven epidemics such as Indonesia, Thailand and Malaysia. In response to concerns voiced by several delegations, the Global Fund Board passed a decision at its 26th Board meeting in May 2012 to freeze the implementation of the '55% rule.'[53] A critical component informing this decision was the mobilisation of civil society organisations to document evidence of the short-term effects brought on by the '55% rule' at country level, and to bring this evidence into high-level discussions.[27, 54] At the time of writing, it is unclear how financing for harm reduction will be prioritised as part of the new Global Fund funding model that is being developed.

The limited donor landscape for harm reduction approaches is further undermined by a shift in bilateral aid priorities and a narrowing of international aid budgets in some countries. Between them, the main bilateral donors for harm reduction – the UK, Australia and the Netherlands – accounted for US$67.4 million in 2007.[45] Recently however, these donors too have shifted their priorities away from middle-income countries, and in some cases have noticeably reduced spending on HIV/AIDS. For example, the UK Department for International Development's (DFID) bilateral HIV programmes will be cut by 30% over the next three years, and remaining funds will largely focus on low-income countries.[55] The President's Emergency Plan for AIDS Relief (PEPFAR) increased its investment in HIV programmes targeting PWID from US$18.1 million in 2009[56] to US$27.7 million in 2011.[57] However, PEPFAR's funding for harm reduction represents only 0.65% of this budget.[54] The recent re-instatement of a federal funding ban on needle exchange programmes, both domestically and abroad, places further constraints on global harm reduction resources.[6]

Few national governments have been willing or able to finance the implementation and scale-up of HIV and harm reduction interventions within their own borders, with a few notable exceptions (such as Malaysia and Taiwan).[44] For example, when Romania became ineligible for Global Fund resources in 2010, the government failed to support existing NGO-run harm reduction programmes. As a result, the percentage of PWID reached by harm reduction programmes decreased from 76% in 2009 to 49% in 2010. In 2011, the number of newly reported HIV infections among PWID was higher than in previous years, and cases attributed to IDU increased as a proportion of new infections.[27] Numerous countries with IDU-driven epidemics are likely to experience a lack of government support following the exodus of international donor funds. Some private donors including the Gates Foundation and Open Society Foundations (OSF) have stepped in to support harm reduction approaches in the absence of national, bilateral and Global Fund support in certain settings. However, this support remains insufficient to maintain and allow sufficient scale-up to halt and reverse existing and emerging epidemics among PWID in the long-term.

Although there is no accurate estimation of the total spend on harm reduction globally, nor the shortfall in 2012, it is clear that recent developments significantly limit potential progress toward international commitments, such as halving HIV transmission among PWID by 2015[58] and achieving universal access to HIV prevention, treatment, care and support for PWID.[59] There is an urgent need for civil society (including international and local NGOs, organisations of PWUD) as well as donors and national governments to mobilise as a matter of urgency in order to ensure the continuation and sustainability of programmes and avoid reversing gains[w] already made in preventing HIV and other blood-borne viruses among PWID.

The regional updates in **Section 2** of this report provide a more detailed documentation of the state of harm reduction in different parts of the world, particularly highlighting developments since 2010. **Section 3** explores key thematic areas for building an integrated harm reduction response, including specific barriers to access faced by women and young people who inject drugs, and drug use among men who have sex with men, and implications for harm reduction service provision. Additional chapters provide a global overview of drug decriminalisation policies around the world, and an exploration of sustaining and scaling up services in challenging social and political environments.

u For a more in-depth discussion of repercussions internationally see McLean S, Wong F & Konopka S (2012) *HIV, Drug Use and The Global Fund: Don't Stop Now*. Brighton: International HIV/AIDS Alliance. For a detailed discussion in relation to Eastern Europe and Central Asia, see Raminta S, Votyagov S and Pinkham S (2012) *Quitting While Not Ahead: The Global Fund's retrenchment and the looming crisis for harm reduction in Eastern Europe & Central Asia*. Vilnius: EHRN.

v According to official Global Fund guidance, the term 'essential' for the purposes of the Transitional Funding Mechanism includes programmes for PWID.

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w Please see Section 2.2 of this report for a discussion of the situation in Greece as an example of a setting where HIV can re-emerge in the absence of well-resourced responses.

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2.1 | Regional Update
Asia

Table 2.1.1: Epidemiology of HIV and Viral Hepatitis, and Harm Reduction Responses in Asia

Country/territory with reported injecting drug use	People who inject drugs[a]	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[1]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[1]	Harm reduction response[b]	
					NSP[c]	OST[d]
Afghanistan	20,000 (18,000–23,000)[2]	7[2]	36	5.8	✔ (19)[3] (NP)	✔ (1)(M)[3]
Bangladesh	21,800–23,800[2]	5.3[2]	>50[e]	9.4	✔ (120)[4] (P)	✔ (1)
Bhutan	nk	nk	nk	nk	✖	✖
Brunei Darussalam	nk	nk	nk	nk	✖	✖
Cambodia	1900[f 2]	24.1[2]	nk	nk	✔ (2)	✔ (1)[5]
China	2,350,000[2]	6.4[g 2]	67 (60.9–73.1)	9.6 (3.8–15.4)	✔ (>900)[2]	✔ (738)[2](B,M)
Hong Kong	30,000[6]	nk	--	--	✖[7]	✔[1]
India	177,000–180,000[4]	9.2[4]	41	10.2 (2.7–17.8)	✔ (261)[4]	✔ (72)[h 8] (M,B,O)
Indonesia	105,784 (73,663–201,131)[i 9]	36[2]	77.3	2.9	✔ (194)[2]	✔ (74)[2](B,M)
Japan	400,000	nk	64.8 (55–74.5)	3.2 (2–4.3)	✖	✖
Korea (Republic of)	nk	nk	57	4	✖	✖
Laos PDR	1700[2]	nk	nk	nk	✔[2]	✖
Macau	238[10]	1.32[11]	80.4[11]	10.7[11]	✔ (4)[11](P)	✔ (4)[11](B,M)
Malaysia	170,000[2]	8.7[2]	67.1	nk	✔ (297)[2 j] (P)	✔ (674)[2 k](B,M)
Maldives	793 (690–896)[2]	0[l 12]	0.7[i 12]	0.8[i 12]	✖	✔ (1) (M)
Mongolia	nk	nk	nk	nk	✔ (1)	✖
Myanmar	75,000[2]	21.9[2]	79.2	9.1	✔ (40)[2](P)	✔ (10)(M)[2]
Nepal	(30,155–33,742)[13]	6.3[2]	87.3 (80.5–94)	5.8 (5.5–6)	✔ (43)	✔ (3)[2 m] (B,M)
Pakistan	91,000[2 c]	27.2[2]	84 (75–92.9)	6.8 (6–7.5)	✔ (81)	✖
Philippines	15,506	13.6[2]	70	nk	✔ (3)	✖
Singapore	nk	nk	42.5	8.5	✖	✖
Sri Lanka	nk	nk	nk	nk	✖	✖[n]
Taiwan	nk	13.8 (2–25.6)	41	16.7	✔ (1103)	✔ (90)(B,M)
Thailand	40,300[14]	21.9[2 o]	89.8	nk	✔ (10)(P)	✔ (147)[p] (M)
Vietnam	158,414[2]	13.4[2 f]	74.1	19.5	✔ (297)[2](P)	✔ (41)[2](M)

nk= not known

a Unless otherwise stated, data are sourced from Mathers B. et al for the Reference Group to the UN on HIV and Injecting Drug Use (2008) Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review, *Lancet*, 372(9651):1733–1745.
b Unless otherwise stated, data on NSP and OST coverage are sourced from Mathers B, Degenhardt L, Ali H, Wiessing L, Hickman M, Mattick RP, Myers B, Ambekar A & Strathdee SA for the Reference Group to the United Nations on HIV and Injecting Drug Use (2010) HIV prevention, treatment and care for people who inject drugs: A systematic review of global, regional and country level coverage, *Lancet*, 375(9719):1014-28.
c The number in brackets represents the number of operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = needles and syringes reported to be available for purchase from pharmacies or other outlets, and (NP) = needles and syringes not available for purchase.
d The number in brackets represents the number of operational OST programmes, including publicly and privately funded clinics and pharmacy dispensing programmes. (M) = methadone, (B) = buprenorphine, (O) = any other form (including morphine and codeine).
e HIV Serological Surveillance conducted in six cities, with the highest prevalence reported among PWID in Kanshat at 95.7% (Bangladesh, Ministry of Health and Family Welfare, 2011).
f Year of estimate: 2007.
g Figure represents national average only and may significant regional variations.
h Figure represents the number of sites managed by the National AIDS Control Organisation (NACO). Researchers in the region estimate that at least 80 additional sites are implemented by external development partners.
i Figure has been queried by civil society sources, with some estimating that it is closer to 60,000. A World Bank survey was underway at the time of writing.
j The total number of NSP sites includes 221 NGO sites and 76 government-run sites.
k Total number of OST sites includes 218 in government hospitals and clinics and 406 private health care practitioners.
l Based on 2009 surveillance in two cities, Addu and Male.
m At least two additional sites were not included as part of this figure since anecdotal reports from civil society indicate that these sites provide buprenorphine for detoxification only rather than for maintenance therapy.
n Although there are no official programmes operating in Sri Lanka, anecdotal reports indicate that some psychiatrists and general practitioners prescribe methadone as OST.
o Estimate based on men who inject drugs only.
p Civil society and experts in the region have suggested that this estimate is too high and may not be representative of the actual level of OST provision in Thailand. It has been suggested that numbers may include clinics which require periodic detoxification and re-enrolment.

Map 2.1.1: Availability of needle and syringe exchange programmes (NSP) and opioid substitution therapy (OST)

Both NSP and OST available

OST only

NSP only

Neither available

Not known

Harm Reduction in Asia

At least one quarter (4.5 million) of the total estimated number of people who inject drugs (PWID) live in the Asia region, with over half of these residing in China.[47] At the regional level approximately 16% of PWID are living with HIV,[47] but significantly higher rates have been detected at local level within several countries. In five countries with updated figures as of 2012 – Cambodia, Indonesia, Myanmar, Pakistan and Thailand – over one fifth to one half of PWID may be living with HIV.[2]

Regionally, most countries in Asia now offer essential harm reduction services for PWID, although current data do not assess their quality (see Table 2.1.1). Seventeen countries implement needle and syringe exchange programmes (NSPs) to varying degrees, including new programmes in border regions within Laos PDR.[15] Provision of opioid substitution therapy (OST) has expanded in several countries including Myanmar, Malaysia, Indonesia, China, Vietnam and the Maldives, and two countries – Cambodia and Bangladesh – have newly established programmes since last reported in 2010. However, coverage of both interventions remain substantially below minimum levels recommended by international guidance.[38] Despite progress made in recent years in improving HIV surveillance, the continued lack of or controversy over reliable data on the size of PWID populations in some parts of the region limit the accuracy of available coverage estimates, knowledge of the true burden of tuberculosis (TB), HIV and viral hepatitis among PWID, evaluation of impacts and planning for scale-up and resourcing needs.

Co-infection with HIV, viral hepatitis (B and C) and/or TB among PWID pose significant challenges across Asia. Greater integration of antiretroviral therapy (ART) with OST services, TB and viral hepatitis treatment, and peer involvement in treatment delivery, are key to achieving sufficient intervention coverage among this population.[16, 48] Increased prevalence of injection as the route of drug administration for amphetamine-type stimulants (ATS), the most commonly used drugs in Thailand, Laos, South Korea, Cambodia and Japan, has been documented in some countries.[17] Cross-border mobility of PWID may contribute to epidemics among PWID, requiring increasingly collaborative prevention efforts in border areas within Bangladesh, Myanmar, China and Laos. The increasing overlap between injecting drug use (IDU) and sex work may pose an emerging challenge in several local and national contexts, including Sri Lanka, Pakistan and Malaysia.[2]

There is increased awareness of harm reduction as an evidence-based public health approach to reduce HIV and other co-infections and address the health needs of PWID in the region. Nineteen countries or territories[q] identify PWID as a target population for the HIV response and explicitly include harm reduction in their national plans and/or drug policies, pointing to clear progress since 2009[18] when this was the case for only 14 countries. However, despite these significant improvements, 61% of countries in Asia Pacific still have laws and policies that pose major impediments to the provision of effective HIV prevention, care, treatment and support services for PWID.[19]

The funding environment in Asia has become increasingly precarious in the last two years due to the withdrawal of support for harm reduction services by key bilateral donors and a reduction in Global Fund funds. There is an urgent need for strategic investment of available funds in the coverage and quality of high-impact, cost-effective interventions such as NSPs and OST.[20-21]

Developments in harm reduction implementation

Needle and syringe exchange programmes

Of the 25 countries and territories in Asia where IDU has been reported, 17 – two more than reported in 2010[r] – implement NSPs to varying degrees (see Table 2.1.1). In Cambodia, Mongolia, the Philippines and Thailand, NSP provision remains small-scale. In August 2011, the first NSPs in Laos were established at four remote health centres in the northern districts of Phongsaly and Houaphanh Provinces bordering Vietnam.[15]

NSPs are delivered through various modalities across the region. In some settings there has been a shift from provision through stand-alone sites targeted at PWID to service delivery integrated within existing facilities, such as health clinics and pharmacies.[26] Additional examples include 24-hour anonymous provision of sterile injecting equipment and condoms through self-service boxes at commune health stations and community hotspots in Vietnam,[2] and harm reduction services and provision through a grocery store on the China/Myanmar border.[15]

In some countries in Asia, the number of NSP sites has increased: for example, in Bangladesh (from 93 in 2010 to 120 in 2012), India (from 200–219 in 2010 to 261 in 2012), Indonesia (from 120 in 2006 to 194 in 2011) and Malaysia (from 117–130 to 297 in 2012).[2, 4] Despite these increases, NSP coverage in most Asian countries remains insufficient to have an impact on HIV and viral hepatitis epidemics among PWID.[s] Coverage of NSPs varies widely across the region, from 263.7

q Afghanistan, Bangladesh, Cambodia, China, Hong Kong, India, Indonesia, Macau, Malaysia, Maldives, Mongolia, Myanmar, Nepal, Pakistan, Laos PDR, Philippines, Taiwan, Thailand, Vietnam.

r Laos PDR and Macau. Although NSPs started operating in Macau before 2010, this information was reported as 'not known' in the 2010 edition of this report.

s The 2009 WHO, UNAIDS, UNODC *Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users* categorises NSP coverage levels as follows: low (<100 needles/syringes per injector per year), medium (>100–<200 needles/syringes per injector per year) and high (≥200 needles/syringes per injector per year).

needle-syringes per PWID per year distributed in Bangladesh – the highest level of needle-syringe distribution among low- and middle-income countries worldwide – to less than 10 needle-syringes per PWID per year in Thailand, Indonesia and the Philippines. New estimates since 2010 suggest that NSP coverage reaches medium levels in Malaysia (116 needle-syringes per PWID per year), Myanmar (118 needle-syringes per PWID per year), Cambodia (120.2 needle-syringes per PWID per year), Vietnam (140 needle-syringes per PWID per year) [t] and China (180 needle-syringes per PWID per year). Coverage remains low in Pakistan and Nepal, where provision amounts to less than 100 needle-syringes per PWID per year.[2]

In eight countries[u] in Asia with reported IDU there are no operational NSP sites. Since 2010, NSP provision was scaled back or interrupted in Pakistan,[22] Nepal[23-24] and Cambodia. In Pakistan and Nepal site closures were due to the withdrawal of national funding support.[25-26] In Cambodia, the provision of needles and syringes is dependent upon the availability of NSP licences issued at the discretion of the National Authority for Combating Drugs (NACD).[84] In 2011 the government revoked or failed to renew licences for existing NSP services, as part of a move to relocate services to the government.[26] As of December 2011, there were no licensed NSP sites operating in Cambodia, leading to a drastic downturn in service coverage.[27] At the time of writing, a small number of services run by non-governmental organisations (NGOs) in Cambodia had resumed provision of sterile injecting equipment, but the reach of existing programmes remains restricted.[28]

Fear of arrest and detention in compulsory detoxification centres that violate the human rights of PWID and fail to provide evidence-based programmes continues to deter many individuals from accessing NSP services and carrying sterile injecting equipment.[29]

Geographical distance, costly transportation, inappropriate size of needle-syringes, lack of adequate training and limited capacity of peer outreach workers pose further barriers to access. Legal age restrictions for accessing NSPs in some Asian countries pose obstacles for PWID under 18 years old, despite evidence that age of initiation to injecting is gradually decreasing in some areas (see Chapter 3.2 for a broader discussion of legal age restrictions for harm reduction services).[30]

t 2011 estimate based on men who inject drugs only.
u Bhutan, Brunei-Darussalam, Hong Kong, Japan, Republic of Korea, Maldives, Singapore, Sri Lanka.

Service provision cuts in Pakistan

Harm reduction service provision to a sizeable portion of PWID in Pakistan has been severely threatened since 2010. The largest harm reduction project in the country, running since 2005 with support from the World Bank, was suddenly terminated by the Government of Punjab using discretionary powers in May 2010. At the time of cancellation, the programme had reached over 14,000 PWID across eight cities in Punjab, and plans were in progress to scale up services to an additional four cities, reaching up to an estimated 22,000 PWID. Although no official reason for the programme's termination was provided, civil society advocates cite the refusal on the part of the implementing organisation (Nai Zindagi) to disclose personal details of the project's beneficiaries to government officials as part of an accountability audit as a potential trigger for subsequent official decisions. Recent surveillance data suggest that the closure of services has already begun to reverse important gains made in the past five years of implementation.[31]

A portion of the gap in harm reduction service delivery will be filled by Pakistan's Global Fund Round 9 grant scheduled to begin in 2012 and covering an estimated 28,000 people with NSP services across 24 districts in Punjab and Sindh provinces over four years. However, the crisis persists, as the eight cities in which programmes were originally terminated continue to lack harm reduction provision and will not be covered by this grant.

Opioid substitution therapy

Availability and coverage of OST has been scaled up in several Asian countries since 2010 (see Table 2.1.1). For example, provision was expanded in Myanmar (from 7 sites in 2010 to 10 by December 2011, reaching 1637 PWID),[2] Malaysia (from 95 in 2010 to 674 sites reaching 44,428 PWID in 2012),[v] Indonesia (from 11 sites in 2006 to 74 in 2011), China (from 600–675 sites in 2010 to 738 across 28 provinces currently reaching 140,000 PWID) and India (from 61–63 in 2010 to at least 72 in 2012).[w8] In Vietnam a small-scale methadone programme has been significantly scaled up from four clinics in two provinces in 2009[39] to 41 clinics across 11 provinces presently reaching 6900 PWID.[32] Plans are underway to further expand access to 80,000 PWID across 30 provinces by 2015.[2] As of June 2011 the Ministry of Labour, Invalids and Social Affairs (MOLISA) has contributed to financing the first methadone maintenance therapy (MMT) clinic, an important development for harm reduction in the country considering the increasingly narrow resourcing landscape for PWID.[32] In

v This includes provision through government hospitals and clinics (218 sites), private health care practitioners (406 sites), National Anti-Drug Agency (NADA) service centres (32 sites) and prisons (18 sites).
w This includes four MMT pilot sites initiated by UNODC between January and April 2012.

the Maldives, the second phase of OST was initiated in 2011 following a pilot methadone project established in 2009 with support from the UNODC Regional Office for South Asia (ROSA).[2, 33] Thailand's Department of Medical Services reports that there were 6085 patients enrolled on MMT during the period of April 2010 to April 2011.[x34] Community-based and civil society organisations (CSOs) play an important role in service implementation and success in Myanmar, China and Bangladesh.

Two countries in the region have initiated OST since last reported in 2010.[35] The first pilot methadone clinic in Phnom Penh, Cambodia, began dosing in July 2010.[26] As of December 2011, 113 PWID, 20% of whom are women, were receiving methadone, with imminent plans to scale up to three sites.[5, 27] In Dhaka, Bangladesh, an OST pilot with methadone was implemented in June 2010 by the International Centre for Diarrheal Disease Research (iccr-b) in collaboration with the Government of Bangladesh. To date, 150 PWID are receiving methadone, with another 150 to be enrolled at a second site being planned through funds from Save the Children under the Global Fund RCC programme.[2]

Although rollout of OST to 6000 PWID in Pakistan is supported under Global Fund Round 9, implementation will be dependent upon successful piloting by UNODC planned to commence in late 2012.[25] In Nepal, plans to scale up the national OST programme and revise guidelines and training curricula on OST in collaboration with the German Agency for International Cooperation (GIZ) were underway at the time of writing.[2] Malaysia has gradually moved away from supporting compulsory detention since 2010, instead focusing its efforts on scaling up existing NSP and OST programmes, including a rare MMT programme that operates inside a mosque.[36-37] Recognising the lack of services for female PWID in Afghanistan, UNODC, in partnership with Médecins du Monde (MdM) and local Afghan NGO Nejat, has recently initiated a referral mechanism to facilitate access to MMT by women who inject drugs, and expand the capacity of local NGOs to start up and implement MMT.[3]

Despite recent increases in service coverage, OST provision remains very limited in some countries. Where reported, measures of OST coverage remain imprecise, using PWID as a denominator, although not all PWID inject opiates or require OST.[38] Available data suggest that less than 3% of PWID receive OST in Cambodia, Indonesia, Myanmar and Vietnam.[39] In Nepal, coverage has remained the same since last reported in 2010 (349 PWID on OST at three sites).[35] The only existing methadone pilot programme in Afghanistan implemented by MdM reached 63 male clients as of November 2011.[3] Scale-up was on hold as of June 2012 pending an independent evaluation conducted by Johns Hopkins University as requested by Afghanistan's Ministry of Counter Narcotics.[3] OST remains unavailable in ten countries with reported IDU: Bhutan, Brunei Darussalam, Republic of Korea, Japan, Laos PDR, Mongolia, Pakistan, the Philippines, Sri Lanka and Singapore.

The availability and scope of OST is constrained by several factors. The poor quality of programmes, including inadequate or insufficient information on OST and its benefits, lack of proper follow-up among drop-outs and inappropriate dosing are commonly cited reasons for lack of retention in OST across the region.[26] In Indonesia, despite increases in the number of PWID receiving OST since 2010, a significant proportion of PWID (39%) continue to inject while on MMT, particularly in the early months following the start of treatment.[40] Programme quality requires increased documentation across the region and significant strengthening if harm reduction interventions are to produce measurable results.

Legal and policy barriers that prohibit or restrict OST pose significant obstacles to implementation and scale-up in Asia.[41] For example, policies requiring government approval of methadone quotas for provision in Afghanistan can cause emergency stock-outs and restrict programme scale-up.[2] In Vietnam, a barrier to access is posed by the requirement to register as a drug user with law enforcement authorities to receive OST.[42] Limited service provider capacity, fear of arrest and detention, geographical distance to sites and high transportation costs,[y] lack of gender-sensitive programmes[43] and the absence of clear strategies to reach young PWID all restrict the reach of existing programmes.[26]

Amphetamine-type stimulant use in Asia

Use of amphetamine-type stimulants (ATS), and particularly that of methamphetamines, has significantly increased in recent years in East and Southeast Asia. ATS use is associated with a range of harms including HIV, viral hepatitis, TB and other sexually transmitted infections (STIs).[44] ATS use is predominantly found within vulnerable groups such as women, young people, sex workers and migrants.[45]

ATS users tend not to access 'traditional' harm reduction services, as these are predominately aimed at people who use opiates. Moreover, services generally do not reach this group, due to differences in their drug user networks as compared with people who use opiates.[45]

To meet the needs of people who use amphetamines, further research and investment is needed,[46] as well as the development of a comprehensive package of evidence-based interventions specifically tailored to the needs of amphetamine users and developed with input from the community.[45]

x Estimate refers to the cumulative total and may include duplicates of individuals who dropped out and re-registered.

y As OST programmes in most Asian countries require daily visits by clients, transportation costs and time spent travelling pose significant barriers to access. For example, it is estimated that in Myanmar and Bangladesh travel time to dispensing sites for some PWID exceeds two and three hours daily.

Antiretroviral treatment

Wide variations in HIV epidemics among PWID exist among and within Asian countries. For instance, although an overall decrease in HIV prevalence among men who inject drugs from 33.85% in 2010 to 13.4% in 2012 was detected in Vietnam, prevalence continued to exceed 50% in Dien Bien and Quang Ninh provinces, while in Da Nang it was only 1% – the lowest prevalence in the country.[2] Rising prevalence has been recently documented in numerous cities in Pakistan,[2] two northern border provinces and Vientiane in Laos PDR,[2] and in Jakarta, Indonesia, where prevalence among PWID rose from 33% to 44% from 2007 to 2011 despite decreases in the rest of the country.[9] The heterogeneity of the HIV epidemic in the region is similarly highlighted by the Philippines, where new estimates suggest that 13.56% of PWID are living with HIV, yet prevalence among women who inject drugs (26.98%) is more than twice as high as among their male counterparts (12.87%).[2] On the island of Cebu in the Philippines an emerging epidemic among PWID – HIV has shot up significantly from 0.40% in 2007 to 53.8% in 2010[2] – has been attributed by experts to the delayed implementation of harm reduction programmes.[39]

Conversely, reductions in HIV prevalence among PWID in some countries in the region have been largely attributed to the early implementation and scale-up of key harm reduction programmes such as NSP and OST.[39] HIV prevalence among PWID has decreased significantly in Kathmandu, Nepal (from 68% in 2003 to 20.7% in 2009 and 6.3 % in 2011), in China (from 9.3% in 2009 to 6.4% in 2011) and in Indonesia (from 52% in 2007 to 36% in 2011).[2]

Although regional and global monitoring mechanisms have improved,[z] disaggregated data on ART access, coverage and treatment needs among PWID in Asia are scarce. According to the World Health Organization (WHO), 22 of 26 countries surveyed in Asia in 2010 reported ART availability for PWID.[39] Nevertheless, the scope and coverage of ART in the region remains limited. In 2010, the Reference Group to the UN on HIV and Injecting Drug Use reported that ART was accessed by only a small proportion of PWID living with HIV in nine countries in Asia.[47] For example, in Indonesia, the country with the highest level of coverage in the region, only 6% of PWID living with HIV were receiving ART.[47] In Afghanistan, the only two available ART centres located in Kabul and Herat are not accessed by most ART-eligible individuals due to geographical distance,[2] and over 40 existing drug treatment centres (providing treatment other than OST) across the country lack any voluntary counselling and testing (VCT) services.[3]

Access to ART by PWID is disproportionately low compared with other key populations at higher risk of HIV, and remains restricted by systemic and structural barriers.[48] In 2010, 47% of PWID living with HIV in low- and middle-income countries came from five nations,[aa] three of which (China, Vietnam and Malaysia) are in Asia.[48] PWID comprise 67% of cumulative HIV cases in these five countries, but only 25% of ART recipients. Systemic and structural barriers such as the continuing policy in some countries to detain people who use drugs (PWUD) in compulsory detention centres, and imprisonment for drug possession for personal use, severely restrict access to prevention and treatment services among PWID in the region.[48-49] Other barriers to ART access for PWID in Asia include the lack of quality adherence counselling, effective support or follow-up plans, which are essential for treatment success among PWID,[16] stock-outs[50] and lack of access to OST, among several obstacles.[51]

Recent studies point to increased access to HIV testing, ART and improved treatment outcomes for PWID in Vietnam[52] and Bangladesh.[2] In Bangladesh, nine VCT centres designated for PWID across five cities provided ART to 2316 PWID between October 2009 and September 2011.

According to recent estimates submitted by eight Asian countries[ab] to UNAIDS as part of the 2012 Global AIDS Progress reporting mechanism, uptake of HIV testing and counselling[ac] ranges from less than 10% in the Philippines and Pakistan to over 50% in Indonesia – the country with the highest reported percentage of PWID accessing HIV testing.[ad2] The generally low levels of testing among PWID in the region corroborate global data from the WHO and UNICEF, who reported in 2011 that the median uptake of VCT was only 25% in 13 reporting countries in the previous 12 months.[39] Given the small number of countries worldwide, and in the region specifically, that monitor and report on this indicator, greater efforts and investments are required to adequately track access to and increase uptake of VCT among PWID.

Viral hepatitis

Rates of hepatitis C (HCV) and hepatitis B (HBV) in PWID vary widely among countries in Asia. A recent systematic review reported Asia is the world region with the largest populations

z For example, in March 2012, countries reported to UNAIDS on updated indicators to monitor progress towards the targets set in the *2011 Political Declaration on HIV/AIDS*, including halving HIV transmission among people who inject drugs by 2015. While the new set of indicators includes indicators measuring uptake of HIV testing and counselling and coverage of NSP among PWID, it does not include coverage indicators for other interventions in the WHO comprehensive harm reduction package. For more information, see UNAIDS (2011) *AIDS Response Progress Reporting 2012 Guidelines: Construction of Core Indicators for Monitoring the 2011 Political Declaration on HIV/AIDS*. Geneva: UNAIDS. Additionally, there was an increase of 18% between 2009 and 2010 in the number of countries reporting to the WHO in preparation for its 2011 report, *Epidemic update and health sector progress towards Universal Access*. A total of 109 low- and middle-income countries reported information on the existence of programmes and policies targeted at and engaging people who inject drugs in 2010, compared with the 92 countries providing data in 2009. See WHO, UNAIDS, UNICEF (2011) *Global HIV/AIDS Response: Epidemic update and health sector progress towards Universal Access*. Geneva: WHO.

aa China, Vietnam, Russia, Ukraine, Malaysia.

ab Vietnam, Thailand, the Philippines, Pakistan, Nepal, Myanmar, Indonesia and Cambodia.

ac According to Global AIDS Progress Reporting 2012 guidance, this indicator is measured as the percentage of PWID that have received an HIV test in the past 12 months and know their results.

ad Figures from Indonesia are based on NSP and OST attendees. Among NSP participants, 56% had undertaken an HIV test. HIV test uptake among methadone clients was nearly 100%, as enrolment in MMT requires an HIV test. The high update of HIV testing among PWID in Indonesia is partly attributed to the increase in supportive legislation on harm reduction and to the integration of NSP into primary health services. For more information see: UNAIDS (2012) *Indonesia Global AIDS Progress Report*. Geneva: UNAIDS, http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/progressreports/2012countries/ ce_ID_Narrative_Report.pdf Accessed 24 June 2012.

of PWID with hepatitis B surface antigen (HbsAg)[ae] (300,000, range 100,000–700,000) and HCV (2.6 million, range 1.8–3.6 million). China is home to more than half (1.6 million, range 1.1–2.2 million) of PWID living with HCV worldwide.[1]

Where estimates are available, all countries report an HCV prevalence of over 30% among PWID, and in four countries or territories[af] rates exceed 80%. HBV prevalence among PWID ranges from 2.9% in Indonesia to 10–20% in India, Macau, Taiwan and Vietnam.[1] The quality of existing global data on viral hepatitis is variable. The large ranges of available figures indicate inexact estimates resulting from varying prevalence between different sub-populations of PWID and different recruitment settings (see Table 2.1.1).[1] Co-infection of HIV and HCV is a significant challenge in some parts of the region, particularly Bangladesh, India, Indonesia, Myanmar, Nepal and Thailand, where 50–100% of PWID living with HIV are also co-infected with HCV.[53] Research indicates that co-infection with HIV and HCV and/or HBV is highly prevalent among PWID in the China–Myanmar border region.[54]

Viral hepatitis testing and treatment is rarely state-funded in countries in Asia. The main medicine used in the current standard treatment for hepatitis C is Pegylated Interferon-alfa, which is patent protected by two pharmaceutical companies, Roche and Merck, and remains beyond the means of the majority of PWID in Asia, costing between US$11,255 and $18,202 in the region.[55ag] Despite the inclusion of viral hepatitis diagnostics and treatment in the 'comprehensive package' of harm reduction services recommended by UNODC, WHO and UNAIDS for PWID, HCV is rarely addressed in the HIV response for this population.[38]

Tuberculosis

In addition to experiencing a high burden of co-infections such as HBV and HCV, PWID living with HIV are at increased risk of developing TB, including multi-drug resistant strains (MDR-TB).[56] South-East Asia accounts for nearly 15% of the global burden of new cases of HIV/TB co-infection.[57] Although no systematic prevalence figures exist among PWID in the region, individual studies indicate that they experience high prevalence of TB and other co-infections. For example, TB rates among PWID living with HIV were 33.9% in Chennai, South India,[58] and 4.8% in Pokhara, Nepal.[59] In Vietnam, HIV infection was concentrated among PWUD with TB, particularly young men aged 15–34 years,[60] and was the most common cause of death (40%) within six months of starting ART among a cohort of PWID living with HIV.[61] Transmission of TB among PWID living with HIV has been linked with a lack of adherence support and inadequate prescription of ART, as well as with having been incarcerated.[62-63]

Although several countries in Asia including India, Nepal, Thailand and Myanmar have increasingly taken steps to address TB/HIV co-infection more generally,[53] it is unclear to what extent activities target PWID specifically. For instance, in Pakistan, TB testing and treatment services can only be offered to PWID via direct linkages through harm reduction services providers, as PWID tend not to access general health services in the same manner as the general population.[25]

Barriers to addressing TB among PWID include poor health infrastructure, administrative obstacles to effective TB and HIV programme collaboration, low awareness, stigma and discrimination by service providers and criminalisation of drug use.[57, 64] For example, in Bangladesh, PWID are generally referred for testing and treatment to specialised TB clinics, where they are often refused anti-TB treatment due to service providers' flawed perception that PWID have low rates of adherence.[25] While referrals from harm reduction services to TB centres are reported to be robust in Afghanistan, there is a need to strengthen referral systems for HIV screening from TB centres.[3] Additional obstacles are posed by lack of access to methadone or buprenorphine therapy in some settings, which may cause PWID to drop out of treatment when admitted to in-patient TB wards due to opioid withdrawal symptoms that go unaddressed.

Overdose

Although studies from an increasing number of countries have examined mortality among people who use opioids,[65] estimates on the occurrence of overdose mortality and non-fatal overdose outside high-income countries remains very limited.[66-67] A recent global meta-analysis of prospective studies on mortality associated with heroin and other opioid use found that Asia had the highest crude mortality rate (CMR) at 5.23 deaths per 100 person-years, with overdose most commonly cited as the cause of death.[65] In a prospective cohort of PWID in Liangshan, Sichuan province in China, 64.3% deaths during a one-year period were attributed to overdose.[68] In Thai Nguyen province, Vietnam, drug overdose accounted for 27% of deaths among a cohort of PWID between 2005 and 2007.[69] Rates of non-fatal overdose among people who inject opioids are similarly high. For instance, in local studies 30% of heroin injectors in Bangkok, Thailand,[70] 83% in Ban Ninh, Vietnam,[71] and 12% in Southwestern China[72] reported experiencing at least one overdose.[66]

The quality of available data is highly variable. Common limitations include the reporting of mortality risk estimates among PWUD and PWID derived from retrospective cohort studies, which greatly reduces their reliability, lack of standardised reporting of mortality cause among this group, and small sample sizes largely drawn from treatment centres,

ae HbsAg indicates active (either acute or chronic) infection. Approximately 95% of adults with acute HBV infection clear the virus and develop anti-HBc and hepatitis B surface antibodies (anti-HBs). People who inject drugs may have lower clearance rates for HBV than the general population because more PWID may become chronically infected. For more information see Nelson PK, Mathers BM, Cowie B, Hagan H, Des Jarlais D, Horyniak D & Degenhardt L (2011) Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews, *Lancet,* 378(9791): 571–583.

af Macau, Nepal, Pakistan and Thailand.

ag Generally to manage HIV/HCV co-infection, a year-long treatment with Pegylated Interferon and Ribavarine (peg-IFN/RBV) is required.

which may not be representative of out-of-treatment PWID, thus limiting the strength of international comparisons.[65-66]

Responses to overdose have only recently been recognised as integral components of harm reduction programmes in some Asian countries. For example, naloxone is available in a majority of hospitals and ambulances in China and Sri Lanka, and through pharmacies, harm reduction drop-in centres and outreach workers in Afghanistan.[3] Although the national MMT programme in China requests that each clinic keep naloxone readily available, it is unclear to what extent this is implemented in practice.[26] In 2011, community naloxone distribution programmes have been piloted in Vietnam[73] and in four provinces in China.[74]

Despite these increases in provision, availability of naloxone for peer distribution in community settings remains limited in Asia.[66] Five countries in the region (Afghanistan, China, India, Thailand and Vietnam) implement community-based naloxone programmes to some extent.[67] In most settings in Asia, naloxone is classified as a scheduled drug and cannot be sold over the counter. Shortages of naloxone, even in licensed government-run health care facilities, and a lack of skills in addressing overdose among service providers pose ongoing obstacles to the prevention and management of overdose. In Vietnam, a law prohibiting laypeople from providing injections hampers scale-up of community-based naloxone programmes.[42] In some countries, it is challenging for NGOs to procure naloxone for distribution, whether due to high prices or due to special licences (i.e. medical licences) needed to purchase medications. Intranasal naloxone is very costly and remains unavailable throughout Asia.[75]

Harm reduction in prisons

IDU is widespread in prisons and other places of detention across the region. For instance, a study on prisoners for drug-related crimes in nine prisons across Indonesia found that almost 90% had consumed an illicit drug, and more than one-third had injected heroin.[76] While some prisoners continued to inject drugs with decreased frequency, and others stopped injecting while incarcerated, 0.5–4% of PWID actually injected for the first time while in prison.[2] Among PWID in three cities in Afghanistan, 62.9% had previously been imprisoned, of whom 17.2% reported injecting while in prison.[77] Similarly, in a sample of 252 PWID in Bangkok, Thailand, 78% reported a history of incarceration, and approximately 30% of them injected drugs while in prison.[78]

A 2010 national survey in Indonesian prisons and detention centres detected higher HIV rates among a subset of male prisoners with a history of injecting drugs (6.7%) compared with the general male prison population surveyed (1.1%). Rates were higher among women than among their male counterparts, and twice as high among women with an injecting history (12.0%) compared with incarcerated women with no history of IDU (6.0%).[2] Rising HIV prevalence among Afghanistan's 23,800 prisoners and detainees also appears to be linked to the high proportion of PWID in prison.[2] A new report by the Cambodian human rights group LICADHO indicated that imprisonments for drug-related charges (including drug use) increased by 163% in 2011. In the 13 prisons surveyed by LICADHO, this number has nearly quadrupled since 2008.[79]

Implementation of harm reduction programmes in prisons and other closed settings remains a serious challenge in most countries in Asia. There are no NSPs operating in prisons in the region. In some countries, such as Bangladesh, the distribution of needles and syringes in prisons is considered a criminal offence. OST programmes operate in four Asian countries: India, Indonesia, Malaysia and Thailand. In India, the only existing prison OST pilot launched in 2008 has been scaled up, reaching nearly 120 inmates in one prison.[8] However, where they do exist, prison harm reduction services remain limited: only four prisons in Indonesia and 11 in Malaysia implement the intervention.[80]

As of March 2012, discussions were ongoing among government and police officials in the Maldives to introduce a comprehensive harm reduction package in prisons.[2] Plans to initiate OST in prisons are also underway in Vietnam.[2] In Bangladesh, the 3rd National Strategic Plan for HIV and AIDS Response 2011–2015 now supports implementation of prison OST, noting, however, that policy advocacy and reform will be required to facilitate programme start-up.[81]

In Pakistan, Bangladesh and Afghanistan, limited drug treatment (other than NSP and OST) and HIV prevention services are provided in some prisons. This includes an UNODC-supported project that provides drug treatment and other health services (other than OST) to 450 female inmates out of approximately 500 female prisoners in six female prisons in Afghanistan.[3]

In Japan, a proposed amendment will allow PWUD in prison to qualify for early release and undergo abstinence-based drug treatment in the community. Although harm reduction services remain unavailable in both settings, the proposed amendment represents an important shift away from treating drug dependence as a crime.[82] In June 2011 a ruling by the Supreme Court in Indonesia strengthened diversion sentencing to rehabilitation instead of prison for non-violent drug users not convicted of drug trafficking or other felony charges in the country's otherwise highly criticised narcotics law.[83] Diversion sentencing for PWUD in Indonesia is an important development since 2010, considering that drug-related offences greatly contribute to prison overcrowding.[ah]

ah According to Indonesia's Ministry of Law and Human Rights, the number of prisoners for drug-related crimes in Indonesia has increased steadily as a proportion of the general prison population from 7122 (10% of prisoners) in 2002 to 37,295 (26% of prisoners) by the end of September 2009.

Policy developments for harm reduction

Harm reduction is an important component of HIV and drug strategies in most countries in Asia. Nineteen countries or territories[ai] identify PWID as a target population for the HIV response and explicitly include harm reduction in their national plans and/or drug policies (see Table 2.1.1). This is a clear improvement since 2009 when this was the case for only 14 countries.[18]

Despite significant improvements in policy that have facilitated implementation and scale-up of harm reduction services, the existence of national policy on harm reduction does not equate to the provision of an adequate response in either scope or quality. Nearly two-thirds (61%) of countries in Asia Pacific still have laws and policies that pose major impediments to the provision of effective HIV prevention, care, treatment and support services for PWID.[19]

In many countries in the region, harm reduction efforts are undermined by inconsistencies in drug control policy, which often conflicts directly with national HIV or drug plans. For example, the government of Vietnam removed Article 199 of the Penal Code in 2009, effectively decriminalising drug use.[32] However, under the new regulations PWID can still be sent to compulsory treatment centres for two years.[32] In Cambodia the Commune Safety Policy introduced in August 2010 and enforced in April 2011 by the Deputy Prime Minister applies a zero tolerance approach to drug use, has further stigmatised PWID and greatly undermined harm reduction efforts.[aj84-85] Additionally, in December 2011, the National Assembly of Cambodia approved a drug law that mandates up to two years of compulsory treatment for PWUD, and fails to recognise essential harm reduction interventions, leaving NSPs and OST programmes vulnerable to arbitrary closure.[84] Civil society advocates have strongly criticised the new drug law, pointing out that the term 'drug addict' is too broadly defined and can feasibly include anybody under the influence of drugs at any point.[84] A new amendment to Thailand's national drug policy in 2010 explicitly mentions harm reduction, yet this nominal improvement is overshadowed by the Deputy Prime Minister Chalerm Yubamrung's recent proposal to 'solve' the drug crisis in Thailand within one year.[86] This is a concerning approach to drug use and trafficking that echoes the disastrous 2003 'war on drugs' and could have serious implications for access to and scale-up of harm reduction programmes.[87]

The continued commitment to compulsory treatment centres for PWID in several countries in the region undermines harm reduction efforts, elevates the risk of HIV transmission and violates international human rights law.[88-89] Over 400,000 people in the region are arbitrarily detained in drug detention centres,[47] and up to 1000 people are executed for drug offences each year, in direct violation of international law.[90]

Efforts have been taken in some Asian countries to mitigate the unintended consequences of drug policies and improve utilisation of harm reduction services through dialogue and negotiation with law enforcement officers. For example improved police practices reflecting a less punitive approach and increased understanding of harm reduction approaches have been observed in Kaski and Morang districts in Nepal as a result of joint programme implementation between law enforcement agencies and civil society.[2]

Civil society and advocacy developments for harm reduction

Civil society advocates in the region have played an increasingly visible role in informing and liaising with governments, law enforcement and donors on the importance of harm reduction service scale-up and the need for an enabling policy environment.

In 2010 the Asian Network of People Who Use Drugs (ANPUD) was registered in Hong Kong, a new regional coordinator was selected, and the Secretariat office was established in Bangkok, Thailand. ANPUD has since focused on developing and strengthening the network through a number of meetings and workshops, and providing its members with an avenue to become more meaningfully involved in policy and programming at the national, regional and international levels.

The Asian Harm Reduction Network

The Asian Harm Reduction Network (AHRN) has continued to develop, successfully making the transition to a federation structure with ten initial members throughout the Asian region. Since 2010 a separate organisation, Access Quality International (AQI), has emerged to take on service delivery, technical assistance and capacity-building roles previously held by AHRN, while AHRN has repositioned itself as a regional network. Following a series of strategic planning consultations between 2010 and 2011 that brought together key experts from around the world, AHRN recently launched its new five-year strategic plan for 2012–2016. In its newly defined role, AHRN seeks to provide a platform for harm reduction policy dialogue and collaboration throughout Asia and facilitate networking and communication among member networks and other key stakeholders.

ai Afghanistan, Bangladesh, Cambodia, China, Hong Kong, India, Indonesia, Macau, Malaysia, Maldives, Mongolia, Myanmar, Nepal, Pakistan, Laos PDR, Philippines, Taiwan, Thailand and Vietnam.

aj Anecdotal reports indicate that in efforts to enforce the Commune Safety Policy guideline, Cambodian police have recently become increasingly active in rounding up people who use drugs, who are in principle referred to compulsory rehabilitation treatment. If they decline treatment or are found to be engaged in crime, they are imprisoned. For further information, see Azariah S (2011) *HAARP Cambodia Annual Review 2011*. Canberra: HAAARP.84

At the regional level, notable events included the Asian launch of the *Lancet* special series on HIV in PWUD, organised by the University of Malaya's Centre of Excellence for Research in AIDS (CERiA) in December 2010 in Kuala Lumpur, Malaysia. The symposium featured panel discussions with local, regional and international experts on topics particularly important to region including, among others, structural risk environments, women who use drugs, human rights, drug policy reform and compulsory drug detention centres.[91] The '10th International Congress on AIDS in Asia and the Pacific' (ICAAP) was held in Busan, South Korea, in August 2011. Despite widely condemned clashes between local law enforcement and community activists in Busan,[92] the event provided an opportunity around which regional civil society groups could mobilise. AHRN, supported by the Open Society Foundations' Global Drug Policy Program (GDPp), organised a satellite session exploring how the 'war on drugs' impacts the current response to drugs and HIV in the region. The meeting was well attended by more than 100 international delegates.

Developments at the national level include the establishment of the first Afghan Drug Users' Group (ADUG) in Kabul, Afghanistan, in 2011. ADUG is a movement of Afghan current and former PWUD, representing users' interests and promoting their participation in decision-making, policy and service planning. ADUG participated in the '22nd International Harm Reduction Conference' in Beirut, Lebanon, and is a recognised member of the International Network of People Who Use Drugs (INPUD). A new group comprised of several member organisations from across Vietnam, the Vietnam Network of People Who Use Drugs (VNPUD), was established in late 2011.

Civil society in Nepal has continued to engage actively in advocacy at the local, national and regional levels. In August 2011, Nepalese civil society and local groups of PWUD produced a joint statement[93] responding to poor government–donor coordination that often led to interruptions to harm reduction services and serious concerns about programme sustainability.[94] In January 2011, Recovering Nepal, in partnership with the government, organised the first national harm reduction media conference, bringing together 144 active media representatives along with civil society networks, government officials and technical partners to highlight the need for sustainable and accelerated HIV and harm reduction services.[95]

In an increasingly precarious funding environment, financial support for civil society advocacy in the region is extremely scarce and poses considerable challenges to sustainable and coordinated actions.

Multilaterals and donors: developments for harm reduction

The international economic crisis, combined with a shift in aid priorities toward lower-income countries (LICs), and structural changes at the Global Fund to Fight AIDS, Tuberculosis and Malaria have had a considerable impact on existing and future harm reduction funding commitments in the region.

Bilateral aid to the region has decreased markedly as countries, particularly in Southeast Asia, have transitioned to middle-income country (MIC) status. There has been a general exodus of funding from donor countries such as the UK (DFID), the Netherlands (Dutch Development Cooperation Program) and Sweden (Swedish International Development Agency). The Australian government's overseas aid programme's (AusAID) HIV/AIDS Asia Regional Program (HAARP) remained one of the most significant donors funding harm reduction in the region as of early 2012, shouldering an estimated 30–50% of harm reduction costs.[36] The Global Fund has played an important role in financing harm reduction programmes in the region, committing a total of US$166.7 million for interventions targeted at PWID between 2002 and 2010 (see Table 2.1.2). Major private donors such as the Gates Foundation and OSF have filled in some of the resource gaps, but funding levels remain far below what is needed to sustain and scale up programmes.

Table 2.1.2: Approved Global Fund investments targeting people who inject drugs in Asia, Round 1 (2002) to Round 10 (2010)[96]

COUNTRY / TERRITORY	TOTAL (US$)	
Afghanistan	1,300,000	
Bangladesh	10,800,000	*
Bhutan	<100,000	
Cambodia	5,800,000	*
China	23,400,000	
India	20,800,000	*
Indonesia	14,000,000	*
Malaysia	6,100,000	*
Mongolia	100,000	
Maldives	500,000	
Myanmar	7,700,000	*
Nepal	7,600,000	*
Pakistan	13,800,000	*
Philippines	1,500,000	
Sri Lanka	200,000	*
Thailand	28,000,000	*
Timor Leste	<100,000	*
Vietnam	25,100,000	*
TOTAL	166,700,000	

Notes
Figures are rounded. Data are correct as of March 2012. Data are based on detailed grant budgets submitted to the Global Fund and may not reflect actual expenditures.
* Figure includes projections for future years of grants that have not yet been formally committed.

Some governments such as China, India, Malaysia and Taiwan are filling in the gap and investing in harm reduction programmes within their own borders. In its national strategic plan 2011–2015, Laos PDR earmarks $3.6 million to reach 60% of PWID with sterile injecting equipment and condom provision.[2] However, core national funding for harm reduction in the region remains comparatively low, small-scale and short-term. Sustainable financing strategies, and prioritisation of investment in high-impact, cost-effective interventions such as NSP and OST, involving increasing contributions from national governments, are essential to enable countries to develop and bring harm reduction interventions for PWID to scale. Even as there are shortfalls for harm reduction funding, new research by Harm Reduction International has documented international donor support for drug detention centres and the death penalty for drug offences in several Asian countries.[85] For example, Australia, Luxembourg and Sweden contributed US$1,649,800 for a UNODC project on capacity-building for drug detention centre staff in Vietnam, while the USA, Japan, Thailand, China, Brunei, Singapore, Sweden and Germany contributed funds to drug detention centre infrastructure in Laos PDR. Additionally, several countries that apply capital punishment for drug offences, such as China and Vietnam, continue to receive international funding and UN assistance for drug enforcement.[85]

After the Global Fund in China: a future for civil society in the harm reduction response?

Compiled by Sarah Konopka, International HIV/AIDS Alliance

In light of a worsening HIV epidemic among increasing numbers of people who inject drugs, the Chinese government has gradually advanced a harm reduction approach and in 2004 invested in the piloting of eight OST clinics in five provinces.[96] Despite the scale-up of China's harm reduction programme in recent years, coverage remains low, and recruitment and retention are ongoing challenges. Drop-out rates are high, particularly where outreach, psychosocial support and community engagement are lacking.[97-99]

Harm reduction resources from the Global Fund began to fill the service provision gap in China in 2003,[100] directing funds through the Chinese Centre for Disease Control (CDC) for capacity development of local community-based organisations (CBOs) to supplement the government's clinic-based OST programme with peer-led interventions including outreach, peer education, drug user support groups, family support services and community education. The impact of such services on quality has been documented: CDC-affiliated OST clinics receiving funding from the national HIV prevention programme have better adherence rates and coverage than non-CDC-affiliated clinics.[97] This demonstrates how valuable CBOs are in making MMT programmes work.

In 2011 the Global Fund announced that it would no longer fund upper-middle-income countries. Remaining Global Fund monies in China will expire in the end of 2012, and with that, the end of resources for the community-based harm reduction efforts. The Chinese government has pledged to fill the HIV resource gap,[101] but civil society groups are unclear about what their priorities will be and what this will mean for the future of a civil society role in the harm reduction response.

After 2012 it is anticipated that the government will contract the services of some CBOs and organisations/communities of people who use drugs to provide HIV and harm reduction services. Government-imposed restrictions on the NGO registration process remain an important concern.[102-103] For CBOs to register as an NGO and, therefore, be eligible to receive government funding directly, they must have a sponsoring government organisation that will share responsibility for the management of funds.[102-103] With Global Fund resources, some drug-user-led CBOs were able to strengthen internal systems and structures and build relationships with local government agencies. This has been vital to their success. As the response in China shifts to a primarily government-funded response, civil society groups are concerned that their capacity development needs will be overlooked and that they will find it more difficult to engage and negotiate with local agencies.

Commitments from other donors, including AusAID, Levis Foundation and the government of the Netherlands (BUZA), will contribute to maintaining a space for the engagement of communities of people who use drugs and CBOs. For example, the multi-country Community Action on Harm Reduction (CAHR) project of the International HIV/AIDS Alliance, funded by BUZA, works with Alliance China and drug user groups in Sichuan province to partner with the local CDC to improve MMT and NSP provision and access to peer-led services.[104] Small-scale efforts like these will make a difference to the lives of the drug user groups involved and people who use drugs enrolled in their programme. But this will not be enough to influence policy on a national scale.

Experience in China shows that civil society engagement will be essential to the delivery of a comprehensive national harm reduction programme. With the exiting of the Global Fund, it will now be up to the Chinese government to support community-based and peer-led models of service delivery and work with communities of people who use drugs to ensure that peer-led and community-based interventions are an essential feature of the national programme.

In February 2011 the UN Regional Task Force held its meeting on IDU and HIV/AIDS in India.[105] Key topics discussed included compulsory rehabilitation centres, the regional strategy for harm reduction in Asia Pacific 2010–2015 and key findings and recommendations of the external review of the UNRTF. A particular need was identified around the need for a regional advocacy strategy, including a feasible estimate of costs required to realise advocacy goals, to complement national strategies.

The 'Asia-Pacific High-level Intergovernmental Meeting on the Assessment of Progress against Commitments in the 2011 Political Declaration on HIV/AIDS and the Millennium Development Goals (MDGs)' was held in Bangkok in February 2012. IDU and harm reduction were addressed in the context of insufficient coverage, continuing stigma and discrimination and legal and policy barriers that affect PWUD living with HIV, such as those that criminalise the possession of injecting equipment.[106]

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2.2 | Regional Update
Eurasia

Table 2.2.1: Epidemiology of HIV and Viral Hepatitis, and Harm Reduction Responses in Eurasia

Country/territory with reported injecting drug use	People who inject drugs[a]	HIV prevalence among people who inject drugs (%)[a]	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[b]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[b]	Harm reduction response[c]	
					NSP[d]	OST[e]
Albania	4,500–5,000[1 f]	<1%[2]	29.2[1]	nk	✔ (3)	✔ (6)[3](M)
Armenia	3310 (2797–4057)[4]	10.7[5]	nk	nk	✔ (7)	✔ (4)[3](M)
Azerbaijan	300,000[h]	9.5[5]	62.9[5]	10.9[5]	✔ (12–14)	✔ (2)(M)
Belarus	50,000[5]	13[5]	nk	nk	✔ (33)[5]	✔ (13)[6](M)
Bosnia and Herzegovina	nk	nk	nk	nk	✔ (6)	✔ (8)(BN,M)
Bulgaria	20,250 (16,200–24,300)	2.2[(s) 7]	62.3[(s) 8]	3.1[(s) 9]	✔ (100)	✔ (31)[3](BN, M,O)
Croatia	8,500[g]	0.0[1]	27.1[(s) 8]	2.4[(s) 9]	✔ (42)	✔ (B,M)
Czech Republic	29,000 (25,494–33,823)[(s)]	0.0–0.6[7]	13.6[8]	15.1	✔ (109) (P)	✔ (150–240)[3](B,M, BN)
Estonia	13,801 (8178–34,732)	54.3–89.9[(s) h 7]	90.5	21.3	✔ (36)	✔ (10)[10](B,M)
Georgia	40,000[11]	3.9[5]	58.2	7.2	✔ (10)	✔ (16)[13](BN,M)
Hungary	5,699[12]	0.0[7]	21.4[(s) 8]	0.3[(s) 9]	✔ (25)	✔ (10)[3](BN,M)
Kazakhstan	119,140[13]	3.8[5]	61.3	7.9	✔ (155)[5]	✔ (3)[3](M)
Kosovo	nk	0	--	--	✔	✔ (3)[14](M)
Kyrgyzstan	25,000[15]	14.6[5]	50[16]	nk	✔ (29–49)[5] (P)	✔ (17–20)[3](M)
Latvia	nk	11.2[5]	50.0[(s) 8]	nk	✔ (18)[5]	✔ (10)[3](B,M)
Lithuania	5,458[16]	0.0–21.4[(s) 7]	70.3–89.7[i (s) 8]	3.3–8.9[h 9]	✔ (12)[17]	✔ (21)[17](B,M)
Macedonia	15,000-20,000[17]	nk	70[18]	nk	✔ (15)	✔ (10)(M, B)[3]
Moldova	31,562[5]	16.4[5]	42.7	nk	✔ (31)	✔ (10) [j] (M)
Montenegro	nk	nk	37.8 (22–53.6)	0	✔ (18)	✔ (3)[3](M)
Poland	nk	6.8[7]	44.3–72.4[(s) 8]	2.5-3.8[9]	✔ (27)	✔ (22)(B,M)
Romania	17,000[5]	4.2[18]	82.9[(s) 8]	4.7[9]	✔ (3)	✔ (7)(B,M)
Russia	1,815,000	37.15 (0.3–74)[k]	72.5 (49–96)	9	✔ (4)	✖
Serbia	30,383 (2682–48,083)[5]	2.4–4.5[(s) 5]	60.5–77.4[(s) 5]	nk	✔ (13)	✔ (30)[3](B,BN,M)
Slovakia	18,841 (13,732–34,343)	0.3[7]	40.3[(s) 8]	nk	✔ (20)	✔ (2)(BN,B,M)
Slovenia	7,310	0.4[7]	21.5[8]	3.4[l]	✔ (17)(P)	✔ (20)(BN,B,M,O)
Tajikistan	25,000 (20,000–30,000)[19]	16.3[20]	61.3	nk	✔ (49)	✔ (3)[3](M)
Turkmenistan	nk	nk	nk	nk	✔ (2)	✖
Ukraine	296,000[5]	21.5[5]	67 (60.9–73)	6.7	✔ (1667)[5]	✔ (131)[3](B,M)
Uzbekistan	83,500	8.4[5]	51.7	nk	✔ (235)	✖

nk= not known
[(s)] = sub-national data

a Unless otherwise stated, data on the estimated number of people who inject drugs in each country are sourced from Mathers B et al. for the Reference Group to the UN on HIV and Injecting Drug Use (2008) Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review, Lancet, 372(9651):1733–1745. The year of estimate is provided for each figure that is sourced from 2007 or earlier.
b Unless otherwise stated, estimates for hepatitis B and C are sourced from Nelson PK, Mathers BM, Cowie B, Hagan H, Des Jarlais D, Horyniak D & Degenhardt L (2011) Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews, Lancet, 378(9791): 571–583.
c Unless otherwise stated, data on NSP and OST coverage are sourced from Mathers B, Degenhardt L, Ali H, Wiessing L, Hickman M, Mattick RP, Myers B, Ambekar A & Strathdee SA for the Reference Group to the United Nations on HIV and Injecting Drug Use (2010) HIV prevention, treatment and care for people who inject drugs: A systematic review of global, regional and country level coverage, Lancet, 375(9719):1014–28.
d The number in brackets represents the number of operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = needles and syringes reported to be available for purchase from pharmacies or other outlets, and (NP) = needles and syringes not available for purchase.
e The number in brackets represents the number of operational OST programmes, including publicly and privately funded clinics and pharmacy dispensing programmes. (M) = methadone, (B) = buprenorphine, (BN) = buprenorphine-naloxone combination, (O) = any other form (including morphine and codeine).
f Figure based on expert opinion and based on problem drug use rather than injecting only.
g Year of estimate: 2007.
h Year of estimate: 2005.
i Year of estimate: 2006.
j Seven of these are prison NSPs.
k Year of estimate: 2003.
l Year of estimate: 2002.

Map 2.2.1: Availability of needle and syringe exchange programmes (NSP) and opioid substitution therapy (OST)

Harm reduction in Eurasia

Of the estimated 15.9 million (11–21.2 million) people who inject drugs (PWID) worldwide,[20] 3.7 million – nearly a quarter – live in Eastern Europe and Central Asia (Eurasia). Based on national-level estimates, the largest PWID populations are reported in Russia (1.8 million)[21] and Ukraine (296,000).[22 m]

Eurasia is the only region in the world where the number of people living with HIV has almost tripled since 2000, reaching an estimated total of 1.4 million (1.3 million–1.6 million) in 2009 compared with 760,000 (670,000–890,000) in 2001.[20] Injecting drug use (IDU) remains the leading route of HIV transmission in Eurasia.[23] An estimated one quarter of the 3.7 million PWID in Eurasia are living with HIV.[21] In several countries, particularly in Eastern Europe, HIV prevalence among PWID in prisons is substantially higher than prevalence in the general population.[24]

Viral hepatitis is considerably more widespread than HIV among PWID in Eurasia, with five countries in the region reporting hepatitis C (HCV) prevalence higher than 70% among this population. Estonia has the highest HCV prevalence among PWID (>90%), followed by Romania (82.9%), Serbia (77.4%), Russia (72.5%) and Lithuania (>70%).[25] The disproportionately high burden of HCV among PWID is exacerbated by limited access to testing and treatment, particularly for incarcerated PWID, who experience higher rates of viral hepatitis than PWID in the community.[26]

Increasing rates of HIV/tuberculosis (TB) co-infection and limited access to treatment for both diseases contribute to the increased vulnerability of PWID in Eurasia. Fatal overdose caused approximately 21% of deaths among all people living with HIV in Russia in 2007, second only to TB.[27]

Although harm reduction programmes across Eurasia have generally expanded since 2010, coverage remains low to medium by international targets.[n] Needle and syringe exchange programmes (NSPs) are available in all 25 countries of the region, but coverage varies widely among countries, from 19 syringes distributed per PWID per year in Latvia[28] to 174 per person per year in Estonia.[29] None of the 12 countries in the region for which coverage data are available reached the international recommended level of 200 syringes per person per year,[30] although five countries distributed between 100 and 200 syringes per person per year: Estonia, Kazakhstan, Kyrgyzstan, Slovakia[31] and Tajikistan.[o]

Twenty-six countries in the region, with the exception of Russia, Turkmenistan and Uzbekistan, implement opioid substitution therapy (OST). Substantial scale-up of OST provision since 2010 has occurred in Bulgaria, the Czech Republic, Georgia, Lithuania, Moldova and Serbia, and new programmes were established in Tajikistan in 2010 and Kosovo in 2012.

Despite progress in several areas, harm reduction remains politically marginalised in some countries in the region, particularly Russia and Uzbekistan. Since 2010, Hungary's national drug strategy has been amended to exclude harm reduction as a priority and limit access to drug treatment instead of criminal sanctions for people who use drugs (PWUD).[32]

The international financial crisis and the restructuring of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) has significantly affected harm reduction efforts in many countries in Eurasia, with the notable exception of successful Round 10 applicants Kazakhstan, Kyrgyzstan, Ukraine and Uzbekistan.[33] Since the cancellation of Round 11 in November 2011, a number of countries in the region, namely Armenia, Azerbaijan and Belarus, face a different set of eligibility criteria for new funding and potentially long-term funding cuts, as is the case of Albania.[33] Despite the inclusion of harm reduction in national HIV or drug strategies in 26 countries,[p34] the majority of governments in Eurasia do not financially support harm reduction programmes. Five countries reported non-governmental and non-Global Fund funding sources for harm reduction, while another 11 reported some governmental contributions toward the delivery of harm reduction programmes.[q35] Overall, non-governmental organisations (NGOs) are the main implementers of NSPs, either through stand-alone sites or in the context of broader HIV prevention services, while governmental institutions tend to manage OST provision. However, in several countries, including Tajikistan and Uzbekistan, more governmental institutions have initiated NSP provision with support from the Global Fund.

Civil society organisations (CSOs) and regional networks have played an increasingly important role in advocacy for harm reduction in Eurasia. Since 2010 the European Harm Reduction Network (EuroHRN)[r] which includes 13 countries in Eastern Europe,[s] was newly established with support from the European Commission, and the International Drug Policy Consortium (IDPC) initiated a new drug policy network for South East Europe.[36] In 2011, several important events took place in European capitals as part of the Count the Costs Campaign,[t] on the occasion of the 50th anniversary of the

m This report included both 250,000 and 296,000 PWIDs as population size estimates.
n According to the 2009 WHO, UNODC, UNAIDS target-setting guide, <100 syringes distributed per person who injects drugs per year is considered low coverage, 100–200 is medium coverage, and >200 is high coverage.
o Data extracted from UNGASS country reports, Country questionnaires, Petersen et al. (2012),16 Latypov et al. (2012)3 for: Armenia, Azerbaijan, Belarus, Estonia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Romania, Tajikistan and Ukraine.
p Figure includes Azerbaijan, which passed a new HIV law in 2010.
q Kyrgyzstan, Latvia, Romania, Russia, and Tajikistan reported additional funding sources in addition to government and GFATM, while Azerbaijan, Bulgaria, Bosnia & Herzegovina, Estonia, Kazakhstan, Latvia, Lithuania, Macedonia, Montenegro, Poland and Serbia reported governmental funding for OST/NSP and related activities.
r The European Harm Reduction Network (EuroHRN) has been recently formed by ten organisations with a shared interest in advocating for and sharing knowledge on harm reduction within Europe. It is made up of three sub-regional networks covering North, South and Eastern Europe and managed by a coordinator based at the Harm Reduction International in the UK. For more information see www.eurohrn.eu.
s Albania, Bosnia and Herzegovina, Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Macedonia, Poland, Romania, Serbia, Slovakia, Slovenia.
t To learn more about Count the Costs, see www.countthecosts.org.

Single Convention on Narcotic Drugs on 30 March 2011. 'Urban Drug Policies in the Globalized World', an international workshop conference that took place in Prague, Czech Republic, in 2010, brought together civil society partners and networks from Eurasia, enabling them to exchange information on policy and best practices.

Developments in harm reduction implementation

Needle and syringe exchange programmes (NSPs)

NSPs operate in all 29 countries and territories in Eastern Europe and Central Asia (see Table 2.2.1). Since 2010, three countries have scaled up provision: Kyrgyzstan, Tajikistan and Ukraine: for example, the number of NSP sites in Ukraine has increased significantly from 985–1323 reported in 2010 to 1667 in 2011.[5] During the same period, five countries have scaled back provision due to funding cuts: Belarus, Hungary, Kazakhstan, Lithuania and Russia.

Several countries reported that an increased proportion of PWID are being reached by NSP services. These include Armenia, Croatia and Kosovo, with coverage rates ranging from 10% in Georgia[37] to 72% in Belarus.[35] A recent report by the Eurasian Harm Reduction Network (EHRN) estimates that on average only 10% of PWID in Eastern Europe and 36% in Central Asia access NSPs.[33] New data covering the period from January 2010 to December 2011 submitted by countries to UNAIDS as part of Global AIDS Progress reporting indicate that sharing of injecting equipment varies widely across the region. The number of PWID who report using sterile equipment during their last injection ranges from only 15.58% in Romania to 95.5% in Ukraine.[5] New models of service delivery are applied in some countries including a pilot NSP in a prison in Tajikistan and a mobile NSP in Albania.[u]

However, even in countries that report increased availability of NSPs, research and consultations with PWID indicate that many actively avoid seeking health services due to the risk of being stigmatised, ostracised or discriminated against by health care providers.[16, 35, 38] Additional barriers to service access include limited or uneven geographical reach of programmes,[35, 39] fear of being threatened, abused, extorted or arrested by the police,[35, 41-43] criminalisation of possession of illicit substances or injecting equipment with traces of substances,[44] lack of political will and funding,[45] and limited or insufficient supply of injecting equipment.[13, 35, 46]

Overall, harm reduction programmes that focus on women who use drugs are in place in Georgia, Kyrgyzstan, Russia and Ukraine with the support of the Open Society Foundation, UNICEF and GIZ. However, in most cases, although NSPs do not openly discriminate against women, gender-specific NSP services that recognise and address the specific barriers faced by women who inject drugs are limited or difficult to access. In Romania, cultural stereotypes and stigma prevent many women from accessing NSP.[35] In Tajikistan women who use drugs experience high levels of stigma, especially from male PWID.[47] Anecdotal reports from Macedonia and Albania indicate that the lack of NSP programmes sensitive to women's needs limits women's access to these services.[35] The intersection between drug use and sex work, particularly in the case of Roma sex workers in Hungary and Romania, renders addressing the needs of women drug users particularly challenging.[35, 48]

Access also appears to be limited for young PWID. Legal age restrictions or required parental consent prevent young people from accessing NSPs in Czech Republic, Estonia, Lithuania, Macedonia, Moldova and Romania.[49-51] However, since NSP services are often anonymous and client ages unrecorded, it is hard to assess whether some PWID are under 18.[49] There are no legal age restrictions reported for accessing NSPs in 16 countries in the region.[v] In Serbia a new law due to be implemented beginning in August 2012 will allow minors aged 15 and above to have exclusive privacy over their medical charts and consent rights regarding their health issues, meaning that parental consent will be no longer be required when accessing harm reduction services.[52]

Opioid substitution therapy (OST)

OST is available in various forms in 26 countries and territories, with the exception of Russia, Turkmenistan and Uzbekistan. Despite the increased availability of OST at the national level, programmes continue to have limited reach, and coverage varies significantly among and within states. Ukraine has the highest number of clients on OST (6517),[3] while the Czech Republic has the highest estimated OST coverage in the region, with 40% of people who inject opiates enrolled in OST.[3] It is followed by Lithuania, Bulgaria and Poland, with rates of 13.1%,[53] 12% and 7% of PWID enrolled in OST, respectively.[3] In the majority of former Soviet countries coverage remains extremely limited, with under 5% of PWID accessing OST.[3] Although most programmes continue to have limited reach and are still in pilot stages,[16] the number of OST sites has increased in 16 countries and territories[w] since 2010.

Greater coverage in the Czech Republic and Croatia can be partially attributed to the fact that medications used for OST (except methadone) can be prescribed by general practitioners and purchased in pharmacies.[3] The opposite is the case in Estonia and Latvia, where prescription regulations limit access.[35, 46] Positive developments in OST delivery have

u The NSP in Albania has been newly integrated into the Break the Cycle (BTC) intervention model, which aims to enable PWID to use drugs safely by providing of services, skills and information and encouraging their commitment to not recruit others to drug use.

v Slovakia, Croatia, Bulgaria, Albania, Slovenia, Serbia, Hungary, Bosnia, Kosovo, Armenia, Belarus, Kazakhstan, Kyrgyzstan, Russia, Tajikistan and Ukraine.

w Albania, Armenia, Bosnia & Herzegovina, Bulgaria, Czech Republic, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Macedonia, Moldova, Poland, Romania, Serbia and Ukraine.

been reported in Serbia and Bosnia and Herzegovina, where services have recently been decentralised.[35] Additional forms of OST in addition to methadone have been introduced in Serbia (buprenorphine and buprenorphine-naloxone combination), as well as in Czech Republic and Georgia (buprenorphine-naloxone combination).[37] In Bulgaria the quality of OST services is presently being addressed in a new set of guidelines for good clinical practice planned to come into force in 2012.[3]

Despite encouraging developments in OST provision in the region, a number of barriers remain around implementation and scale-up. Only nine countries – Albania, Bulgaria, Kyrgyzstan, Latvia, Lithuania, Macedonia, Poland, Serbia and Ukraine – reported access to takeaway doses. However, even in countries where takeaway OST is available, access is limited by strict regulations:[3] strict admission criteria are in place in at least seven countries, including proving a past history of opiate use, as well as one or several failed treatment attempts.[55-57] Scarce provision of OST outside major urban centres results in uneven coverage within countries,[35] and the cost of existing OST services, limited funding[3, 40, 58] and long waiting lists[35] pose additional barriers. Limited funding was cited as the reason why some services reportedly prescribe methadone doses below WHO recommendations in Kyrgyzstan[55] and Moldova.[40] In several Eurasian countries, protocols for administering OST are inappropriate or non-existent, and there is a need for increased capacity-building among staff.

Access to OST is also subject to strict age restrictions, with legal age restrictions in place in at least ten countries and parental consent needed for young people under 16 years old in Bosnia and Herzegovina and Slovakia.[35] Barriers faced by women who inject drugs are similar to those faced by men, although the limitation of civil rights, particularly the removal of parental rights, affects women disproportionally in several countries including Macedonia and Ukraine.[59-60] Often this is executed through the implementation of registries of PWUD at harm reduction services for women who inject drugs, rendering them vulnerable to discrimination and the loss of parental rights during child custody cases. Fear of stigma and discrimination remains a barrier to access for all PWID.[35]

Antiretroviral therapy (ART)

Eurasia is home to nearly 1 million PWID living with HIV.[61] PWID comprise 62% of people living with HIV in the region but only 22% of those receiving antiretroviral therapy (ART).[33] The proportion of PWID living with HIV who receive ART in Eurasia varies between 3.5% in Kazakhstan and 10% in Moldova, although it should be noted that new data on exact coverage since 2010 were only available for three countries.[16] The highest numbers of PWID living with HIV who access ART are in Ukraine (1732)[16] and Poland (1372).[61] Providing PWID with fully comprehensive prevention, treatment and care services is particularly important given the high rates of co-infection with TB and viral hepatitis among this population.[62]

Accessing confidential voluntary counselling and testing (VCT) is an important element in increasing the uptake of ART for PWID. Recent country-level data from 2012 Global AIDS Progress reports submitted to UNAIDS indicate that the percentage of PWID who tested and are aware of their status ranged between 3.9% in Azerbaijan, 64.4% in Lithuania and 64.7% in Kazakhstan.[63] Barriers to testing for HIV included non-confidential VCT, parental consent requirements for those less than 18 years old,[35] availability of testing only in medical facilities, procedural delays,[35] funding issues for VCT programmes[35] and discrimination against PWID by health care providers.

Due to relatively low rates of HIV in Albania, Croatia, Georgia, Kosovo, Macedonia, Slovakia and Slovenia, most individuals in need of ART are reported to access it.[35] The requirement to undergo additional tests prior to initiating ART, the need for mandatory documentation that PWID have difficulty accessing such as local registration, national identity card and fixed residence, and lack of ART treatment guidelines for PWID all act as deterrents to their accessing ART in several countries in the region.[35]

Challenges with adherence to ART are generally linked to limited access to OST, stigma and discrimination by police and health care providers, a lack of counselling and support, limited funding for ART, geographical distance from treatment centres and complexity of ART regimens.[10, 64] Adherence among PWID is facilitated by socio-emotional support by family and friends and access to OST, such as methadone or buprenorphine, which attenuate the impact of active drug use on the uptake of ART.[16] Fears that adherence rates among PWID will be lower than among the general population are not supported by a recent systematic review and meta-analysis, which found rates of 60% adherence among PWID, which are similar to adherence rates found among the general adult population living with HIV that do not inject drugs.[65]

Viral hepatitis

A recent systematic review of the global epidemiology of viral hepatitis (B and C) among PWID concluded that Eastern Europe was home to the largest population of PWID with HCV, or 2.3 million of the total estimated 10 million PWID living with HCV globally in 2010 (range 6.0–15.2 million).[25] Following HIV infection trends, Russia, where the largest PWID population in Eurasia resides, had the second largest population of PWID living with HCV in the world, after China. Prevalence data for HCV are available for 24 of the 29 countries and territories in Eurasia, ranging from 13.6% in the Czech Republic to 90.5% in Estonia. Lithuania, Romania and Estonia were the three countries with the highest recorded prevalence: 76.3–89.7% among PWID in two cities in 2006,[66] 82.9% among PWID in Bucharest in 2009[66] and 90.5% in 2002, respectively.[25]

Of the 1.2 million PWID living with hepatitis B (HBV) worldwide in 2010, 300,000 live in Eurasia; however, it should be noted

that[25] available data on HBV are of a lower quality than data on HCV. Only 11 of the 29 Eurasian countries and territories had ever conducted a prevalence study on HBV among PWID. Where data were available, prevalence varied widely from less than 1% in Montenegro and Hungary to over 20% in Estonia (see Table 2.2.1). The quality of prevalence data and the timing of the existing studies varied significantly among the 29 countries in the region, with no data available on either HCV or HBV from eight countries[x] and several countries' latest available data being from 2001 or earlier. Systematic research on the extent of viral hepatitis, particularly in light of the limited access to testing and treatment for both HCV and HBV among PWID,[25] is urgently required.

Access to HCV treatment among PWID remains extremely limited in Eurasia.[67] The high cost of patented Pegylated-Interferon used in the treatment of HCV (up to $18,000 for a 48-week course in some countries in the region) remains a critical barrier to access.[68] Few countries (such as Kazakhstan, Russia, Lithuania, Estonia and Bulgaria) are reported to provide any state-funded HCV treatment, but obtaining concrete data on the qualification criteria for receiving treatment and the number of people treated remains challenging. In Russia, HCV treatment is provided by the state for those with HCV/HIV co-infection, but access continues to remain limited for those with a history of drug use, and particularly for people actively using drugs.[68] Diagnostic tests for viral hepatitis, mainly viral load qualitative and quantitative tests and genotype tests, remain unaffordable, ranging from $10 in Ukraine to $121 in Georgia, and are usually paid for by the patient.[68]

The WHO Regional Office for Europe (WHO-EURO) has developed HIV/HCV co-infection guidelines;[69] however, the absence of HCV mono-infection or co-infection treatment guidelines in some countries can pose an obstacle to expanding treatment access. Where such guidelines do exist, they do not address the special needs of PWID (for example, guidelines often fail to address treatment adherence and management of side effects). Additionally, some guidelines are not based on internationally recognised standards of care, which involves dual therapy with Pegylated-Interferon and ribavirin.[70 y]

Lack of political commitment to make viral hepatitis a priority poses another critical barrier to expanding access to treatment. Civil society organisations (CSOs), including harm reduction and drug user groups, have mobilised in many Eurasian countries to seek improved access to HCV treatment by demanding that national governments increase their commitment to address HCV, including providing treatment for PWUD, and that pharmaceutical companies reduce prices for Pegylated-Interferon.[71]

x Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Kyrgyzstan, Macedonia and Turkmenistan.

y For example, the Russian guidelines indicate treatment with linear interferon, or other medicines, such as *phosphoglia,* which are not based on best practice or on guidelines developed by WHO.

Tuberculosis (TB)

Six countries report that targeted harm reduction, HIV, viral hepatitis and TB testing and treatment services operate in an integrated manner in their country.[z] Most countries indicate that in the absence of integrated services, 'strong referral systems' between different services are in place. In Slovakia the NGO Odyseus has recently introduced low-threshold HIV/TB testing through outreach for marginalised groups, including migrants and mobile populations who engage in drug use.[58]

Efforts to reach PWID who may require TB testing and treatment are limited. Few countries in the region implement HBV vaccination among populations at higher risk of HIV.[72] In Romania, for instance, PWID are not included in routine TB testing or in national TB surveillance, despite being one of the groups at higher risk of acquiring the infection.[35] In some former Soviet countries, people living with HIV cannot start ART if they have opportunistic infections (such as TB), as these infections need to be treated first.[16] TB services in some settings also deny access to TB treatment to PWID who are living with HIV.[16] In addition to limited integration among services, another key barrier to TB testing and treatment is the lack of direct observation treatment short course (DOTS) in most countries, especially integrated in NSP or OST services.[35, 73] Barriers to accessing TB treatment vary by country: in Serbia, PWID without insurance have problems accessing TB treatment, in Kazakhstan PWID can only access treatment if they have a local registration document, and in Bulgaria, TB hospitals do not offer any drug dependence treatment, leading many PWUD to interrupt treatment and leave hospital early due to withdrawal symptoms.[35]

Improved referral systems and integration among ART programmes, harm reduction services and testing and treatment for TB and viral hepatitis remain to be urgently addressed in this region.

Overdose responses

Overdose mortality in the region generally tends to be underestimated, and most governments in the region have not acknowledged the full extent of the overdose epidemic among PWID. For example, while national authorities in several Central Asian republics report conservative numbers of fatal overdoses, 25.1% of PWID surveyed in Kazakhstan, Kyrgyzstan and Tajikistan in 2010 reported having witnessed someone die due of an overdose in the past 12 months.[74] PWID in Eurasia also tend to have high prevalence of non-fatal overdose. For example, non-fatal overdose was experienced at least once by 59% of people injecting heroin surveyed across 16 Russian cities.[75]

z Bosnia & Herzegovina, Croatia, Bulgaria, Poland, Slovenia and Serbia.

For most countries where data are available, overdose prevention responses include limited or rare provision of overdose information material to PWUD, individual overdose risk assessment, overdose response training and risk education on drug-related deaths.[58, 76] Across the region, overdose prevention programmes are often sporadic and generally run by local NGOs.

Naloxone, a highly effective opioid antagonist used to reverse the effects of opiate overdose, is registered as a medication or included in the essential medicine list in all Eurasian countries, with the exception of Albania.[76] Across the region, naloxone is mainly available via doctors in emergency departments, hospitals and ambulance workers, as well as for community-based distribution in Armenia, Belarus, Estonia, Georgia, Russia and Ukraine.[35] Access through peers and harm reduction services in the community, such as NSP providers, is also reported in Georgia, Kazakhstan, Kyrgyzstan, Tajikistan and Russia; however, distribution often occurs unofficially via local NGOs.[35, 76] Despite the availability of naloxone in emergency departments and ambulances, supply is not consistent across all types of facilities and at all times.

Additional barriers to the effective implementation and scale-up of overdose responses, including naloxone provision, include laws limiting management and transportability of naloxone by non-medical personnel and delays in the provision of emergency care responses for overdose.[58] Ongoing advocacy in several countries, including Georgia, Kazakhstan, Kyrgyzstan, Russia and Tajikistan, aims to expand access to naloxone by building political commitment, ensuring local or international funding for naloxone programmes and advocating for the removal of policy and legal barriers that prevent NGOs from distributing naloxone. There is an urgent need for advocacy around scaling up the distribution of naloxone beyond medical services to harm reduction programmes, outreach workers and PWUD, their families and communities.

In December 2011, Tajikistan's Ministry of Health approved the distribution of naloxone via NGOs working directly with PWID. Three local NGOs (Apeiron, Volonter and ROST), in collaboration with Soros Foundation Tajikistan and the Global Health Research Center of Central Asia, successfully advocated for authorisation to store 500 vials of naloxone at a time at NGO locations around the country and to distribute these directly to clients as needed. In addition to issuing an order to allow NGOs to store naloxone, the Ministry of Health has also endorsed guidelines developed by civil society which formalise and legitimise naloxone distribution through community harm reduction sites. Although the decision limits activity only to NGOs that hold a pharmaceutical activity licence, prior to this decision, NGOs in Tajikistan were not legally permitted to store naloxone on their premises, posing a major barrier to access by people who need it most. Similarly, in Kyrgyzstan, civil society reports indicate that NGOs are now permitted to distribute naloxone directly to their clients in Osh and Bishkek, through Kyrgyzstan's Global Fund Round 10 grant. Prior to this, NGOs were not allowed to store or distribute naloxone.[77]

Harm reduction in prisons

Availability of harm reduction interventions in prisons is very limited across Eastern Europe and Central Asia, with wide variations in service coverage among countries and in facilities within countries. By mid-2012, five countries – Armenia, Kyrgyzstan, Moldova, Romania and Tajikistan – were implementing NSPs in prisons. OST is available in prisons in 18 of the 26 countries and territories that also provide OST in the community,[aa] including two new OST pilots in Bosnia and Herzegovina and Latvia since the beginning of 2012.[3] In several countries OST is available in prisons only to clients who were on treatment prior to incarceration; in others it is available only in custody centres, while in a third group it is only available in a limited number of centres.[35] For example, some degree of OST provision is reported in prisons in Croatia and pre-detention trial units in Albania, Georgia and Kyrgyzstan, although programmes are not available as an integral part of health services in Albanian prisons.

The Czech Republic, Hungary, Romania and Slovenia provide initiation of OST on entering prison and continuation of OST in the community upon release from prison to varying degrees. Continuation of OST in prison is available in Bulgaria, Estonia, Poland and Montenegro provided that the inmate was already receiving OST prior to arrest.

Data on prevalence of TB and HCV/HBV among PWID are lacking, mainly due to the lack of TB screening and HCV/HBV testing in prisons. Nonetheless, the burden of TB, HCV/HBV and HIV among prisoners is significant, especially given higher rates of co-morbidities than the general population.[62] Co-infection of HIV and TB in overcrowded prisons also poses significant challenges to both detention and health systems in Russia and post-Soviet Union countries,[78] especially given the highly rigid level of vertical integration of each system, which often results in lack of coordination.[62] Given the high proportion of PWID in prisons and correctional facilities and the high rate of re-offending among PWID, an important opportunity to reach this population is through integrated vaccination, testing and treatment for HCV and HBV within these settings.[79-81]

Barriers to implementation and scale-up of harm reduction interventions in prisons include lack of political will, denial of the existence of drug use in prisons, shortages of staff for medical services within prisons, lack of funding and data gaps on the extent of IDU in prisons across the region.

aa Albania, Armenia, Bulgaria, Czech Republic, Croatia, Estonia, Georgia, Hungary, Kyrgyzstan, Macedonia, Moldova, Montenegro, Poland, Romania, Serbia and Slovenia.

Policy developments for harm reduction

In 2010, HRI reported that 25 Eurasian countries and territories had national HIV or drug policies explicitly supporting harm reduction.[34] Since then, seven countries – Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Tajikistan and Ukraine – have finalised HIV strategies and national programmes that include harm reduction activities, in some cases focusing on scaling up NSP and OST, although in the case of Ukraine this strategy has yet to be approved.[35] The HIV law passed in Azerbaijan in 2010, which previously had no legal provisions in place regarding harm reduction, now emphasises the role of harm reduction in HIV prevention, including NSP and OST provision in penitentiaries.[82] Additional policy developments include Serbian by-laws to the new Law on Rehabilitation, Resocialisation and Treatment that legalise harm reduction and remove parental consent as a barrier for accessing NSP and OST, relaxation of OST criteria in Belarus and plans to implement community-based naloxone in Estonia.[76]

The decriminalisation of drug use in Estonia and the amendment of penalties for drug possession for personal use from incarceration to administrative offences in Kazakhstan and Poland[35, 83-84] constitute further favourable policy developments.

Despite an overall trend toward a policy environment conducive to harm reduction implementation and scale-up, a number of important challenges remain. Since 2010 the policy context for harm reduction has deteriorated or remained highly unfavourable in Hungary, Russia and Ukraine. The national drug policy in Russia portrays NSP as a threat to effective drug control, while the 2009–2011 HIV strategic plan in Uzbekistan fails to recognise harm reduction and cites drug use and sex work as antisocial behaviours.[35]

In December 2010, without prior consultation with civil society or medical professionals, the Hungarian government rejected the progressive harm-reduction-oriented drug strategy and introduced a new draft strategy excluding any mention of harm reduction. The new strategy does not list NSP and voluntary HIV/AIDS testing and counselling among its aims and refers to OST as a form of treatment that 'may be necessary' for those 'who cannot be treated effectively with other methods'.[85] A recent review of OST provision across Eurasia evaluated Lithuania to have one of the least favourable policy environments in the region: Lithuania's drug policy does not include services for PWID, while the national HIV programme includes no targets for NSP and OST services.[55, 86-87]

Since 2010, stricter penalties[ab] for drug possession have been put in place in Russia and Ukraine.[88-89] For the first time, the Czech Republic introduced threshold quantities for possession of illegal drugs, with unauthorised possession for personal use continuing to hold an administrative penalty.[90-91] Although the impact of this policy is unclear, evidence from other settings suggests that the reduction in threshold quantities for personal use will result in reduced access to NSP and OST due to fear of police harassment and raids.[92] Georgia remains one of a few countries where the non-medical use of controlled drugs constitutes a criminal offence. This has a direct impact on both the rights and health of PWUD: currently there are more PWUD in prisons than there are in treatment facilities.[93]

New legal highs

The past two years have seen an exponential increase in new psychoactive substances commonly referred to as 'legal highs' across Europe. Between 1997 and 2010 the early-warning system of the European Monitoring Agency on Drugs and Drug Addiction (EMCDDA) identified more than 150 legal highs, 65 in the past two years (24 in 2009 and 41 in 2010).[94]

Legal highs have contributed to the increased risk of HIV and viral hepatitis transmission in several countries in the region, particularly Hungary and Romania, where a significant proportion of heroin and amphetamine users have turned to injecting designer 'legal highs'. Injection of 'legal highs' is often more frequent than heroin injection, with the potential to increase the sharing of injecting equipment.

The response from governments has generally been default criminalisation, even in the absence of clear evidence. Romania has criminalised 36 new substances in 2010, and over 900 shops were closed down in Poland.[95-96] In 2011 the Czech Republic and Slovakia joined the race and criminalised 33 and 42 new substances, respectively, in their countries.[97 ac] From 1 January 2012 nine new substances were banned in Hungary. Although the Hungarian government plans to introduce generic legislation aimed at preventing traffickers from creating new legal substitutes of prohibited substances, it has stated that it does not aim to criminalise PWUD, but only the distributors of new psychoactive substances.[98] This approach has led to the displacement of one substance with another, rather than a cessation of 'legal high' use.

ab These included harsher penalties for drug-related crimes including administrative detention for drug use for up to 15 days and life sentence for large-scale drug offences in Russia. In March 2012 the Federal Drug Control Service of the Russian Federation proposed an amendment to the Criminal Code providing for up to two years of prison or hard labour for drug use, if the episode of drug use is repeated within a year after the first drug use episode has been recorded. In addition, Ukraine's Ministry of Health issued a resolution in 2010 setting very low threshold amounts of illicit drugs that trigger criminal liability; for instance, minimum amount of heroin is set at 0.005 g, thus making all individuals possessing one dose of heroin without intention to sell criminals.

ac Czech Republic Act No. 167/1998 Coll., on addictive substances, was amended in the spring of 2011. See http://portal.gov.cz/zakon/106/2011.

Civil society and advocacy developments for harm reduction

Civil society has played an increasingly important role in effectively advocating for harm reduction in Eurasia and internationally. Active lobbying and advocacy from national and/or regional-level CSOs and networks has been instrumental in amending the Slovenian Penal Code to allow for the establishment of settings where illicit drugs may consumed under medical supervision,[35] the development of the new HIV law in Azerbaijan and actively participating in the working group to change the law in Romania, all with varying degrees of success. Advocacy for wider availability of naloxone in Tajikistan resulted in guidelines for overdose prevention and management by the Ministry of Health,[35] while an aggressive campaign in Ukraine succeeded in overcoming the government's opposition to OST.[3] In Bosnia and Herzegovina the Ministry of Security, in cooperation with the Ministry of Health, initiated a process of accreditation of harm reduction NGOs, although this process is based on the assumption that harm reduction programmes will be funded by these two ministries after the contract with Global Fund expires in 2014.[35]

Advocating for drug policy change in Poland

Civil society organisations in Poland have long been campaigning to reform the country's drug law. During 2010–2011 the Polish Drug Policy Network (PDPN) initiated a national advocacy campaign that aimed to amend the restrictive drug law in Poland.[99] Advocacy activities included legal actions such as cooperation with the Office of the Ombudsman for Addicts, active participation in public debate and numerous open letters including one signed by a former Polish president and other prominent figures[100] addressed to the Ministry of Health, Minister of Justice, Prime Minister, Polish Seim and Senate, and the National Bureau for Drug Prevention. PDPN also launched an online sign-on campaign targeting both Polish and international audiences to put pressure on Bronislaw Komorowski, the President of the Polish Republic, to sign the bill.

On 25 May 2011 the President signed an amendment to the country's drug law. The new amendment draws a greater distinction between drug dealers and drug users, and allows prosecutors the choice not to criminalise small-scale drug offenders. The next steps will be to ensure that the current amendment is implemented and to open a broader public debate on decriminalisation.

The Eurasian Network of People who Use Drugs (ENPUD) was established in February 2010 following a meeting of representatives of the drug user community and OST clients from Armenia, Georgia, Kyrgyzstan, Kazakhstan, Ukraine, Russia, Tajikistan, Uzbekistan and Moldova.[101] This initiative represents the first attempt by people who use or have previously used drugs in the region to join efforts at the regional level. ENPUD aims to facilitate greater involvement of PWUD in local and international drug policy, to improve the quality of medical, social and legal services. A strategic follow-up meeting and needs assessment exercise is planned to take place in Kiev in July 2012.

EHRN has continued to actively promote harm reduction and the rights of PWUD across 29 countries in Central and Eastern Europe and Central Asia. In 2011, EHRN mobilised and supported over 30 drug user activists to testify to the Global Commission on HIV and the Law on a range of human rights violations faced by their community. Their joint statement was voiced at the Regional Consultation of the Global Commission and was delivered at the UNAIDS Programme Coordinating Board (PCB).[92] At the 54th UN Commission on Narcotic Drugs (CND), EHRN organised a side event on overdose, 'Illicit Drug Overdose: Major Cause of Preventable Death', which was well attended by key multilateral agencies and civil society representatives. A key outcome of the event was the formation of a multisectoral initiative to develop internationally recognised overdose prevention guidelines.

In 2010 the South East Europe NGO Drug Policy Network, an initiative led by NGOs in the region and supported by the International Drug Policy Consortium, was launched. The network aims to create open and objective dialogue with experts, key policymakers in national governments, regional bodies and international organisations to promote humane and effective drug policies.

As part of the international Count the Costs campaign supported by the Open Society Foundations, the Hungarian Civil Liberties Union (HCLU) and the European Drug Policy Initiative (EDPI) coordinated actions in five European cities – Sofia, Bucharest, Warsaw, Oslo and Porto – to raise public awareness on the health and human rights costs of the war on drugs, to mark the 50th anniversary of the Single Convention on Narcotic Drugs in June 2011.[102]

CSOs in Eurasia are well positioned to engage in ongoing advocacy to reverse the disproportionate focus on punitive approaches to IDU, common in countries in the region.[103] In the current precarious funding environment, the provision of adequate financing for CSOs and local organisations of PWUD to enable them to continue this important work is particularly crucial.[33]

Multilaterals and donors: developments for harm reduction

Increased engagement by multilateral agencies in harm reduction implementation is reported in Albania, Bosnia and Herzegovina, Latvia, Kyrgyzstan, Serbia and Tajikistan. UNICEF is an active partner in research among young PWID and in preparation of the new Law on Rehabilitation, Re-socialisation and Treatment in Serbia but plans to scale down its activities in Romania. UNODC supports ongoing harm reduction services in prisons in Latvia and Tajikistan and at the time of publication was investigating how to best support the scale-up of harm reduction services in prisons in Albania, Serbia and Macedonia in partnership with EHRN. UNDP is the primary recipient for Global Fund grants in Kyrgyzstan and Tajikistan, both of which include support for harm reduction services.

Funding for harm reduction responses in Eastern Europe and Central Asia largely originates from the Global Fund. The Global Fund invested over US$366 million for harm reduction in Eurasia alone – more than all other international sources combined (see Table 2.2.2).[33] Other donors that support harm reduction in the region include the European Commission, OSF, UNAIDS, UNODC, UNDP and UNICEF. Along with international donors, additional funding for harm reduction is contributed by national governments in Azerbaijan, Bulgaria, Bosnia and Herzegovina, Czech Republic, Croatia, Estonia, Georgia, Hungary, Kazakhstan, Latvia, Lithuania, Macedonia, Montenegro, Poland, Slovenia, Slovakia and Serbia.[35] Overall, government funding prioritises provision of medical services and OST, as well as NSP and OST in prisons, while CSOs and international partners largely support NSP and community-based harm reduction separately or in the context of comprehensive HIV prevention programmes.[3, 35]

Table 2.2.2: Approved Global Fund investments targeting PWID in Eastern Europe and Central Asia Round 1 (2002) to Round 10 (2010)[104]

COUNTRY / TERRITORY	TOTAL (US$)	
Albania	1,400,000	
Armenia	3,100,000	*
Azerbaijan	6,000,000	*
Belarus	17,500,000	*
Bosnia & Herzegovina	9,800,000	*
Bulgaria	9,500,000	
Croatia	600,000	
Estonia	2,700,000	
Georgia	12,700,000	*
Kazakhstan	29,800,000	*
Kosovo	2,000,000	
Kyrgyzstan	25,800,000	*
Macedonia	15,600,000	*
Moldova	7,200,000	*
Montenegro	1,600,000	*
Romania	4,200,000	
Russian Federation	38,400,000	
Serbia	6,500,000	*
Tajikistan	15,600,000	
Ukraine	143,900,000	*
Uzbekistan	12,200,000	*
TOTAL	366,100,000	

Notes

Figures are rounded. Data are correct as of March 2012. Data are based on detailed grant budgets submitted to the Global Fund and may not reflect actual expenditures.

* Figure includes projections for future years of grants that have not yet been formally committed.

Increased state support for harm reduction is expected in Macedonia; in 2011 the Ministry of Health financed the provision of 30,000 syringes and 50,000 condoms via NSPs for the first time.[73] In Bosnia and Herzegovina, a new NGO accreditation process may result in more harm reduction programmes funded by the state in the coming years; currently only 40% of harm reduction programmes are funded by the national government.[35] In other countries where the state supports harm reduction, funding is allocated on an annual basis, and government funds are often delayed and insufficient to sustain and scale-up service coverage to levels needed to have an impact on HIV and viral hepatitis epidemics.[58] The financial crisis has had significant effects on the governmental allocations in these countries. For example, funds decreased by 50% in 2009–2010 in Latvia, with cuts disproportionally affecting populations at higher risk of HIV and the health budget for prisons,[35] and significant cuts were made to the NSP budget in Lithuania.[87]

The cancellation of Round 11 and insufficient donor contributions to the Global Fund have had a major impact in the region. Compared with ten national and one regional

HIV grant proposals originally planned for Round 11 and the second wave of National Strategy Applications (NSAs), only Russia (two NGO grants, including the Russian Harm Reduction Network/ESVERO after a special decision by the Global Fund Board to allow it to apply), Serbia and Tajikistan applied for HIV support from the Transitional Funding Mechanism (TFM) by the 31 March 2012 deadline.[33] As of 2012, six countries are not eligible for Global Fund funding, although NGOs from Bulgaria, Latvia, Lithuania and Russia can apply for support under the NGO scheme.[ad] Almost all harm reduction services in Azerbaijan, Bulgaria, partly in Bosnia and Herzegovina, Kosovo, Serbia, Azerbaijan and Macedonia are funded by the Global Fund.[ae] Of significant concern is the situation in Albania, Armenia and Moldova, where harm reduction services are at risk of closure after March 2012 when the Global Fund grant comes to an end. Of the five Eurasian countries that applied for Round 10, Georgia, Kazakhstan, Ukraine and Uzbekistan were successful. Harm reduction through Round 10 funding includes planned OST scale-up in Kazakhstan; HIV prevention for most-at-risk populations, including harm reduction services for PWID in Ukraine; as well as NSP, testing and vaccination for viral hepatitis, and OST for PWID in Uzbekistan.[35]

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ad Armenia's RCC grant is signed until September 2012.

ae In the case of Azerbaijan, Bulgaria, Bosnia and Herzegovina, Kosovo and Serbia this support expires in 2014; for Azerbaijan and Macedonia in 2016.

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2.3 | Regional Update
Western Europe

Table 2.3.1: Epidemiology of HIV and Viral Hepatitis, and Harm Reduction Responses in Western Europe

Country/territory with reported injecting drug use	People who inject drugs[a]	HIV prevalence among people who inject drugs (%)[b]	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[c]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[d]	Harm reduction response		
					NSP[1 e]	OST[2 f]	DCR[g]
Andorra	nk	nk	nk	nk	✖	✖	✖
Austria	17,500 (12,000–23,000)[h]	0.7–5.3	43.4–65.3	nk	✔ (31)	✔ (B,M,O)	✖
Belgium	5,125 (3,377–7,829)[3]	3.4–6 [(s)]	28.1–80 [(s)]	0–2.8 [(s)]	✔ (69)(P)	✔ (B,H,M)	✖
Cyprus	467 (418–539)[3]	0–1.3	51.3	1.7	✔ (1)(P)	✔ (1)(B,O)	
Denmark	12,754 (10,066–16,821)[i 3]	2.1[i]	52.5	1.3[j 4]	✔ (135)[i]	✔ (B,H,M)	✖
Finland	15,650 (12,200–19,700)	0.7 [(s)]	60.5	nk	✔ (40)	✔ (B,M,O)	✖
France	122,000[l]	5.1–8[i (s)]	41.7[l (s)]	4.8 (3.4–6.2)[m 4]	✔ (532)(P)	✔ (19,484)(B,M,O)	✖
Germany	94,250 (78,000–110,500)	3.4[j]	75[j n]	7.2 (6–8.4)[o 4]	✔ (250)	✔ (2,786–6,626)(B,H,M)	✔ (27)
Greece	9,439 (8,110–11,060)[3]	0.7–0.8	48.7–68.8	2.9–3.6	✔ (6)(P)	✔ (17)(B,M,O)	✖
Iceland	nk	nk	63[p 4]	nk	✖	✔ (B,M)	✖
Ireland	6,289 (4,694–7,884)[q]	5.8[v 4]	74.6 (72.3–76.9)[4]	0[k 4]	✔ (32)(P)	✔ (332)(B,M,O)	✖
Italy	326,000[q]	11.5	58.5	5.1 (0.9–9.3)[r 4]	✔	✔ (B,M,O)	✖
Luxembourg	1,485 (1,253–1,919)[j 3]	2.4	71.8–90.7[s]	3.9[s]	✔ (8)	✔ (B,M,O)	✔ (1)
Malta	nk	0	36.3		✔ (7)	✔ (≥2) (B,M)	✖
Monaco	nk	nk	nk	nk	✖	✖	✖
Netherlands	2,390 (2,336–2,444)[3]	0 [(s)]	47.6–67.4 [(s)]	1–13 [(s)]	✔ (175)[5] (P)	✔ (B,H,M)	✔ (40)
Norway	10,238 (8,810–12,480)[3]	2.4	69.9	0 [(s)]	✔ (29)[rr](P)	✔ (B,M)	✔ (1)
Portugal	10,950–21,900[3 s]	4.9–17.2	36.5–83.1	2–3.4	✔ (1,620)(P)	✔ (B,M)	✖
Spain	83,972[t]	32.3	79.6 (73.3–85.9)[u 4]	3.6 (1.8–5.3) [4]	✔ (2,274)(P)	✔ (497–2,229)(B,H,M)	✔ (7)
Sweden	nk	2 [(s)]	59.7[(s)]	2.3 [4]	✔ (2)	✔ (B,M)	✖
Switzerland	31,653 (24,907–38,399)[v]	1.4 [4]	78.3[w 4]	4[4]	✔ (101)(P)	✔ (B,H,M,O)	✔ (7)
Turkey	nk	0.5	5.3 [(s)]	5.2 [4]	✖	✖	✖
United Kingdom	133,112 (126,852–143,278)[3 x]	0–4.3 [(s)]	26.1–61.2	8.9 (0–17.8)[y 4]	✔ (1,523)(P)	✔ (B,H,M,O)	✖

nk= not known
[(s)] = sub-national data

a Unless otherwise stated, data are sourced from Mathers B et al. for the Reference Group to the UN on HIV and Injecting Drug Use (2008) Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review, Lancet, 372(9651):1733–1745.
b Unless otherwise stated, data are sourced from European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) (2012) Statistical Bulletin 2012: Table INF-1. Prevalence of HIV infection among injecting drug users in the EU countries, Croatia, Turkey and Norway, 2010 or most recent year available, http://www.emcdda.europa.eu/stats12#display:/stats12/inftab1.
c Unless otherwise stated, data are sourced from EMCDDA (2012) Table INF-2. Prevalence of HCV antibody among injecting drug users in the EU countries, Croatia, Turkey and Norway, 2010 or most recent year available, http://www.emcdda.europa.eu/stats12#display:/stats12/inftab2.
d Unless otherwise stated, data are sourced from EMCDDA (2012) Table INF-3. Prevalence of markers for HBV infection among injecting drug users in the EU countries, Croatia, Turkey and Norway, 2010 or most recent year available, http://www.emcdda.europa.eu/stats12#display:/stats12/inftab3.
e The number in brackets represents the number of operational NSP sites, including fixed sites, vending machines, pharmacy-based NSP sites and mobile NSPs operating from a vehicle or through outreach workers. (P) = needles and syringes reported to be available for purchase from pharmacies or other outlets, and (NP) = needles and syringes not available for purchase.
f The number in brackets represents the number of operational OST programmes, including publicly and privately funded clinics and pharmacy dispensing programmes. (M) = methadone, (B) = buprenorphine, (BN) = buprenorphine-naloxone combination, (H) = heroin-assisted therapy, (O) = any other form (including morphine and codeine).
g DCR = drug consumption room.
h Year of estimate: 2000
i Year of estimate: 2006
j Year of estimate: 2007.
k Year of estimate: 2003.
l Year of estimate: 1999.
m Year of estimate: 1992–1995.
n Year of estimate 2004.
o Year of estimate: 1992–1994.
p Year of estimate: 1990–1993.
q Year of estimate: 1996.
r Year of estimate: 1990–91 and 1992–93.
s Year of estimate 2005.
t Year of estimate: 1998.
u Year of estimate: 1999–2001, 2003.
v Year of estimate: 1997.
w Year of estimate: 2002.
x Year of estimate: 2004–2010.
y Year of estimate: 1996–2000.

Map 2.3.1: Availability of needle and syringe exchange programmes (NSP) and opioid substitution therapy (OST)

- Both NSP and OST available
- OST only
- NSP only
- Neither available
- Not known
- DCR available

Harm Reduction in Western Europe

Injecting drug use (IDU) remains common in Europe for both opioids and amphetamines, with significant user populations in Italy, France, Spain, the UK and Germany. Approximately 1 million people who inject drugs (PWID) reside in Western European countries.[6] While low HIV prevalence among PWID in many countries in Western Europe has been linked with the early implementation of harm reduction programmes, the scope and reach of programmes remains uneven. Almost all countries in the region have operational needle and syringe exchange programmes (NSPs) and opioid substitution therapy (OST), but some national programmes are too small to have any clear impacts, and many of the larger programmes are under constant threat of closure. European countries continue to feature among those with the highest coverage of harm reduction programmes globally,[z] but to protect and promote these services moving forward will require concerted cooperation between harm reduction advocates and policymakers, particularly in a time of ever-increasing financial hardship.[7]

NSPs are available in all countries in the region except for Andorra, Monaco, Iceland and Turkey. Geographical coverage, however, varies greatly from country to country, with only one NSP site reported in Cyprus, for example, compared with more than 1,000 in Spain and Portugal.[2] No considerable expansion in NSPs has been reported in the region since 2010, although one new programme has opened in Helsingborg in Sweden, which is the first such development in over two decades in the country.

Various forms of OST are provided across the region through publicly and privately funded clinics and pharmacy dispensing programmes. These include methadone maintenance treatment (MMT), buprenorphine maintenance treatment (BMT), heroin-assisted therapy (HAT) and other forms of OST including morphine and codeine. Turkey introduced buprenorphine-naloxone combination for substitution therapy in 2010. Even though regional and national OST coverage rates vary substantially, levels of coverage in Western Europe (61% of PWID receiving OST) are high compared with other world regions.[2] In some countries, however, OST programmes are implemented on a very small scale. Cyprus and Malta operate only one and two OST sites, respectively.

The majority of the countries in Western Europe lead in the provision of harm reduction services in prisons. However, coverage of prison NSPs and OST varies across the region, and there is lack of data for all countries. Extensive prison NSPs are in place in Spain and Luxembourg.[7]

z According to the 2009 WHO, UNODC, UNAIDS target-setting guide, <100 syringes distributed per person who injects drugs per year is considered low coverage; 100–200 is medium coverage, and >200 is high coverage.

The decrease in new HIV infections within the EU over the last decade has been brought about by a number of factors, including more easily available harm reduction measures and a decline in IDU, as well as better prevention and treatment services. But while NSPs and OST have become widely accepted within the EU, other effective interventions such as drug consumption rooms (DCRs) and HAT remain controversial and rare. There are 85 DCRs in six countries across the region.[8] Denmark is the first country in the world to have passed legislation to regulate the operation of such facilities via a new law adopted on 1 July 2012.

Western Europe is reported to have the highest regional level of antiretroviral therapy (ART) coverage among PWID in the world, but considerable barriers to universal access remain. Coverage of ART in prisons varies across the region,[7] while poverty and social exclusion impede access and adherence. In some countries (such as Portugal) it has been reported that doctors have refused to allow people who use drugs (PWUD) to initiate ART.[7]

In those Western European countries that saw the first heroin epidemics, populations of PWID are growing older. Harm reduction services will need to monitor their specific health and social needs, as well as the challenges that an ageing population presents to service providers.[9]

While heroin remains the most popular drug among older users, amphetamine-type stimulants (ATS) are the most popular amongst young people.[9] ATS users are estimated to make up 28% of those entering treatment in Sweden, 17% in Finland[10] and smaller proportions in Belgium, Denmark, Germany and the Netherlands.[10] Solid data on prevalance of ATS injection, however, are not available.

Indeed, while the monitoring of drug use and related harms in Europe continues to be good, there are significant gaps in knowledge, particularly in relation to young people, migrants, street-involved people and other vulnerable populations. In the case of young people, the focus on home and school surveys inevitably excludes those outside mainstream education and outside the home, and more attention and funding is needed for other forms of data collection. Drug use studies also tend to examine imprecise and problematic criteria such as lifetime or last yearly use, which may obscure specific patterns of use that may be driving drug-related harms. Service and treatment data in many countries, meanwhile, obscure non-service-using populations, contributing to a general paucity of data that diminishes the potential impact of harm reduction.

Funding for drug policies, meanwhile, has been hit hard by European governments' responses to the economic crisis. In its 2011 annual report, the European Monitoring Centre for Drugs and Drug Addiction estimates that from 2008 to 2011 these cuts ranged from 2% to 44%.[10] Meanwhile, the European

Union (EU) is becoming increasingly fragmented on a political level in its approach to harm reduction. Countries such as the UK that have championed the harm reduction approach in the past are beginning to shift towards more abstinence-oriented policies.[11] How this will impact the EU as a whole is, as yet, uncertain, but is likely to become clearer with the drafting of the new EU drugs strategy due for completion at the end of 2012.

Developments in harm reduction implementation

Needle and syringe exchange programmes

With a few exceptions, NSPs are widely available in Western Europe (see Table 2.3.1). Across the region a variety of service delivery models are in place including stand-alone sites, pharmacy-based services, vending machines (in Austria, Denmark, France, Germany, Italy and Spain), outreach and peer outreach services,[1] and mobile NSPs exist in roughly half of the countries in the region.[1] Portugal and France have high proportions of NSP sites with outreach workers (96 and 91, respectively), while with 1,360 sites Portugal is leading the way in pharmacy-based services to supplement fixed NSP outlets.[1]

Despite good levels of provision across most of Europe in comparison with other world regions, the reach of interventions remains uneven among and within countries. Only one operational NSP site is reported in Cyprus, three in Sweden and up to 2,274 in Spain and 1,620 in Portugal. The number of NSP sites has doubled in Luxembourg and Belgium, while in Sweden, a third NSP site was established in Helsingborg in 2010, and an additional site is planned to be opened in Kalmar in late 2012. No considerable expansion in other countries was reported since 2010. Furthermore, national NSP coverage estimates often hide dramatic geographical variations. This represents an important gap in accessibility in smaller cities and rural areas in, for example, Spain, Portugal, Ireland, Germany, Finland, Belgium and Austria.[12]

Another measure of service coverage, however, and one that allows for international comparisons of available data, is the number of syringes distributed per PWID per year.[13] Luxembourg and Norway are the only two countries in the region that distribute 200 or more syringes per person per year, which represents high coverage according to the joint WHO, UNODC and UNAIDS technical target-setting guide.[13] Coverage remains low in Sweden, Cyprus and Greece, where less than 100 syringes are distributed per person per year.[14]

Increased occurrence of non-opioid injecting, such as the use of anabolic steroids, has been documented in some parts of Europe (for example, Belgium and the UK). However, shortage of data on the prevalence of steroid injecting and its low priority within national drug budgets have prevented the development of targeted strategies to address this user group's needs.[15]

Due to service-user anonymity there are no available data on the average age of NSP clients, but data from EMCDDA and WHO Europe indicate that, as a group, the population of PWID across the region is growing older.

Opioid substitution therapy

All countries in the region, with the exception of Andorra and Monaco, provide MMT and BMT (see Table 2.3.1). Additional OST options, including HAT, buprenorphine plus naloxone combination and slow-release morphine, are widely available across the region. Turkey is reported as providing licensed buprenorphine-naloxone combination since 2010.[16] However, the number of clients currently enrolled in the programme is not known. In several countries, data on OST coverage at the national level are unavailable due to variation in the types of service provision sites, as well as a lack of strong national monitoring systems.

Fifteen EU Member States[aa] provide 95% of the total OST in Europe, and the number of OST sites in these countries continues to increase.[17] More than half – 700,000 – of Europe's population of people who use opioids are enrolled in OST.[ab] This demonstrates a strong coverage exceeding the UN's recommended target figure of 40% as sufficient to address the spread of HIV among PWID.[18] However, within Europe this coverage is far from even, with some countries such as Germany and Italy exceeding this average, and others such as Cyprus far below it at 5%.[19, 20] France has 19,484 OST sites, the highest number of any country in the region where data are available.[2]

In many countries OST provision includes access through general practitioners (GPs), although levels of regulation governing OST prescription by GPs vary considerably. For example, in Norway GPs can prescribe MMT and BMT to patients already enrolled in OST at a specialised centre, but they are not legally allowed to assess a patient's need for treatment. In France, experts estimate that two-thirds of GPs who are licensed to prescribe MMT and BMT are reluctant to do so, thus limiting accessibility for individuals living outside large cities.[21]

As with NSP clients, significant changes have been noted in the age profile of OST clients in Europe. In Greece 61% are aged 40 or over, while in the Netherlands the figure is around 75%, with the 40–49 age group making up almost half of all OST clients.[22] This trend has also been noted, albeit to a lesser extent, in other countries where data are available.

aa Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, UK.
ab Based on estimates derived from EMCDDA regional divisions, which may be different than those of HRI in this report. For more information, please see www.emcdda.europe.eu.

Heroin-assisted treatment in Europe

Heroin-assisted treatment (HAT) has increasingly emerged as an effective second-line treatment among individuals for whom OST and other drug treatment modalities have produced limited benefit.[18, 23] As of 2012, seven countries implemented supervised injectable heroin (diacetylmorphine) as maintenance treatment: Denmark, Germany, the Netherlands, Spain, Switzerland, the UK and Luxembourg (pilot programme). In 2011, Belgium's pilot HAT project was expanded to deliver treatment nationally.[24] According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), overall there were approximately 1,000 HAT patients in EU Member States and a further 1,400 in Switzerland as of April 2012.[18]

*For more information, see EMCDDA (2012) *EMCDDA Insights: New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond*. Lisbon: EMCDDA.

Antiretroviral therapy

While Western Europe as a whole has the highest level of coverage across the globe, there is significant variation between countries.[2]

In Luxembourg, for example, the country with the greatest percentage of PWID living with HIV on treatment, 70% of PWID were enrolled on ART in 2010, while in Portugal only 10% of PWID living with HIV were on treatment.[2]

With early diagnosis of HIV, many more PWID are likely to obtain the maximum benefit from ART. For instance, a decrease in AIDS diagnoses in Austria, the Netherlands and Finland has been attributed to early diagnosis and initiation of ART.[25] High incidence rates of AIDS in some countries may indicate that PWID living with HIV are not accessing ART in the early stages following an HIV diagnosis.[2] Austria has one of the highest rates of HIV tests per capita in Europe, but it is unclear whether PWID are accessing the service in numbers comparable with other groups at higher risk of HIV.[25]

Across the region there remain significant barriers to PWID accessing and adhering to ART, including homelessness, lack of insurance, lack of support and stigma from health professionals.[26] Moreover, national data on ART coverage for PWID are not universally available within Western Europe, limiting a full understanding of availability, coverage and adherence.

Responding to an HIV outbreak among people who inject drugs in Greece

In 2011 Greece reported an outbreak of new HIV infections among people who inject drugs.[27-29] By the end of July 2011, 113 cases had been reported by the national surveillance system, compared with between three and 19 reported cases per year from 2001 to 2010. A rapid situation analysis by the EMCDDA found that several factors may have contributed to the increased risk of acquiring HIV, including the absence of comprehensive harm reduction programmes for HIV prevention among PWID, as well as targeting of injectors by the police, which has previously been shown in other settings to hinder service uptake and encourage increased risk-taking behaviour such as needle and syringe sharing. The rapid assessment also revealed that Greece has relatively few low-threshold programmes for PWID (OST waiting lists range from five to seven years), and coverage of NSPs and OST is low.[30]

The response from public health authorities and civil society in Greece has included a major restructuring of the OST programme, including the immediate provision of 28 new OST units, a switch from high to low dead space syringes, and an awareness campaign targeted at injectors in Athens, where incident cases are concentrated.[31]

Drug consumption rooms

The provision of DCRs varies across the region, with nationwide coverage in Switzerland and the Netherlands, regional coverage in Germany and Spain, and DCRs in the capital cities only in Norway and Luxembourg. In total there are 85 DCRs across 56 cities in these six countries, the majority of them integrated into more general health and social service provision networks.[32] With a widespread switch from injecting to sniffing drugs across the region there has been an increase in DCR booths dedicated to this purpose, including a pilot study in Luxembourg in 2012.[33]

New legislation governing DCRs was introduced in Denmark in July 2012, making it the first country in the world to have legally regulated DCRs. This followed political discussion generated by a mobile DCR operated by an NGO without police interference in Copenhagen since 2011.[32]

Despite the progress that has been made in the implementation of DCRs in Europe, most countries still do not allow their operation. Moreover, a number of barriers to access remain in relation to those DCRs that do exist such

as exclusion criteria that deny access to clients who receive OST (Luxembourg and Germany) and exclude non-nationals (Switzerland), as well as restricted opening hours, age restrictions for under 18s and regulations around the type of substance that can be consumed on the premises.[7]

Viral hepatitis

In contrast to low HIV prevalence among PWID in many countries in Western Europe, rates of viral hepatitis (HBV and HCV), and HCV in particular, remain disproportionately high among PWID. According to a recent systematic review on the epidemiology of viral hepatitis among PWID, there are an estimated 727,500 PWID with HCV and 480,000 PWID with HBV across the region.[4]

Prevalence of HCV varies widely across the region, from a high of 71.8–90.7% in Luxembourg, a significant public health issue, to a low of 5.3% in Turkey[34] (see Table 2.3.1). Rates of HCV among PWID in Cyprus have increased significantly between 2004 and 2010, with a steep rise from 9.1% to 51.3%,[34] based in part on widespread equipment sharing as well as a general shortage of services.[35] HCV rates are particularly high among new injectors, and there are reported rises in prevalence among these populations in Greece and Portugal.[34] Reported prevalence can also vary significantly within countries, based on sampling biases and regional variations.[34]

Barriers to HCV testing and treatment include lack of data, lack of awareness among medical professionals of the risks of co-infection with HIV, and restrictive costs, which are often not covered by health insurance or unavailable to the uninsured. In Spain and Finland PWUD are excluded from HCV treatments.[7]

HBV rates among PWID are similarly varied across the region, although general levels of prevalence are low. The highest is in the UK with 8.9%, while Ireland and Norway report 0%.[4] HBV vaccination programmes targeting specific high-risk groups, including PWID, operate in most countries in Western Europe, with the exception of Malta and the Flemish part of Belgium.[37] In Portugal, the requirement to pay for HBV vaccination is reported to prevent many PWID from accessing this service.[38]

Tuberculosis

Data on tuberculosis (TB) prevalence among PWID in Western Europe are scarce. Estimated incidence of TB in the general population vary, but are less than 24 per 100,000 population in almost all countries for which data are available.[39] The only exceptions are Spain and Portugal, where TB rates exceed those in other Western Europe countries at 25 and 49 per 100,000 population, respectively.[39] According to the EMCDDA, high rates of TB were reported among PWID in treatment in Greece, while systematic testing in drug treatment facilities in Austria and Norway did not identify any cases.[40] An increase in the number of cases of TB among migrants who use drugs has been reported in Ireland, Sweden and Switzerland, but data are not available for this population. In Portugal, distrust of the public health care system and fear of discrimination from health professionals are reported to pose barriers to TB testing and treatment.[38]

Models for delivering integrated HIV, viral hepatitis and TB services are not well documented across Europe. Recently, the WHO Regional Office for Europe prioritised investigating strategies for the effective delivery of integrated HIV-TB interventions.[41] A WHO-supported assessment of existing strategies in Porto, Portugal, documented two models[ac] and emphasised the importance of a client-centred approach that combines collaboration among existing services, outreach programmes and uninterrupted provision of OST and other drug treatment while providing TB-HIV care.[42]

Harm reduction in prisons

Data from the EMCDDA on HIV and viral hepatitis infection among PWID in prisons across the region are only available for four countries: Spain, Malta, Finland and Sweden.[43] HIV prevalence among prisoners who inject drugs ranges from 0.2% in Finland to a high of 39.7% in Spain.[43] The highest reported HCV levels among PWID in prisons are in Luxembourg, where 90.7% of PWID are HCV-positive.[44]

Although data on TB among prisoners who inject drugs are scarce, studies show that the risk of TB in prisons is on average 23 times higher than in the general population.[45]

Relative to other world regions, countries in Western Europe lead in the provision of harm reduction services in prisons. Prison NSPs are available in Spain, Luxembourg, Switzerland and Germany, and very limited NSP pilot programmes exist in Scotland. Only one prison, however, offers the service in Germany, and in Switzerland provision of NSP in prisons depends on the decision of each canton.[46] The only pilot NSP that was available in Portuguese prisons was terminated in 2007 due to logistical challenges and resistance from prison guards.[1]

OST is available in prison settings to varying degrees in most countries in the region, with the exception of Greece. In Sweden, OST in prison started as a pilot project in 2007 and was continued as a national programme in 2010, but coverage remains poor.[47] Switzerland is the only country in the region which provides HAT in prisons, with two facilities presently offering this service.[48] In Finland, Sweden and Malta OST cannot be initiated in prison, but PWID may continue treatment if they were already accessing OST in community settings at the time of their arrest.[49, 50]

ac The two strategies included a 'combined model' where all services are provided within a central location by a multi-disciplinary team, and a 'collaborative' model, characterised as client-centred and informal, which involves collaboration of service providers and outreach teams to deliver treatment in a location convenient to the client.

Overdose

Opioid overdoses are a major cause of mortality among PWID, accounting for between 10% and 23% of drug-related deaths in the 15–49 age group.[51] The most likely periods for PWID to overdose are after release from prison or if OST is interrupted. A study of 382 PWID taking part in a prison-based OST programme documented no deaths during OST but 13 deaths when OST was interrupted – eight of them overdose-related.[52]

Across the region, overdose prevention responses are implemented to varying degrees but include the provision of overdose information material to PWUD, individual overdose risk assessment and overdose response training. Naloxone is a registered medication in all Western European countries, but its availability varies across the region and within countries. In Scotland, for example, nurses and pharmacists can prescribe and dispense the Scottish Naloxone Programme's kits, while elsewhere in the UK the medication is only currently available through limited-scale pilot programmes, with scale-up anticipated soon.[53] In a new review released in May 2012 the UK Advisory Council on the Misuse of Drugs (ACMD) recommended that the government take concrete steps to make naloxone more widely available[ad] including by easing restrictions on who can be supplied with naloxone and investigating how peers can be trained to administer it in emergencies. In 2011 Scotland promoted the availability of naloxone to approved services without prescription for use in emergencies.[54]

Naloxone is only available on a takeaway basis in Italy, Germany, Spain, Scotland and Norway.[55] In Denmark a small-scale trial of peer distribution of naloxone operates in the country's capital, with a limited number of social workers prescribed the medication, and further expansion of the programme is still pending.[56]

Policy developments for harm reduction

At a national level all countries in the region,with the exception of Italy and Sweden, explicitly support harm reduction in their national drug policy strategies. Implementation of harm reduction services in many countries, however, is carried out by local governments. In Sweden, for example, the provision of NSPs is reliant on local political approval, which has hindered the scale-up of new programmes, including in the country's two largest cities.[57]

Despite long-standing support for harm reduction within the region, however, since 2010 there have been incidences of policy shifts away from harm reduction from countries that have traditionally been strong advocates for the approach. For example, the UK has one of the lowest levels of HIV among PWID in Europe, which is often attributed to the early introduction of harm reduction programmes in the country.[58] But support for harm reduction in the UK has been undermined in the past two years due to leadership changes, although tensions remain between ministries. In March 2012 the UK government published a new roadmap document entitled *Putting Full Recovery First*, which strongly prioritised an abstinence-based approach. In response to the roadmap, civil society organisations (CSOs) such as the Terrence Higgins Trust, the National AIDS Trust and Release have addressed an open letter to the UK government, warning that ministers will be putting lives at risk and reversing decades of success in HIV prevention if harm reduction is undermined.[59]

At the regional level, policy developments currently centre around the drafting of the new EU drugs strategy. The current strategy will come to an end in 2012, and the new drug policy framework will be the first adopted under the Lisbon Treaty. At the time of writing, the new strategy is being drafted, but it has been a relatively closed process. CSOs were not invited to provide input, and it is, therefore, not possible to comment on its content. Moreover, although harm reduction objectives are strongly present in the demand reduction area of current EU drug policy documents, the recent rollback of EU funding opportunities for harm reduction may become an obstacle for its sustainability in Europe.

The EU, as a bloc, has traditionally been a strong voice for harm reduction at the international level. But recently the EU has become increasingly fragmented. This shift can be attributed in part to ongoing advocacy from countries that are anti-harm reduction (in particular Sweden and Italy) and in part to harm reduction being viewed as less important for diplomacy for countries that had previously adopted strong leadership roles at the international level.[ae]

ad Although naloxone has been available under UK law since 2005, it remains a prescription-only drug and is only licensed for use in injectable form. As such, non-medical services and people who use drugs, their families and peers, who may be more frequently present during the occurrence of opiate-related overdoses, are not able to legally hold stocks of naloxone and administer it in emergencies.

ae See section 1 'Policy Development' for further information on the EU at an international level.

Civil society and advocacy developments for harm reduction

CSOs and organisations of PWUD continue to play a central role in harm reduction advocacy and responses in the region. National harm reduction networks are active in many countries including Germany, the UK, Ireland, France and Portugal. Italian harm reduction organisations are currently in the process of forming a national network, planned to be launched in late 2012. At the time of writing, CSOs in Portugal were mobilising a national civil society forum on harm reduction to respond to significant funding cuts for harm reduction services.[60]

Many CSOs are involved at the European level and internationally through participation in several networks such as the Eurasian Harm Reduction Network, EuroHRN, Correlation, the International Drug Policy Consortium and others. Regular Europe-wide events bring CSOs together to share the latest experiences on harm reduction and drug policy. Over the past two years, these have included the first European meeting on harm reduction in Marseille,[61] the EU Civil Society Forum on Drugs,[62] the EU Civil Society Forum on HIV[63] and the final conference of the Correlation Network in Ljubljana, Slovenia.[64]

In April 2010 the European Harm Reduction Network, a project funded by the European Commission (EC), was launched with the aim of advocating for and sharing knowledge on harm reduction within Europe. The project culminated in a meeting of network members at a pan-European conference in October 2011 in Marseille, France during which the European Network of People who Use Drugs (EuroNPUD) was formed. The second phase of the project will focus on overdose prevention and advocacy, recommendations on the set-up, development, study and impact of DCRs in Europe as well as supporting harm reduction stakeholders in Europe in sharing best practices.

The Correlation Network, established in 2005 and also funded by the EC, has undertaken two phases of development. Correlation I (2005–2008) identified gaps and inequalities in access to health and social services, with a focus on marginalised groups. It looked specifically at health issues such as HCV and HIV/AIDS within most-at-risk populations, particularly drug users and young people at risk. Correlation II (2009–2012) built on this experience, focusing on the improvement of prevention, care and treatment services and targeting blood-borne viruses, in particular HCV and HIV/AIDS, among vulnerable and high-risk populations. Correlation has recently undergone an organisational restructure and has become a more sustainable network.[65]

Documenting organisations of people who use drugs in Europe[af]

In 2011, as a part of the European Harm Reduction Network (EuroHRN) project, the first comprehensive survey of organisations of people who use drugs in the European Union was carried out. The aim of the survey was to map the current state of drug user organising across Europe to inform recommendations for initiating such organisations in those countries where they are currently lacking, and to strengthen them where they are weak. The methodology used to acquire this data included the creation of a Directory of Organisations of People who Use Drugs in Europe. The second component was a detailed report of the state of drug user organising in Europe.

Results of the survey show that more than half of drug user organisations are based in Northern Europe (18 entries out of 30), and six countries from both Northern and Southern Europe are totally unrepresented. All groups surveyed are people who use/inject heroin, and the vast majority of them define themselves as activists and lobby groups who primarily represent active drug users. Many of the groups that took part in the survey came together at the first European meeting on harm reduction in Marseille and founded the European Network of People who Use Drugs.

Multilaterals and donors: developments for harm reduction

Although support for harm reduction from multilateral agencies is not targeted towards the high-income countries of this region, the EC has been an important donor for regional projects relating to injecting drug use and HIV. It has funded a range of new projects in recent years including the Access to Opioid Medication in Europe (ATOME) project which was launched in 2009 and will conclude in 2013. The overall goal of ATOME is to develop tailor-made recommendations for improving the accessibility, availability and affordability of controlled opioid medications, including OST medications. To date, the project has identified legal and regulatory barriers in the area of prescribing and dispensing opioid medication, including OST, in Cyprus, Greece and Turkey, with further country reports containing recommendations for legislative changes on their way. The EC has also funded a new project as part of its Lifelong Learning Programme (Leonardo) which will look to develop training guidelines and a professional profile for harm reduction outreach workers entitled 'Prowfile'.

af The directory of organisations of people who use drugs in Europe is available online at www.eurohrn.eu.

Despite a successful record of funding harm reduction since the early 1990s, however, the EC's Health for Growth Programme 2014–2020 call for proposals does not address the issue of drugs and harm reduction.[66] Furthermore, in its Justice Programme call for proposals, the EC indicates that in future funding it will address drug demand and supply through the angle of crime prevention and anti-drug trafficking only.[66] Finally, the Drug Prevention and Information Programme will become redundant after 2013, with no plans to replace it with alternate funding opportunities for drug demand reduction at the regional European level.[66] In response to these changes, the EU Civil Society Forum on Drugs[ag] appealed to the EC in January 2012 and urged for continuation of an effective civil society response to HIV/AIDS and drugs.

The WHO Regional Office for Europe, in collaboration with the European Centre for Disease Prevention and Control (ECDC), continues to collect data and monitor HIV epidemics across the region. In September 2011, 53 countries in the WHO European Region agreed on a new European Action Plan for HIV/AIDS 2012–2015.[67] Targets in the new action plan reflect those agreed by UN Member States at the 2011 High Level Meeting on HIV/AIDS and include reducing the number of new infections acquired through IDU by 50% by 2015. The EU drugs agency, the EMCDDA, launched its 2012 work programme[68] and is in the process of developing strategies for treatment monitoring and a new strategy for monitoring and reporting on drug-related issues in prisons across the European region.

Several European governments provide essential funds for harm reduction in low- and middle-income countries. These include the UK Department for International Development, the Netherlands MOFA, NORAD (Norway), GTZ (Germany) and the Swedish SIDA, but in this sector, too, budgets are becoming tighter.

The recent period of economic crisis has had a considerable impact on harm reduction financing at national level across the European region. In the UK, a recent survey of 540 UK drug service users and providers found that 75% have already witnessed cuts in funding for services.[69] Other countries such as Belgium, Ireland, Germany and Denmark report that funding harm reduction programmes is becoming increasingly difficult due to recent financial cuts by governments.[70] In Portugal, where harm reduction programmes were under threat of partial closure, funding from the government is regularly late, harm reduction programme workers do not receive their salaries on time, and financial resources to keep clients in programmes are more and more scarce.[71] In addition, to reduce costs, the Portuguese government plans to abolish the national institute for monitoring the drug situation (IDT).[71]

The financial crisis is likely to lead to greater scrutiny of drug service funding, and it will be increasingly important to highlight the financial and social implications of HIV outbreaks and other likely implications of cuts to services. This is also an opportunity to advocate for the most efficient and effective drug services.

ag The Civil Society Forum on Drugs (CSF) meets at least once a year and serves as a platform for informal exchanges of views and information between the European Commission and EU civil society organisations.

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2.4 | Regional Update
Caribbean

Table 2.4.1: Epidemiology of HIV and Viral Hepatitis, and Harm Reduction Responses in Caribbean

Country/territory with reported injecting drug use[a]	People who inject drugs[b]	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[c]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[c]	Harm reduction response[d]	
					NSP[e]	OST[f]
Bahamas	nk	nk	nk	nk	✖	✖
Bermuda	nk	nk	nk	nk	✖	✖
Dominican Republic	nk	nk	nk	nk	✖	✖
Haiti	nk	nk	nk	nk	✖	✖
Jamaica	nk	nk	nk	nk	✖	✖
Puerto Rico	29,130	12.9[g]	89%[h]	nk	✔ (13)	✔ (6)(M)
Suriname	nk	nk	nk	nk	✖	✖

nk= not known

a In 2008 the UN Reference Group found no reports of injecting drug use for Antigua and Barbuda, Barbados, Belize, Dominica, Grenada, St Kitts and Nevis, St Lucia or St Vincent and the Grenadines.
b Unless otherwise stated, data are sourced from Mathers B et al. for the Reference Group to the UN on HIV and Injecting Drug Use (2008) Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review, Lancet, 372(9651):1733–1745.
c Nelson PK et al. (2011) Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews, Lancet, 378(9791): 571–583.
d Unless otherwise stated, data on NSP and OST coverage are sourced from Mathers B et al. for the Reference Group to the United Nations on HIV and Injecting Drug Use (2010) HIV prevention, treatment and care for people who inject drugs: A systematic review of global, regional and country level coverage, Lancet 375(9719):1014–28.
e The number in brackets represents the number of operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = needles and syringes reported to be available for purchase from pharmacies or other outlets, and (NP) = needles and syringes not available for purchase.
f The number in brackets represents the number of operational OST programmes, including publicly and privately funded clinics and pharmacy dispensing programmes. (M) = methadone, (B) = buprenorphine, (O) = any other form (including morphine and codeine).
g Estimate from 1998–2001.
h This figure is sub-national and relates to San Juan only.

Map 2.4.1: Availability of needle and syringe exchange programmes (NSP) and opioid substitution therapy (OST)

Harm Reduction in the Caribbean

After sub-Saharan Africa, the Caribbean has the highest regional HIV prevalence worldwide.[1] Seven of the larger Caribbean islands have adult HIV prevalence of more than 1%, the highest being the Bahamas at 3.1%.[2] UNAIDS reports, that the generalised epidemic slowed significantly between 2001 and 2011, with HIV incidence declining by 25% in the Dominican Republic and Jamaica, and by 12% in Haiti.[1]

Injecting drug use (IDU) is rare across most of the Caribbean with the exception of Puerto Rico and Bermuda.[2] Currently only seven countries and/or territories have reported IDU.[i 3] Reliable data on the number of people who inject drugs (PWID) and the prevalence of HIV among injecting populations are only available for Puerto Rico, where unsafe injecting is a major contributor to the HIV epidemic. In 2006 it was reported that this mode of transmission accounted for 40% of new infections among men and 27% among women.[4] The most recent estimate indicates that there are 29,130 PWID in Puerto Rico, with HIV prevalence among them reported to be 12.9%.[j 5] Researchers have found that Puerto Ricans who inject drugs tend to inject frequently (on average six times a day) and use the same syringe multiple times (on average eight times). They are more likely to share drugs and injecting equipment and inject in shooting galleries than Puerto Ricans who inject drugs living in mainland USA.[6] A 2007 study found HIV prevalence to be higher among female non-injecting heroin users (4.3%) than among their male counterparts (0.6%). The researchers called for supportive systems for women who use drugs to be made a high-priority public health issue in the country.[7]

Several Caribbean countries have reported a link between sexual HIV transmission and the use of crack cocaine, which is widely available and extensively used on some islands.[8] Reported HIV prevalence among people who use crack cocaine reach 5% in Jamaica and 7.5% in St Lucia (11.1% among women and 6.8% among men).[9] Researchers have reported that crack cocaine users, particularly women, are more likely to sell sex to support their drug use and engage in high-risk sexual practices.[k 2, 10-11] Impaired judgement associated with drug use is also reported to contribute to sexual risk behaviours in Barbados.[12] Research plans in Belize for 2012 included further investigation into the link between drug use and HIV transmission.[13] In 2006, UNAIDS recommended that countries devise indicators on targeted HIV prevention programmes among people who use crack cocaine, to ensure these activities are captured in UNAIDS progress reporting.[9]

However, few countries have included information on this in their latest progress reports.[14]

The harm reduction response remains very limited throughout the region. Needle and syringe exchange programmes (NSPs) and opioid substitution therapy (OST) are only available in Puerto Rico.[3] Services for people who use drugs (PWUD) throughout the rest of the region are predominantly abstinence-based, high-threshold interventions, with the exception of a small number of drop-in centres in St Lucia, the Dominican Republic, Trinidad and Tobago and Jamaica.[8] With the initiation of a Round 9 Global Fund programme in the region, there are planned activities related to harm reduction in Jamaica, the Dominican Republic and Trinidad and Tobago, including the development of a harm reduction training programme.[15] There are also efforts underway to include drug use and harm reduction within peer education curriculum for sex workers and men who have sex with men (MSM), as part of the Global Fund programme.[15]

There have been no significant policy developments related to harm reduction in the Caribbean in the past two years.

Developments in harm reduction implementation

Needle and syringe exchange programmes (NSPs)

Regional NSP coverage is very low, with a reported distribution of 0.3 syringes per PWID per year.[3] Puerto Rico is the only territory with NSPs, with currently 13 active NSP sites based in communities around the capital city of San Juan, equal to 0.4 NSP sites per 1000 PWID.[3] Although Law 110 that classified syringes as illegal injecting paraphernalia was amended in 1997, there are anecdotal reports of law enforcement authorities entering *el punto* (shooting galleries) and destroying the available sterile injecting equipment.[16]

Despite reports of IDU in six other Caribbean countries and/or territories, no NSP services have been established outside Puerto Rico. In the Dominican Republic, it is reported that sterile syringes can be purchased in pharmacies.[15]

Opioid substitution therapy (OST)

Puerto Rico remains the only territory in the region that has any OST provision. There are reported to be six operational OST sites (five in the community and one in a prison), which is equal to 0.2 OST sites per 1000 PWID.[3] In 2007, there were an estimated 5570 people receiving methadone in Puerto Rico, representing 19% of the injecting population.[3] Despite opiate use reported in the Dominican Republic, there are no OST sites operating in the country.[15]

i Trinidad and Tobago's progress report to UNAIDS in 2012 stated that it is 'by and large not an injecting society' and that the few reported cases have been linked to 'deportees returned from abroad'.

j Estimate from 1998–2001.

k In a study conducted in St Croix in 2005 involving 254 drug and alcohol users, women not only reported higher levels of crack use (85% compared to 49% of male participants) but also significantly more sexual partners in the month previous to the study (5.6 compared to 2.3) with more unprotected sexual acts (11.2 compared to 6.5). Female participants also reported a notably higher HIV prevalence of 8.8%, compared to 1.4% in men.

In Puerto Rico a majority of PWID report starting to inject at a very young age. In contrast to many other countries outside the Caribbean, there are currently no legal restrictions inhibiting anyone under eighteen from accessing available NSP and OST services.[17]

Anecdotal reports indicate that harm reduction coverage in Puerto Rico is negatively impacted by funding restrictions. Since 2010 the Punto Fijo programme of Iniciativa Cominitaria that previously worked across twenty five communities in the northeastern part of the island, now covers only fifteen communities in the San Juan municipality, with no renewed services in the other ten areas.[16] The situation in Puerto Rico is not captured by UNAIDS reporting processes as it is a territory of the USA but unfortunately not included within the 2012 USA report.[18]

Harm reduction for people who use crack cocaine

A small number of drop-in centres primarily for people who use drugs (PWUD) have been established across the region. Programmes advocating a harm reduction approach have been set up in Santo Domingo (Dominican Republic), Port of Spain (Trinidad), Kingston (Jamaica) and Vieux Fort and Castries (St Lucia).[19] The Castries facility offers shelter and other services for homeless crack cocaine users living with HIV, providing adherence support for residents receiving antiretroviral therapy (ART). Although it does not distribute cannabis, the centre advocates the use of the drug for residents as a method of combating crack cocaine addiction and the nausea that is often a side effect of ART.[19] In Jamaica, the National Council on Drug Abuse (NCDA) provides homeless PWUD with HIV treatment, prevention and care services as well as rehabilitation and detox services and links to services providing food, shelter and primary health care.[20]

While countries have not developed indicators specifically related to targeted prevention for people who use crack cocaine,[19] several UNAIDS progress reports in 2012 include mention of this group as a vulnerable population. Jamaica, for example, now includes responding to HIV among crack cocaine users within its National Strategic Plan.[20]

Hepatitis C

There is very limited information available on hepatitis C (HCV) among PWUD in the Caribbean. The national HCV prevalence among PWID in Puerto Rico is not available. However, sub-national data relating to San Juan indicate that HCV prevalence among PWID is very high (89%).[21] Positive HCV status has been found to be strongly associated with the number of years of IDU, use of shooting galleries, receiving a tattoo while incarcerated and having a history of sexually transmitted infections (STIs).[21] HCV treatment is currently not being distributed by the Puerto Rican Health Department due to prohibitive cost.[17] Obtaining treatment from private health providers remains the sole option for people living with HCV, with associated costs prohibiting most from accessing treatment services.[17]

Tuberculosis

Data on the extent of tuberculosis (TB) infection among Caribbean PWUD are lacking. However, TB remains an important public health issue in the region, particularly among people living with HIV. In Puerto Rico, one study reported that TB incidence was highest among PWID living with HIV.[22] A recent visit to Puerto Rico by the Centers for Disease Control and Prevention (CDC) was prompted by a reported outbreak of TB within a 'drug addiction centre' in the village of Trujillo Alto.[23] The extent to which TB prevention and treatment is available to PWID in Puerto Rico is not known.

Antiretroviral therapy (ART)

Alongside Latin America, the Caribbean leads globally in ART coverage among low- and middle-income countries; Belize, Haiti and Jamaica are reported to have ART coverage of 40–59%, with Cuba reporting to reach 80% of people who require ART.[1] Increased access to ART has led to a considerable drop in the number of people dying of AIDS-defining illnesses, with an estimated 26,000 averted deaths.[2] While there are programmes in place on some islands to provide ART adherence support to PWUD,[15] there are no estimates of the numbers of PWUD receiving ART in the Caribbean.[3] A regional synthesis of UNAIDS progress reports from 2008 emphasised the need for the region to quickly increase the meaningful involvement of its most vulnerable populations within the HIV response. It also called for more targeted prevention, as currently HIV prevention efforts primarily target the general population and reach a very low percentage of MSM, male and female sex workers and PWUD.[9] Similarly, there is a need for increased access to HIV treatment, care and support programmes among populations with elevated HIV prevalence including PWUD and prisoners.

Harm reduction in prisons

Drug use is highly criminalised and incurs severe sentences across the Caribbean region, resulting in the incarceration of large numbers of PWUD and subsequent overcrowding within prisons. The criminalisation of sex between men and drug use, and high-risk sex within prisons, contribute to high HIV prevalence among Caribbean prisoners. While estimates of HIV prevalence within prisons are limited to results from routine HIV screening and seroprevalence studies (i.e. no systematic research has yet been undertaken), there is evidence of elevated HIV prevalence in prisons from several countries and/or territories, ranging from 2% in St Lucia to 4.9% in Belize and 5.24% in Guyana.[24]

There are no NSPs operating within prisons in the Caribbean, and only one OST programme operating in one prison in Puerto Rico. There are no systematic data on access to HIV prevention, treatment, care and support within prisons, but indications are that service provision remains limited.

Overdose

Data on overdose prevalence among PWUD in the Caribbean are lacking. One cross-sectional survey in Puerto Rican prisons found that almost half of 1179 prisoners had witnessed an overdose in prison, and one-third had known someone to have died of an overdose while incarcerated.[25] The likelihood of witnessing an overdose incident was associated with age, being male and using drugs in prison (particularly poly-drug use).[25] Of those reporting IDU before incarceration, 60.6% had witnessed an overdose incident and 44.9% had known of an overdose death.[25] The majority of participants who injected drugs in prison reported high-risk injecting practices.[25]

The researchers note the need to develop and improve appropriate responses within prison settings.[25] They also highlight the need for further investigation into the structural factors and staff attitudes that facilitate or hinder the implementation of overdose prevention programmes in prisons.[25]

Policy developments for harm reduction

There have been few developments in harm reduction policy at either national or regional levels in the Caribbean during the past two years. Harm reduction is included within Trinidad and Tobago's National Anti-Drug Plan for 2008–2012 as a key component of the national response to drugs,[26] but this remains the sole national policy related to HIV or drugs in the region which includes harm reduction.

Local respondents have reported an increase in discussions surrounding the decriminalisation of cannabis in the Caribbean, but as yet there has been no actual legislative action.[15]

The awarding of a regional bid from Round 9 of the Global Fund to fight AIDS, Tuberculosis and Malaria, entitled 'Fighting HIV in the Caribbean: a Strategic Regional Approach', signified an important advance for harm reduction in the Caribbean.[27] A total of US$29,812,507 will be disbursed to the Pan Caribbean Partnership Against HIV/AIDS (PANCAP) over a period of five years, from January 2011 to December 2015.[27] The programme includes harm reduction initiatives for people who use crack cocaine both in the community and in prisons. Priority area 3 of the Caribbean Regional Strategic Framework (CRSF) 2008–2012 is 'to achieve universal access to targeted prevention interventions among the most-at-risk populations (such as, MSM, SW [sex workers], drug users, prisoners, and migrant populations).'[28] An expected result articulated in the Grant Application is that six countries will report adoption of HIV prevention programmes among cocaine users with harm reduction measures by 2014 (up from two in 2008 – St Lucia and Jamaica).[27]

As reported in the *Global State of Harm Reduction 2010*, the involvement of government representatives within Country Coordinating Mechanisms (CCMs) for Global Fund grants provides some indication of national support for a harm reduction approach from Caribbean governments.

Civil society and advocacy developments for harm reduction

The few drop-in centres with a harm reduction approach operating in the region are primarily implemented by civil society organisations (CSOs). The civil society initiative within the PANCAP Round 9 Global Fund programme continues to play a significant role in the regional HIV response. It is jointly led by the Caribbean Vulnerable Communities Coalition (Jamaican coalition of civil society actors known as CVC) and El Centro de Orientación e Investigación Integral (Dominican Republic-based CSO COIN). They work to challenge the structural drivers of the epidemic, focusing on socially marginalised populations affected by HIV.[29] CVC/COIN provides technical support to community partners to help scale up and develop innovative programme models targeting key population groups that include PWUD.[30]

The Caribbean Drug Abuse Research Unit (CDARI) continues to support research into the public health risk of hidden populations by assessing prevention, treatment and legislative methods as well as promoting a public health approach to substance use and dependency issues.[31]

The 2011 Caribbean HIV conference was held in the Bahamas to discuss the forging of a sustainable response to the regional HIV epidemic, highlighting critical issues of sustainability and evidence-based interventions.[32] The conference attracted more than 2000 participants from across the region, with individuals from vulnerable population groups, members of community organisations and representatives of regional and international governments.[32]

Caribbean civil society will have some involvement in the upcoming 6th Latin American & Caribbean Forum on HIV/AIDS and STIs to be held in Sao Paolo, Brazil, in August 2012. The theme of the conference will be 'health systems, community networks and the challenge of prevention', and it will offer an opportunity to strengthen regional dialogue on key objectives in the prevention of STIs, AIDS and viral hepatitis throughout the two regions.[33]

At the international level, civil society engagement in the Commission on Narcotic Drugs (CND) remains limited, with only a small number of Caribbean countries sending CSO representatives to participate and/or observe the CND.[34]

Multilaterals and donors: developments for harm reduction

The most significant advance in harm reduction funding within the region has been the regional Global Fund grant. The five-year programme includes US$1.2 million allocated for HIV prevention, treatment and care among drug users and prisoners.[19] Harm reduction activities within the programme focus on HIV transmission among people who use crack cocaine and as such do not include implementation of the comprehensive package of interventions for PWID.[19]

The US President's Emergency Program for AIDS Relief (PEPFAR) has continued to fund HIV programmes within the region. A five-year collaborative framework between the USA and the Caribbean to support the implementation of strategic, regional efforts to combat HIV/AIDS was confirmed in 2010.[19] Although it is potentially a mechanism to provide financial and technical support for harm reduction initiatives across the region, recent changes to PEPFAR funding restrictions prohibit the funding of NSPs. The current USAID grant is administered by the Caribbean HIV/AIDS Alliance (CHAA) and currently covers sex workers, MSM and people living with HIV in some of the smaller Caribbean territories.[15] As yet, no international programmes target PWID in the region.

A new Strategy on Substance Use and Public Health was approved at the WHO/PAHO 50th Directing Council meeting in September 2010.[35] While advocating a primary health care approach with integrated service delivery networks, the strategy directly articulates the benefits of evidence-based health initiatives that include harm reduction and preventive interventions targeting vulnerable population groups.[35]

A recent initiative of the Organization of American States (OAS) involved the training of 40 Caribbean delegates on the Drug Treatment Courts (DTCs) model that has proved an effective alternative measure to incarceration for drug use.[36] The delegates included judges, prosecutors, defence attorneys, treatment providers and health care and justice professionals from Trinidad and Tobago, Jamaica, Barbados, the Bahamas and Grenada.

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2.5 | Regional Update
Latin America

Table 2.5.1: Epidemiology of HIV and Viral Hepatitis, and Harm Reduction Responses in Latin America[a]

Country/territory with reported injecting drug use	People who inject drugs[b]	HIV prevalence among people who inject drugs (%)[b]	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[1]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[1]	Harm reduction response[c]	
					NSP[d]	OST[e]
Argentina	65,829 (64,500–67,158)	49.7 (35.4–64)	54.6	8.6	✔ (25)	✖
Bolivia	nk	nk	nk	nk	✖	✖
Brazil	540,500	48 (18–78)	63.9	2.3	✔ (150–450)	✖
Chile	42,176	nk	nk	nk	✖	✖
Colombia	nk	1[f]	nk	nk	✖	✔ (4)
Costa Rica	nk	nk	nk	nk	✖	✖
Ecuador	nk	nk	nk	nk	✖	✖
El Salvador	nk	nk	nk	nk	✖	✖
Guatemala	nk	nk	nk	nk	✖	✖
Honduras	nk	nk	nk	nk	✖	✖
Mexico	nk	3 (1.9–4.1)	97.4 (96–98.7)	nk	✔ (19)	✔ (21–25)(M)
Nicaragua	nk	6	nk	nk	✖	✖
Panama	nk	nk	nk	nk	✖	✖
Paraguay	nk	9.35 (3.7–15)	9.8	nk	✔ (3)	✖
Peru	nk	13[g]	nk	nk	✖	✖
Uruguay	nk	nk	21.9	4.5	✔	✖
Venezuela	nk	nk	nk	nk	✖	✖

nk= not known

a Latin American civil society respondents reviewing the data above expressed concern that many of the estimates were outdated and did not accurately represent the current national situation in relation to the number of PWID and HIV among PWID. Where more recent alternative estimates were available, these are included in the text of this chapter. Similar concern was expressed regarding the number of NSP and OST within countries, but in most cases up-to-date figures were not available.

b Unless otherwise stated, data are sourced from Mathers B et al. for the Reference Group to the UN on HIV and Injecting Drug Use (2008) Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review, Lancet, 372(9651):1733–1745.

c Unless otherwise stated, data on NSP and OST coverage are sourced from Mathers B et al. for the Reference Group to the United Nations on HIV and Injecting Drug Use (2010) HIV prevention, treatment and care for people who inject drugs: A systematic review of global, regional and country level coverage, Lancet, 375(9719):1014–28.

d The number in brackets represents the number of operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = needles and syringes reported to be available for purchase from pharmacies or other outlets, and (NP) = needles and syringes not available for purchase.

e The number in brackets represents the number of operational OST programmes, including publicly and privately funded clinics and pharmacy dispensing programmes. (M) = methadone, (B) = buprenorphine, (O) = any other form (including morphine and codeine).

f Estimate from 1999: UN Reference Group.

g Estimate from 1994–1995: UN Reference Group.

Map 2.5.1: Availability of needle and syringe exchange programmes (NSP) and opioid substitution therapy (OST)

Harm Reduction in Latin America

HIV continues to affect marginalised populations across the Latin American region, including people who use drugs (PWUD). Though widely under reported, injecting drug use (IDU) is a significant route of HIV transmission in the region, especially in the southern cone of South America and in Mexico.[2] The Reference Group to the United Nations on HIV and Injecting Drug Use estimates that there were over two million people who inject drugs (PWID) in Latin America in 2008, with the largest number residing in Brazil (540,000). Where data on HIV prevalence among PWID are available, there are wide variations among and within countries. Latest UN Reference Group estimates are that over one quarter (580,500) of the 2 million PWID in Latin America were living with HIV.[3] The highest HIV prevalence among injecting populations was reported in Brazil and Argentina at 48% and 49.7%, respectively (see Table 2.5.1).

Further insights into the HIV epidemic among PWID in the region can be obtained from national reports to UNAIDS and WHO. For example, the following Latin American countries reported to WHO on HIV prevalence among PWID: Brazil (6%), Colombia (2%), Mexico (4%) and Paraguay (9%).[2] In Colombia, reported HIV prevalence among PWID ranged from 1.9% in Pereira to 9% in Cucata.[4] There are plans for further studies on HIV and injecting drug use in Cali, Armenia and Bogota, three areas where injecting heroin use is on the rise.[5] While unprotected sex between men remains the dominant mode of transmission in Mexico, intersections between IDU and sex work are reported to play an important role in Mexico's epidemic.[6]

There is increasing research into the prevalence and harms related to non-injecting use of cocaine and its derivatives within the Latin American region.[7] As in the Caribbean region (see Chapter 2.4), studies in several Latin American countries indicate that HIV prevalence among people who use crack cocaine is often elevated when compared with the general population.[7-10] In addition, the use of coca paste, *bazuco* or *paco* is of increasing concern in Colombia, Argentina, Bolivia, Chile, Ecuador, Peru and Uruguay.[11-12]

Civil society organisations continue to be the primary implementers of harm reduction initiatives in Latin America. Six countries are currently implementing harm reduction programmes: Argentina, Brazil, Colombia, Mexico, Paraguay and Uruguay. No additional countries have adopted a harm reduction approach in the past two years.[13] The vast majority of needle and syringe exchange programmes (NSPs) operate in Brazil, with projects also running in Argentina, Mexico, Paraguay and Uruguay. Opioid dependence is uncommon throughout much of Latin America, with most heroin use concentrated in Mexico and Colombia. Consequently, opioid substitution therapy (OST) coverage is low with services only available in these two countries (see Table 2.5.1).

Harm reduction programmes targeted towards people who use crack cocaine are operating in some countries but in general, these experiences are yet to be documented.

Across the region, there are very limited comprehensive care programmes available for those living with HIV, viral hepatitis or TB. Few health services target or address the specific needs of PWUD and linkages or referral systems between existing services for PWUD and other health services are often poor.[13] However, in Colombia there are indications that they intend to '[move] forward in the integration of the agenda of HIV with the agenda of drugs, which have historically worked very separately.'[5]

Latin America is at the forefront of a growing global movement to decriminalise drug use. Civil society advocacy in several countries has been instrumental in bringing about preliminary changes in national drug policy.[13] While these developments have clear implications for PWUD and harm reduction policy and practice, in no country have legal reforms been followed up with an increase in harm reduction services. Civil society organisations continue to be the primary service providers of harm reduction initiatives throughout the region. However, in the absence of state support they are frequently confronted with funding difficulties and are increasingly forced to rely on international resources.[13]

Multilateral agencies and international donors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the World Health Organization's Pan American Health Organization (PAHO) continue to provide limited support to harm reduction initiatives throughout the region.[13] However, the absence of adequate government support and poor financing for harm reduction continues to inhibit the introduction and/or scale-up of services in many Latin American countries.[13]

Developments in harm reduction implementation

Needle and syringe exchange programmes (NSPs)

Estimates of NSP coverage are very limited for Latin America. Where available, data indicates extremely low coverage with only 2% of PWID accessing NSP services across the region and 0.3 syringes received per PWID per year.[14] only five countries currently operate NSP programmes, leaving twelve that have reported injecting drug use with no available NSP facilities. No new countries have introduced NSP sites in the past two years, and there has been very little scale-up of established NSP services.[13] Brazil still reports the highest number of active NSP sites, with between 150 and 450 currently in operation[14] (see Table 2.5.1). Recent national reporting to UNAIDS indicates that 54.3% of PWID reported to have used sterile injecting equipment the last time they injected.[4]

In Paraguay this figure is reported at 92.11% despite there being only three NSP sites in operation.[4]

In Mexico, there are reported to be 0.4 NSP sites per 1000 PWID, providing equivalent to 2.7 syringes per PWID per year;[2] significantly higher than the regional average. State funds subsidise the distribution of sterile injecting equipment to Centres for Youth Integration (CIJ) and some CAPASITS (State Coordinating of HIV/AIDS/STIs).[13] In Ciudad Juarez, the NGO intervention Companeros Program distributes equipment packs containing sterile needles and HIV and hepatitis C prevention information.[13]

There are still no NSP programmes in Colombia, despite widespread heroin use and high-risk injecting practices. A recent study found that 40% and 60% of PWID in Medellin and Pereira respectively reported sharing injecting equipment.[4] The majority of participants reported using tap water to clean syringes, with a small number using alcohol. The interconnection between PWID and their sexual networks in HIV transmission has also been highlighted.[4] Approximately 22.9% of PWID in Medellin and 22.7% in Pereira reported giving a used syringe to a casual partner.[4]

The criminalisation of drug use and strict law enforcement across the region remains a significant barrier to PWID accessing health services. There are anecdotal reports from Mexican civil society of the frequent seizing of used injecting equipment from PWID to be used as evidence against them.[15] The registration requirements of Mexican NSPs are also reported to deter many PWID from accessing these services.

Prohibition policies in Colombia have given rise to high levels of stigma, social discrimination and exclusion of PWUD.[13] Discrimination against PWUD from health service providers is reported.[16] Studies in Medellin and Pereira revealed that, while the majority of PWID participants had purchased syringes in pharmacies, most reported discrimination by pharmacy employers.[4]

In those countries that offer limited harm reduction facilities, restricted access hours, waiting times, insufficient resources and inadequately trained service providers deter many PWID from accessing services.[13] The Brazilian NGO, Viva Rio, in coordination with the Department of Mental Health of Rio de Janeiro, is working to improve service access in the area, training community health operators who work in the *favelas* in harm reduction intervention.[h] [13] The Intercambios Civil Association, in coordination with the governments of various provinces and the support of the Levi Strauss Foundation, is also developing training in Argentina under the project 'Reducing stigma and discrimination of drug users'.[17]

Further research and programme-monitoring in countries implementing NSPs is required to determine accurate levels of coverage across the region. Although concentrated epidemics within key populations are reported throughout Latin America, services targeting the needs of vulnerable population groups are limited. More harm reduction initiatives that actively engage with networks of PWUD and include community and interdisciplinary interventions are required.

Further developments for harm reduction targeting PWID include the investment of US$500,000 of the National Drug Council of Uruguay to open two crisis centres for PWUD, based in the Maciel and San Jose Hospitals.[13] In Paraguay, the National Centre on Addiction Control with the National HIV/AIDS and STI Control Programme and regional NGOs, is developing harm reduction initiatives, although it is not yet clear what these will involve.[13] An Advisory and HIV Testing Centre has recently opened in Argentina.[4] The National Policy for the Reduction of Substance Abuse in Colombia is leading localised harm reduction developments for people who inject heroin.[13] Street-based outreach services are being initiated in accordance with local authorities to deliver educational activities and monitored distribution of condoms and sterile syringes. Pilot schemes have been established in the Cucata, Pereira, Santander de Quilichao, Cali, Armenia and Medellin areas.[13]

Harm reduction for people who use crack cocaine

As the association between HIV transmission and non-injecting drug use in the region is being increasingly reported, [4, 7] there is a need for guidance on the development of interventions that specifically aim to prevent HIV for those drug users who do not inject. This is of particular urgency in South American countries where researchers and CSOs have called for increased access to HIV prevention and voluntary counselling and testing (VCT) for crack cocaine users.[18]

Some harm reduction initiatives in the region are tailored toward people who use crack cocaine, but these need to be more systematically documented. One such programme was developed in 2010 in Rio de Janeiro. The 'crack-land' project provided a safe place for young people to congregate and smoke crack cocaine in the Rio favela of Yacarecinho.[13] Pipes, lip balms, condoms and syringes were provided by the scheme, which was run by health workers specifically trained in the needs of crack cocaine users. Though initially supported by a number of government and state bodies as well as UNODC, funds supporting the project have since been suspended.[13]

h *Favelas* are poor and precarious housing settlements.

Opioid substitution therapy (OST)

Opioid use is rare throughout most of Latin America. Mexico and Colombia remain the only countries with OST programmes in operation (see Table 2.5.1).[14] There have been limited developments in OST service provision in the past two years. In 2010, the estimated number of active services in Mexico was between twenty-one and twenty-five sites and in Colombia, four operational services were reported to be providing methadone maintenance treatment (MMT) across three districts.[14] In 2012, local respondents reported there being eight public OST programmes in operation across Colombia, each serving an average of 100 patients, with an additional four privately run institutions offering OST services.[13] It is also reported that expanding the range of available OST doses and forms is being considered in Colombia.[13]

Viral hepatitis

Population prevalence of HCV in Latin America varies by country but averages less than 1% across the region.[19] Contaminated blood products are responsible for most HCV infections in Latin America.[19] Injecting drug use is an important risk factor in parts of the region, most notably major urban areas and northern Mexico.[19] Data on viral hepatitis among PWID remains limited for the Latin America region. Estimates of hepatitis C antibody (anti-HCV) prevalence among PWID range from 9.8% in Paraguay to 97.4% in Mexico. Estimates for hepatitis B surface antigen (anti-HBsAg) are only recorded for three countries, and range from 2.3% in Brazil to 8.6% in Argentina (see Table 2.5.1). HCV prevalence is also elevated among non-injecting cocaine users in Brazil and Argentina. Studies have indicated high levels of HIV/HCV co-infection among PWID in the region.[19]

With the exception of one programme in Brazil,[13] there are currently no integrated HIV, tuberculosis (TB) and viral hepatitis testing and treatment programmes in Latin America. Attempts have been made to address this situation. The Ministry of Health and the Social Security (CCSS) in Costa Rica and Panama have pledged to guarantee access to testing and treatment services for HIV and viral hepatitis to all.[20] In 2011, the Ministry of Health of the province of Buenos Aires (Argentina) launched the Programme for Prevention and Detection of Viral Hepatitis to work in conjunction with the HIV/AIDS and Sexually Transmitted Infections (STIs) Programme.

Tuberculosis

Brazil is one of the twenty-two countries recognised as having a high TB burden, reporting forty-eight TB cases per 100,000 of the population in 2010.[21] Infections with drug-resistant strains are beginning to occur in areas of Central America. While research on TB prevalence among PWUD in Latin America is lacking, there is evidence to suggest that both injecting and non-injecting drug use are associated with elevated TB infection rates.[21]

Most countries in the region offer an HIV test to anyone presenting with TB.[13] Similar diagnosis services are, in theory, available for people who use drugs, though compliance to such practices is not always consistent.[13] Integrated TB and HIV programmes are beginning to emerge in the region, including in Uruguay, Argentina and parts of Central America. However, there are currently no services that specifically target PWUD.[20]

Overdose

Data on the prevalence of overdose in Latin America is very limited. Research in Colombia reported 25% and 33.3% of PWID in Pereira and Mendellin respectively to have experienced a non-fatal heroin overdose.[4] In both cities, six out of ten revealed that they would not access health services if they had another overdose episode for fear they would be referred to law enforcement authorities.[4]

There are currently no overdose prevention programmes established in the region.[13] Naloxone is registered in a number of South American countries including Argentina, Brazil, Peru, Chile, Uruguay, Mexico, Paraguay and Venezuela. However, it is not yet available to PWUD or for medical emergencies in any of these areas. In Colombia, where heroin and opiate use is more widely reported, naloxone is available and its use included in regional health care plans.[13]

Prevailing laws and the criminalisation of drug use continue to inhibit the introduction of overdose prevention and treatment initiatives in the region.

Antiretroviral therapy (ART)

Latin America and the Caribbean continue to lead globally in ART coverage levels for low- and middle-income countries.[22] In December 2010, it was reported that ART was being provided to 521,000 of the 820,000 (710,000–920,000) in need of treatment, which equated to 63% ART coverage.[2] Coverage varied between countries, from less than 70% in Ecuador and Guatemala to above 80% in Chile and Nicaragua.[22] Brazil is the only country with estimates for the number of PWID living with HIV and receiving ART. While past estimates have been much higher, the UN Reference Group found only 2,974 PWID to be receiving treatment: between one and four of every hundred PWID living with HIV in Brazil.[14]

Latin America reports twenty-four ART facilities per 100,000 of the population.[2] Yet at 11%, the region reported the smallest percentage increase in the number of people receiving ART between 2009 and 2010.[2] While ART coverage is generally high in the region, this figure may also reflect challenges in scaling up VCT and in early HIV diagnoses.[2] Significant improvements in access to adequate diagnosis and care services are necessary to reach all those in need of ART in the region, particularly vulnerable populations.[23]

The criminalisation of drug use continues to greatly inhibit service access and treatment adherence among key populations. Attitudes among health professionals that patients must stop the use of illegal drugs or alcohol to receive ART is also reported to be impeding the success of many ART treatment programmes.

Limited medical resources and the cost of ART are of growing concern in Latin America. In a survey conducted by PAHO/WHO in 2011, eight out of twelve countries in the region reported episodes of ART shortages, which required people to change treatment regimens or to have treatment interruptions, increasing the risk of HIV resistance and treatment failure.[24]

Harm reduction in prisons

In most Latin American countries, the cultivation, distribution and personal use of drugs remains a criminal offence. The predominant 'war on drugs' approaches in the region have led to large proportions of the drug-using population being incarcerated. While there are a lack of data on the prevalence of HIV, viral hepatitis and TB within Latin American prisons, it is clear that prison populations are at an increased risk of infection. In Argentina, for example, TB patients with a history of incarceration were six and 18 times more likely to test positively for HBV and HCV infection, respectively.[25]

More thorough and systematic research is required to provide an accurate analysis of the current situation of HIV, viral hepatitis and TB epidemics and drug use within prisons in Latin America. There are currently no prison-based harm reduction services operating in the region.[13]

Policy developments for harm reduction

As reported in 2010, six Latin American countries include harm reduction within their national policies on HIV and/or drugs: Argentina, Brazil, Colombia, Mexico, Paraguay and Uraguay. The extent to which this indicates government support for harm reduction varies. For example, though harm reduction is now recognised as part of national public health policy in Paraguay, it is implemented only by non-governmental organisations and often without the support of the state.[13] While there has been little development in the specific inclusion of harm reduction within national policy across the region, there has been a notable increase in the debate about drug policy and legislation at both national and international levels. In most Latin American countries, and particularly in Central America, drug policy and legislation remains focused on supply reduction and combating drug trafficking. These policies are largely determined by security and justice ministries and incorporate extensive military and policing operations.[26] However, during the 'Strategic Meeting of Public Security and Drug Policy', held in Rio de Janeiro in November 2011, law enforcement representatives from eighteen countries expressed concern at the negative consequences of the current 'war on drugs' strategy and called for more effective and constructive policy approaches.[27]

Moreover there is a growing awareness within policy circles of the vulnerability of key affected population groups. The 47th Regular Session of the Inter-American Drug Abuse Control Commission (CICAD/OAS) in May 2010 saw the approval of the new Hemispheric Drug Strategy.[28] Although there are no explicit mentions of harm reduction initiatives, the strategy does call for comprehensive evidence-based prevention programmes targeting key vulnerable and socially marginalised populations as well as a stronger institutional presence to establish and implement new policy initiatives.[28]

In September 2011, the 51st Directing Council of PAHO endorsed the Plan of Action on Psychoactive Substance Use and Public Health Strategy aimed at reducing the burden of drug use while strengthening an integrated public health response.[29] Shortly afterwards, delegations from the twelve UNASUR nations of the regional bloc met for the 2011 South American Council to discuss the ratification of the Drug Action Plan to reduce narcotic supply and demand. Prevention initiatives and treatment programmes for high-risk populations were addressed as well as institutional strengthening and the harmonising of anti-drug legislation to create mechanisms for regional coordination.[30]

In January 2011, representatives of The Latin American Commission on Drugs and Democracy (comprised of 17 drug policy campaigners, including former presidents of Brazil, Colombia and Mexico) presented an initiative to create the Global Commission on Drug Policy. The first meeting and official launch of the Global Commission was held in Geneva, June 2011. Chaired by Fernando Henrique Cardoso, the Global Commission condemns the global 'war on drugs' as a failure and advocates a paradigm shift towards harm reduction, decriminalisation of drug use and the legal regulation of certain substances. It seeks to create space for a debate on evidence-based drug policies.[13, 31]

There have been several developments in drug policy in the region that have implications for harm reduction, some of which are summarised below. For more information on these and other developments globally, refer to Chapter 3.4.

Drug policy developments in Latin America

In June 2011, the **Bolivian** government announced its formal withdrawal from the UN Single Convention on Narcotic Drugs of 1961. This followed the rejection of a proposal to amend Article 49 to remove the coca leaf from the list of classified drugs as identified by the Convention. Despite its withdrawal, Bolivia indicated its intention to adhere to the main outlines of the Convention with the exception of the prohibition of the traditional use of coca leaf. It remains explicitly in favour of criminalising the use of cocaine – 'Coca Yes, Cocaine No'.[13]

The **Chilean** government has decided to use Drug Treatment Courts for those convicted for problematic drug use. The initiative allows the accused to participate in a voluntary rehabilitation programme under the direct supervision of the judge, and on completion of the treatment, the case is dismissed and criminal records erased.[13]

In **Argentina,** the Mental Health Law now prohibits involuntary internment, previously a common practice for PWUD. It also denotes the rights of patients to be adequately informed of care options and to receive treatment that does not infringe on their personal freedoms. The regulation is still pending but the enactment of the law marks a step towards addressing addiction within mental health policy.[13]

Ecuador has some of the toughest drug laws in the region, resulting in the incarceration of many small-scale drug traffickers. The Constitution drawn up by the National Constituent Assembly in 2008 declared that drug consumption should be decriminalised and substance dependency addressed as a public health issue. A complete review of the judicial system has since been put forward by the Ministry of Justice and Human Rights. The proposed legislation distinguishes between small and large-scale drug trafficking and street distribution, and introduces proportional sentences. Yet there is still no guarantee that either the broader reforms or drug legislation will be implemented.[13]

In November 2010 in **Mexico**, the Law for Integral Support to Psychoactive Substance Use was approved. This law proposes an alternative justice model focusing on the prevention and treatment of addictions through public services.[32] However, drug policy in Mexico has continued to adhere to the 'war on drugs' approach.

The **Brazilian** government is to invest US$2 billion toward creating a public health network for the treatment of PWUD, with a particular focus on crack cocaine use. Funds are to be used to establish 300 health centres and 600 temporary shelters for drug dependency.[33]

In June 2012, **Colombia's** constitutional Court approved the government proposal to decriminalise the possession of small amounts of cocaine and marijuana for personal use.[34] The recent court ruling stated that anyone caught with less than 22g of marijuana, or less than one gram of cocaine, may receive physical/psychological treatment depending on their level of intoxication, but may not be prosecuted or detained.[34]

Civil society and advocacy developments for harm reduction

Civil society organisations (CSOs) have continued to play an important role in advocating for drug policy reform at both regional and national levels. A second edition of the Latin America Conference on Drug Policy was held in Rio de Janeiro in 2010, and a third in Mexico City in September 2011.[13] Organised by Intercambios Civil Association and its respective local partners, Psicotropicus and CUPIDH, the events brought together key representatives from across the region to promote and continue discussions on drug policy and reform.[13] Various satellite events were held at each conference to encourage further dialogue between governments and society. The 2011 Mexico convention incorporated a 'Drug Policy in Latin America' seminar for journalists, sponsored by PAHO, to generate a critical mass of trained reporters engaged with advocating for inclusive, harm reduction policy development in line with human rights.[13] Contact between regional civil society organisations and the International Network of People who Use Drugs (INPUD) led to the formation of the LANPUD (Latin American Network of People who Use Drugs)[13] which has plans to hold a further strategic meeting in October 2012.[35]

Such dialogues on drug policy, initiated in 2007 by the Transnational Institute (TNI) and Washington Office on Latin America (WOLA), to promote the free and confidential exchange of ideas between officials and nongovernmental experts, have continued to further the debate on current trends and how existing contradictions within international drug policy might be resolved.[13] In recent years informal dialogues have been conducted in Rio de Janeiro (February 2009 and 2010), Buenos Aires (October 2009), Montevideo (February 2011) and most recently in Lima (February 2012).[36]

i For more information about this topic, see TNI Publication, Drugs and Conflict, Debate Documents, Nº 13, May 2006, 'Coca Yes, Cocaine No' Legal Options for the Coca Leaf, http://www.tni.org/briefing/coca-yes-cocaine-no.

The RAISSS network of institutions includes many community-based organisations committed to addressing the problems of drug use and harm reduction in conditions of social inequality across the continent.[13] It currently comprises organisations throughout Latin America and the Caribbean, in Brazil, Chile, Haiti, Guatemala, Honduras, El Salvador, Nicaragua, Costa Rica, Panama, Bolivia, Mexico and Colombia. RIOD is a similar non-profit organisation network of Latin American NGOs working on prevention, treatment and social inclusion within the drug field.[13]

At the national level, CSOs continue to play a key role in advocating for drug law reform and the increase of harm reduction service provision. CSOs in Colombia are calling for a reform of the national drug statute to align drug policy with human rights and public health.[13] Advocating a rejection of compulsory treatments and the repression, persecution and criminalisation of PWUD, they have demanded that the government readdress the failure of the punitive policies of previous years.[13] Civil society advocacy for harm reduction and the involvement of drug users remains weakest in Central America, although some NGOs cover these issues in their work.[13]

Multilaterals and donors: developments for harm reduction

Multilateral agencies and international donors have continued to support several harm reduction initiatives in Latin America in recent years.[13] As in other regions, the most significant donor has been the Global Fund. Over the past five years, close to US$90 million has been allocated to programmes in Argentina, Panama, Peru, Uruguay, Colombia and Honduras.[13] However, the 2011 selection of proposals was made in the context of a global financial crisis. With imposed restrictions on the access to resources for middle-income countries, the sustainability of many of the projects in Latin American is now at risk.

UNAIDS and WHO recently investigated the challenges specific to Latin America of engaging PWID in HIV prevention trials. Information collated at the regional consultation held in Buenos Aires in 2011 has been used to supplement previous guidance on ethical considerations in biomedical HIV prevention trials initially conducted in 2007.[13, 37] WHO, UNODC and UNAIDS have also produced a region-specific draft of their Technical Guide for countries to identify and set targets for universal access to HIV prevention, treatment and care for PWID.[13, 38] The modified document addresses HIV transmission risks and interventions for PWUD in the regional context of Latin America and the Caribbean. The HIV/STI Project of PAHO/WHO held a regional consultation in April 2010 in El Paso, Texas. Experts met to discuss research, policy and intervention strategies to address HIV transmission associated with or resulting from drug use in the region of the Americas. A draft for discussion to review the state of harm reduction in Latin America and the Caribbean was produced.[13] In June 2011 the Global Commission on HIV and the Law hosted a Regional Dialogue to discuss the experiences and perspectives of individuals, communities, policy makers and law enforcement officials in the Latin American region.

Open Society Foundations (OSF) continues to support advocacy activities of regional CSOs in drug policy reform and advocacy for harm reduction.[13] Caritas (Germany) has provided support to the RAISSS network activities and the Levis Straus Foundation has continued its support for projects in Argentina.[13]

Government support is essential for sustainable harm reduction programmes within the region. In addition, and particularly given the global economic crisis, support from international donors and multilateral agencies in the region remains critical to ensuring that harm reduction forms an integral part of drug policy and public health responses throughout the region.

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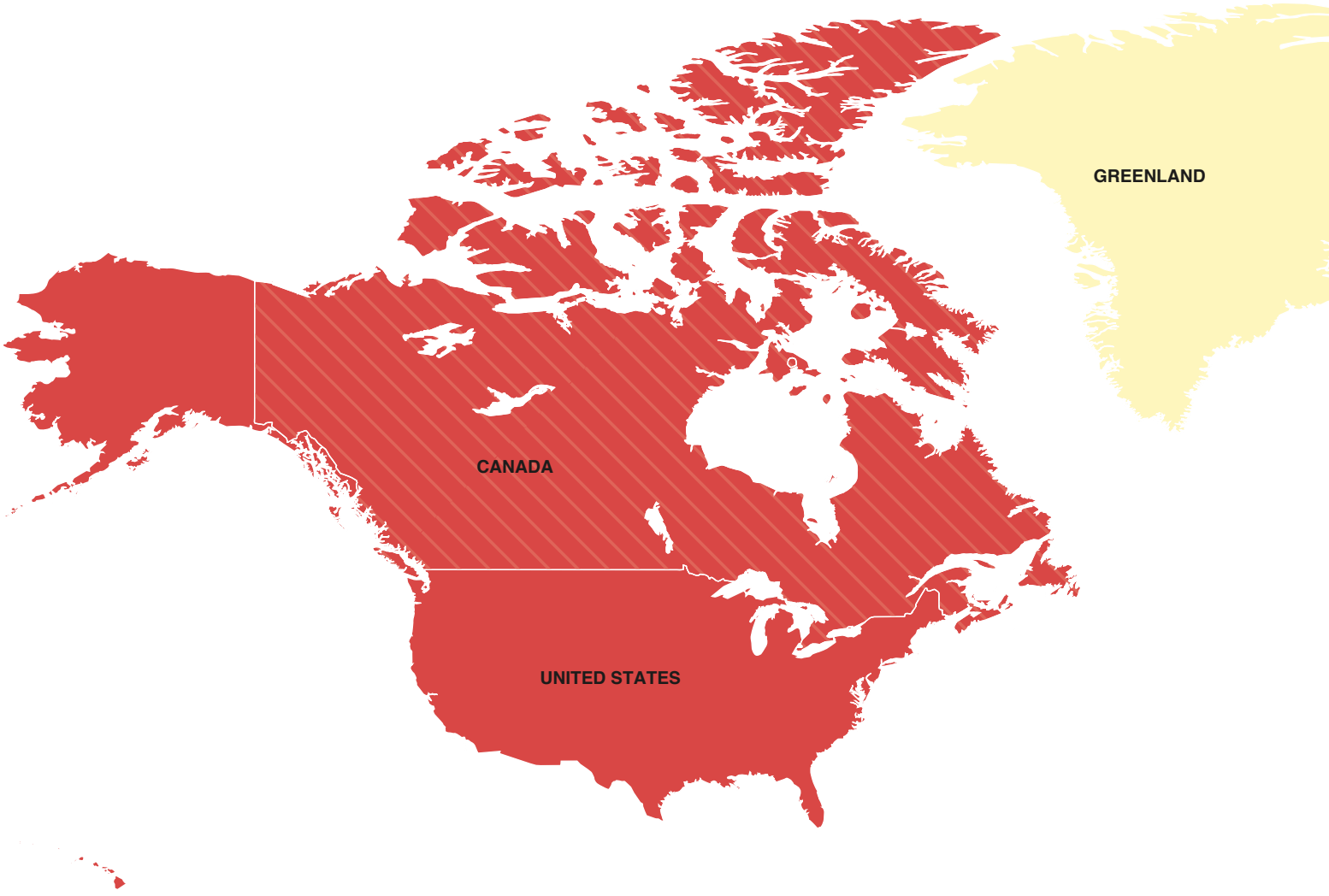
Table 2.6.1: Epidemiology of HIV and Viral Hepatitis, and Harm Reduction Responses in North America

Country/territory with reported injecting drug use[a]	People who inject drugs[b]	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[1]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[1]	Harm reduction response[c]		
					NSP[d]	OST[e]	DCR[f]
Canada	286,987 (220,690–375,173)	5.8[2]	64 (51–77)	nk	✔ (>775)[g] (S) (P)[3]	✔ (B,M)	✔
United States	1,857,354 (1,294,929–2,589,858)	15.57[c] (8.74–22.4)	73.4 (69.7–77)	11.8 (3.5–20)	✔ (186) (P)	✔ (1,433) (B, BN,M)	✖

nk= not known

a There are no identified reports of injecting drug use in Greenland.
b Unless otherwise stated, data are sourced from Mathers B et al. for the Reference Group to the UN on HIV and Injecting Drug Use (2008) Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review, *Lancet*, 372(9651):1733 – 1745.
c Unless otherwise stated, data on NSP and OST coverage are sourced from Mathers B et al for the Reference Group to the United Nations on HIV and Injecting Drug Use (2010) HIV prevention, treatment and care for people who inject drugs: A systematic review of global, regional and country level coverage, Lancet, 375(9719):1014–28.
d The number in brackets represents the number of operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = needles and syringes reported to be available for purchase from pharmacies or other outlets, and (NP) = needles and syringes not available for purchase.
e The number in brackets represents the number of operational OST programmes, including publicly and privately funded clinics and pharmacy dispensing programmes. (M) = methadone, (B) = buprenorphine, (BN) = buprenorphine-naloxone combination, (O) = any other form (including morphine and codeine).
f DCR = Drug consumption room, also referred to as safer injection facility (SIF).
g This figure represents the number of sites in two Canadian provinces: British Columbia and Quebec. The number of sites in other provinces was not known at publication in July 2012.

Map 2.6.1: Availability of needle and syringe exchange programmes (NSP) and opioid substitution therapy (OST)



- Both NSP and OST available
- OST only
- NSP only
- Neither available
- Not known
- DCR available

Harm Reduction in North America

More than 10% of all people who inject drugs (PWID) worldwide reside in Canada and the USA.[4] The USA, after China and Russia, has one of the highest estimated populations of PWID globally.[4] Injecting drug use (IDU) accounted for about 17% of HIV cases in Canada at the end of 2008[5] and 9% of new HIV cases in the USA in 2009.[6] The HIV epidemic among PWID in both countries mirrors broader disparities in the HIV epidemic, with racial and ethnic minorities in the USA and Aboriginals in Canada disproportionately affected.[5, 6] There are no data available on IDU in Greenland.

Although key harm reduction programmes such as needle and syringe exchange programmes (NSPs) and opioid substitution therapy (OST) are in place in both countries, provision remains uneven across smaller cities and rural areas. Coverage of NSPs and OST in North America remains below that in Australia and several countries in Western Europe[7] (see Chapter 2.3). Since last reported in 2010, overdose prevention and response programmes, including distribution of community-based naloxone, have become increasingly widespread across the continent. Prison NSPs remain unavailable in North America, while provision of methadone for substitution therapy is offered in federal and provincial prisons in Canada and on a very limited basis in some US jails.

Significant policy developments with implications for harm reduction have occurred since last reported in 2010. The Supreme Court of Canada ruled that the Minister of Health had violated Canada's Charter of Rights and Freedoms by not allowing InSite, the country's only safe injecting facility (SIF), to remain open, and ordered its continuing operation.[8] On 16 December 2011, US Congress reinstated the ban on US federal funding for NSPs.[9] In a context of global financial uncertainty, this policy decision contributes to critical concerns around the expansion of HIV prevention programmes to meet global targets and commitments on coverage for PWID.[10]

Civil society organisations (CSOs) in the USA and Canada have actively engaged in activities around overdose prevention and community naloxone distribution in the last two years, as a result of which there has been growing awareness of the issue at various levels of policy and programme delivery. The Canadian Drug Policy Coalition (CDPC), an independent civil society network of organisations and individuals advocating to improve Canada's drug policies, is the newest addition to the strong civil society presence working for harm reduction in the region.

Developments in harm reduction implementation

Needle and syringe exchange programmes

National-level estimates of NSP coverage are not collected in Canada or the USA, making it difficult to accurately monitor service provision levels.[h] The latest available data, as reported in 2010, indicate that an average of 23 syringes are distributed per PWID per year across North America, amounting to low coverage by international targets,[i 11] and placing North America behind other high-income regions such as Europe (59 syringes) and Australasia (202 syringes).[12]

Civil society reports since 2010 suggest that funding is one of the most significant barriers to service provision and scale-up in both countries. The reinstatement of the US federal funding ban for NSPs in December 2011 comes just two years after the 21-year-old ban was repealed by President Barack Obama.[9] While the lifting of the ban in 2009 mobilised funders to consider access to sterile injecting equipment for financial support, and propelled advocacy efforts by harm reduction funders to reach out to other potential donors, the recent move undermines programme scale-up and marginalises existing programmes away from mainstream HIV policy and funding.[13] Since individual states determine the legality of syringe exchange or distribution, some US states have only underground NSPs, or none at all, which is largely the case throughout the southern region of the USA.[14] In Canada the lack of federal support for NSPs means that harm reduction services are delivered by community agencies, NGOs, municipalities, provinces and territories. Although programmes are available in most major cities, individual jurisdictions may independently prohibit the provision of harm reduction services, including NSPs and safe-injection sites, within the city limits.[j]

Anecdotal evidence indicates that a small number of programmes in the USA have closed in the past two years, largely due to financial limitations and shifting political priorities. For example, when the Washington State government reallocated HIV funding away from primarily government-supported programmes, the survival of rural services was threatened.[13] As NSP implementation is a state rather than federal responsibility, the impact of the shifting funding landscape varies across the country. In some states such as California, new bills passed as of 1 January 2012 enabling the expansion of access to needles and syringes and allowing pharmacists to sell syringes without requiring a prescription.[15] Likewise, Colorado expanded its NSP provision following an authorisation bill from the state, while syringe access legislation in Nevada has stalled.[13]

h The HRSA HIV/AIDS Bureau in the USA began tracking client-level data on utilisation of services in 2011, but data were not available at the time of writing.

i According to the 2009 WHO, UNODC, UNAIDS target-setting guide, <100 syringes distributed per person who injects drugs per year is considered low coverage; 100–200 is medium coverage, and >200 is high coverage.

j See, for example, The Canadian Press: 'End Needle Exchange Ban', Advocates Tell B.C. city, 5 July 2012, CTV News.

The limited geographical reach and opening hours of available sites also pose barriers to access, especially for women who inject drugs, who experience added stigma and fear of exposure to authorities in light of strict child custody and welfare laws. In Canada, confidentiality and fear of stigma pose a barrier to access in rural and remote areas and on Aboriginal reserves, where those accessing harm reduction services may be easily identified.

Safer crack use kit distribution

A significant increase in crack use, particularly among PWID, has been documented in Canada over the past decade.[16] People who smoke crack are particularly vulnerable to the transmission of viral hepatitis (B and C), tuberculosis (TB) and HIV through sharing crack use paraphernalia.[17, 18] Safer crack use kit distribution programmes have resulted in health benefits to individuals who use drugs and communities in Canada, including a decreased need among users to share paraphernalia, increased health awareness and improved personal and community safety.[19]

Safer crack smoking supplies have been available in a number of cities across Canada for over a decade. Recently, however, negative media attention around a new pilot to distribute free crack kits in Vancouver's Downtown Eastside[20] has led to the slow implementation of this initiative and to the shutting down of Safeworks, a programme providing crack smoking equipment since 2008 in Calgary.[21] Despite these challenges, new initiatives are being discussed in some settings.[22] For example, a comprehensive approach to the distribution of safer crack kits, including an evaluation of the proposed programme, is being considered in Alberta for roll-out in August 2012.[23] Continuing barriers to programme initiation and scale-up include lack of resourcing, public opposition,[23] limited geographical reach, interference by the police as well as the need for further research to evaluate the impact of this intervention.[19]

Opioid substitution therapy (OST)

Provision of OST has increased steadily in both countries, although it is by no means universal. Over 1,433 licensed facilities provide OST in the form of methadone, buprenorphine and buprenorphine-naloxone combination across the USA. The most recent available data indicate that in the USA in 2009 there were 640,000 individuals on buprenorphine or buprenorphine-naloxone combination for maintenance therapy (up from 96,000 in 2005) and 266,818 on methadone (up from 236,836 in 2005).[24] All ten Canadian provinces deliver methadone maintenance therapy (MMT) services through a variety of models, including government-funded programmes, for-profit private clinics and family practice, but the number of sites is unknown due to lack of monitoring as part of national surveillance.[25] Only one of three Canadian territories provides MMT, and buprenorphine is not widely used due to its prohibitive cost.[25] In Canada, there has also been an increase in demand, including in First Nations communities and prisons.[25] However, the lack of physicians who can prescribe methadone and limited provision through low-threshold services remain a significant barrier to addressing the increasing demand for MMT in Canada.

Several developments related to OST provision and access have occurred in North America since 2010. Limited funding options and budget cuts threaten the quality of service provision in Canada. For example, in December 2011, as part of broader budget cuts, the Canadian province New Brunswick's Department of Social Development placed an 18-month limit on the time period during which methadone clients can receive travel subsidies (for example, bus passes or reimbursements for petrol and taxis) to attend a dispensing pharmacy as part of a new MMT benefit programme.[26, 27] Benefits were also capped at C$200 per month, potentially restricting access to the 1,328 people who use drugs (PWUD) who used the travel subsidy to access OST in 2011.[28] Additional obstacles to OST access in Canada include geographical distance from sites, stigma and misconceptions around drug dependence at every level of the treatment system and, as with NSPs, issues of confidentiality, especially in small cities and remote areas. Furthermore, there is often powerful community resistance to the establishment of new programmes, with some cities amending their zoning by-laws to restrict or limit programmes (such as Coquitlam and Surrey, BC).[k] Civil society reports highlighted a need for more low-threshold services and diversification of service models, as well as provision of integrated psychosocial and mental health support, especially in First Nation communities.

The clinical trial 'Study to Assess Longer-term Opioid Medication Effectiveness' (SALOME) is currently underway in Vancouver.[29] The trial will investigate the effectiveness of hydromorphone, the active ingredient in heroin, as compared to injectable medical-grade heroin (diacetylmorphine), at benefiting people with chronic opioid dependence for whom other maintenance treatments have not been successful.

In the USA, growing concerns about the diversion of buprenorphine[30] have the potential to decrease access to the medication. For example, newly imposed restrictions as a result of diversion concerns include mandatory counselling and urine toxicology tests, as well as requirements by insurance companies for prior approval for each patient, placing greater time demands on physicians who administer buprenorphine maintenance therapy.[31] Additional barriers to OST access in the USA include uneven Medicaid coverage across states, leaving many uninsured PWUD unable to access the medication, as well as many physicians opting to

k Examples include Coquitlam, BC, where a by-law regards methadone clinics as 'undesirable businesses' and limits the location of their operation to five small areas; Surrey, BC, which prohibits methadone clinics in business parks, commercial, special care housing, single family residential and multiple residential commercial zones; Abbotsford, BC, which has amended its zoning by-laws to limit harm reduction services including fixed NSPs and mobile dispensing vans as well as supervised injection sites in its municipality; and Kelowna, BC, where a municipal by-law restricts possession of harm reduction supplies in any park or public space.

discharge patients for poor attendance, active drug use or not participating in counselling. Methadone clinics in the USA are rarely low-threshold, with waiting lists of at least six months to a year, or longer outside major cities. Barriers are compounded for pregnant women who use drugs or those with children, as they are at risk of being reported to Child Protection Services and losing custody of their children for enrolling in treatment or actively using drugs. The need for frequent attendance (in some cases, seven days a week) can be further complicated by child care and increased stigma.

Restricting prescription opiates in Canada

Diversion of the prescription time-release opiate OxyContin, and adverse effects arising from its illicit use, have risen considerably in Canada in the past few years. A 2009 study linked the introduction of OxyContin to the market in 2000 with a five-fold increase in painkiller-related deaths during the following five years.[32] The problem is particularly widespread in First Nations communities, where more than 50% of adults on some Canadian reserves are dependent on the medication.[33]

The knee-jerk response from several Canadian provinces, including Prince Edward Island, Nova Scotia, Ontario, Manitoba, Saskatchewan and British Columbia, has been to either delist OxyContin entirely or restrict its availability under provincial health care coverage plans.[34, 35] In February 2012, the federal government announced that it would no longer pay for OxyContin for patients under the Non-Insured Health Benefits Program (NIHB).[36] Purdue Pharma Canada, the pharmaceutical company behind OxyContin, plans to replace it with a new version, OxyNEO, but several provinces have already announced that this, too, will have restricted access. Without providing support for people who may be going into withdrawal, individuals may turn to other narcotics such as heroin, increasing the potential for switching to less regulated, potentially more harmful opioids.[k]

Antiretroviral therapy (ART)

An estimated 40,334 PWID in Canada and 308,208 PWID in the USA were living with HIV as of 2008.[5] In the USA, 9% of new HIV infections are among PWID.[6] According to the US Centers for Disease Control, African-American PWID are ten times more likely to be diagnosed with HIV than white PWID.[14] In Canada, Aboriginal (composed of First Nations, Inuit and Métis) PWID are more likely to acquire HIV than non-Aboriginal PWID, and IDU accounts for more HIV cases among Aboriginal women than among Aboriginal men.[37, 38] This group comprises only 3.8% of Canada's overall population but represents a disproportionately high number of new HIV cases (12.5%) and all prevalent infections (8%) at the end of 2008.[39]

There are no national-level data on antiretroviral therapy (ART) coverage among PWID in either Canada or the USA. Differing approaches, targets and implementation structures across states, provinces and jurisdictions impact the ability to monitor service provision. It can be inferred that a sizeable proportion of those who may need treatment could be unaware of their HIV status. As of 2008, 26% of the estimated 65,000 Canadians living with HIV were unaware that they were infected.[39] A majority of these individuals represent key populations at higher risk of HIV, including PWID. Although recent data indicate that 85.5% of PWID took an HIV test and received their results in the past 12 months,[2] this proportion is substantially lower among sub-groups at higher risk, such as Aboriginal people and women who inject drugs.[6, 37]

Civil society reports in the USA cite the lack of access to antiretroviral drugs, especially in the southern region of the country where there is a growing waiting list[40] for the AIDS Drug Assistance Program, as a major barrier to PWID starting ART.[41] Additionally, some physicians are reported to initiate treatment only when the patient abstains from drug use.

Viral hepatitis

The USA and Canada have significant numbers of people co-infected with HIV and hepatitis C (HCV).[39] A recent systematic review reported rates of over 60% and 70% HCV prevalence among PWID in Canada and the USA, respectively (see Table 2.6.1). High lifetime prevalence of HCV (91%) was also detected among transgender people who inject drugs.[6] Rates of hepatitis B (HBV) are unknown in Canada, and exceed 10% in the USA.[1]

In 2011 the US Department of Health and Human Services released its Viral Hepatitis Action Plan.[42] The Plan included strong language on strategies for PWUD, with a separate chapter dedicated to HCV prevention, treatment and research for PWID. In particular, the Plan commits to expanding access to syringes as a critical prevention strategy.

The extent of testing and treatment for viral hepatitis among PWID is not clear. In the USA, access to testing and treatment services for viral hepatitis is limited by several factors, including the prohibitive cost of treatment, geographic distance from centres that may offer the service, and the current lack of an effective test that can determine current infection status instead of history of exposure. In Canada, comprehensive HIV and viral hepatitis services are available in some jurisdictions but remain limited in most places where populations at higher risk may need them most, such as on Aboriginal reserves.[23] A recent study estimated that approximately

l Public health officials in Ontario have already warned that their treatment programmes are overwhelmed. See *The Toronto Star* (2012) Ontario must boost addiction services and treatment programs to help OxyContin addicts, 2 April 2012.

137,000 PWID will experience HCV-related disease each year until 2026, and it will cost C$3.96 billion to provide them with treatment, highlighting the urgent need to develop targeted HCV prevention strategies and ensure adequate allocation of resources for future treatment needs in Canada.[43]

Tuberculosis

Integration of TB, viral hepatitis and HIV services vary from region to region across Canada and the USA. The lack of free TB testing and treatment targeted at PWUD and poor awareness of the relevance of TB for PWID hinder many of them from seeking these services. The US Centers for Disease Control and Prevention have recently launched a Program Collaboration and Service Integration (PCSI) mechanism to promote increased collaboration and integration of testing, treatment and surveillance for HIV, viral hepatitis, sexually transmitted infections (STIs) and TB in the USA.[44] The impacts of this initiative are yet to be determined.

Overdose

Drug overdose death rates have increased steadily in the USA since 1990. Currently, overdose is the most frequent cause of death among PWID,[45] and the number of these deaths has overtaken motor vehicle fatalities in the USA.[46] In 2008, a total of 36,450 drug overdose deaths[m] were reported, with prescription opioid analgesics such as oxycodone, hydrocodone and methadone, as well as cocaine and heroin, most commonly involved.[47] Research has detected fatal overdose rates two to three times higher among First Nations Canadians compared with the general population.[48] Although national estimates for lifetime non-fatal overdose are rare, high rates have been detected at the local level (for example, 41% in Baltimore[49] and 42% in New York City).[50]

Community-based programmes in the USA have increasingly offered opioid overdose prevention services to PWUD, their families and service providers, including the opioid antagonist naloxone hydrochloride. As of October 2010, 50 community-based opioid overdose prevention programmes distributing naloxone were known in the USA.[51] Since the first opioid overdose prevention programme began distributing naloxone in 1996, kits with naloxone have been distributed to 53,032 persons, and programmes received reports of 10,171 overdose reversals. These 50 programmes operate in 15 US states and the District of Columbia and include nearly 200 sites where naloxone is distributed in the community to PWUD, their friends and family. New Mexico, New York and Massachusetts operate state-wide naloxone distribution programmes through their state Departments of Public Health. North Carolina has recently agreed to make naloxone available state-wide through its Medicaid health insurance programme to patients who are prescribed opioids for pain management or dependence treatment, and others at risk of an opioid overdose. The US Army also distributes naloxone to soldiers on active duty who are at risk of overdose from prescription opioids or heroin, as part of a pilot project on one of its largest bases.[52]

Since 2010, there has been growing activity in Canada around the implementation of overdose death prevention programmes through the delivery of naloxone. Several provinces are considering implementing initiatives for distributing naloxone in collaboration with local NGOs. One such example, the Harm Reduction Program at the BC Centre for Disease Control, is developing an initiative to increase access to naloxone across BC. Working alongside its many partners, the Harm Reduction Program hopes to increase the public's awareness of and accessibility to naloxone, as well as have naloxone made available at community service organisations.[53] Education and overdose prevention training are implemented through some NSPs and methadone clinics across the country, with varying availability across provinces. Streetworks in Edmonton has operated a naloxone distribution programme since 2005,[54] and a new programme was initiated by Toronto Public Health in late 2011.[55] In Canada, naloxone distribution through peers in the community is only implemented in Edmonton and Toronto.

New evidence has emerged suggesting that among other health benefits, Canada's SIF in Vancouver has had a positive impact on the number of overdose deaths in its vicinity. A 2011 study observed a 35% reduction in overdose deaths in the city's Downtown Eastside after the SIF opened in September 2003, while overdose deaths in the rest of the city declined only 9% over the same period (see chapter 3.6 for a Vancouver-based case study which includes Insite).[56]

The legal battle over InSite

In the autumn of 2011 the Canadian Supreme Court ordered the federal Minister of Health to continue the Section 56 exemption to the Controlled Drugs and Substances Act that permits InSite, Canada's only supervised injection site (SIF), in Vancouver, BC, to continue to operate.[8] Extensive research has proven that InSite reduces crime, overdose deaths and transmission of HIV and other blood-borne viruses, and has helped people access treatment when they were ready to do so.[56-59] The Court found that the Minister of Health had violated Canada's Charter of Rights and Freedoms in not allowing the project to remain open, and ordered the Minister to remedy the situation. Several Canadian cities are in the process of discussing the implementation of supervised injection sites including Victoria, Montreal, Ottawa, Toronto and Quebec City.

m Including unintentional, intentional (suicide or homicide) or undetermined intent.

Harm reduction in prisons

Despite high levels of IDU,[60, 61] high rates of HIV and high prevalence of viral hepatitis and TB among inmates, particularly among those who are released and re-incarcerated,[62] harm reduction initiatives within these settings remain limited in North America.

There are no NSPs operating in prisons in either Canada or the USA. MMT is available in federal correctional facilities and provincial prison systems in Canada,[25] and minimal access to substitution treatment is offered in some jails in the USA. Other HIV and viral hepatitis prevention strategies, such as safe tattooing programmes, were abolished by Canada's current Conservative government in one of the first actions after it attained office in 2007.

Policy developments for harm reduction

Significant developments have occurred at the national level in Canada and the USA since last reported in 2010. On 16 December 2011, US Congress reinstated the ban on US federal funding for NSPs,[9] just two years after it was repealed and signed into law by President Barack Obama. In the precarious global economic context, the US government's policy shift on NSPs is a significant step backward in meeting international commitments to halve HIV transmission among PWID by 2015.[10] Concerns around essential harm reduction programmes being discontinued or scaled back within the USA have also since increased.

Several developments have taken place on the Canadian drug policy landscape. Following public consultations on its Marihuana Medical Access Program,[n] Canada's federal government announced a series of proposed changes that would see an end to licences for individuals to produce medical marijuana for personal use or the use of others.[63] These changes would limit the cultivation and supply of medical marijuana to commercially licensed producers. The potential impacts of these changes on the quality, variety and accessibility of medical cannabis have yet to be determined.

In March 2012 the Canadian federal government passed into law changes that implement mandatory minimum sentences for drug crimes as part of the Safe Streets and Communities Act, which will come into effect in November 2012.[64] Drawn from the US approach to drug policy, these harsher penalties,[o] many focused on youth and Aboriginals, are among several 'anti-crime' approaches which were recently introduced into Canadian law. The changes prioritise punishment as an objective of criminal law rather than access to treatment and health programmes.

n See, for instance, http://www.hc-sc.gc.ca/dhp-mps/consultation/marihuana/_2011/program/consult-eng.php.

o For example, these include mandatory minimum sentences of one year in a provincial jail for possession of five cannabis plants, and an increase in sentences for larger quantities of marijuana and other drugs.

Amid more conservative developments at the federal level, the debate at the provincial and local levels in Canada appears to be broadening. For example, despite opposition to the decriminalisation of currently prohibited drugs by the federal government, in the autumn of 2011, the Health Officers Council of British Columbia released a revised version of its public health model for a regulated market for all currently prohibited substances.[65] Another example is the Thunder Bay Drug Strategy, an official community plan to address substance use in Thunder Bay, Ontario. Ratified by the City Council in September 2011, the Thunder Bay Drug Strategy Implementation Panel explicitly supports harm reduction and includes in its three-year action plan the investigation of harm reduction services for youth.[66]

Civil society and advocacy developments for harm reduction

CSOs working for harm reduction and drug policy advocacy in North America have been increasingly active during the past two years. For example, a joint working group, comprising government representatives and NGOs organised by the Substance Abuse and Mental Health Services Administration (SAMSHA), and an all-NGO Naloxone Overdose Prevention Education Working Group have increasingly mobilised around overdose prevention and community naloxone distribution in the USA. Notable civil society events since 2010 include the first conference of the Peer Delivered Syringe Exchange Network in New York in 2011, the annual Harm Reduction Coalition conference in Austin in November 2010 and the Drug Policy Alliance conference in November 2011. Although drug user organising remains uncommon in the USA, there is a growing awareness and legitimacy around the distinct expertise provided by PWUD, and the need to meaningfully involve this group in the planning and execution of programmes that affect them.

Organisations of PWUD operate in a number of cities and regions in Canada. They are active in Vancouver (VANDU), Victoria (SOLID) and Toronto (TODUU). Two groups – the BC/Yukon Association of Drug War Survivors and AAWARE in Alberta – operate at the regional level. Most organisations of PWUD remain small and have minimal budgets. In the past two years, smaller groups have been initiated at the local level in some cities and provinces, including around InSite, Canada's SIF.[23] A national meeting of groups of PWUD around the country is being planned for later in 2012.

In Vancouver, BC, a group of former patients in the North American Opiate Medication Initiative (NAOMI)[p] have joined efforts to advocate for better integrated services in the

p The findings of the NAOMI trials conducted in Vancouver indicated that medically prescribed diacetylmorphine, the active ingredient in heroin, was more effective than methadone therapy for individuals with chronic opioid dependence who were not benefiting from other conventional treatments. The results showed that patients treated with injectable diacetylmorphine were more likely to stay in treatment and to reduce their use of illegal drugs and other illegal activities than patients treated with oral methadone.

wake of clinical trials of heroin-assisted therapy. After the research trial was completed, participants were not offered medically prescribed heroin. For some of these individuals, discontinuation of treatment precipitated a downward slide in their health and other outcomes. The NAOMI Patients Association (NPA) has now released its own study of the experience of participating in this research trial.[67] The NPA has also made recommendations for future 'experimental drug maintenance programmes' including the provision of an umbrella of support and services and the continuation of heroin-assisted treatment after the end of research trials. This group challenged future research programmes to consider the context of consent when a prohibited drug is offered as a treatment. The NPA has been supported by VANDU (see chapter 3.6 for a Vancouver-based case study which includes the NAOMI trial).

Other significant CSOs working for harm reduction in Canada include the Canadian Harm Reduction Coalition, a virtual forum for information exchange for individuals and organisations working in the areas of harm reduction and drug policy,[q] and the HIV/AIDS Legal Network, a national organisation actively engaged in advocacy on legal and human rights issues surrounding HIV, including among PWID in communities and in prisons.

The Canadian Drug Policy Coalition

The Canadian Drug Policy Coalition (CDPC), a new independent civil society network of organisations and individuals advocating to improve Canada's drug policies, was launched in 2011. It envisions a safe, healthy and just Canada in which drug policy and legislation as well as related institutional practice are based on evidence, human rights, social inclusion and public health.

The CDPC is focused on five key policy areas: a comprehensive health, social and human rights approach to drug policy; scaling up harm reduction; challenging criminalisation as a barrier to belonging for people who use drugs; moving beyond prohibition; and promoting human rights both inside Canada and globally.

A 15-member steering committee extending across the country through partnerships and networks oversees the work of CDPC, which is based at the Centre for Applied Research in Mental Health and Addictions at Simon Fraser University in Vancouver, BC.

Though not explicitly focused on harm reduction, a civil society group – Stop the Violence BC (STVBC) – has formed a coalition of law enforcement officials, legal experts, medical and public health officials and academic experts concerned about the links between cannabis prohibition in BC and the growth of organised crime and related violence in the province. This coalition has released several reports that examine the context of marijuana production in BC and explore options for its regulation. Its campaign has received intense media scrutiny as well as support from currently serving and former mayors, former provincial attorney generals and key supporters in the USA.

Multilaterals and donors: developments for harm reduction

Harm reduction in Canada is largely funded by provinces and territories, as well as municipalities, and covers programming, community-based research and direct service delivery. Other sources of funding include MAC AIDS Fund and the Open Society Foundations.

A number of foundations consistently support harm reduction implementation and advocacy in the USA, with the largest percentage of funding being directed to direct services. In the absence of federal funding, the Syringe Access Fund (SAF) is the largest private funding source for syringe access in the country and is comprised of AIDS United, Elton John AIDS Foundation, Levis-Strauss Foundation, Open Society Foundations, Tides Foundation, Irene Diamond Fund (closed in 2011) and the North American Syringe Exchange Network. In 2010, the total reported funding for NSPs in the USA totalled $21,674,495, over 60% of which was provided by state (43.1%), city (27.8%) and county (10.7%) governments.[68]

In addition to the contributions made by the SAF, as well as separate funding provided by individual SAF partners, MAC AIDS, amfAR, Ford Foundation, Broadway Cares/Equity Fights AIDS and the Comer Foundation have provided ongoing support to both harm reduction implementation and policy advocacy projects. In response to the reinstatement of the federal funding ban, community and corporate foundations that fund harm reduction services reported an increase in grant requests from public health departments looking to offset projected loss of federal funding.[13]

q For more information, see http://canadianharmreduction.com/.

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2.7 | Regional Update
Oceania

Table 2.7.1: Epidemiology of HIV and Viral Hepatitis, and Harm Reduction Responses in Oceania

Country/territory with reported injecting drug use	People who inject drugs[a]	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[1]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[1]	Harm reduction response[b]		
					NSP[c]	OST[d]	DCR[e]
Australia	149,591 (89,253–204,564)	1.0[2]	54.6 (41.2–68)	4 (2.9–5)	✔ (1372) (P)	✔ (2132) (B,M)	✔
Fiji	nk	nk	nk	nk	✖	✖	✖
New Zealand	20,163 (13,535–26,792)	0.4[2]	51.9	2.8 (1.2–4.4)	✔ (>200)[4] (P)	✔ (B,M)	✖
Papua New Guinea	nk	nk	nk	nk	✖	✖	✖
Samoa	nk	0	nk	nk	✖	✖	✖
Timor Leste	nk	nk	nk	nk	✖	✖	✖

nk= not known

a Unless otherwise stated, data are sourced from Mathers B et al. for the Reference Group to the UN on HIV and Injecting Drug Use (2008) Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review, *Lancet*, 372(9651):1733 – 1745.
b Unless otherwise stated, data on NSP and OST coverage are sourced from Mathers B, Degenhardt L, Ali H, Wiessing L, Hickman M, Mattick RP, Myers B, Ambekar A & Strathdee SA for the Reference Group to the United Nations on HIV and Injecting Drug Use (2010) HIV prevention, treatment and care for people who inject drugs: A systematic review of global, regional and country level coverage, *Lancet*, 375(9719):1014–28.
c The number in brackets represents the number of operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = needles and syringes reported to be available for purchase from pharmacies or other outlets, and (NP) = needles and syringes not available for purchase.
d The number in brackets represents the number of operational OST programmes, including publicly and privately funded clinics and pharmacy dispensing programmes. (M) = methadone, (B) = buprenorphine, (BN) = buprenorphine-naloxone combination, (O) = any other form (including morphine and codeine).
e DCR = Drug consumption room, also referred to as safer injection facility (SIF).
f This figure represents the number of sites in two Canadian provinces: British Columbia and Quebec. The number of sites in other provinces was not known at publication in July 2012.

Map 2.7.1: Availability of needle and syringe exchange programmes (NSP) and opioid substitution therapy (OST)

Harm Reduction in Oceania

The Oceania region includes Australia, New Zealand and the Pacific island countries and territories (PICTs).[g] There are approximately 170,000 people who inject drugs (PWID) in Australia and New Zealand combined, a low proportion of whom (0.4–1.0%) are living with HIV,[2] and over half of whom have hepatitis C (HCV).[1] The prevalence of injecting drug use (IDU) is higher and accounts for a greater proportion of HIV transmission (18%) among Aboriginal Australians than among non-Aboriginals (3%).[3] Few recent, reliable and representative data exist on population size estimates of people who use and inject drugs, or on the prevalence of blood-borne viruses and other drug-related harms in the PICTs.[4]

Although the early implementation of harm reduction programmes in Australia has been widely credited with low levels of HIV among injecting populations, available evidence points to significant ethnic disparities and uneven coverage regionally and among affected groups. No significant changes have occurred in Australia or New Zealand in terms of harm reduction service coverage since 2010. Civil society reports suggest that engagement with the federal and some state governments in Australia has become increasingly challenging around issues such as the need for increased funding for needle and syringe exchange programmes (NSPs), diversification of opioid substitution therapy (OST) options including heroin-assisted treatment and improvement in the range of service provision for people who inject drugs other than heroin.[5] Culturally sensitive, integrated services targeting Aboriginal and Torres Strait Islander Australians, particularly in remote and rural areas, and the meaningful involvement of these communities in service delivery and evaluation, remain important gaps.[3]

With the exception of Papua New Guinea, which has a generalised HIV epidemic, epidemics in the PICTs have remained small.[6] IDU is a minor route of transmission in this sub-region. For instance, in French Polynesia approximately 12% of the cumulative reported HIV cases have been attributed to IDU.[7] Poly-drug use, particularly involving alcohol – both legally and illegally produced homebrew – as well as cannabis, inhalants, kava (for example, on Samoa, Tonga and Vanuatu) and emerging markets for amphetamine-type stimulants, are more common in the PICTs than injecting drug use.[4] Anecdotal evidence indicates that levels of licit and illicit drug use and the availability of new drugs may be increasing in the region.[8]

Responses to drug and alcohol use in the PICTs have relied largely on abstinence-based approaches and law enforcement methods focused on supply reduction. Some broader public-health-focused approaches, including multisectoral education and awareness campaigns and integration of drug services with the mental health system, have been implemented to some degree in individual Pacific island states.[4] However, these have not been systematically evaluated, and a clear framework for addressing drug use in this sub-region is yet to be developed.

The engagement of civil society organisations (CSOs) and organisations of people who use drugs is integral to the harm reduction response in Australia. In the PICTs, the lack of resources and of reliable, active data collection continue to pose barriers to understanding the extent of drug use and designing appropriate policies and responses.

Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

There are over 1372 NSP outlets across Australia operating through a diverse range of service provision models such as needle-syringe vending machines and pharmacy-operated sites. Approximately 203 syringes per person per year were distributed to PWID in 2011.[9] The low rate of HIV among PWID in Australia has often been attributed to the early implementation and scale-up of NSPs. Recent cost-effectiveness analyses have estimated that between 2000 and 2009 over 32,000 HIV infections were averted, and for every $1 invested in NSPs $4 were returned in health care cost savings.[10] Along with Australia, New Zealand has one of the highest NSP coverage rates in the world, having distributed 2.7 million needle-syringes from the approximately 200 outlets across the country at an estimated rate of 270–280 needle-syringes per person per year.[2]

Despite relatively high coverage rates by international standards,[h] recent estimates indicate that only 12.4% of PWID in Australia and 70% in New Zealand reported using sterile injecting equipment the last time they injected.[2] Evidence suggests that the use of non-sterile equipment and re-use of injecting paraphernalia may be relatively high among key sub-groups of PWID, such as Aboriginal Australians, who also tend to experience a multiplicity of health and socio-economic disparities compared with their non-Aboriginal counterparts.[3] Access to NSP services by these groups is limited by inadequate provision in remote and rural areas, the lack of culturally sensitive service delivery or service models that recognise the Aboriginal definition of health[i] and

g The PICTs comprise 22 countries and territories subdivided into Micronesia, Polynesia and Melanesia. They are American Samoa, Cook Islands, Federated States of Micronesia, Fiji, French Polynesia, Guam, Kiribati, Marshall Islands, Nauru, New Caledonia, Niue, Northern Mariana Islands, Palau, Papua New Guinea, Pitcairn Islands, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, and Wallis and Futuna.

h The 2009 WHO, UNAIDS, UNODC *Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users* categorises NSP coverage levels as follows: low (<100 needles/syringes per injector per year), medium (>100–<200 needles/syringes per injector per year) and high (≥200 needles/syringes per injector per year).

i Aboriginal community-controlled health services (ACCHS) in Australia consider three different social dimensions: the individual, the family, and the community. For more information, see Australian National Council on Drugs (2011) *Injecting drug use and associated harms among Aboriginal Australians*. Canberra: Australian National Council on Drugs.

stigma and discrimination by the community and by medical personnel.[3, 10]

A recent survey by the Australian Injecting and Illicit Drug Users' League (AIVL) found that not only does much of the general population discriminate against people who use drugs (PWUD), but many feel that discrimination may deter people from using drugs, and as such is a positive event.[11] Additional barriers to access are posed by legislation limiting the distribution of injecting equipment.[12] For example, it is illegal for a person to provide injecting equipment to a peer, which often translates into services placing limits on the amount of equipment distributed per person. The limited range of equipment supplied at NSPs is also a challenge in many states in Australia, particularly for people injecting drugs other than heroin. In most states, for example, equipment such as sterile water, large-sized barrels, filters and winged-tip syringes are not supplied by state health departments, and service users must purchase them from pharmacies or other suppliers.[10]

NSPs do not operate in any PICTs, and it is not known whether needle-syringes can be purchased from pharmacies in these settings. Where drug and alcohol services for PWUD exist, these tend to be abstinence-based and are often located within mental health services.[4]

Legal status for Australia's only medically supervised injecting centre

Australia's only medically supervised injecting centre (MSIC) originally began operating for a trial period of 18 months in Sydney in May 2001 and continued to operate as a 'trial' project for over a decade, during which it underwent numerous evaluations.[13] The MSIC has provided sterile injecting equipment for use alongside a range of additional services to all people who inject drugs, with the exception of pregnant women who inject drugs or young people under the age of 18.[5]

On 1 November 2010 the MSIC was ultimately awarded legal status through the enactment of the Drug Misuse and Trafficking Amendment (Medically Supervised Injecting Centre) Bill 2010 into law.[14] This allows the facility to operate as other health services – without requiring an extension from the State Parliament to continue operation every four years. Although the MSIC has strong support within the local community, plans to trial or open similar facilities are not currently on the agenda anywhere else in Australia.

Opioid substitution therapy

Over 2132 outlets provide OST across Australia.[7] A key change in the provision of OST in Australia since 2010 has been the introduction of buprenorphine-naloxone film to replace buprenorphine and buprenorphine-naloxone combination pills for substitution therapy.[5] Presently, pills are being phased out over a two-year period, following which they will cease to be covered through the government scheme. However, some clinics, pharmacies and doctors have reportedly been forcing a shift to the film without prior consultation or patient involvement in the decision.[5]

As reported in 2010, a major barrier to accessing OST remains the cost prescribed by dispensing pharmacies and private clinics,[j] with people on OST paying between A$40 and A$85 per week for the medication.[15] Qualitative research has shown that the high costs of OST services may compel some people to choose between basic necessities such as food and their medication, while others report engaging in crime or selling takeaway doses to pay for OST.[13] While demand for OST has increased in Australia in recent years, the availability of treatment has remained the same, resulting in frequent delays and waiting lists, particularly in remote and rural areas.[16] In some regions, where one prescribing doctor or dispensing pharmacist often covers a wide geographical area, clients have reported travelling more than two hours daily or several times per week to access OST.[5] Pregnant women and women with children who use opiates are often hesitant to access services for fear that Child Protection Services may potentially take their children into protective care.[5] Guidelines for prescribing and administering pharmacotherapies in Australia were being reviewed at the time of writing.

In New Zealand, approximately 4600 individuals are receiving OST, mostly in the form of methadone.[17] Significant waiting times and restrictions on takeaway doses have been reported among the top three perceived barriers to OST.[11] Resource constraints pose an additional obstacle in the transfer of OST provision from specialist OST sites and its integration into primary care settings.[17]

There is generally a lack of treatment options, and no OST provision, in the PICTs. Existing responses to drug and alcohol use are usually abstinence-based and largely delivered through mental health and counselling programmes.[4] A 2008–9 situational analysis by the Burnet Institute identified a focus on prevention-focused education and training programmes around drug and alcohol use for young people; however, it is unclear whether these interventions have had an impact on behaviour change in the sub-region, and there has been little evaluation of their effectiveness.[4]

j Methadone and buprenorphine are provided free to pharmacies and clinics in Australia by the federal government under the Pharmaceutical Benefits Scheme (PBS). These services then charge the client for dispensing, often charging more for takeaway doses.

Antiretroviral therapy

HIV prevalence among PWID remains low in Australia (1.0%) and New Zealand (0.4%) (see Table 2.7.1). However, the drug-related HIV burden is not consistent across sub-groups of injectors. In 2011, a higher proportion of HIV cases among Aboriginal and Torres Strait Islander people (19.4%) were attributed to IDU compared with new HIV diagnoses among non-Indigenous people (2.5%),[7] and HIV rates within these sub-populations who inject drugs are high by comparison. It is estimated that in Australia the total number of people prescribed antiretroviral therapy (ART) increased from 9463 in 2006 to 11,523 during 2010.[10] It is unclear how many of these people are PWID.

New data indicate that almost half (47.6%) of PWID in Australia accessed HIV testing in the last year. This proportion is lower than in New Zealand, where 80% of PWID reported having an HIV test in 2009.[2]

In 2010, Australasia was reported to have the second highest level of ART coverage among PWID after Western Europe.[18] Papua New Guinea, Fiji, Timor Leste and states in Micronesia provide ART, but it is unknown how many PWID living with HIV are receiving treatment.

Viral hepatitis

In contrast to low HIV prevalence among PWID in the region, viral hepatitis rates are high and increasing in key areas of the region. Australia and New Zealand both have HCV rates over 50% among PWID.[1] Liver disease, most commonly as a result of viral hepatitis, has become the most common cause of mortality among ageing people who are dependent on opioids.[19] For example, incidence of HCV among PWID enrolled in the Hepatitis C Incidence and Transmission Study community (HITS-c) in Sydney increased from 5.0 per 100 person years in 2009 to 9.3 in 2010.[10] In some regions, such as South Australia and Western Australia, levels of HCV are substantially higher in the Aboriginal and Torres Strait Islander population than in the non-Aboriginal population.[10]

Hepatitis B (HBV) prevalence among PWID has remained stable over the past decade – 2.8% in New Zealand and 4% in Australia, according to a 2011 systematic review.[1] Surveillance studies show that there has been an increasing number of newly diagnosed HBV cases among Aboriginal Australians, despite vaccination programmes,[3] with IDU reported as the most frequent source of exposure.[10]

Targeted, integrated HIV and viral hepatitis programmes operate free of charge across Australia and are particularly common in capital cities. Despite high levels of provision, the AIVL estimates that less than 10% of people living with chronic HCV access treatment every year.[20] Barriers to HCV testing and treatment among PWID include stigma and discrimination in the health care sector, lack of housing, treatment and post-treatment support.[5]

In Christchurch, where the largest population of PWID in New Zealand resides, a specialised pilot programme dedicated solely to addressing HCV testing, treatment and support has operated since January 2009, enrolling more than 530 clients as of November 2011.[21] The Christchurch Hepatitis C Community Clinic operates as an integrated model attached to an NSP and liaises with various local agencies, including OST programmes, hospitals offering antiviral therapy and general practitioners (GPs). Its low-threshold services and accessible community setting have attracted PWID who may feel stigmatised by mainstream health services.

Little is known about the prevalence of viral hepatitis in the PICTs. HBV is highly endemic in Tonga, where more than 10% of the population is estimated to have active HBV infection.[22] The WHO Western Pacific Regional Office (WHO-PRO) has also documented HBV in Guam, Kiribati, Solomon Islands, Fiji, Vanuatu, New Caledonia, Federated States of Micronesia and Samoa.[23] Low HCV prevalence has previously been recorded among Samoans and American Samoans, with tattooing practices potentially contributing to infection.[24] It is unclear what role drug and alcohol use plays in the viral hepatitis context in the PICTs.

Tuberculosis

The incidence of tuberculosis (TB) cases is low at between 5–6 cases per 100,000 people in Australia, or 1062 bacteriologically confirmed cases of TB in 2009.[25] Incidence rates in New Zealand are higher than those in Australia at around 10 per 100,000 people, representing approximately 350–400 cases per year.[26] Foreign-born individuals are disproportionately affected: for instance, all cases of multidrug-resistant TB (MDR-TB) in Australia in 2009 were among individuals from Papua New Guinea and the Torres Strait Islands cross-border region, and over two-thirds of all TB cases in New Zealand are in foreign-born individuals, particularly among people from the PICTs. It is estimated that 11,000 people across 22 PICTs acquire TB every year, 50% of whom are infectious cases.[27]

It is not known what proportion of PWID across the region have had TB diagnosed and treated successfully, or to what extent TB/HIV co-infection occurs among PWUD.

Overdose

A recent meta-analysis showed that among other world regions, Australasia had the lowest pooled crude mortality rates (CMRs) among people who use opioids, with overdose reported most commonly as the cause of death.[28] Non-fatal heroin overdose is highly prevalent,[29] while drug overdoses attributed to prescription drugs are overrepresented in remote and rural areas of Australia.[30] Recent evidence has shown the positive effect of the Sydney MSIC on overdose-deaths: calls to ambulance services to attend to opioid-related overdoses declined significantly in the vicinity of the Sydney safe injecting facility (SIF) after it opened, compared to the rest of New South Wales.[31]

Naloxone is a prescription-only drug administered to reverse the effects of overdose by ambulance paramedics and other medical staff through registered health services in Australia. In late 2011 the first trial piloting distribution of naloxone for peer administration was launched in Canberra.[32] The two-year training programme seeks to make naloxone more widely available by training 200 PWID, their families and friends to respond to drug overdoses. This will include training on the administration of naloxone, which will be funded by the government.[31]

Harm reduction in prisons

Drug use and injecting are common in Australasian prisons. Almost half of participants (48–49%) in the 2011 Australian Needle and Syringe Program Survey reported a lifetime history of imprisonment, and 10% reported incarceration in the last year.[33] One in three (31–37%) of those who reported having been incarcerated in the past year had injected drugs while in prison.[33] Studies have shown that Aboriginal Australians, and Aboriginal women in particular, are overrepresented in prisons and tend to experience elevated rates of HIV, HCV and other blood-borne viruses.[34] Previous research in Australian prisons has suggested that prisoners are more likely to share injecting equipment in custody than people in the general community, and found that HCV rates among prisoners were higher than 20%.[35]

There are currently no NSPs in prisons in the Oceania region. However, OST is available in most Australian and New Zealand prisons. In 2011 the Australian Capital Territory (ACT) government invited public submissions on a proposed NSP trial at the Alexander Maconochie Centre (AMC) in Canberra.[36] At the time of writing, plans to initiate the NSP had been placed on hold amid debates among key stakeholders, with an implementation date yet to be determined.[5]

Policy developments for harm reduction

Although no significant changes to harm reduction policy have occurred at the national level in Australia, the debate around drug policy reform and decriminalisation has broadened considerably. In response to the Global Commission on Drug Policy's 2010 report,[37] Australia 21,[k] an independent, multidisciplinary NGO, brought together 24 former senior state and federal politicians, experts in drug policy and public health, young people, a business executive and former law enforcement officers to discuss Australia's present drug policy and explore moving toward a decriminalisation approach to illicit drugs. The report that followed the 21 January 2012 high-level roundtable, *The prohibition of illicit drugs is killing and criminalising our children and we are all letting it happen*, has since called for a review of Australia's drug law toward a decriminalisation and regulation approach of illicit drugs.[38] Despite more open debate around drug policy reform, there has been increased interest by some state governments and funders in the 'New Recovery' movement, which in the Australian context has promoted abstinence as an externally enforced goal for people who use opiates, and limits the time period during which a person may be able to access OST.[5]

In 2010, Australia released its Third National Hepatitis C Strategy 2010–2013[39] and accompanying National Surveillance and Monitoring Plan.[40] The inclusion of concrete targets and dedicated resources in the new document is a significant improvement on the previous strategies between 1999 and 2008, as it will allow for monitoring and evaluation of its effectiveness.[41] Targets to be measured include increasing access to sterile injecting equipment through NSPs, and reducing the burden of disease attributed to chronic HCV in Australia.

An extensive review of New Zealand's drug law began in early 2010. In June 2011 an independent, government-funded law advisory body, the Law Commission, tabled in Parliament its final report and 144 recommendations for reforming the Misuse of Drugs Act 1975. The review called the current policy 'outdated' and recommended greater investment in harm reduction, education and addiction treatment, amendment of drug paraphernalia laws and decriminalisation of small amounts of drug possession.[42]

Many of the same concerns as in 2010 are still applicable to the context of the PICTs. Responses to drug use in the region have generally been law-enforcement-centred.[4] However, recent reports have cited the development of a broadening perspective that takes into account public health and development approaches.[4] Increased engagement in the region from agencies such as WHO-PRO, the Secretariat of the Pacific Community (SPC) and the Pacific Drug and Alcohol Research Network (PDARN) have increasingly brought attention to drug and alcohol issues in the PICTs. For instance, a significant concern emerging out of the 2011 meeting of PDARN remains the lack of national frameworks to address the production of homebrew alcohol, which has been linked to increased crime, particularly violence against women.[4, 40] The lack of data and resources to conduct comprehensive research continues to hamper the design and implementation of appropriate policy responses.[43]

k For more information, visit http://www.australia21.org.au.

Civil society developments for harm reduction

Civil society organisations (CSOs) and organisations of people who use drugs have been integral to Australia's harm reduction response at the national and state levels. Although advocacy on behalf of PWUD remains underfunded, the AIVL and its member organisations across the country regularly engage in advocacy within academic, community and policy forums. AIVL recently completed its Online Discrimination Survey as part of the broader National Anti-Discrimination Project which aims to reduce stigma and discrimination, improve access to services and reduce social exclusion among PWID and those on OST.[10] A report summarising the findings and exploring the history of stigma and discrimination against PWUD was published in July 2011.[8]

In August 2011 the New Zealand Drug Foundation and the New Zealand Society on Alcohol and Drug Dependence organised a Drug Policy Symposium that brought together experts from New Zealand and overseas. The aim of the symposium was to engage policymakers and funders in a conversation around integrated and effective treatment for drug dependence in light of the government's commitment to provide additional funding for treatment.[44]

Although civil society in the PICTs has established a more visible presence in recent years, its engagement in regional forums around harm reduction has remained very limited. Activities have largely been hindered by inadequate resources. The Pacific Regional Rights Resource Team (RRRT) is active in the region, providing training, technical support and policy and advocacy assistance on issues of governance, democracy and human rights. PDARN is the only research and information network in the Pacific Region with a specific focus on substance use and related issues. The network first met in 2005 in response to a lack of data describing drug and alcohol issues in the PICTs, and held its most recent meeting in 2011 in Fiji. The gathering brought together government officials, NGOs, representatives from multilateral agencies, researchers and law enforcement representatives to exchange information and collaborate on joint activities.[8] Among the priorities identified for the region are the urgent need for technical and financial support to develop effective national alcohol policies and action plans, the need for adequate funding for conducting comprehensive research to inform responses and the need for ongoing support to strengthen networks within countries and the region.[8]

Multilaterals and donors: developments for harm reduction

Bilateral funds from Australia and New Zealand remain an important source of support in the PICTs.[4] Multilateral agencies such as WHO-PRO have increasingly worked with the SPC and PDARN to improve the level of engagement in the region. The Australian government, through the Australian Agency for International Development (AusAID), is also an important source of bilateral support for HIV and harm reduction programming across Asia and the Pacific.

Support for harm reduction services and for organisations of PWUD in Australia has long been provided by the federal government and state governments, generally via health departments. In the past two years, a competitive funding model has been introduced whereby a larger number of NGOs compete for a smaller pool of funding in one-year cycles, resulting in increasingly insecure funding year to year.[5] The level of funding for harm reduction programmes such as NSPs and OST nationally has remained the same as reported in 2010. No significant changes in funding or support for harm reduction were reported in New Zealand.

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2.8 | Regional Update
Middle East and North Africa

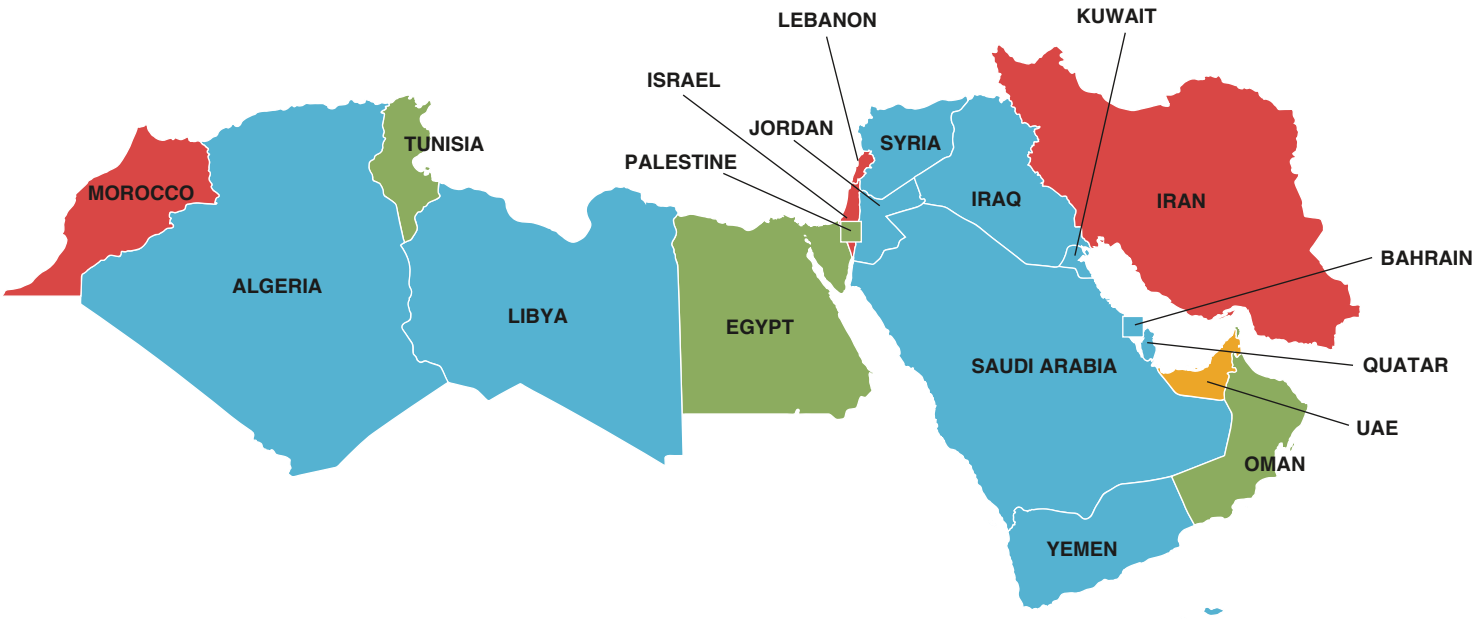
Table 2.8.1: Epidemiology of HIV and Viral Hepatitis, and Harm Reduction Responses in Middle East and North Africa

Country/territory with reported injecting drug use	People who inject drugs[a]	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[1]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[1]	Harm reduction response[b]	
					NSP[c]	OST[d]
Algeria	nk	nk	nk	nk	✖	✖
Bahrain	nk	nk	nk	nk	✖	✖
Egypt	85,000[2 (s)]	6.5–6.8[2 e (s)]	49.4 (35.8–63)	13.5 (10.9–16)	✔ (2) (P)	✖
Iran	170,000 – 230,000[3]	15 (9.5 - 22.9)[4]	50.2 (34.5–65.9)	17.3 (3.7–30.9)	✔ (421)[3] (P)	✔ (3,373)[3] (B,M)
Iraq	nk	nk	nk	nk	✖ (P)	✖
Israel	nk	2.94 (2.07–3.81)	67.6	2.8 (0–5.5)	✔ (5)[3]	✔ (B,M)
Jordan	nk	nk	nk	nk	✖ (P)	✖
Kuwait	nk	nk	nk	nk	✖	✖
Lebanon	nk	0[5]	52.8[6]	2.5 (0–5)	✔ (1–5) (P)	✔ (1)(B)
Libya	1685	877 [s]	nk	nk	✖	✖
Morocco	18,500[2]	11.4 (0.4–21.8)[3]	nk	nk	✔ (6)[3] (P)	✔ (3)[3] (M)
Oman	nk	11.8 (5–18.6)	nk	nk	✔ (1)	✖
Palestine	nk	0[8 (s)]	38.2[8 (s)]	6.4	✔ (1)	✖
Qatar	nk	nk	nk	nk	✖	✖
Saudi Arabia	10,000[2]	0.6[h 3]	49.8 (14.1–85.4)	18.5	✖	✖
Syria	10,000[2]	nk	60.5	nk	✖ (P)	✖
Tunisia	nk	2.4[3]	nk	nk	✔ (3)[3]	✖
United Arab Emirates (UAE)	nk	nk	nk	nk	✖	✔[3] (BN)
Yemen	nk	nk	nk	nk	✖ (NP)	✖

nk= not known
[s] = sub-national data

a Unless otherwise stated, data are sourced from Mathers B et al. for the Reference Group to the UN on HIV and Injecting Drug Use (2008) Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review, *Lancet*, 372(9651):1733–1745.
b Unless otherwise stated, data on NSP and OST coverage are sourced from Mathers B, Degenhardt L, Ali H, Wiessing L, Hickman M, Mattick RP, Myers B, Ambekar A & Strathdee SA for the Reference Group to the United Nations on HIV and Injecting Drug Use (2010) HIV prevention, treatment and care for people who inject drugs: A systematic review of global, regional and country level coverage, *Lancet*, 375(9719):1014–28.
c The number in brackets represents the number of operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = needles and syringes reported to be available for purchase from pharmacies or other outlets, and (NP) = needles and syringes not available for purchase.
d The number in brackets represents the number of operational OST programmes, including publicly and privately funded clinics and pharmacy dispensing programmes. (M) = methadone, (B) = buprenorphine.
e Sub-national data from 2010 behavioural/biological surveillance conducted in two cities: Alexandria and Cairo.
f Year of estimate: 2007.
g Includes sites in the community and in prisons.
h 2010–2011 estimate based on people who inject drugs (n=3441) enrolled in the detoxification centre at Al-Amal Hospital in Riyadh, and may not be representative of out-of-treatment and other populations of people who inject drugs.
i Population size estimate reported by NAP for 2011, but no information was available at the time of writing as to how this size estimate was arrived at.

Map 2.8.1: Availability of needle and syringe exchange programmes (NSP) and opioid substitution therapy (OST)



Both NSP and OST available

OST only

NSP only

Neither available

Not known

Harm Reduction in the Middle East and North Africa

The Middle East and North Africa (MENA) is one of two regions in the world where HIV rates continue to increase.[9] People who inject drugs (PWID), men who have sex with men (MSM) and female sex workers (FSWs) remain the most affected groups. Estimates of the numbers of PWID across the region vary from over 300,000[10] to approximately 1 million,[11] a wide range that is complicated by the lack of reliable size estimates for populations of PWID in most countries in this region. Although important progress has been made in improving monitoring and surveillance to inform data gathering, and to target prevention and treatment efforts among key populations at higher risk of HIV, availability of reliable data remains extremely poor.

Available data indicate that injecting drug use (IDU) contributes to HIV epidemics in most MENA countries, is increasing in some (for example, Syria, Egypt, Libya, Oman and Bahrain) and is driving the HIV epidemic in others (Iran, Libya). Since 2010 there have been significant policy developments and scale-up of harm reduction programmes as an HIV prevention strategy in several countries in the region, pointing to an increased willingness from governments to address key populations at higher risk of HIV, including drug-related epidemics among PWID.

Eight countries in the region implement needle and syringe exchange programmes (NSPs) to varying degrees, and five provide opioid substitution therapy (OST) (see Table 2.8.1). The reach of harm reduction programmes has expanded in Iran and Morocco. In 2010, Morocco started prescribing methadone for substitution therapy at three pilot sites in Tangier, Salé and Casablanca, with plans to scale up its methadone maintenance therapy (MMT) programme to seven additional sites.[3] Significant scale-up of harm reduction programmes have occurred in the community and in prisons in Iran, where programmes covered an estimated 42.6% of PWID as of 2010, and expanded provision to 3,373 MMT sites in public and private treatment centres and in prisons as of August 2011, compared with 680 to 1100 sites reported in 2010.[3] Despite these positive developments in service provision, the scope and coverage of existing services remain insufficient to have a marked impact on reversing HIV and viral hepatitis epidemics among PWID. Where programmes already exist, improvements in scale and quality are urgently needed to ensure that interventions achieve the greatest impact.

Poly-drug use is common across the region, particularly with pharmaceutical prescription drugs, as well as other substances such as hashish. A recent increase in use of amphetamine-type stimulants (ATS) among people who use drugs (PWUD) in the community, those enrolled in MMT and those in prisons has been documented in recent years in some countries, with potential for these substances to be injected.[3] Overlaps between IDU and the exchange of sex for money – but also for drugs, food and shelter – have been increasingly documented in the region (for example, in Syria and Egypt).[3] Improved monitoring systems at the local and national levels in most countries are urgently required to gain a more nuanced understanding of local drug-related epidemics and intersections with other populations at high risk of HIV such as sex workers and MSM, and inform integrated, targeted responses across sectors.

A significant concern in the MENA region remains the high prevalence of viral hepatitis and tuberculosis (TB) among inmates, particularly those who engage in IDU in prisons and other closed settings. Harm reduction initiatives in prison settings are only available in Iran, despite evidence that injecting equipment is commonly shared in prisons across the region, including in Iran, Jordan, Kuwait and Lebanon. Improving the coverage of TB and HIV co-treatment is a persisting challenge for the region and is particularly relevant to addressing the needs of the most marginalised populations of PWID.[12]

Severe levels of marginalisation and criminalisation of PWID across the MENA region pose substantial barriers to effective service provision and outreach. Women who inject drugs comprise a small proportion of all PWID in the region but tend to experience higher levels of HIV, hepatitis C (HCV) and other blood-borne viruses and increased levels of stigma and discrimination. They are also less likely than men who inject drugs to access harm reduction programmes.[5, 13, 14] Gender-sensitive harm reduction programming remains a considerable gap, with the notable exception of Iran, the only MENA country to have successfully developed female-operated harm reduction services targeted at women.[15] Since the first female drop-in centre was opened in 2007, the gender-specific programme been has expanded to 27 sites in several major cities in Iran.[15] Strengthening the response among PWID in the MENA region will require a reorientation of laws and policies that continue to criminalise PWID and hinder the implementation of evidence- and human-rights-based HIV prevention and treatment services.

Several countries in the region now explicitly mention key populations at higher risk of HIV, including PWID, as part of their national HIV strategies, including Jordan, Syria and Tunisia since last reported in 2010. This suggests a slight shift in the regional policy environment toward greater acceptance of harm reduction as a core strategy for HIV prevention among PWID. The Middle East and North Africa Harm Reduction Association (MENAHRA) has been an important catalyst for increased government and civil society attention to harm reduction since its founding in 2007. Regional momentum for harm reduction implementation and policy has increased further following MENAHRA's multi-country Round 10 grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria,

which has been implemented beginning in January 2012. The US$6.2 million grant awarded to MENAHRA in 2010 is the first regional Global Fund grant exclusively dedicated to support harm reduction and civil society activities. The grant came into effect in 2012, and over the next five years MENAHRA will work together with the Global Fund and other international, regional and national stakeholders to advocate for an improved policy environment for implementing harm reduction programmes, and to build the capacity of civil society organisations (CSOs) working for harm reduction in 12 countries in the region.[j]

Developments in harm reduction implementation

Needle and syringe exchange programmes (NSPs)

As reported in 2010, eight countries in the MENA region have operational NSPs (see Table 2.8.1). Iran continues to have the highest level of provision in the region, with a total of 6,022,834 free needles and syringes distributed through 421 sites across the country over a one-year period ending in September 2011.[3] There has been an increase in service provision in Morocco, where six NGO-run sites are now operating in Nador, Al Hoceima, Rabat, Oujda, Tangier and Tetouan. Although no formal harm reduction programmes distribute sterile injecting equipment in Oman, anecdotal evidence of small-scale, unofficial syringe distribution has been reported in the Muscat area.[3] Importantly, Syria's new 2011–2015 National Strategic Plan on HIV and AIDS prioritises prevention among populations at higher risk of HIV including PWID.[3] As of early 2012, plans were underway to initiate an NSP pilot with support from the Global Fund channeled through MENAHRA. Sterile needles and syringes are extremely difficult to obtain in Bahrain, where pharmacy provision is only possible on prescription. PWID are highly criminalised, with reports of arrest for possession of drug paraphernalia including new needles and syringes.[16]

Estimates of NSP service coverage are sparse in the region, due largely to the lack of reliable size estimates of numbers of PWID and inadequate monitoring of existing services. Global AIDS progress reports submitted by governments to UNAIDS suggest that coverage remains extremely limited. Iran has the highest NSP coverage in the region, distributing 26–35 syringes per PWID per year[3] – a slight decrease from the average 41 syringes per person per year reported to be distributed in 2010.[17] In Morocco 13 syringes were distributed per person per year in 2011, a minor improvement compared with 7 syringes per person per year distributed in 2010,[3] but still far below levels needed to have a positive impact on HIV and viral hepatitis epidemics in this population.[k 9] During the same period, three NGOs with support from the Global Fund in Tunisia distributed 137,000 free needle syringes to 9000 PWID, amounting to similarly low coverage at 15.2 syringes per person per year. No national data on coverage are available for Lebanon, but reports from Soins Infirmiers et Développement Communautaire (SIDC), an NGO providing this service, indicate that coverage was exceptionally low at 1.6 syringes per person per year.[3] The majority of PWID in Tunisia, and nearly half in Jordan (49.8%) and Iran (48.6%) access injecting equipment from pharmacies.[3]

Research indicates that there is a high prevalence of sharing syringes and other injecting equipment such as cookers, vials, containers, filters or rinse water in MENA countries.[18] For instance, 63% of PWID in Jordan report engaging in the high-risk practice of 'frontloading',[l] and almost three-quarters report sharing injecting paraphernalia.[3] Where figures are available, high rates of syringe-sharing are also reported in Lebanon (21%),[19] Bahrain (53.4%)[16] and Syria (46%).[20]

The criminalisation of PWUD and acute stigma, discrimination and human rights violations against them pose significant obstacles to accessing existing services. For example, in a 2011 study among 300 PWUD in Northern Morocco, 87% reported experiencing police violence, and 50% reported human rights violations by medical personnel; when asked to elaborate on the type of police abuse, 83% reported recurrent harassment and 65% reported illegal practices.[21]

Opioid substitution therapy (OST)

In 2012, five countries in the MENA region provide OST to varying degrees: Iran, Israel, Lebanon, Morocco and the United Arab Emirates (UAE). The most significant programme scale-up occurred in Iran, where there were 3373 sites in public and private treatment centres and in prisons providing MMT as of August 2011 – a considerable increase in provision compared with 680 to 1100 sites reported in 2010.[3] Buprenorphine and opium tincture are also offered as maintenance therapies in Iran, with 3500 persons receiving the latter as of February 2012.[3]

Progress was also made in Morocco, where methadone was approved for substitution therapy in November 2009, and OST pilot sites in three cities – Tangier, Salé and Casablanca – began prescribing in June the following year. Responding to positive results from a 2011 evaluation, the government of Morocco approved the scale-up of the MMT programme to a further seven sites in Oujda, Rabat, Marrakech, Tetouan, Nador, Al Hoceima and Agadir.[3] Information on the availability of OST in

j Iran, Pakistan, Libya, Lebanon, Syria, Jordan, Bahrain, Morocco, Egypt, Afghanistan, Oman, and West Bank and Gaza.

k The 2009 WHO, UNAIDS, UNODC *Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users* categorises NSP coverage levels as follows: low (<100 needles/syringes per injector per year), medium (>100-<200 needles/syringes per injector per year) and high (≥200 needles/syringes per injector per year).

l 'Frontloading' is a drug-sharing ritual that involves injecting with a syringe after someone else has squirted drugs into it from his/her used syringe, either by removing the plunger (backloading) or needle (frontloading) from the receiving syringe.

the UAE was unknown in 2010, yet since then the government has confirmed that there are eight patients receiving buprenorphine-naloxone combination for substitution at the National Rehabilitation Centre, a drug treatment facility run by the Dubai police in Abu Dhabi.[3] A decree on OST implementation was signed by Lebanon's Ministry of Health and a national OST taskforce put in place to provide technical support for developing OST clinical guidelines in September 2010. By March 2012, 120 clients were reported to be receiving buprenorphine as substitution therapy from two government hospitals in Beirut.[3] Authorities in Oman have recently approved the implementation of an OST pilot, but it is as yet unclear when it will start.[3] Methadone is available in Bahrain but used only for detoxification on an inpatient basis, rather than maintenance. Saudi Arabia has established the first OST committee and agreed to initiate MMT services through one pilot site in Al-Amal Psychiatric Hospital in Riyadh.[22]

OST coverage estimates are almost non-existent in the MENA region, with the exception of Iran. Bio-behavioural surveillance in Iran in 2010 indicated that at the time of study 42.6% of people who had injected in the last year were receiving MMT.[4] Women who inject drugs in Iran, as women injectors in other settings,[23] experience higher levels of HIV, HCV and other blood-borne viruses and increased levels of stigma and discrimination but are less likely than men who use/inject drugs to access harm reduction programmes.[13, 15] A clinic for women who use drugs that provides a range of services including MMT was established in Tehran in 2007 and has now expanded to 27 sites around the country.[24] Subsequent research showed that women who use drugs respond well to MMT: within six months of initiating MMT, decreases were observed in heroin use, levels of dependence and engagement in high-risk injecting behaviour and criminality.[15] A gender-sensitive setting designed and operated for women was key to engaging this population in harm reduction and drug treatment services.[13]

HIV testing and antiretroviral therapy (ART) for people who inject drugs

Although an increasing number of countries[m] in the region now conduct bio-behavioural surveillance among populations at higher risk of HIV, including PWID,[3] data on HIV prevalence, testing and antiretroviral therapy (ART) in the region are largely based on detoxification services, police registers and prison records. As such, available figures in many countries tend to be underestimated, are highly susceptible to reporting bias and are unlikely to be representative of the broader population of PWID.

Voluntary counseling and testing (VCT) is available in several MENA countries, yet where it exists, there are few, if any, facilities specifically targeted at PWID. Mandatory testing is widely implemented across the region, with the exception of Morocco, the only country with explicit national policies prohibiting mandatory testing.[12] In early 2012, the government of Libya announced plans to establish eight VCT centres targeted at key populations at higher risk of HIV, including PWID.[25] The UAE has recently reviewed existing policies on mandatory HIV screening, allowing for the introduction of VCT for the first time.[3] Testing for drug users is mandatory on entering treatment or on arrest/imprisonment in several countries, including the UAE, Iraq and Bahrain. Available estimates reported by countries to UNAIDS in March 2012 indicate that only a small proportion of PWID are getting tested and following up their test results: 19.5% in Tunisia, 11% in Morocco, 26.9% in Jordan, 40.9% in Egypt and 24.8% (16.9% among PWID under 25 years old) in Iran.[3] In Syria, uptake of existing VCT services was generally low (1541 clients in 2011), representing only 0.23% of all tests conducted that year. However, it is unknown what proportion of VCT clients are PWID, since there are no VCT services targeting this population.[3] In Bahrain, a country where HIV is primarily driven by IDU, mandatory testing of HIV, hepatitis B (HBV), HCV and TB is routinely performed, particularly among migrants and mobile populations, all of whom are deported upon a positive diagnosis. Most newly identified HIV cases in Bahrain are among males, three-quarters of whom are non-Bahraini migrants, with 58.1% of these attributed to IDU.[3]

Regionally, recent estimates of HIV prevalence among PWID range from 0.6% in Saudi Arabia[n] to over 10% in Iran, Libya, Morocco and Oman.[3] However, much higher rates of HIV have been detected at the local level within some countries. A surveillance survey conducted by the Liverpool School of Tropical Medicine with the support of the European Union in the Libyan capital, Tripoli, detected 87% HIV prevalence among PWID.[25] In the past, IDU has accounted for as many as 90% of HIV cases in Libya.[26] In Iran, HIV estimates range considerably, from 2.2% to 44.4%, with the highest prevalence documented in Tehran, Fars and Lorestan provinces.[4] Increases in prevalence have been documented in some parts of the region, particularly in Tehran, Khuseztan, Fars and Sistan-Baluchestan provinces in Iran, as well as in Egypt, where HIV prevalence among PWID rose sharply from 0.6% in 2006 to 6.7% in 2010.[3, 27]

Despite improved access to ART in some countries at the end of 2010, including Lebanon (37%), Morocco (30%) and Oman (45%), the estimated regional coverage remains low at 13% in 2011.[2] It is unknown what proportion of ART recipients are PWID and how ART coverage in this population fares compared with regional coverage among all people living with HIV. In Libya, ART is currently provided for free to an estimated 2000–2500 people living with HIV from four sites including hospitals in Tripoli, and one each in Benghazi and Sabha, but information on the proportion of ART recipients

m Tunisia, Morocco, Jordan, Iran, Egypt, Algeria, Libya, Oman (planned) and Syria (planned).

n Estimate based on mandatory testing among clients enrolled in detoxification at Al-Amal Hospital in Riyadh, and cannot be generalised to the entire population of people who inject drugs in Saudi Arabia.

who are PWID is unavailable.[o] [3] According to the World Health Organization (WHO), nine of 11 countries surveyed in the MENA region in 2010 reported ART availability for PWID; however, data on the scope and reach of treatment were not known.[2] In Iran in 2010, 580 PWID were reported to be receiving ART.[28] Estimates of ART coverage among PWID are very limited across the region.

Viral hepatitis

According to a 2011 global systematic review, figures on HBV and HCV prevalence among PWID are available for only a fraction of MENA countries.[1] The large ranges for available figures suggest that the quality of estimates in the region is limited, and existing estimates are inexact at best (see Table 2.8.1). All seven countries that reported data had HCV prevalence close to or above 40% among PWID. In Israel and Syria, HCV rates among PWID exceed 60%. Prevalence of HBV ranges from 2.5% in Lebanon to 18.5% in Saudi Arabia. Additionally, a local study in Tehran, Iran, found that co-infection with HBV and HCV was significant in PWID living with HIV: up to 61.2% and 85.1%, respectively.[29]

Information on the extent of the response to viral hepatitis among PWID in MENA is limited. In 2011, the WHO reported that among 11 countries surveyed in the region, seven provided viral hepatitis diagnosis, treatment and vaccination services for PWID.[9] However, the scope and coverage of such interventions among PWID are unknown. The high prevalence of HBV in the region highlights the need for intensified efforts to increase provision and uptake of HBV vaccination targeting this population.

Tuberculosis

There are no systematic data on rates of TB, multi-drug-resistant TB (MDR-TB) and TB/HIV co-infection among PWID in the MENA region. Data from Libya indicate that there were 731 new TB cases in 2011, 128 of which were TB/HIV co-infected.[3] However, people living with HIV are not routinely screened for TB, and there is no information on rates among PWID. In Iran, approximately 14,000 people were affected by TB in 2010, 50 of whom had MDR-TB; it is not known what proportion of these also used drugs.[30]

According to UNAIDS 2011 Universal Access reporting, coverage of treatment for people with TB/HIV co-infection in the region ranges from less than 10% in five countries to between 22% and 55% in another four, and nearly full coverage in Oman (100%) and Algeria (99%).[27] However, disaggregated data by population are not available, and as such the proportion of PWID with TB/HIV co-infection among those receiving treatment is not known. Similarly, in 2011, six countries in the region reported availability of prevention, diagnosis and treatment of TB among PWID, but the scope and reach of these interventions are unclear.[2]

National treatment policies and guidelines in some countries may pose barriers to accessing treatment for the most vulnerable sub-populations of PWID. For example, current policy in Libya does not allow for simultaneous treatment with ART and TB medications for patients with TB/HIV co-infection,[p] despite international guidelines advising against this practice.[31] A significant challenge in MENA countries remains the strengthening of data collection and monitoring systems to obtain a true picture of the extent of TB and HIV among marginalised groups, and the required scale of prevention and treatment.

Overdose

Data on the occurrence of fatal and non-fatal overdose remain largely elusive in the MENA region. Where data are available, rates of overdose appear to be substantial. A study examining overdose prevalence among PWUD across 29 provinces in Iran detected significantly higher non-fatal overdose rates among the sub-group of injectors (56.1%) compared to pooled rates for all drug users (injecting and non-injecting) participating in the study (42.1%). Lifetime experience of overdose was highest in those whose primary substance was Norgesic, a type of locally produced illicit opioid vial (53.9%) and heroin (50.2%).[32] Previous research has suggested that opium is the dominant cause of overdose in Tehran, Iran.[33] In Oman, more than two-thirds of the current and former PWID participating in a recent qualitative research study reported overdosing at least once in their lifetime, with a range of 1–30 overdoses per respondent.[3]

Responses to overdose in MENA countries are very limited. Naloxone, a highly effective opioid antagonist that reverses the effects of overdose, is not available for peer distribution in the community anywhere in the MENA region. Isolated initiatives addressing overdose as part of broader interventions have been documented in some instances. For instance, the Association for Justice and Mercy (AJEM), a Lebanese NGO comprised of social workers and nurses, has recently launched a one-year campaign in partnership with MENAHRA and supported by the Global Fund with the aim of sensitising policymakers, prison managers and 300 inmates across six prisons to harm reduction approaches.[34] As part of the campaign, AJEM will conduct a series of information, education and communication (IEC) activities with inmates which include overdose prevention and management.

Harm reduction in prisons

A high proportion of PWID have spent time in detention, and IDU is a common practice in prisons across many MENA countries. In Syria, for instance, half of the 336 PWID

o Interruptions in treatment for over six months in 2011 due to internal conflict in Libya led to an increased number of people living with HIV reporting to Tripoli Central Hospital in very advanced stages of disease, high mortality and potentially increased risk of developing resistance to existing ART regimens.

p If a person living with HIV on ART is diagnosed with TB, treatment is discontinued and only re-started after the six-month TB treatment has been completed.

participating in a local survey in the Greater Damascus area had previously spent time in prison, and almost half reported using drugs while incarcerated.[20] Among 300 PWUD in three cities in Northern Morocco, 82% reported they had been incarcerated, and 6% reported inhumane treatment while in detention.[21] At Roumieh prison in Lebanon, 34% of inmates surveyed in 2011 had newly started using drugs, with 37% of those injecting them.[34] Qualitative data from Oman have also indicated that many PWID spend time in prison, with most continuing to inject and share needles, syringes and other injecting paraphernalia while incarcerated.[3]

Inmates who inject drugs in MENA countries tend to experience high rates of viral hepatitis and TB, and comparatively low levels of HIV. Bio-behavioural surveillance across 13 correctional facilities in Jordan in 2011 found 1.5% HBV, 3.6% HCV prevalence and no cases of HIV among inmates, and an observed (but not necessarily causal) association between IDU and viral hepatitis infections.[3] A recent study in Iran corroborates this observation: in addition to a history of tattooing and sharing needles and syringes, having a history of incarceration was a significant predictor of high HCV prevalence in PWID.[35] Surveillance among both male and female inmates in Iran also found an overall HIV prevalence of 2%; however, this figure reached 8.1% in prisoners who had a history of IDU (2.1% to 12.5%).[4] At Roumieh prison in Lebanon a significantly higher prevalence of HBV (2.4%) and HCV (3.4%) was found among 580 prisoners, compared with only one case of HIV.[34] The majority (89%) of inmates with HCV injected drugs and reported a previous history of imprisonment. In Kuwait, HCV was detected in approximately 10% of the total prison population, and 75% of cases were among inmates who engaged in IDU.[3]

Iran remains the only country in the region to implement NSPs and OST in prison settings. By February 2012, more than 38,000 inmates were receiving MMT out of an estimated 120,000 inmates who use both injecting and non-injecting drugs and have been deemed eligible for OST.[3] Other responses to harms associated with IDU in prison settings in the region include HIV prevention education and awareness programmes for prisoners and managers in Morocco and social and medical support for prisoners in Qatar. Morocco is presently exploring strategies to introduce OST in prisons in the future.[22] In Egypt a multisectoral Prisons Health Steering Committee has been established to initiate activities and coordinate integrated health services in prisons, including joint responses (other than OST and NSP) to illicit drug use, HIV and TB.[3] In Libya, UNODC, with funding from the Libyan government, recently re-launched the second phase of an HIV awareness project suspended in 2011 due to the security problems, focusing on PWID in prison settings. The project, funded by the Libyan government, was interrupted and is now being resumed.

Policy developments for harm reduction

Seven countries in the region – Iran, Israel, Lebanon, Morocco and, since 2010, Jordan, Tunisia and Syria – explicitly support a harm reduction approach to drug use as part of their national strategy documents on drugs and HIV. In 2010, Tunisia developed a harm reduction strategy for the first time, with support from UNAIDS. During the same year, Syria developed a national strategic plan which was the basis for the first successful Round 10 application to the Global Fund to implement harm reduction interventions. Morocco's new five-year AIDS strategy launched in April 2012 retains a focus on key populations at higher risk, including PWID, and is closely aligned with targets in the 2011 Political Declaration on HIV/AIDS.[36]

At the 57th session of the WHO's Regional Committee for the Eastern Mediterranean in August 2010, Ministers of Health endorsed the *WHO Regional Strategy for the Health Sector Response to HIV 2011–2015*.[37] The strategy includes a set of priorities relevant to strengthening the response among PWID in the region, including strengthening surveillance systems and improving access to VCT and prevention and care services for key populations at increased risk of HIV.

In March 2012, at the 37th Session of the Council of Arab Ministers of Health in Jordan, member country representatives of the League of Arab States launched the Arab AIDS Initiative, aimed at accelerating responses to HIV in the region to achieve the targets set in the 2011 Political Declaration on HIV/AIDS.[38] A technical committee will develop a regional roadmap to reach global targets – including reducing transmission among PWID by 50% – by 2015, and work with states to monitor and implement the new strategy.

Although the policy environment in the region appears to have moved towards greater acceptance and acknowledgement of harm reduction as a core strategy for HIV prevention for PWID, a significant proportion of MENA countries still have no explicit policies on harm reduction. Many countries continue to promote abstinence-based approaches to drug use and remain politically opposed to introducing NSPs and OST. In a significant number of states, drug-related offences are subject to severe penalties, including the death penalty, which is upheld in most of the region.[q 39]

The criminalisation of populations at higher risk of HIV such as PWID and MSM and the lack of an enabling policy environment in many parts of the MENA region severely limit the implementation of current interventions and the introduction of public health and human-rights-based approaches.

q The death penalty for drug offences is present in legislation in the following countries, although some countries have not carried out executions for drug offences in recent years: Iran, Saudi Arabia, Egypt, Syria, Yemen, Libya, Kuwait, Iraq, Oman, UAE, Bahrain and Qatar.

Bringing the 22nd International Harm Reduction Conference to Lebanon

In 2011, Harm Reduction International staged the International Harm Reduction Conference in Beirut – the first time the event was held in the Middle East. This represented a significant success for harm reduction in the region. The five-day conference brought together over 800 delegates from 79 countries to discuss, debate, share and advocate for harm reduction policies and practices.

The event included three days of practical training workshops and demonstrations, many presented in local languages, to help build harm reduction capacity in the region. Highlights included training on overdose prevention, implementing harm reduction in prisons and developing and improving hepatitis C treatment services. A 'dialogue space' was offered to provide delegates with an opportunity to engage in a less formal and more interactive programme of events.

During the closing ceremony, the Middle East and North Africa Network of People Who Use Drugs, which had coalesced during the conference, was officially launched. This newly formed network aims to promote the health and defend the rights of people who use drugs in and around the MENA region, and will work closely with the International Network of People who Use Drugs.

Civil society developments for harm reduction

CSOs in the MENA region have played an increasingly active role in advocating for and implementing harm reduction approaches in the last two years. MENAHRA, a regional network of CSOs, governments and researchers founded in 2007 and composed of three knowledge hubs in Iran, Lebanon and Morocco and a secretariat based in Lebanon, has acted as a catalyst for civil society strengthening, cooperation and mobilisation across 20 MENA countries. CSOs participating in training and advocacy workshops through the knowledge hubs report that these information-sharing activities have contributed to increasing acceptance of both harm reduction policy and practice.

In 2010, the Global Fund awarded US$8.3 million as part of Round 10 to a multi-country project coordinated by MENAHRA – the first regional Global Fund grant exclusively dedicated to support harm reduction and civil society activities. Over the next five years, MENAHRA will work together with its partners through the Global Fund to advocate for a conducive policy environment for implementing harm reduction programmes, and build the capacity of CSOs to scale up the provision of harm reduction services in 13 countries in the region: Iran, Pakistan, Libya, Lebanon, Syria, Jordan, Bahrain, Morocco, Egypt, Afghanistan, Oman, Tunisia, and Palestine.

In March 2011, the International Drug Policy Consortium, in collaboration with the National Rehabilitation Centre in Abu Dhabi, organised the first seminar on drug policy in the MENA region. The event was attended by over 150 participants from 12[r] different countries and provided a rare forum for dialogue on existing law enforcement approaches to drug policy prevalent in MENA countries, as well as the benefits of evidence-based alternatives such as harm reduction.

MENAHRA will be organising a regional meeting for religious leaders on advocacy and harm reduction in September 2012, to sensitise them towards harm reduction strategies.

In Morocco, the CSO Association de Lutte Contre le Sida (ALCS) in collaboration with RDR, ASCMP clinic and the National Council of Human Rights, organised a conference entitled 'Towards a new approach for drug users based on health and human rights' in October 2011. Findings from a community study led by ALCS documenting widespread human rights abuses against PWUD by the police, the justice system and the health care system were presented,[10] after which participating organisations adopted the Rabat Declaration, calling for policy change on the human rights of PWUD in Morocco.

Despite significant developments, in many settings across the MENA region, the work of CSOs working with populations at higher risk of HIV is impeded by high levels of stigma and discrimination, repressive laws and limited government support for harm reduction.

r Afghanistan, Egypt, Gaza, Iran, Jordan, Lebanon, Pakistan, Saudi Arabia, Tunisia, the United Arab Emirates, the West Bank and Yemen.

Multilaterals and donors: developments for harm reduction

The role of multilateral agencies and donors remains crucial in the MENA region. The Global Fund is the most significant source of financial support in the region, having committed approximately US$24 million to date (see Table 2.8.2), including $6.2 million of committed funds for the MENAHRA multi-country grant and separate grants for eight countries or territories.[s] [40] The majority of countries in the region rely on external funds to finance at least 50% of their harm reduction responses. Although recognition of harm reduction and its role in addressing drug-related epidemics among PWID has increased, national funding commitments for programmes remain limited.

Table 2.8.2: Approved Global Fund investments targeting people who inject drugs in the Middle East and North Africa Round 1 (2002) to Round 10 (2010)[40]

COUNTRY / TERRITORY	TOTAL (US$)	
Algeria	500,000	
Egypt	800,000	
Iran	8,200,000	*
Jordan	300,000	
MENAHRA	6,200,000	* †
Morocco	4,600,000	*
Syrian Arab Republic	1,200,000	*
Tunisia	1,400,000	
West Bank and Gaza	800,000	
TOTAL	**24,000,000**	

Notes
Figures are rounded. Data are correct as of March 2012. Data are based on detailed grant budgets submitted to the Global Fund, and may not reflect actual expenditures.
* Figure includes projections for future years of grants that have not yet been formally committed.
† MENAHRA received a multi-country grant that covers Afghanistan, Bahrain, Egypt, Iran, Jordan, Lebanon, Libya, Morocco, Oman, Pakistan, Syrian Arab Republic, Tunisia, and the West Bank and Gaza.

The WHO Eastern Mediterranean Regional Office (EMRO) is directly involved in the provision of technical support to civil society in the region through MENAHRA and directly to country missions. Moreover, WHO is directly involved with countries in building their capacities and providing the necessary technical assistance to collect, analyse and report strategic information, including epidemiological and programme monitoring information on IDU and harm reduction.

UNODC supports harm reduction in 18 Arab countries[t] through a new five-year project launched in 2010 largely focused on criminal justice reform.[41] UNODC has recently restarted the four-year 'Drugs and HIV' project in post-conflict Libya with financial support of US$6 million from the government. The project will involve establishing two drug treatment centres for PWUD, providing capacity-building for local CSOs to engage in outreach to key populations at higher risk and conducting an HIV assessment in prisons, including training and awareness among prison staff and inmates.

s Algeria, Egypt, Iran, Jordan, Morocco, Syria, Tunisia, and West Bank and Gaza.

t Algeria, Bahrain, Egypt, Iraq, Jordan, Kuwait, Lebanon, the Libyan Arab Jamirihiya, Morocco, Oman, Qatar, Saudi Arabia, Sudan, the Syrian Arab Republic, Tunisia, UAE, Yemen and Palestine.

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2.9 | Regional Update
Sub-Saharan Africa

Table 2.9.1: Epidemiology of HIV and Viral Hepatitis, and Harm Reduction Responses in Sub-Saharan Africa

Country/territory with reported injecting drug use[a]	People who inject drugs[b]	HIV prevalence among people who inject drugs (%)[b]	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[1]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[1]	Harm reduction response[c]	
					NSP[d]	OST[e]
Côte D'Ivoire	nk	nk	nk	nk	✖	✖
Djibouti	nk	nk	nk	nk	✖	✖
Gabon	nk	nk	nk	nk	✖	✖
Ghana	nk	nk	40.1	nk	✖	✖
Kenya	49,167[2]	18.3[2]	51.4 (42.2–60.6)	6.4	✖	✔ (M,O)[f]
Malawi	nk	nk	nk	nk	✖ (P)	✖
Mauritius	9,253 (5,699-10,444)[3]	47.4[3]	97.3[3]	9	✔ (52) (P)	✔ (16)(M,O)
Nigeria	nk	4.2[4]	nk	nk	✖	✔
Senegal	nk	9.2[4]	nk	nk	✖	✔ (B,O)
Seychelles	1,671 (673–1,706)[4]	5.8[9]	53.5	0.1	✖	✖
Sierra Leone	nk	nk	nk	nk	nk	✖
South Africa	67,000[5]	19.4[4]	nk	nk	✔ (1)(P)[5]	✔ (6)(M,B)
Uganda	nk	nk	nk	nk	✖	✖
Tanzania	25,000-50,000[58]	42[58]	22.2	3.8	✔ (1) (P)	✔ (1)
Zambia	nk	nk	nk	nk	✖	✖

nk= not known

a The countries included in the table are those which have reported injecting drug use (IDU) and/or NSP or OST according to the latest UN Reference Group systematic reviews. However, HRI data collection in 2007/08 also identified IDU reports in Angola, Benin, Burkina Faso, Cameroon, Cape Verde, Ethiopia, Gambia, Guinea, Liberia, Mali, Mozambique, Niger, Rwanda, Seychelles, Somalia, Togo, Zanzibar and Zimbabwe.

b Unless otherwise stated, data are sourced from Mathers B et al. for the Reference Group to the UN on HIV and Injecting Drug Use (2008) Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review, Lancet, 372(9651):1733–1745.

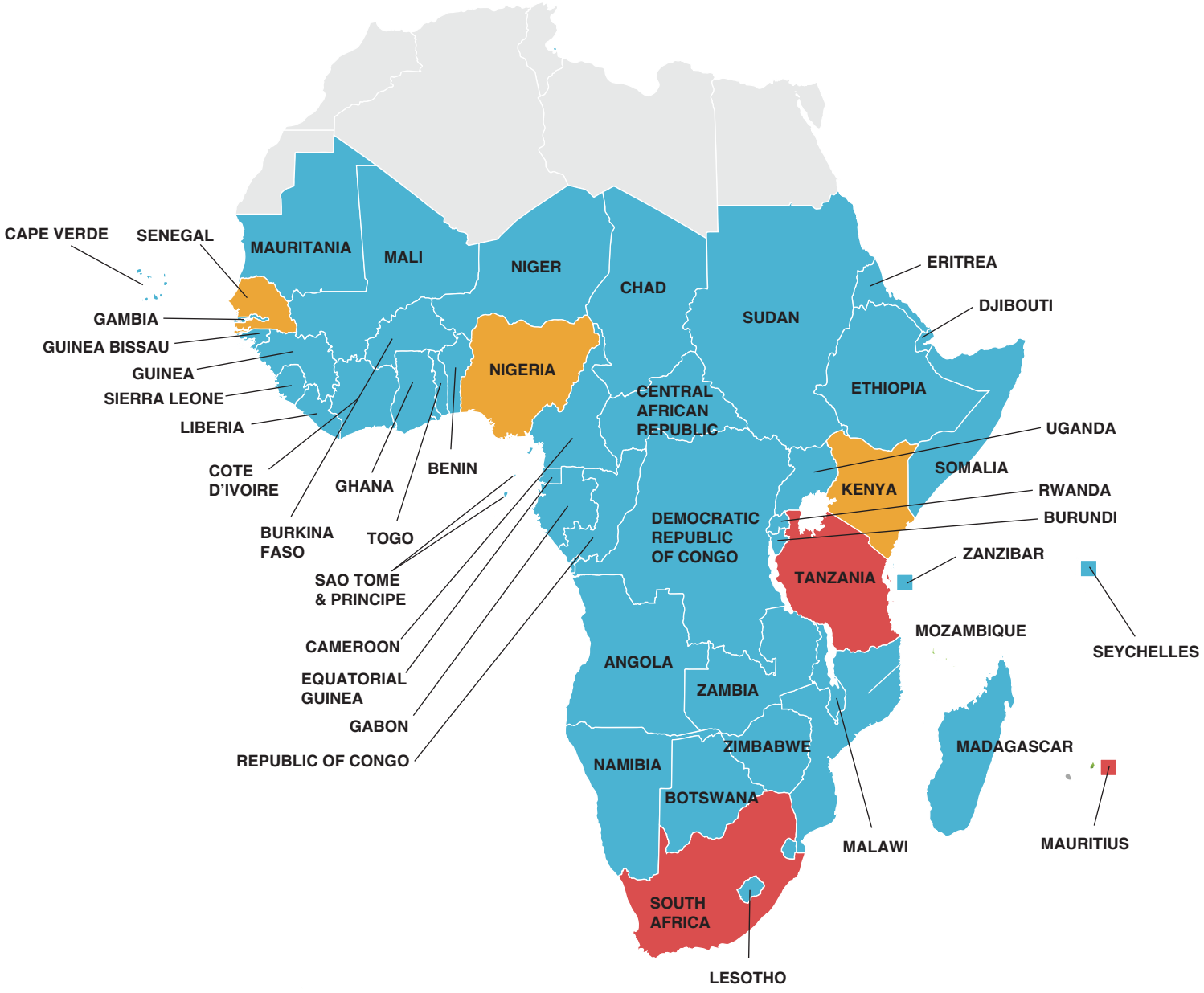
c Unless otherwise stated, data on NSP and OST coverage are sourced from Mathers B, Degenhardt L, Ali H, Wiessing L, Hickman M, Mattick RP, Myers B, Ambekar A & Strathdee SA for the Reference Group to the United Nations on HIV and Injecting Drug Use (2010) HIV prevention, treatment and care for people who inject drugs: A systematic review of global, regional and country level coverage, Lancet, 375(9719):1014–28.

d The number in brackets represents the number of operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = needles and syringes reported to be available for purchase from pharmacies or other outlets, and (NP) = needles and syringes not available for purchase.

e The number in brackets represents the number of operational OST programmes, including publicly and privately funded clinics and pharmacy dispensing programmes. (M) = methadone, (B) = buprenorphine, (O) = any other form (including morphine and codeine).

f Methadone is available on a very limited basis from private clinics only.

Map 2.9.1: Availability of needle and syringe exchange programmes (NSP) and opioid substitution therapy (OST)



Both NSP and OST available

OST only

NSP only

Neither available

Not known

Harm Reduction in Sub-Saharan Africa

Available estimates suggest that there may be 1,778,500 people who inject drugs (PWID) in sub-Saharan Africa (range: 534,500–3,022,500).[6] Among them, an estimated 221,000 (range: 26,000–572,000) may be living with HIV.[6] However, since this estimate is based on only 13 out of 47 countries in sub-Saharan Africa, it is likely that current figures underestimate the true extent of injecting drug use (IDU) and HIV among injecting populations in the region. In 2009, the prevalence of IDU across the region was estimated at 0.2% in the general population.[7]

Available estimates of HIV prevalence among PWID in sub-Sahara Africa range from 4.2% in Nigeria to 51.6% in Mauritius, among a small number of countries for which data exist (see Table 2.9.1).[3] Unsurprisingly, HIV prevalence among PWID is higher than in the general population; for example, in 2011 HIV rates among PWID in Zanzibar were approximately 25%, compared to less than 1% among the general population.[8] Significant proportions of PWID in Kenya, Tanzania, Mauritius, Mozambique and South Africa engage in high-risk injecting practices, including sharing of needles, syringes and other injecting paraphernalia.[9-11]

The growing number of PWID in sub-Saharan Africa has been closely associated with the emergence of many African countries as key transit points in the global trafficking of heroin, cocaine and other drugs.[7, 13] For example, the Indian Ocean coastal regions of Tanzania and Zanzibar are situated on the path of multiple trafficking routes.[7] South Africa and several countries in Western Africa likewise act as key transit points for cocaine trafficking routes from Latin American producers.[7] Ineffective border controls, limited cross-border and regional cooperation and deficiencies in the criminal justice systems allow for relatively easy access to heroin from Afghanistan, Thailand, India and Pakistan.[58]

Sub-Saharan Africa remains significantly behind global efforts to implement and scale up harm reduction interventions as part of a comprehensive HIV response for PWID. Existing needle and syringe exchange programmes (NSPs) have been scaled up in Mauritius, and new programmes have been established in South Africa and Tanzania. In South Africa, provision is small-scale, based in Cape Town only and targeted specifically at men who have sex with men (MSM), whereas in mainland Tanzania the opioid substitution therapy (OST) programme is backed by the government and has been in operation since February 2011.

Existing interventions are largely restricted to major cities and coastal regions where IDU appears to be more concentrated.[9] Although anecdotal evidence suggests that IDU may also occur in rural areas and smaller towns,[14] existing programmes in Kenya and Tanzania are focused in and around Mombasa, Nairobi and Dar es Salaam.[9] In all cases, the scale of existing services remains far below estimates needed to reverse the HIV epidemic among this population.[15]

There are substantial evidence gaps on the epidemiology of HIV and viral hepatitis among PWID, particularly for Central and Western African countries. Since 2010 there have been attempts to address the dearth of population-based studies among PWID and injecting-related HIV infection in the sub-Saharan Africa region,[9] with bio-behavioural surveillance projects now being conducted in the major drug consumption cities of Nairobi and Mombasa in Kenya.[10] However, even in East and Southern African countries that conduct surveillance, these assessments are not conducted regularly enough to track trends in IDU and HIV. As a result, in most countries there is still insufficient understanding of the size and distribution of key affected populations, rendering calculations of intervention needs and coverage very challenging.[16] Further investigation is urgently needed to understand the extent to which existing interventions effectively meet the needs of PWID to determine the scale of the response required.[17]

Major legal and policy barriers, including criminalisation of people who use drugs (PWUD), present significant barriers to accessing existing programmes where these do exist, and exacerbate unsafe injecting practices and HIV transmission among PWID.[7, 18] Although there has been an increasing awareness of the need to address IDU-related HIV in the region since 2010, approaches in many countries continue to focus on supply reduction and law enforcement rather than public health.

Developments in harm reduction implementation

Needle and syringe programmes

Provision of NSPs in sub-Saharan Africa is limited to isolated efforts by non-governmental organisations (NGOs) in a small number of countries. In June 2012 the Kenyan government announced that it will begin distributing sterile needles and syringes to PWID across the country.[19] At the time of writing, the proposed NSP was still in the early phases of discussion, and potential implementation sites in Kenya had yet to be identified.[20] A small NSP programme was launched in Cape Town, South Africa in August 2010 as part of Health4Men, a project providing free sexual health care to MSM.[21] However, its reach remains limited to a small number of MSM. There are plans to open a second site in Gauteng in South Africa.[21] In late 2010 Médecins du Monde-France (MdM-F) initiated the first NSP site in Tanzania, in the Temeke district of Dar es Salaam.[8] Although still in the early stages of development with a relatively small reach, by September 2011 the MdM team had made contact with 1307 PWID, distributing a total of 32,700 needle and syringes.

The number of operational NSP sites in Mauritius, the first country in the region to implement NSPs, was scaled up from 39 sites in 2010 to 52 sites in 2012.[5] Despite increases in the number of sites, coverage of existing NSP services in Mauritius remains low compared to international coverage targets,[15] with 30 syringes distributed per PWID per year.[22g] Some NGOs in Seychelles distribute needles, syringes and other injecting equipment sporadically; however, these efforts are not officially recognised or accounted for by government authorities.[23]

In countries where data are available, sharing of injecting equipment among PWID appears to be common. In Nigeria, the percentage of PWID reported to have used sterile equipment for their last injection has decreased over the past two years, from 89.2% in 2010 to 70.8% in 2012.[24] More than a third of the 540 participants in a Kenyan study reported sharing injecting equipment with close friends or primary sex partners.[2] Reasons for sharing injection equipment included lack of personal needles when required (23%), difficulty in accessing new needles or cost (17%), pressure from peers (14%) and being in prison (2%).[2] HIV prevalence was six times higher (30%) among those that reported ever having shared needles and syringes than among those that never shared (5%), and 47% reported sharing a needle or syringe in the past month.[2] In South Africa, 86% of PWID reported sharing needles and syringes, with some reporting re-using injecting equipment up to 15 times.[25]

Legal barriers and social stigma present major barriers to accessing sterile injecting equipment, often forcing PWID to hide injecting equipment and engage in unsafe injecting.[10, 26] Even in places where it is legal to purchase needles and syringe, fear of discrimination or disapproval from the community often deters individuals from accessing the services they need.[5] In a study from Kenya, an average of 31% of respondents reported having been confronted by the police or having injecting equipment confiscated by law enforcement authorities within the past six months.[2] The threat of arrest for possessing residual traces of heroin in the syringe barrel when returning used injecting equipment remains a significant deterrent to those seeking to access NSP facilities.[27]

An emerging concern is the overlap between the injecting and sexual networks of several key populations at higher risk of HIV, including PWID, MSM and sex workers. Research from South Africa highlighted a significant intersection between IDU and high-risk sexual practices.[28] A 2010 study of 509 MSM in Zanzibar reported that 60% used a needle after someone else had used it, with 68% passing a needle on to someone else after injecting.[58] Effective responses to overlapping high-risk behaviours require both the mainstreaming of harm reduction services within broader HIV prevention services as well as the inclusion of population-specific needs, such as those of women or MSM, within existing harm reduction programmes. It is unclear whether and to what extent such integrated services are available in countries within this region.

As in other parts of the world,[29-30] women who inject drugs in the region experience disproportionately higher levels of negative health outcomes compared with their male counterparts.[2, 8, 31] Though fewer in number compared with their male counterparts, women who inject drugs have consistently higher HIV prevalence than male injectors.[10] In a 2011 Kenyan study, HIV prevalence was 47% among women injectors compared with 17% among male injectors.[10] Flashblood,[h] which has previously been documented among women who inject drugs in Tanzania and Zanzibar,[32] is now also evident along the Kenyan coastal towns of Mombasa and Malindi,[33] indicating cross-border influences of drug consumption trends among countries in the same geographical region.

Opioid substitution therapy

OST remains largely unavailable throughout sub-Saharan Africa (see Table 2.9.1). Tanzania is the only country in the region that has initiated an OST programme since 2010, in addition to the program already operating in Mauritius.[17] Located within Muhimbili University Hospital, Tanzania's OST programme began operating in February 2011.[8] Although the outreach capacity of the existing single facility is limited, 175 PWID received treatment through this programme as of September 2011.[8] Plans to open an additional site were in progress at the time of writing.

Limited OST services are available in South Africa and Senegal, but there is very limited government support. In South Africa, legal restrictions for using methadone for substitution therapy have been lifted, and buprenorphine is also available for substitution, only in the private health sector.[34] This effectively limits access to these medicines for the vast majority of people who use opiates who are not covered by private health insurance and cannot afford the medicines.[5] Despite evidence that access to OST could prevent 14% of new HIV infections projected to occur in Nairobi between 2010 and 2015,[35] methadone for detoxification is only available in one clinic on a very limited basis.

Antiretroviral therapy

In December 2010, an estimated 5,064,000 people were receiving antiretroviral therapy (ART) in the sub-Saharan Africa region. This represented almost half of the people living with HIV that were eligible for ART. Coverage differed significantly between Eastern and Southern Africa (56%) and West and Central Africa (30%).[31]

g If the 4728 clients on Methadone Maintenance Therapy are excluded from the calculation, the number of syringes distributed per PWID per year would be 60.

h Flashblood is high-risk practice that involves blood-sharing by injecting the blood of the person who got the main hit to experience some of the effect of the drug.

National reporting to WHO in 2010 on the availability of HIV prevention, treatment and care services for PWID revealed that only nine out of thirty-five reporting sub-Saharan African countries had services in place providing ART to PWID.[31] There remain very limited data on the numbers of PWID that may be accessing ART within the region. The Reference Group to the UN on HIV and Injecting Drug Use reported that thirty-eight PWID in Kenya and 138 PWID in Mauritius were receiving ART in 2008. These estimates were equal to less than 1% of HIV-positive PWID in Kenya and 1.1% (range 0.4–9.2%) of HIV-positive PWID in Mauritius receiving ART.[17] The global average, according to the UN Reference Group was 4% of HIV-positive PWID receiving ART.[17] Despite the significant caveats on these calculations,[i] it is clear that the response to HIV among PWID is much further developed in Mauritius than in the rest of the region. While more data are necessary to accurately assess the situation, with an absence of targeted HIV interventions for PWID, along with substantial barriers to accessing health care services,[36] the overwhelming majority of PWID eligible for ART in sub-Saharan Africa are currently unlikely to receive it.

Where services providing ART are available to PWID, there are significant factors which may impede service access. These include, but are not limited to, institutionalised stigma and discrimination against PWID within health care systems, a perceived or real lack of confidentiality and subsequent fear of health care professionals reporting drug use to the police, as well as treatment providers refusing access to ART on the basis of drug use.[36]

Viral hepatitis

The prevalence of hepatitis C (HCV) among the general population in sub-Saharan countries varies but is generally high.[37-38] Similarly, the majority of countries in the region have considerable hepatitis B (HBV) epidemics among the general population.[39]

There is a paucity of available data on viral hepatitis among PWID across sub-Saharan Africa. In the five countries where estimates are available, HCV prevalence may be significantly higher than HIV prevalence among PWID. Estimates were available for Tanzania (22.2%), Ghana (40.1%), Mauritius (97.3%), Kenya (51.4%, range 42.2–60.6%)[1] and Seychelles (53.5%)[40] (see Table 2.9.1). In a Tanzanian study, HCV prevalence was 28% among PWID compared with 2% in their non-injecting peers.[8] Data on HBV among PWID are similarly limited, with estimates only available for four countries: Tanzania (3.8%), Kenya (6.4%), Seychelles (0.1%) and Mauritius (9%).[1] For many countries in the region, the failure to acknowledge the existence of PWIDs continues to thwart systematic surveillance efforts to monitor viral hepatitis and other IDU-related harms among this population.

i Not all HIV-positive people who inject drugs will be eligible for ART. The calculation of the ratio of PWID receiving ART is based on the UN Reference Group (C grade) estimate of 130,748 PWID in Kenya and an estimated HIV prevalence of 42.9% among them. More recent data suggests both the number of PWID and the HIV prevalence among PWID to be significantly lower (see Table 2.9.1).

While the cost and quality of HCV treatment regimens may change in the near future, at present the cost and complexity of treatment delivery pose substantial barriers to implementation in high-prevalence, low-resource settings.[1,41] The significance of viral hepatitis among populations engaging in IDU needs considerably more recognition in the region. Targeted messaging for hepatitis prevention must be integrated within comprehensive HIV prevention and treatment services.[58] There are indications that such services may be developed in Zanzibar, where plans include the establishment of integrated HIV/viral hepatitis facilities that will target key affected populations.[58]

Tuberculosis

Tuberculosis (TB) prevalence in the sub-Saharan region is notably high. Where available, TB rates per 100,000 in the population were reported to be highest in South Africa (981) and Zimbabwe (633), with Mozambique (544) and the Democratic Republic of Congo (327) also reporting substantial rates.[42] South Africa currently reports the third highest TB burden in the world, with TB incidence having increased by 400% over the past fifteen years.[25] An estimated 80% of South Africa's population are currently infected, and TB/HIV co-morbidity is estimated to reach 60% among people living with HIV.[25] While the majority of people infected with TB will not develop active TB disease, PWUD and prisoners are more vulnerable to progressing to active TB disease.[42]

Although integrated TB/HIV testing and treatment is beginning to emerge in South Africa[25] and other parts of the region, there are no known interventions specifically targeting PWID. The challenges posed by TB/HIV co-infection among PWID are intensified by incarceration, with TB prevalence amongst prison populations much higher than prevalence in the general population.[43] High rates of TB in prisons are further exacerbated by overcrowding, poor sanitation, late diagnosis, inadequate treatment of infectious cases, high transfer rates and gaps in continuity of care upon release.

Overdose

Data on the prevalence of and responses to overdose in sub-Saharan Africa are extremely scarce. Available data indicate that risk of overdose is high in some parts of the region. For instance, overdose cases in Kenya are estimated to be 83–90% higher in Nairobi than in the coastal areas, and approximately 58% of PWID in Kenya reported knowing at least one person who had experienced a fatal overdose.[10]

Naloxone, a highly-effective opioid antagonist used to reverse the effects of overdose, has been approved and is available for the management of overdose in hospital emergency departments in Tanzania.[9] However, in the context of significant stigma and criminalisation of PWID, who may be reluctant to access services for fear of being reported, managing overdose remains a challenging feat in countries

in the region.[44] Community distribution of naloxone through peers is unknown to operate in any countries within the region.[44] Given the paucity of data available on this issue, further investigation is required to better understand the extent of overdose in countries in sub-Saharan Africa and to expand access to overdose prevention programmes that include peer distribution of naloxone among PWID, their families and communities.

Harm reduction in prisons

Criminalisation of drug use and possession and drug-related crime contribute to a high proportion of PWID among sub-Saharan African prison populations.[10] Anecdotal evidence suggests that prison settings may be contributing considerably to accelerating HIV transmission due to the high availability of drugs and the lack of sterile injecting equipment.[7]

IDU has been documented in prisons in Côte d'Ivore, Mauritius, Kenya and Ghana.[10] Kenyan prisons are predominantly populated by adult males, with a significantly smaller number of female and juvenile inmates.[45] Drug trafficking and trading in prison is reported to be common, with drugs often brought in by inmates attending court dates or by security officers either supplying the drugs or facilitating their entry.[2] HIV prevalence in the Kenyan prison population is 8.2% compared with a national prevalence of 6.4%, and is significantly higher (19%) among female inmates than among male inmates (6%).[45]

Access and take-up of testing services is limited, particularly for TB and viral hepatitis. Approximately 77% of Kenyan inmates reported ever being tested for HIV, 23% for TB and less than 2% for viral hepatitis.[45] In neighbouring Uganda, HIV prevalence in the prison population is nearly twice as high as the national prevalence in adults.[46] Where data are available, a high percentage of PWID report sharing injecting equipment while incarcerated. The overwhelming majority of PWID (81%) surveyed in Nairobi and coastal provinces in Kenya report having been previously incarcerated.[2] Approximately 7% reported injecting drugs while in prison, and of these, 61% reported sharing needles or syringes.[2]

NSP and OST are not implemented in any prisons in the sub-Saharan Africa region. Although Nigerian government objectives outline a commitment to increased access for PWID to a full range of harm reduction measures, planned services in prisons are limited to drug treatment, telephone hotlines and drop-in centres for providing information and referrals.[47]

Policy developments for harm reduction

Progress in terms of the development of a conductive policy environment for harm reduction remains limited across the region, with a few exceptions. Harm reduction is mentioned in the Tanzanian National Strategy for Non-Communicable Diseases (NCD) 2009–2015, with key objectives on the most-at-risk populations outlined in the National Multisectoral Strategic Framework on HIV/AIDS.[48] In Kenya the recently launched national HIV strategy similarly denotes a national response to emerging evidence of changing epidemiological dynamics, affirming universal access to HIV prevention, treatment, care and support.[46] Recent steps have also been taken to increase the engagement of provinces, districts and local communities in HIV service planning across the country.[46] Ongoing strategic objectives in Mauritius include dialogue and sensitisation with the Anti-Drug Smuggling Unit to improve the running of the NSPs, advocacy for the decriminalisation of the distribution and carrying of syringes, the implementation of harm reduction programmes in prisons and the implementation of awareness-raising programmes in the community to mitigate stigma and discrimination.[22]

Despite these advancements, for the majority of countries in the region, relevant policies continue to focus on supply reduction and the criminalisation of PWUD, impeding efforts to implement evidence-based harm reduction interventions.[2] For instance, despite progress with the implementation of the first NSP in Tanzania, the possession of needles is still illegal across some jurisdictions.[8, 49] Although HIV-related discrimination is now prohibited in Kenya, national legislation and policy fail to offer legal protection for certain key populations.[46] Furthermore, although reference to harm reduction appears in Nigeria's National Policy on HIV and AIDS,[50] the country's National Drug Law Enforcement Agency (NDLEA) continues to focus on supply control and demand reduction via seizures and arrests. PWID are routinely harassed, raided and detained in already overcrowded prisons in the attempt by the NDLEA to control drug availability.[47]

While there is an increasing awareness of the need to address IDU-related HIV in region, as can be seen above, drug policy continues to focus on supply reduction and rely on law enforcement rather than public health approaches, with very few exceptions. Progress toward the overhaul of current drug policies and regulations in favour of harm-reduction-based strategies is impeded by the lack of political will and support. Increased advocacy efforts are essential to strengthen political support for public health and human-rights-based approaches to addressing HIV related to IDU in the region.

Civil society and advocacy developments for harm reduction

Although civil society organisations (CSOs) with a focus on PWID and harm reduction are limited in number within the region, there has been a marked increase in the number of local CSOs working alongside international organisations to advocate for the introduction and/or scale-up of harm reduction services since 2010.

In the continuing absence of local government support for harm reduction, regional CSOs remain the main advocates for harm reduction. A meeting of civil society groups was held at a pre-conference event during the 16th International Conference on AIDS and Sexually Transmitted Infections (STIs) in Ethiopia in December 2011. Among the outputs of this meeting was the formation of a sub-regional harm reduction and drug policy network to be hosted by Kenya AIDS NGOs Consortium (KANCO). The objectives of the network include strengthening links between local harm reduction networks in sub-Saharan Africa, promoting awareness and facilitating the adoption of harm reduction initiatives across the continent. The network will continue to work together with national harm reduction networks and organisations in Uganda and Kenya, as well as focal points in Tanzania, Mauritius, Nigeria and Ethiopia.

There are a number of newly formed national networks in the region including those based in Kenya and Uganda. Formed in January 2011 by current and former PWUD based in Kampala, the Ugandan Harm Reduction Network (UHRN) is a national non-profit organisation that works to promote the health of individuals and communities affected by drug use. UHRN engages in advocacy, information sharing and dissemination and capacity-building, and seeks to act as a coordinating body for member associations representing marginalised groups in the country. Similarly the Kenyan Harm Reduction Network was formed in 2011 and is made up of harm reduction organisations that aim to advocate for a harm reduction approach to drug use and drug policy.

Other new initiatives include those in the Seychelles; while key groups are still not directly targeted in national prevention programmes, NGOs have attempted to become more proactive in addressing the specific needs of key populations at higher risk of HIV, including PWID.[23] Moreover, several programmes in Zanzibar are currently being developed to strengthen and extend the capacity of the public health system, community-based organisations and associated peer-education initiatives.[58]

In June 2012 INPUD developed and led capacity-building workshops for drug user advocates in Kenya as part of the CAHR project, and in Tanzania in partnership with MdM. The overall aim of the workshops was to determine existing and potential platforms for PWUD to input into the development, implementation and evaluation of programming and decision-making around national-level services and policy that impact upon PWUD. Activities included information dissemination around harm reduction, training in drug user organising and capacity-building to deliver peer education. As a result of these workshops, national drug user networks were founded in each country.[51]

The region held its second harm reduction conference in 2011, hosted by Collectif Urgence Toxida (CUT), a network of NGOs and individuals working in the field of drug use and HIV/AIDS mainly in Mauritius and the Indian Ocean. The conference was attended by participants from all of the Indian Ocean states as well as Kenya, Tanzania, Zanzibar, Mozambique and Morocco, among others. The theme of the conference was 'Towards a client-centred approach' and aimed to engage the participants in dialogue around the improvement of the quality of harm reduction services delivered in Mauritius. Importantly, the conference emphasised the human rights and public health principles that underscore harm reduction.

Multilaterals and donors: developments for harm reduction

Multilateral agencies and donor NGOs provide the majority of HIV/AIDS spending in sub-Saharan Africa. The German Society for International Cooperation (GIZ) provides technical assistance to exchange initiatives in parts of the region including Mauritius, Sierra Leone and Kenya.

Open Society Foundations, through the International Harm Reduction Development Program (IHRD) and the Open Society Initiative for Eastern Africa (OSEA), has supported organisations working with PWUD in Kenya and Tanzania to increase knowledge and capacity on harm reduction, health and human rights protections. Support has included: study visits for NGO representatives to harm reduction programmes in Africa (Mauritius) and North America; support for legal empowerment, including legal aid, paralegal training and NGO support for PWUD at police stations, in pre-trial detention and in prisons; training on naloxone provision, needle exchange and harm reduction basics; presentations and participation at national, regional and international conferences and advocacy to increase awareness of harm reduction principles, decrease rights abuses, secure national and international funds for harm reduction, and network with other community organisations working with PWUD.

The short-lived 2009 US Congressional decision to allow the use of federal funds for NSPs and subsequent revisions to HIV prevention guidance from the President's Emergency Plan for AIDS Relief (PEPFAR)[52] represented an opportunity to expand and develop existing harm reduction interventions and to rally support for evidence-based approaches targeting PWID.[9] However, the reinstatement of the ban on the use of US

federal funds for NSPs[53] in December 2011 greatly undermined bourgeoning efforts to expand harm reduction in the region.

The Global Fund to Fight AIDS, Tuberculosis and Malaria explicitly supports harm reduction as part of its commitment to fund evidence-based, cost-effective interventions.[54] However, of the 55 countries and territories supported by the Global Fund since its inception, only three African countries with generalised HIV epidemics – Burundi, Kenya and Nigeria – were included (see Table 2.9.2).[55]

Table 2.9.2: Approved Global Fund investments targeting people who inject drugs in sub-Saharan Africa, Round 1 (2002) to Round 10 (2010)[56]

COUNTRY / TERRITORY	TOTAL (US$)	
Burundi	600,000	*
Cape Verde	700,000	*
Kenya	1,900,000	*
Madagascar	1,300,000	*
Mauritius	1,500,000	*
Nigeria	1,300,000	*
Zanzibar	500,000	‡
TOTAL	**7,800,000**	

Notes

Figures are rounded. Data are correct as of March 2012. Data are based on detailed grant budgets submitted to the Global Fund and may not reflect actual expenditures.

* Figure includes projections for future years of grants that have not yet been formally committed.

‡ Zanzibar, a semi-autonomous part of Tanzania, receives separate grants from the Global Fund.

Despite the major concerns posed by IDU-related HIV in these epidemiological settings,[7, 31] no funds were allocated for PWID in countries with generalised epidemics in past rounds, a situation largely influenced by limited technical support, advocacy and political commitment in most settings in the region.[57] Since 2010 the dedicated funding reserve for HIV proposals that focus on most-at-risk populations created as part of Round 10 includes funding support to implement harm reduction programmes planned in Kenya.[55] In total, the Global Fund has provided US$7.8 million for harm reduction programmes targeting PWID in the region.

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DEVELOPING EFFECTIVE HARM REDUCTION SERVICES FOR WOMEN WHO INJECT DRUGS

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Information for the case studies was contributed by Anna Ivanova and Ian Bromage. The authors would also like to thank Ruth Birgin, Jude Byrne and Eka Iakobishvili for their valuable input, and acknowledge Claudia Ahumada and Dr Wendee Wechsberg for reviewing the chapter.

Introduction

Despite evidence of important differences in drug use experiences and access to harm reduction services for women and men, gender-sensitive interventions have not yet been fully integrated into these services around the world. However, research and experience suggest that the provision of enhanced harm reduction services for women can increase uptake and improve the outcomes of these interventions.

This chapter provides an overview of the risks and harms experienced by women who inject drugs, and of women's access to harm reduction and related health services.[a] Drawing on programmes from around the world, the chapter proposes a 'menu' of gender-sensitive services for women who inject drugs.[b] These services aim to provide more accessible, comprehensive and effective care for women by addressing their needs in an holistic way and respecting their human rights and freedom of choice. The chapter concludes with recommendations for policies that support gender-sensitive harm reduction.

Risks and harms experienced by women who inject drugs

Due to a mix of social and biological factors, women and men have different experiences of injecting drug use (IDU) and its accompanying risks and harms.[1-2] A recent systematic review of international research on the risks, experiences and needs of women who inject drugs found the following major themes:

» Compared to their male counterparts, women who inject drugs experience significantly higher mortality rates; an increased likelihood of injecting-related problems; faster progression from first drug use to dependence; higher rates of HIV; and higher levels of risky injecting and/or sexual risk behaviours.[1]

» For women who inject drugs, there is greater overlap between sexual and injecting social networks than there is for men who inject drugs. This may increase women's risk of acquiring HIV through sexual transmission as well as through unsafe injecting. Women who inject drugs are more likely than their male counterparts to have a sexual partner who injects drugs, and to be dependent on them for help acquiring drugs and injecting. Relationship dynamics can make it difficult for women to access harm reduction services, enter and complete drug treatment (if desired) or practise safer drug use and safer sex.[1]

» Intimate partner violence (IPV) is more commonly reported among women who inject drugs than among women in the general population.[1] Violence has an immediate effect on a woman's ability to practise safer sex and safer drug injecting, and can contribute to continued drug use.

» There is significant overlap between women's engagement in IDU and in sex work, especially street-level sex work. Participation in sex work has been associated with syringe sharing and inconsistent condom use, as well as other risks posed by the dangerous circumstances in which sex work often takes place.[1]

» There are a number of differences between men's and women's motivations to enter and complete opioid substitution therapy (OST) and other drug treatment modalities, and in the personal dynamics that play a part in treatment success. Many women cite pregnancy as a central reason for entering treatment, although punitive policies that separate women who use drugs from their children can deter pregnant women and mothers from entering drug treatment. A partner's entry into treatment is another key factor that can facilitate treatment entry for women. OST and certain other types of drug treatment have been found to be especially effective in helping women to reduce their drug use, while detoxification alone is significantly less successful for women who inject drugs than for men.[1]

A systematic review of studies from 14 countries found a significantly higher prevalence of HIV among women who inject drugs than among their male counterparts in settings with high HIV prevalence.[3] Studies in nine EU countries found that the average HIV prevalence was more than 50% higher among women who injected drugs than among their male counterparts.[4]

Access to services

The intense social stigma attached to women's IDU and HIV infection can pose a formidable barrier to their access to harm reduction services, drug treatment, HIV treatment, sexual and reproductive health care, and other medical services, especially in culturally conservative societies.[5-6] As a minority of people who inject drugs (PWID), women are not always included in medical or social programmes for drug users. For example, anti-retroviral treatment (ART) and OST are sometimes available in men's penal institutions, but not in women's.[5,7,8] Many programmes for drug users do not respond to the specific needs of women.

a The scope of this article is limited to women who inject drugs, rather than all women who use drugs. It should be noted that there is also a significant amount of research on women who use drugs without injecting. For a discussion of the general literature on women who use drugs and the implications for future HIV prevention efforts, see El Bassel N, Wechsberg W and Shaw S (2012) Dual HIV risk and vulnerabilities among women who use or inject drugs: no single prevention strategy is the answer, *Current Opinion on HIV/AIDS* (7):326–331.

b For reasons of space, the scope of this article does not address the specific needs of transgender people who use drugs.

Limited data on injecting drug use among women

Women have been estimated to represent roughly 40% of people who *use* drugs in the USA and some parts of Europe, and 20% in Eastern Europe, Central Asia and Latin America.[9, 10] However, data on women as a percentage of people who *inject* drugs are sparse, due in part to the difficulties of estimating the size of a hidden population engaged in an illicit activity. There has been no systematic analysis of the prevalence of IDU among women internationally. While data on the prevalence of IDU and HIV among PWID are available for more than 148 countries, for the most part these data are not disaggregated by gender. In the global data holdings on IDU and HIV maintained by the Reference Group to the UN on HIV and Injecting Drug Use, none of the countries that report IDU have data disaggregated by gender. This failure to collect gender-disaggregated country-level data on IDU makes it difficult to evaluate the precise scope and nature of needs among women who inject drugs, and should be remedied.

Similarly, the Reference Group's global data holdings show that countries that provide HIV prevention, treatment, care and support services for PWID generally fail to report on the number of women served by OST, ART and needle and syringe programmes (NSPs). This lack of data is disquieting, as it makes it difficult to assess whether at a country level there are gendered disparities in access to these essential services, or the degree to which available services are responsive to women's needs. This may have a negative impact on efforts to improve harm reduction service coverage and, consequently, on efforts to curtail the HIV epidemic within this population.

Despite these significant data gaps, evidence suggests that there is indeed a substantial population of women who inject drugs worldwide. In Europe, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) reported that, while precise data on women as a proportion of out-of-treatment PWID were not available, women comprised 22% of new patients for OST and 33% of new patients for amphetamine dependence treatment.[11] This suggests that women are a sizable minority of PWID in the region as a whole. Estimates of the gender balance among PWID in various countries (see Table 3.1.1) show that women are a very sizable minority of PWID in Russia, home to at least 1.8 million PWID, of whom more than 37% are living with HIV;[12] China, where 6.4% of the country's 2.35 million PWID are living with HIV;[12] and Ukraine, which has the highest HIV prevalence in Europe and an epidemic largely concentrated among PWID.[13] This points to the importance of addressing the needs of the large populations of women who inject drugs in these areas. The wide variation among and within countries also points to the importance of geographical difference, and the need for services that are adjusted accordingly.

Table 3.1.1: Women as percentage of all people who inject drugs in selected countries

Country/territory	Women as an estimated (%) of all PWID[14]
Cambodia	10
Canada	33[15]
China	20
Estonia	9[11c]
Georgia	10
Indonesia	11
Kenya	11
Kyrgyzstan	10
Malaysia	10
Russian Federation	30
South Africa	27
Ukraine	26
Vietnam	18

Sexual and reproductive health and pregnancy

While harm reduction programmes usually include condom distribution, information on sexual health and sexually transmitted infections (STI) testing and sometimes treatment, many do not address other aspects of sexual and reproductive health, even though many women who inject drugs experience unplanned pregnancies.[5, 6, 8, 16] Some women do not realise they are pregnant until relatively late, making it more difficult for them to access appropriate prenatal care, harm reduction services, drug treatment (if desired) or other support, or to terminate their pregnancies safely if they so choose.[6, 8, 17]

Faced with pressure to have abortions and high levels of stigma, women who inject drugs sometimes have reduced access to prenatal care.[5, 6, 8] This can lead to reduced levels of prevention of mother-to-child transmission (PMTCT) services among women living with HIV who inject drugs, among other negative effects. A 10-year study in Western and Central Europe of ART during pregnancy found that a history of IDU was associated with the risk of not receiving ART, and with being diagnosed with HIV late in pregnancy.[18]

The comprehensive package for the prevention, treatment and care of HIV among people who use drugs, produced by the World Health Organization (WHO), United Nations Office on Drugs and Crime (UNODC) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), does not include contraceptive methods other than condoms; pregnancy tests; pre- and post-natal care; or links between harm reduction, drug treatment and prevention of vertical transmission of HIV.[19] Adding these services to the comprehensive package

c Based on estimated 10:1 ratio of male to female drug users, based on IDU estimates from HIV reference laboratory, police arrests, overdoses and drug treatment.

could help women who inject drugs to better manage their sexual and reproductive health, thus preventing unplanned pregnancies and improving pregnancy outcomes, including through improved access to prevention of vertical transmission of HIV.

Pregnant women who inject drugs may wish to begin OST or other forms of drug treatment, and prompt, easy access to these services is essential in improving outcomes for these women and their children. While there has been some scale-up of OST worldwide, information and protocols on OST provision during pregnancy and post-partum (including during stays in maternity hospitals) are not always in place.[5, 6, 8, 20] This risks treatment interruptions and makes it difficult for women to access the 'treatment of choice' during pregnancy.[9] Long waits to enter OST and other drug treatment programmes in some countries, and the complete lack of OST in others (notably Russia), threaten the health of all PWID, but are especially troubling in the case of pregnant women.[9]

Sexual and intimate partner violence

Problematic drug use among women is often associated with a history of sexual abuse,[6, 9] and women who inject drugs experience elevated rates of IPV.[1] Violence has an immediate effect on a woman's ability to practise safer sex and safer drug use, and contributes to continued drug use. A history of violence can make women feel uncomfortable in certain situations – for example, in a support group where the majority of participants are men, or when receiving pelvic examinations.[23] Where a history of trauma contributes to problem drug use or risky behaviours, it is important that harm reduction and drug treatment programmes take this into account and that staff are aware of how to deal appropriately with these issues.[9]

Women, injecting drug use and prisons

Just as women's experience of drug use often differs from that of men, women occupy a different stratum of the drug economy. A meta-synthesis of qualitative literature found that the drug economy is gender-stratified and hierarchical, with women mainly confined to the lower levels.[24] Low-level dealers and drug 'mules' are easier to arrest than higher-level traffickers. In addition, they often have fewer resources for legal defence. This, combined with the low thresholds for criminal responsibility for drug possession in many countries, means that low-level players (many of them women) receive long prison sentences.

An increasing number of women are being incarcerated for drug-related offences worldwide.[25-30] A recent study found that more than one in four female prisoners in Europe and Central Asia had been convicted of a drug offence, and that the number of women incarcerated for drug-related offences in Russia is more than double the total number of female prisoners in all EU countries combined.[31] In Tajikistan, up to 70% of all female prisoners have been incarcerated for drug-

Comprehensive care for women and their children

Vancouver, Canada

Recognising that women's social and economic environment has the greatest impact on maternal and foetal health, Sheway brings together representatives from the government and the community to provide comprehensive, non-judgemental health and social services to pregnant and parenting women with current or past issues with substance use. Sheway provides education, referrals and support to help women access prenatal care and reduce risk behaviours – in particular, reducing or ceasing the use of alcohol and other drugs during pregnancy. It also supports the health, nutrition and development of participants' children for up to 18 months after their birth. The programme is absolutely voluntary, and based on the choices women make for themselves.

Sheway's services include:

- Outreach and drop-in services
- Hot lunch, food bags and coupons, formula, clothing, infant items
- Accompaniment to appointments, transportation assistance (taxi vouchers, bus tickets)
- Assistance with securing housing, day care, emergency funds
- 12 transitional housing units
- Pre- and post-natal health care
- Advocacy and counselling
- Needle and syringe exchange (NSP)
- Methadone maintenance therapy (MMT)

Sheway works in partnership with the combined care unit at the Fir Square British Columbia Women's Hospital, which provides flexible, non-judgemental services for pregnant women with a history of drug use. It offers continuous care for mother and child before, during and after birth, including help stabilising and withdrawing from substances if necessary. The multidisciplinary team includes physicians, a senior practice leader, nurses, a social worker, an addictions counsellor, a nutritionist and a life skills/parenting counsellor. Fir Square aims to improve perinatal outcomes, increase the percentage of mothers able to safely retain custody of their babies, increase the number of women seeking drug treatment and their readiness to enter treatment, and increase access to medical services for substance-using women.[21, 22]

related crimes.[31] The dual criminalisation of sex work and drug possession puts sex workers who use drugs at exceptionally high risk of police harassment, extortion and arrest.[26]

In multiple settings, rates of IDU and problematic drug use[d] have been found to be higher among incarcerated women than among their male counterparts.[32, 33] In some settings, HIV prevalence among women prisoners is higher than among men.[34] However, health programmes for male prisoners sometimes do not extend to women's facilities. Because of financial constraints and logistical or bureaucratic obstacles, programmes sometimes prioritise male prisoners, operating only in men's prisons and leaving women without essential care.[5, 7, 8] For example, a 2008 survey of women's access to OST in prisons found that in Georgia, methadone was available in some men's prisons but not in women's prisons.[8] In Kyrgyzstan, though methadone programmes were planned for women's prisons, funding cuts have meant that they are still unavailable, and as a result OST is available only in men's prisons.[5]

Increased advocacy is urgently needed to ensure that all prisoners, regardless of gender, have access to necessary interventions (including NSP, OST, and ART) while incarcerated, including during pre-trial detention, and that no interruptions of ART and OST occur in these settings.[27]

Other needs of incarcerated women who inject drugs include general medical care, mental health care and vocational preparation.[35] Decriminalisation of personal possession of drugs would substantially reduce the number of women who are incarcerated unnecessarily, thus eliminating harms associated with incarceration for women as well as for their children and other family members.

Designing harm reduction services for women who inject drugs

To date, there has been limited research on the efficacy of interventions specific to women who inject drugs. This is partly because gender-sensitive services often mix multiple approaches, are tailored to the individual and are relatively long-term. Services that combine structural, biomedical and behavioural interventions can be more difficult to evaluate through randomised controlled trials (RCTs) measuring HIV incidence, the current 'gold standard' of research on the efficacy of HIV prevention interventions, especially given large data gaps on the epidemiology of drug use and HIV among women. Limited research funding poses another obstacle. Finally, even simpler services, such as NSP, need to achieve considerable coverage before they can have a substantial impact on HIV incidence or prevalence.[36] In some cases, lack

Reaching out to women who inject drugs

St. Petersburg, Russia

Humanitarian Action provides preventive health services to PWID in St. Petersburg. Of 5,000 annual clients, about 2,000 are women, 51% of whom are living with HIV and 30% are supporting their drug use through sex work. (In 2011, there were an estimated 15,000 women who inject drugs in the city.) Russia's extremely punitive drug policies drive drug users underground, incarcerate them en masse, and pose major obstacles to harm reduction services. OST has never been legal in Russia, and NSP faces mounting opposition. Most donors no longer fund NSP in Russia, compromising the crucial first point of contact between drug users and medical services.

In 2008 Humanitarian Action developed a project promoting equal access to prevention, treatment, care and support for women who inject drugs. Mobile street outreach in a special bus provides safer injection and safer sex supplies, including sanitary napkins and women-specific information materials; consultations with doctors, psychologists and social workers; express HIV and pregnancy tests; STI tests; and referrals.

Legal aid helps respond to the frequent loss of parental rights, physical and sexual violence and discrimination in medical settings experienced by clients. Project staff members accompany women to appointments and help them navigate medical and social services. A network of trusted doctors provides women with low-threshold care in a non-judgemental atmosphere. In the past five years, 11,346 women have received services from the project, with in-depth case management for 372 women.

There are no rehabilitation centres in St. Petersburg for women with children, and the city's shelters do not accept women living with HIV or those who actively inject drugs. Because this group of women often faces unstable housing and domestic violence, Humanitarian Action opened a 'Crisis Apartment' where women can live for up to three months. Pregnant women and mothers of small children have priority, since they are most vulnerable and have the most difficulty finding work. Women receive structured assistance with medical, legal, bureaucratic and family problems and in seeking employment and permanent housing.[e]

d The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) defines 'problem' drug use as "injecting drug use or long duration or regular use of opioids, cocaine and/or amphetamines." Definitions of 'problem', 'hard' or 'heavy' drug use can vary, but generally fit this basic description.

e Case study information provided by Anna Ivanova, Programme Coordinator, Humanitarian Action.

of evidence of impact may reflect external limitations, such as a cap on the number of syringes provided daily, rather than a problem with the intervention design.[37]

These limitations have led some experts to push for new methodologies to assess the impact of health promotion programmes, arguing that a lack of data on HIV incidence should not deter programmes that have positive results in practice and could be essential to reducing HIV risk and other harms.[38] Alternative measures of effectiveness could include baseline-to-follow-up reductions in reported risk behaviours and incarceration rates; improvement in health status, family relations, housing, self-efficacy and well-being as reported by clients; and increased uptake of medical and social services. Such indicators are easier to measure, though they cannot be used as proxies for reduced HIV transmission. Community randomised trials that compare a basic intervention to an enhanced intervention pose fewer ethical problems than standard RCTs, and help reduce the biases of observational studies by randomising by group.[37] Some of these methods and indicators were used in evaluating the programmes described below.

To date, HIV risk-reduction interventions among women who inject drugs have been more successful in reducing drug-related risks than unsafe sexual behaviours, likely because of structural factors that shape sexual relationships and limit condom use among vulnerable women.[39-41] This points to a need for interventions that address these broader, structural factors, increasing self-efficacy and autonomy as well as awareness of the importance of safer sex.

The following interventions[f] have documented success among women who inject drugs:[g]

» A woman-focused intervention in an inpatient detoxification programme in St. Petersburg, Russia, found that in comparison with the control group (which received nutritional counselling), women receiving the HIV-focused intervention reported a lower frequency of partner intoxication during their last sexual act and a lower average number of unprotected vaginal sex acts with their main sexual partner who injects drugs. Both groups reported lower levels of injection frequency. The two-session intervention consisted of educational activities, skills-building demonstrations, guided practice and roleplaying, covering topics including drug use and relationships; physical and sexual abuse; rape and violence prevention; ways of discussing and negotiating safer sex; and developing a personalised action plan to help women reduce alcohol and drug use and HIV risk and avoid sexual and physical violence.[42]

» In Baltimore, USA, the JEWEL intervention combined HIV prevention education and skills building with economic enhancement to reduce HIV risk among women who use drugs (injecting and non-injecting) who traded sex for drugs or money. The HIV component aimed to increase women's knowledge about HIV, STIs and drugs, improve their risk reduction knowledge and skills, and enhance self-efficacy and negotiation and communication skills to support safer sex. The economic component taught women how to make and sell jewellery, giving them practical skills while aiming to increase their self-efficacy in relation to licit employment. Self-reports three months after the intervention showed significant reductions in the exchange of drugs or money for sex, the median number of sex trade partners per month, daily drug use and daily crack use, the amount of money spent on drugs daily, and IDU. There was also a small increase in the percentage of women reporting that they never shared needles (from 86.7% to 93.7%). Income from jewellery sales was associated with a reduction in the number of sex trade partners at follow-up. The study suggested that exposing women to the possibility of gaining legal employment could support positive behaviour change, and that sustainability of these positive behaviours would likely require women's access to job training programmes and job opportunities.[43]

» In Miami, USA, a study with female sex workers who traded sex for drugs and used heroin or cocaine regularly compared a standard HIV prevention intervention for drug users with a new sex-worker focused (SWF) intervention. The standard intervention provided pretest counselling on HIV, Hepatitis B and C (HBV/HCV), transmission routes, risky drug use, unsafe sex practices, male and female condom use, disinfection of injection equipment, and the benefits of drug treatment. The SWF intervention was developed through a collaborative process with sex workers, including focus groups and engaging sex workers as outreach workers. It covered many of the topics in the standard intervention but discussed them in language recommended by sex workers themselves, addressing specific misconceptions and needs identified during the focus groups – notably, the need to avoid violence. Both study groups reported significant decreases in the number of days using alcohol and other drugs between baseline and three- and six-month follow-ups. Mean occasions of sex work while drunk or high declined significantly for both groups at six-month follow-up. Group averages for unprotected vaginal and unprotected oral sexual contact decreased significantly at both follow-up time points for both intervention protocols. Both physical and sexual

f A review of the evidence for harm reduction interventions in general is outside the scope of this article. For information on harm reduction interventions in general, see, for example: WHO (2004) *Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users. Evidence for action technical papers*. Geneva: WHO; WHO/UNODC/UNAIDS (2004) *Joint Position Statement: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*. Geneva: WHO; International Harm Reduction Development Program (2007) Delivering HIV Treatment and Care to People Who Use Drugs. New York: Open Society Institute; Hunt N (2003) *A review of the evidence-base for harm reduction approaches to drug use*, http://www.forward -thinking-on-drugs.org/review2-print.html.

g For other examples, see Gay J, Hardee K, Croce-Galis M et al. (2010) What Works for Women and Girls: Evidence for HIV/AIDS Interventions. New York: Open Society Institute. www.whatworksforwomen.org.

victimisation were reduced significantly at three and six months among participants in both intervention protocols. The SWF intervention was significantly more effective in reducing sexual violence at the six-month contact, with participants nearly twice as likely as those in the standard intervention to report a decrease in sexual abuse/victimisation.[44]

» In 2005, Family Health International Bangladesh established drug treatment services especially for women, leading to increasing numbers of women accessing treatment. Because OST was not available, treatment consisted of clonidine-assisted detoxification followed by three months of in- or outpatient care and follow-up. Women received HIV risk-reduction counselling and VCT; screening and treatment of STIs; overdose prevention education; and information on HBV and HCV. Counselling services were based on cognitive behavioural therapy and client-centred approaches. The services were free of charge, targeting homeless women with a history of drug-related harms. They were provided by specially trained female staff members and included childcare, prenatal care and vocational rehabilitation. Treatment for male drug-using partners was offered to reduce barriers to treatment and poor treatment outcomes. A study of the programme found that participation was significantly associated with correct use of condoms, use of condoms during the last sexual act, HIV testing, and correct assessment of risk. A possible association was found between programme participation and reduced borrowing or lending of injecting equipment during the last injection, correct knowledge about where to receive STI treatment, and correct knowledge about where to get VCT for HIV.[45]

» One review analysed studies of alcohol and drug treatment programmes for women that included childcare, prenatal care, women-only programmes, supplemental services and workshops that addressed women-focused topics, mental health programming and comprehensive programming. These components were positively associated with better treatment outcomes, reduced mental health symptoms, improved birth outcomes, employment, improved self-reported health status, and HIV risk reduction. One randomised study of pregnant methadone clinic patients who received prenatal care, therapeutic childcare during visits and relapse prevention support found improved outcomes at delivery and a threefold increase in the number of prenatal visits.[46]

» A qualitative meta-synthesis of studies of US and Canadian integrated drug treatment programmes for pregnant or parenting women and their children found that these programmes, which combined medical and social support, increased women's sense of self and personal agency, engagement with the programme staff and sense of giving and receiving support, openness about feelings, recognition of patterns of destructive behaviours and goal setting. These psychosocial processes were reported to play a role in women's recovery and contribute to favourable outcomes. The motivating presence of children during treatment was also found to support women in their recovery. Perceived outcomes of programmes included improved maternal and child well-being and enhanced parenting capacity.[47]

Women supporting women

Hanoi, Vietnam

In Vietnam, PWID are highly stigmatised. Many are forced into rehabilitation centres that violate international human rights law, and where relapse rates are very high. Women who inject drugs are even more marginalised than men, since drug use runs counter to cultural ideals of motherhood and femininity. Women are also a minority of PWID. They are often neglected by interventions, have less access to harm reduction services and are at greater risk of HIV.

In 2005 the Medical Committee Netherlands-Vietnam (MCNV), in partnership with the Red Cross and others, established a support group for women who inject drugs. Called the 'Cactus Blossoms', the group originally consisted of 10 women with a history of IDU, and aimed to provide mutual support, help give women access to the services they required, and raise public awareness of this issue. Today the group has over 200 members who conduct outreach work with other women who use drugs and sex workers, meet with women in compulsory rehabilitation centres and work with providers to ensure that health services are delivered in a non-discriminatory manner. The Cactus Blossoms provide information within the rehabilitation centres and a mutually supportive environment after release, helping to reduce relapse rates. The group has organised high-profile media events to fight stigma and discrimination within society.

Since the group began, 130 women have received help in finding employment. Women have reported increased self-esteem and confidence. One member said, "After coming back from a rehabilitation centre and going home, I had no rope to cling to. But joining the group provided me with support. Now I feel reborn."[h]

h Case study information provided by Ian Bromage, HIV Programme Manager, MCNV.

Greater involvement of women who use drugs

In recognition of the need for more active involvement of women who use drugs in the international harm reduction and drug policy reform community, two international networks are now in operation.

The International Network of Women Who Use Drugs (INWUD) represents the interests of women who use drugs in the International Network of People Who Use Drugs (INPUD). INWUD actively seeks to collaborate with relevant UN and other international groups and bodies to give greater voice to issues affecting women who use drugs. INWUD helps channel the views and experiences of women who use drugs into advocacy efforts.

The Women and Harm Reduction International Network (WHRIN)[i] is a global platform that seeks to reduce harms for women who use drugs and to develop an enabling environment for the implementation and expansion of harm reduction resources for women. WHRIN provides a forum to discuss the needs of and challenges faced by women who use drugs. It advocates for national, regional and international bodies to adopt and implement policies and programmes that promote and support harm reduction interventions for women and girls. It also aims to provide access to high-quality resources (including educational material) to help women who use drugs and/or the people who work with them to improve access to gender-sensitive harm reduction services.

i To register, visit www.talkingdrugs.org/user/register.

Developing a 'menu' of services for women who inject drugs

The following table draws on examples of existing gender-sensitive harm reduction services to provide a 'menu' of options to improve and expand care for women who inject drugs. Ideally, services should be targeted according to the documented needs of women in a given context. Women who use drugs should always be involved in the design and implementation of these programmes, to ensure that programmes are effective, appropriate, and respectful of the human rights of women who use drugs.[j]

It should be noted that the establishment of gender-sensitive harm reduction services depends on the pre-existence of standard harm reduction services, which remain unavailable in many settings. Basic harm reduction services should be provided on a scale adequate to need and based on internationally endorsed WHO, UNODC and UNAIDS coverage targets necessary for an impact on HIV transmission rates.[36] Gender-sensitive services should then be added as required.

Because the resources available in different settings vary widely, the services are sorted into three groups based on the rough magnitude of cost, time and effort required for implementation.[k] It should be noted that some of the proposed services do not require any additional expenditure – for example, establishing staff gender balance, designating a time when only women visit the drop-in centre, or organising self-help groups specifically for women.

j Recommendations on service provision and advocacy goals are also provided in Pinkham (2007) op cit.; EHRN (2011) op cit.; Global Coalition on Women and AIDS (2011) *Women who use drugs, harm reduction and HIV*. Geneva: GCWA http://www.womenandaids.net/news-and-media-centre/latest-news/women-who-use-drugs--harm-reduction-and-hiv.aspx Accessed 27 June 2012; and International Harm Reduction Development Program (2011) *By Women, For Women*. New York: Open Society Institute.

k These are very rough estimates; real costs would vary widely depending on location.

	SERVICE
Adjustments and small additions to existing services: Added commodities distributed, additional staff training, designation of special activities for women clients	» Addition of women-specific items to basic harm reduction kits (women's hygiene materials and female condoms along with syringes, male condoms, wipes, lubricant)[6, 48, 49] » Additional basic services/material assistance for women at harm reduction sites (pregnancy tests; diapers and other supplies for children; short-term babysitting while women get counselling/participate in support groups; informational materials specific to women; help learning to inject oneself and thereby eliminate dependence on partners) [6, 48, 49] » Staff training on gender issues (counselling techniques for women, needs of women who use drugs etc.)[9, 48, 49] » Gender balance in harm reduction staff, including active involvement of women drug users in service provision and design[48, 49] » Special time for women only ('Ladies' Night')[k] » Women-only support groups, women-specific counselling programmes (including structured HIV prevention counselling interventions)[42] » Relationships with trusted gynaecologists, obstetricians and other specialists for client referrals[49] » Secondary-syringe exchange programme focusing on expanding coverage of women[26] » Training OST providers and OB-GYNs on drug use and drug treatment in pregnancy[9] » (For OST programmes/policymakers): take-home doses, flexible clinic hours[5, 9] » Basic training on drug use for primary care and women's healthcare providers, to enable effective and prompt referrals to harm reduction and related services when needed[50] » Links between services for people who use drugs and for sex workers, including discreet provision of harm reduction for sex workers unable to openly visit a harm reduction site[26, 35]
New services added by existing organisations: Hiring a new staff member, adding new types of services to an existing programme, designating permanent space or significant equipment to women	» Specialist to work with women's children and give counselling on parenting skills[9, 21, 35] » Counselling services to respond to sexual violence, IPV, other trauma, and to address the links between trauma and risky behaviours[9, 35, 48] » Women-only drop-in centre or space in the harm reduction centre devoted specially to women[9, 51] » Appointments with a gynaecologist, other medical specialists at the harm reduction site[6, 51] » Multidisciplinary case management for women and their children, including pregnant women[6, 52] » Mobile harm reduction, OST, basic medical services for women unable to visit service-sites[6, 53] » Legal aid to help women resolve problems with documents, access to social support, legal problems etc.[6, 49] » Free, low-threshold sexual and reproductive healthcare, including PMTCT » Job training, job placement assistance and economic empowerment programmes to increase women's economic independence[35, 43] » Social support for women released from prison, including support related to parenting[35]
New stand-alone services: Creation of an entirely new centre/service site	» Open separate rehabilitation centres for women (if possible, where children can also stay)[9] » Establish comprehensive maternity and post-natal services for pregnant women who use drugs[52] » Provide short-term/transitional housing for homeless women and their children[21, 35]

Building a supportive policy environment

Access to services depends on a supportive policy environment. The following actions are recommended to support effective health and social services for women who inject drugs:

- Whenever feasible, collect gender-disaggregated data on the epidemiology of drug use and HIV; coverage and uptake of essential HIV and harm reduction services such as NSP, OST and ART; health service provision in prisons and incarceration for drug-related crimes; and other relevant subjects.
- Continuously and meaningfully engage women who use drugs in policy and programme design, monitoring and evaluation.
- Establish a system that guarantees free or low-cost, non-judgemental sexual and reproductive health services, including PMTCT, for vulnerable women, including women who use drugs.
- Provide NSP, OST, psychosocial support and ART in women's prisons and pre-trial detention centres, as well as sexual and reproductive healthcare and other forms of gender-sensitive care.
- Eliminate punitive approaches toward pregnant women who use drugs; introduce policies that improve access to voluntary, evidence-based drug treatment on demand and to perinatal care and other supports.
- Establish clinical protocols on OST and other care for pregnant women who use drugs, and provide OST in maternity hospitals.
- Eliminate laws that make drug use, a history of drug use or participation in an OST programme (as opposed to negligence or abuse) grounds for the removal of parental rights, as this is a strong deterrent to mothers in need of care.
- Support links between harm reduction programmes and primary and women's healthcare systems.
- Establish stronger protections for patient confidentiality.

It has become clear that the HIV epidemic demands an approach that addresses multiple health and social factors, on the structural as well as individual level. This lesson should be applied to harm reduction for women who inject drugs. A gender-sensitive approach to harm reduction will benefit not only women but their children, families and communities.

I See Magee C & Huriaux E (2008) Ladies' night: Evaluating a drop-in programme for homeless and marginally housed women in San Francisco's Mission district. International Journal of Drug Policy 19, 113–121.

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EXCLUDING YOUTH?
A global review of harm reduction services for young people

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The authors would like to thank Claudia Stoicescu for organising the data collection and her editorial support, Damon Barrett , Neil Hunt and Dr. Douglas Bruce for their constructive feedback on an earlier version of this chapter, and Larisa Abrickaja for collating the data on age restrictions and producing the data table.

Introduction

UNICEF estimates that there are nearly 2.2 billion children and young people under 18 years of age, accounting for more than a third of the world's population.[1] The UN Convention on the Rights of the Child requires that state parties take 'appropriate measures' to protect this age group from the illicit use of drugs. However, the 'war on drugs' often trumps young people's rights.[2,3] This chapter will provide a global snapshot of the harms experienced via injecting drug use (IDU) among young people aged under 18 and existing harm reduction responses targeted at this population.

Alcohol, cannabis and 'club drug' use remain much more prevalent than IDU among this population. However, this chapter focuses specifically on youth injecting, which continues to represent a significant blind-spot in terms of research and public health responses. The chapter begins by outlining recent trends in IDU among young people. As part of the Global State of Harm Reduction 2012 survey, new international data were collected from civil society and researchers, and this chapter reports our analyses of these data to provide a unique and timely study of legal age restrictions and other barriers to young people accessing harm reduction services. This chapter also highlights case studies of best practice for meeting the needs of this population in different settings, to inform our recommendations for improving policies and services to reduce drug-related harm.

Young people who inject drugs: prevalence and harms

Although overall levels of youth drug use appear to be stabilising or decreasing in many high-income countries[4,5,6] surveys of the general population conceal the drug-related harms experienced by the most vulnerable groups of young people. This includes young people who are not in education and street-involved youth – populations whose drug use is less likely to be transitory and more likely to progress onto more problematic patterns of use, such as IDU.[7] The impact of current economic recessions is likely to further increase the vulnerability of young people,[8] and record levels of child poverty and youth unemployment have already led some commentators to describe a new 'lost generation' of young people devoid of jobs and hope. [9]

Furthermore, drug use is a universal and globalising phenomenon. Young people in Western Europe and North America represent a small fraction of the total global youth population: more than four-fifths of the world's children and young people aged 18 years and younger live in low- and middle-income countries in Eastern Europe, Asia, Africa and South America. Recent reports have drawn attention to a 'historic high' in youth drug use globally,[10] and IDU has spread to new regions. For example, the Pangaea Global AIDS Foundation estimates that there are now over 25,000 people who inject drugs (PWID) in Tanzania, and that over 40% of this population is living with HIV.[11] HIV transmission via unsafe injecting in sub-Saharan Africa is a relatively new phenomenon, and young people are likely to be among the most vulnerable.[12]

While IDU still only represents a small proportion of drug use reported by under-18s overall, in many regions of the world the age of initiation of injecting now appears to be decreasing.[13] Those young PWID who are sharing injecting equipment can transmit blood-borne viruses including HIV and Hepatitis C. These youth are also at greater risk of other preventable diseases such as tuberculosis. Research consistently shows that young injectors are more likely than older ones to report sharing equipment with other injectors and less likely to access needle and syringe exchange services.[14,15] Young people also often have a lack of knowledge and misconceptions about HIV transmission.[16]

According to UNICEF in 2011,[16] globally young people account for 2,500 new HIV infections every day. Failures to meet targets on reducing HIV transmission among young people is in a large part due to unsafe injecting practices and the criminalisation of these behaviours. It is estimated that in countries such as Belarus, China, Italy, Poland, Spain and Russia more than half of HIV infections are due to unsafe injecting,[17] much of this among youth. More generally, young people are also often the first to experiment with new substances, and are often highly connected to dense drug-supply networks, making them highly susceptible to new drug-related harms.

Young people who inject drugs: current responses and data gaps

Despite increasing global coverage of harm reduction services,[18,19] there remains a lack of youth-focused harm reduction services, and a potential gap between the age of initiation of injecting and the age at which services are accessible to young people. Current responses remain dominated by prevention and punishment discourses.

In some regions, strict age restrictions on access to these services have been highlighted as a major barrier, as young people are denied access to evidence-based interventions such as needle and syringe exchange programmes (NSPs) and opioid substitution therapy (OST). Criminal laws increase that risk and other barriers to young people accessing harm reduction services have also been identified, including appointment-based service provision and a lack of youth-work expertise and training among practitioners.[20] Furthermore, youth participation in the design of policies and programmes remains rare.

However, to date, there have been no attempts to map out and synthesise these barriers globally. The Global State 2012 data collection questionnaire offers a novel lens through which to study age restrictions and other barriers to NSP and OST access among the youth population. Data were collected by surveying civil society organisations and key researchers working in the harm reduction field around the world to explore region-by-region developments in harm reduction since the previous Global State report was released in 2010. In the 2012 survey, specific questions were asked for the first time about the barriers to young people accessing services and legal age restrictions in different countries and regions (for more information see the Introduction to this report). Data on young people were available from all the Global State regions except for the Middle East and North Africa, which is, therefore, not included in these analyses.

Harm reduction services for young people: a global snapshot

Overall, of 85 countries reporting at least one NSP or OST site, data on the existence of age restrictions were available for 77 countries. Of those countries that reported data on age restrictions, 18 countries reported an age restriction for accessing NSPs, and 29 for accessing OST. Most commonly the age restriction was 18 years, but in some cases it was much higher (e.g. Georgia, Norway and Sweden). Even in countries with no legal age restrictions, the application of other requirements, such as compulsory parental consent or evidence of previous failed attempts at detoxification or other drug treatment modalities, and 'aiding and abetting' laws limit access to harm reduction services for young people. Table 1 provides more information on the existence of age restrictions by country, and the survey responses have also been synthesised in narrative form and are presented, region-by-region.[a]

a Please see section 2: Regional Overviews for a comprehensive list of countries considered as part of each of the world regions.

Country/territory with at least one reported NSP or OST site	Legal age restriction for accessing NSP (age in brackets)	Legal age restriction for accessing OST services (age in brackets)
ASIA		
Afghanistan	Data n/a	No
Bangladesh	Data n/a	Yes (18)
Cambodia	No	Yes (18)
China	Yes (18)	No
Hong Kong	No NSP	No
India	Yes (18)	Yes (18)
Indonesia	Data n/a	Yes (18)
Macau	No	No
Malaysia	No	No
Maldives	No NSP	No
Mongolia	Data n/a	No OST
Myanmar	No	No
Nepal	No	Yes (18)
Pakistan	Yes (18)	No OST
Philipinnes	Data n/a	No OST
Taiwan	Data n/a	Data n/a
Thailand	No	No
Vietnam	Yes (18)	Yes (18)
LATIN AMERICA		
Argentina	No	No OST
Brasil	No	No OST
Colombia	No NSP	No
Mexico	No	No
Paraguay	No	No OST
Uruguay	No	No OST
CARIBBEAN		
Puerto Rico	No	No
SUB-SAHARAN AFRICA		
Kenya	Data n/a	Data n/a
Mauritius	Yes (18)	Yes (18)
Nigeria	No NSP	Data n/a
Senegal	No NSP	Data n/a
South Africa	Yes (18)	Data n/a
Tanzania	No	No
EURASIA		
Albania	No	No
Armenia	No	Data n/a
Azerbaijan	Data n/a	Yes (18)
Belarus	No	Yes (18)
Bosnia and Herzegovina	No	No
Bulgaria	No	Yes (18)
Croatia	No	No
Czech Republic	Yes (15)	Yes (15)
Estonia	Yes (18)	No
Georgia	No	Yes (21)
Hungary	No	Yes (18)
Kazakhstan	No	Data n/a
Kosovo	No	No
Kyrgyzstan	No	No
Latvia	Data n/a	Data n/a
Lithuania	Yes (18)	Yes (18)
Macedonia	Yes (18)	Yes (16)

Country/territory with at least one reported NSP or OST site	Legal age restriction for accessing NSP (age in brackets)	Legal age restriction for accessing OST services (age in brackets)
Moldova	Data n/a	Yes (18)
Montenegro	Data n/a	Data n/a
Poland	No	No
Romania	Yes (18)	Yes (16)
Russia	No	No OST
Serbia	Yes (15)	Yes (15)
Slovakia	No	Yes (18)
Slovenia	No	Yes (16)
Tajikistan	No	No
Turkmenistan	Data n/a	No OST
Ukraine	Yes (14)	Yes (14)
Uzbekistan	Data n/a	No OST
WESTERN EUROPE		
Austria	Data n/a	Data n/a
Belgium	No	Yes (18)
Cyprus	No	No
Denmark	No	No
Finland	No	No
France	Yes (18)	Yes (15)
Germany	Yes (18)	Yes (18)
Greece	Data n/a	Data n/a
Iceland	No NSP	Data n/a
Ireland	No	No
Italy	No	No
Luxembourg	Data n/a	Data n/a
Malta	Data n/a	Data n/a
Netherlands	No	No
Norway	Data n/a	Yes (25)
Portugal	No	Yes (18)
Spain	Yes (18)	Yes (18)
Sweden	Yes (20)	Yes (20)
Switzerland	No	No
Turkey	No NSP	Data n/a
United Kingdom	No	No
OCEANIA		
Australia	No	No
New Zealand	Yes (16)	No
NORTH AMERICA		
Canada	No	No
United States	No	Yes (18)

Asia

Despite a scale-up in services overall in the last two years, it was reported that harm reduction services in Asia almost always target male, adult PWID. A major barrier to service provision targeted at youth in the region appears to be their relative invisibility as a drug-using population. Few or no data are collected on this population in most countries in the region at present. Young people are, therefore, rarely a focus for intervention, and the vast majority of programmes lack any clear strategy for reaching and engaging under-18s. Even in Bangladesh, which has relatively high levels of NSP coverage in South Asia according to recent reviews,[19,21] there are no data on, or provision for, younger PWID. Furthermore, many young injectors in Asia are using methamphetamine and pharmaceutical drugs (e.g. benzodiazepines), and their needs will not be addressed through OST.[22]

Legal age restrictions are also a barrier in the region. For example, in Nepal and Pakistan harm reduction projects can only work with those aged 18 and above, despite Article 33 of the UN Convention on the Rights of the Child requiring that state parties take 'appropriate measures' to protect under-18s from drug-related harms. This is of particular concern in Pakistan, where the age of initiation into drug injecting is decreasing, according to a recent rapid assessment exercise.[23] Meanwhile, in China and Vietnam, despite an expansion of harm reduction service provision overall, age restrictions prevent under-18s from accessing these new services.

It was reported that legal age limits are a common reason for refusal by services, as they provide an objective way of rationing limited supply in the region. Stigma was also reported to be a major barrier, and many young PWID in the region deny they are dependent on drugs and need harm reduction services. At present, there is a mandate to disclose one's identity, and service-users often have to effectively 'register' with authorities, as is the case in China. This is a clear impediment to accessing OST services and may disproportionately affect younger people. Furthermore, most OST clinics have yet to be integrated into general health services, with the consequence that those accessing treatment can easily be identified and stigmatised.

The 'Opening Doors' project: increasing access to youth-friendly harm reduction in Asia[b]

'Opening Doors' is a response to current legislation across Asia which mostly prohibits access to harm reduction services for young people, as well as the stigmatising and punitive nature of current treatment approaches which exacerbate social exclusion. The project is funded by Aids Fonds, a Dutch NGO, and is a partnership between Access Quality International and the National Drug and Alcohol Research Centre, University of New South Wales, Australia.

Where community options do exist, young people have tended not to engage with these adult-oriented services. Informed by the World Health Organization's model of 'youth-friendly health services',[24] the primary aim of the project is to increase access to harm reduction services for young PWID and those who are at risk of initiating IDU. The target age group is 10–25, with special attention paid to the engagement of difficult-to-reach young people. The project has been implemented in three sites so far: Bangkok, Thailand; Kunming, China; and Kathmandu, Nepal.

In all three sites, participatory focus group research with young PWID has been used to identify local needs, engage them in service design and increase access to locally appropriate harm reduction services. For example, in Kunming, the main drug of concern remains heroin, with significant unmet needs identified following consultation with young people. The project site in Kunming has aimed to increase participation in 'youth-friendly' methadone maintenance therapy (MMT), alongside other activities such as counselling groups, employment assistance, visits and recreation.[25]

An evaluation undertaken by Youth Vision in Nepal in 2010 suggested that there had been a significant increase in the engagement of young people with harm reduction services after adopting the 'Opening Doors' approach. Young people accessing the services also reported improved mental health, less involvement with crime, a reduction in sharing of injection equipment and increased condom use. The projects have helped to establish new partnerships between the health, education, vocational training and employment sectors, building greater capacity for youth-focused harm reduction interventions in the region in the long term.

Latin America

Sporadic and isolated efforts largely characterise the development of harm reduction services in Latin America at present. Similar to Asia, a lack of harm reduction services for young people under 18 was reported in this region. Youth-focused approaches to reducing the harms associated with IDU are rarely an acceptable public health strategy in either South or Central American countries, and national drugs policies do not support this approach. Harm reduction responses which do emerge are normally led by NGOs, and it was reported that even where these do exist stigma, discrimination and criminalisation pose significant barriers to service use, especially for young people.

Despite these barriers, new examples of youth-focused harm reduction projects were reported. For example, in Rio de Janeiro a project was established in 2010 in an area known as 'crack land' where young people gather to use drugs. Work so far has focused on sensitising the health care system to the needs of these young PWID, including the development of a new course to train health workers, and the provision of syringes, pipes, lip balms and condoms. This project was supported by the federal government, the National Health Ministry, the Secretariat of State for Rio de Janeiro, the Federal University of Rio and the UN Office on Drugs and Crime. Also, in Mexico, the state authorities now buy and distribute syringes through centres for youth integration and in some CAPASITS (state provider of HIV, AIDS and STI services) sites.

Sub-Saharan Africa

Even more so than in Asia and Latin America, Africa is a region characterised by a paucity of both data on the number of young PWID and harm reduction services for this group. In East Africa, there are major concerns at present of both increasing IDU in general and also earlier initiation, with reports of young people as young as 11 in Kenya and as young as six in Tanzania injecting drugs.[26] Harm reduction services that target young people in East Africa, particularly in the coastal areas where IDU is concentrated (e.g. Mombasa, Dar es Salaam and Zanzibar) are urgently needed. Such services must also meet the needs of young women who are injecting drugs, who are subject to multiple vulnerabilities.[27] Although there is no official data on the prevalence of IDU and service provision for young people, anecdotal information from some parts of West Africa suggests a rapid rise in IDU among youth and a severe harm reduction service provision gap.[28] As HIV infection through IDU increases in sub-Saharan Africa, young people are a particularly vulnerable population.[12]

b The 'Opening Doors' project has developed a toolkit on enhancing youth-friendly harm reduction, available at: http://ndarc.med.unsw.edu.au/resource/opening-doors-enhancing-youth-friendly-harm-reduction-toolkit.

Eurasia

Many countries in Eastern Europe report high HIV prevalence rates among young people through the sharing of injecting equipment and unsafe sexual practices.[29] Some positive legislative changes which aim to improve harm reduction services for young people were reported in this region. For example, in Serbia a new law allows juveniles aged 15 and over to have exclusive privacy over their medical records and consent rights regarding their health issues, which means no parental consent will be required to access NSP and OST. There are now no legal age restrictions for accessing NSP in Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Hungary, Kosovo, Slovakia or Slovenia. However, since NSPs are often anonymous and client ages unrecorded, it is hard to assess whether PWID under 18 are being reached by these services.[30]

In other countries in the region, age restrictions remain a barrier to accessing harm reduction services. The Czech Republic and Macedonia both have legal age limits for NSPs, allowing only PWID who are at least 15 and 18 years old, respectively, to access sterile injecting equipment. Access to OST is also often subject to strict age regulations. For example, in Bulgaria and Hungary the minimum age for participation in OST is 18, and it is 21 in Georgia. The written consent of a legal representative or a parent of a minor is required prior to starting OST in Bosnia and Herzegovina, Romania and Kosovo, which also poses a significant obstacle.

Additional barriers to service access in the region include stigma, fear of the police, and a lack of funding. NSPs are also rarely, if ever, tailored to young people's needs. There are also a lack of youth-focused OST programmes, and to become eligible in many countries young people have to prove they were not successful in previous detoxification treatment.

Western Europe

The prevalence of injecting heroin and other drugs remains rare among young people in this region – typically only being reported by 1–2% or less of young people in general population surveys – while alcohol and cannabis remain the primary drugs used by young people.[5,6] The incidence of new cases of HIV among PWID is also low in Western Europe, although incidence is still relatively high in some countries (e.g. Portugal), and recent increases have been observed in others such as Sweden.[30] Furthermore, the burden of morbidity associated with IDU is not evenly distributed: certain groups of vulnerable young people are most at risk of transmission of HIV or Hepatitis C and other drug-related harms due to social and structural factors such as poverty and social exclusion.[8]

There is a mixed picture in terms of the application of age restrictions to accessing harm reduction services in Western Europe (see Table 1). For example, legal age restrictions were reported to limit access to evidence-based harm reduction services for vulnerable young people in Belgium, Germany, Norway, Portugal and Sweden. Alternatively, in countries such as the UK, specialist services to safeguard children and young people from harm were reported to have been developed, and 'minors' are not excluded from NSPs (although guidelines make it clear that the service providers should inform their parents and the local child protection agency). Likewise, community-based pharmacological interventions such as OST are now available for young people in the UK and have been developed to recognise the different context of working with young people.[31]

As in other regions, stigma, marginalisation and law enforcement practices were reported as significant barriers to HIV prevention, care and treatment for young people who use illegal drugs. This included a reluctance from young PWID to carry syringes due to social stigma, and who often adopt dangerous drug storage and concealment methods for fear of consequences of police action. Increasing incarceration of young people who inject drugs is also a major public health challenge, as access to harm reduction measures is usually limited or non-existent and HIV/Hepatitis C risk behaviours are more prevalent in prison settings.[32]

Oceania

In Australia, government support for harm reduction service provision and scale-up, and debates on drug policy reform, have become increasingly challenging. In most cases there are no age, gender-based or other criteria that restrict access to NSPs in Australia, although the only operational drug consumption room (DCR) in the country, which provides injecting equipment for use in its service, prohibits access to the service for those under the age of 18. Additional barriers which can prevent young people accessing services in Australia were also reported, including fear of stigma, the limited hours of service operation, limited service availability outside of major cities and discriminatory attitudes of staff towards younger people. While young people under 18 are not precluded from OST, doctors are discouraged from prescribing pharmacotherapies to 'minors' in Australia. Furthermore, if a 'child', that is a person under 18, is accessing injecting equipment or OST, staff are required to report this to the local child protection agency, which may be a further barrier for some young people.

In New Zealand, the minimum legal age for accessing NSPs is 16. Although there is no legal age restriction for OST, for those under 18 parental/caregiver support and consent is preferred. For those under 16, assessment and consent are also needed from an addiction medical specialist and/or a child and youth psychiatrist.

North America

Injecting drug use often starts at a young age in North America.[33] Age restrictions and limited access to NSPs for under-18s represent significant barriers to access to harm reduction services in this region. In the USA, although restrictions vary by state and by type of treatment setting, anyone under 18 must have undergone at least two documented attempts at detoxification or outpatient psychosocial treatment within 12 months in order to be eligible for OST. This inevitably limits the potential for young people to access evidence-based harm reduction programmes.

Cost is also likely to be a barrier to treatment in the USA, as Medicaid insurance can only be used to pay for MMT in some states, and even then it is often time-limited. It was reported that private insurance payment is also usually preferred by PWID to avoid exposure and stigmatisation, but this is unlikely to be an option for young PWID. Additional barriers include lengthy waiting lists for methadone clinics in some USA regions (particularly in regions far from urban centres), regulations around OST programme attendance and regular testing for other drug use, all of which are likely to pose barriers for young people.

No legal age restrictions for accessing NSPs or OST in Canada were reported. Outreach and frontline workers provide sterile equipment to young people who show evidence of use or need, although many youth in Canada still go without services, particularly in rural regions and central/northern Canada.

The TRIP! Project: Youth-Led Harm Reduction in Canada

TRIP! is a youth-led harm reduction project that has been providing peer outreach to the dance music community in Toronto, Canada for over 15 years. TRIP! aims to include young people who use drugs, street-involved and lesbian, gay, bisexual, transgender and queer (LGBTQ) youth in direct service development and delivery, and to encourage safer drug use and safer sex to reduce associated harms including the transmission of HIV, Hepatitis C and other sexually transmitted infections (STIs). TRIP! does outreach work via a variety of venues, including nightclubs, bars, warehouses, bridge parties, house parties, street parades and multi-day festivals. During outreach events, young people can pick up info-cards on dance drugs, routes of administration and safer sex, as well as a variety of harm reduction supplies including condoms, lubricant, straws, needles and syringes.

In addition to outreach, TRIP! engages youth through social networking to circulate messages about safer partying practices. Online surveys are employed to monitor patterns of drug use, injecting, and 'high-risk' behaviours. TRIP! has found that youth tend to be most honest when responding to anonymous online survey questions. As a result, an annual online survey is used to obtain accurate drug use data within this community. Information generated by this type of youth engagement allows TRIP! to monitor and identify emerging health and safety issues, as well as publish alerts about dangerous or new substances and laws affecting the communities.

While young PWID represent a minority of those with whom TRIP! works, injecting is an emerging trend within the Toronto community of young people who use drugs. The 2010 TRIP! survey found that 9% of young people were injecting drugs, with 3% considering doing it in the future. Young people who used crystal meth and ketamine were more likely to inject, with 17% of meth users and 13% of ketamine users reporting injecting. Furthermore, 83% of TRIP! youth reported having tried prescription opioids, often to deal with the come-down and other side effects reported from chronic ketamine use.

It is important to recognise the value of such projects in both increasing young people's 'voice' and also in building the existing network of safer nightlife organisations locally, nationally and internationally to share information and create a peer support network. According to the 2009 Toronto Teen Survey, many youth distrust health workers, instead turning to their friends (53%), siblings, and infolines (55%) for health questions.[34]

Increasing young people's visibility in harm reduction

IDU represents a small minority of youth drug use, but it is an acute problem affecting those most at-risk young people, and it is a much overlooked aspect of the global response to injecting-driven HIV epidemics. Young people are excluded from harm reduction services in every region of the world. Few NSPs or OST programmes target and work with young people. This was a recurring theme in the responses to the Global State of Harm Reduction 2012 questionnaire. Young people face all the same barriers to accessing harm reduction services that adults do – limited coverage, stigma and criminalisation – and these are further compounded by legal age restrictions and other barriers such as a lack of funding for youth-focused services.

At the international-level, the nine core harm reduction interventions recommended by the WHO, UNODC and UNAIDS[35] are not youth-focused, and it appears that key issues regarding young people, IDU and HIV may be falling between the priority areas of different international organisations such as UNAIDS, UNICEF, UNESCO and the WHO. Furthermore, while 'know your epidemic, know your response' has become the rallying cry of UNAIDS,[36] when it comes to young people and injecting we do not yet 'know our epidemic'. Where surveys do monitor prevalence and trends of drug use among young people, they are almost always still based on school samples, and PWID remain largely invisible in the official statistics on youth drug use.[7]

This chapter provides a much-needed global snapshot of legal age restrictions and other barriers to harm reduction services for young people. However, this picture is incomplete, and improved data collection should also be an international priority, as should significantly increased investment in youth-focused harm reduction. This review of harm reduction services for young people suggests the following priority areas:

Avoid legal age restrictions: Removing the barriers caused by legal age restrictions should be a priority, especially where the age of initiation to IDU is decreasing. Removing such restrictions is an important first step towards developing youth-focused services because, although OST provision for young people may raise specific medical concerns and abstinence-based treatments may be more appropriate in some cases, an age restriction on these harm reduction services will likely also mean there is nowhere else to go.

Youth-led, youth-friendly harm reduction: Young people may not identify with more adult-orientated models of treatment and should be involved in designing new services to meet their specific developmental needs. Our case studies highlight how it is possible to use participatory and peer-led methods to engage young PWID to inform more appropriate youth-led and youth-friendly services. International guidelines for OST (for those using opiates) and NSPs for children and young people are also required, as are clear child protection protocols and rapidly applicable legal tests for capacity to consent to treatment and to receive treatment without parental consent.

Improving data collection: Street-based surveys of young people should be more widely implemented to complement existing monitoring systems (e.g. school-based surveys), alongside rapid assessments of youth injecting and its adverse health outcomes. Furthermore, it is important that data on epidemiology and service coverage among PWID be disaggregated by age. To this end, existing recommendations by UNAIDS, WHO and other multilateral agencies to improve country-level data collection via age disaggregation are particularly relevant.[35,37] Removing legal age restrictions may also allow for an improved understanding of patterns of injecting through the collection of age-disaggregated client data.

Investment in young people most at risk: It is imperative that there is sufficient funding and training to support new responses focused specifically on the special needs of young people at highest risk from drug use. UNAIDS has already identified that this is a major problem in Asia, where 90% of the resources for young people are spent on low-risk youth, who represent just 5% of those who go on to become infected with HIV.

Structural interventions – the holistic approach: Social policies and interventions which address the broader 'risk environment' – for example, by addressing poverty, trauma, homelessness and social exclusion – are also needed and may have the greatest impact on reducing drug-related harms at a population level.[38] This is also in line with a children's rights-based approach.[39] Harm reduction in this context is about keeping at-risk youth alive and safe, while also addressing the causes of their vulnerability.

Finally, we would also emphasise that context is key: what works in the United Kingdom and Canada, where child protection services are strong, may not work in Nepal or the Ukraine. Irrespective of context, however, failing to find solutions represents a missed opportunity to protect and improve the health of the next generation of young people across the world. To do so, further questions must be asked about what information is already available, and where further investigation is required about IDU among young people and about the most appropriate responses to reduce drug-related harm among this population.

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DRUG USE AMONG MEN WHO HAVE SEX WITH MEN
Implications for harm reduction

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The author would like to thank Monty Moncrieff of Antidote @ London Friend for his valuable contribution and Dr. George Ayala for reviewing an earlier version of this chapter.

Introduction

Numerous studies have demonstrated that men who have sex with men (MSM) experience disproportionate levels of ill-health[1-3] compared to the general population, and are one of the highest risk groups for HIV in every part of the world.[4, 5] MSM frequently face significant stigma and discrimination from their families, communities and, in some countries, are the subject of systemic repression and persecution.[7] Often this repression and stigmatisation can make accessing appropriate health services, where they exist, problematic.[8, 9]

A significant concern among health professionals and advocates who work to improve the health and well-being of MSM relates to the prevalence of drug use within the population, its uses and its associated harms. The chapter begins with an overview of the range of drugs taken by MSM, followed by a description of prevalence across the world (where such data exist) and a discussion of data quality. It then assesses the reasons for drug use by MSM and the harms that may be associated with such use. The final section highlights interventions to help reduce the harms associated with drug use among MSM.

MSM, gay, homosexual, queer?

Terminology to describe men who are attracted to, or have sex with, other men is often carefully selected. Some men who are attracted to, or have sex with, other men may describe themselves as 'gay', while others do not. Some might use the term 'homosexual' (literally meaning they have a sexual orientation towards people of the same sex) or 'queer' (referring to a sexuality that deviates from the 'norm'). 'Men who have sex with men' (MSM) refers only to the act of sexual contact between two men and is rarely used by men themselves to describe their sexuality. Health professionals often use the term MSM because it relates to behaviour which, when considering issues such as HIV, other sexually transmitted infections (STIs) or drug use, is more important than the identity an individual might assign themselves. When working with this population it is important that you establish the term with which male clients or service users are most comfortable.

The range of drug use among MSM

Studies indicate that MSM utilise a broad range of drugs. This chapter relates only to non-prescription drugs that are considered illegal or otherwise 'recreational' in most countries. The following is a list of drugs known to be used by MSM, and includes street names or regional variations.[a]

- **Amphetamine** (speed, uppers, sulphate, whizz)
- **Cannabis** (marijuana, Mary Jane, dope, pot, spliff, hash(ish), weed, puff, grass, herb, draw, wacky backy, ganja, hemp)
- **Cocaine** (coke, Charlie, C, snow, blow, a toot, Bolivian/Peruvian/Colombian marching powder)
- **Crack cocaine** (rock, base) – essentially a super-strength cocaine
- **Crystal methamphetamine** (Crystal, Tina, meth, ice, crank) – essentially a super-strength amphetamine
- **Ecstasy** (E, MDMA, X, XTC)
- **GHB/GBL** (Gina, G, liquid ecstasy)
- **Heroin** (smack, skag, junk, horse)
- **Ketamine** (K, special K, vitamin K)
- **LSD** (acid, a trip)
- **Mephadrone** (MCAT, Meow-meow)
- **Poppers** (amyl, butyl, isobutyl nitrate, aromas, liquid incense) – the formula frequently changes, but they are chemicals from the alkyl nitrite family.

Prevalence of drug use among MSM

Establishing the prevalence of drug use among MSM in different parts of the world is challenging. In a large number of countries, homosexuality, or sex between men, is illegal, making the collection of data relating to sexuality challenging and complex. Even where research about MSM and drug use has been conducted, it is often difficult, or impossible, to compare because of inconsistent methodologies, such as different recruitment methods, a focus on different drugs or use in different settings or across varying time frames (e.g. within the last month, the last three months, within the past 12 months or drug use ever in life). In addition, the use of drugs may vary wildly not only from one region of the world to another but from one country to the next, between cities in the same country or even among different venues within the same city. As is the case with other populations, drug use among MSM in various areas can change significantly within short spaces of time, meaning that data collected can quickly become redundant.

The literature review that follows is written with the best data publicly available in English.

a For a detailed account of these drugs commonly used by MSM and their effects, see http://www.drugfucked.tht.org.uk/.

Africa

There has been relatively little research in general conducted with MSM in African nations, and only a small number of studies that have specifically explored drug use. Much of the research that has been conducted relates solely to injecting drug use (IDU), with rates among MSM ranging from 3.4 to 12% in Malawi and 8% in Namibia,[10] all within the last six months, and 14% within the last year among MSM in Zanzibar.[11] Drug use among MSM in South Africa has received more attention than in other countries, with one study reporting that 11% of men described having sex while under the influence of drugs within the previous 12 months,[12] and further mixed-method research suggesting significant regional variation in drug use across different cities in the country.[13, 14] For example, crystal methamphetamine was the most commonly used drug among MSM in Cape Town, but dipipanone hydrochloride was more common in Durban.

Asia

The 2010 Asian MSM Internet Sex Survey[15] included 10,861 respondents recruited online from China, Singapore, Malaysia, Taiwan, Hong Kong, Thailand, Japan, Indonesia, the Philippines, Korea and Vietnam. Table 1 displays the levels of reported drug use within the past six months (findings are not publicly available at country level). Data from this survey also indicate that drug use was significantly higher among MSM with diagnosed HIV, particularly with respect to crystal methamphetamine, ketamine and ecstasy. A 2009 study in Thailand identified an association between HIV prevalence and a history of drug use.[16]

Table 1: Levels of drug use among respondents in the Asian MSM Internet Sex Survey

Stimulant drugs	% Use in last 6 months
Crystal meth	4.0
Ecstasy	8.1
Cocaine	1.8
Poppers	6.1
Cannabis	3.6
GHB	2.3
Ketamine	5.3

Several other studies across the continent have explored lifetime usage of drugs, with levels ranging from 6% in Vietnam[17] and 11.7% in Taiwan[18] to nearly 65% in Japan[19] (although much of this variation can be accounted for by differences in sampling and recruitment).

Levels of IDU among MSM in Asia have generally been low.[17, 20, 21] There are currently no data publically available on the prevalence of drug use among MSM living in Central Asian Republics.

Australasia

Frequent gay community surveys in Australia and New Zealand provide a detailed picture of drug use among MSM in these countries, as displayed in table 2.

In Australia, the proportion of men reporting any IDU in the previous six months has remained stable at around 5–6% for the last ten years.[26] While the percentage of men using poppers has fallen slightly over the last nine years, still in 2009 an average of 31.8% of MSM across the country reported use within the previous six months. The Australian surveys typically identify higher rates of all drug use in Sydney compared to other parts of the country.

Table 2: Prevalence of drug use among MSM in Australasia within the previous 6 months

	Cocaine %	Poppers %	Cannabis %	Ecstasy %	Methamphetamine %	Ketamine %	Source
Australia (Sydney)	20.6	40.4	27.9	29.8	11.1	9.6	2011 Gay Community Periodic Survey Sydney[22]
Australia (Melbourne)	12.4	35.4	27.6	21.5	8.9	6.0	2011 Gay Community Periodic Survey Melbourne[23]
Australia (Adelaide)	7.1	21.9	34.6	17.2	9.5	2.1	2011 Gay Community Periodic Survey Adelaide[24]
New Zealand (Auckland)	7.3	40	37.5	21.2	7.9	5.7	2006 Gay Auckland Periodic Sex Survey[25]

Caribbean

Prevalence data for drug use among MSM in the Caribbean is extremely scarce. Secondary analysis of a representative general household survey data collected in Puerto Rico[27] reported lifetime use of cannabis (63.4%), amphetamines (20%) and heroin (20%). A quarter of MSM reported using cannabis (24.4%) and cocaine (24.4%) in the past 12 months. The UNAIDS-sponsored Caribbean Men for Men Internet Sex Survey (CARIMIS) is underway at the time of writing and will report its findings in the summer of 2012. This survey will provide drug use data for each of the Caribbean nations and territories and will be a useful source of information for the development of future interventions.[b]

Europe

Comprehensive data on drug use among MSM was collected as part of the European Man for Man Internet Sex Survey (EMIS). This online survey was open for completion in 25 languages in the summer of 2010 and recruited a total of 181,495 men. It asked questions about use of a range of drugs within the previous 4 weeks (as displayed in table 3). While country-level data will become available in the near future, at present EMIS data are reported on a European sub-regional level.

Research in the UK[29] that explored drug use levels among MSM within the previous 12 months reported levels ranging from 39.4% for poppers, 27.7% for cannabis, 18.5% for ecstasy and 4.7% for methamphetamine (with significant regional variations evident and highest usage in London.)[30] Drug use among MSM in Catalonia, Spain, within the previous 12 months followed a broadly similar pattern (poppers 40.8%; cannabis 26.0%; ecstasy 10.2% and methamphetamine 3.0%.)[31]

Table 3: Use of drugs among MSM across Europe within the previous four weeks

Region of residence	poppers use in last 4 weeks	cannabis (or LSD) use in last 4 weeks	Heroin/crack use in last 4 weeks	party drugs* use in last 4 weeks
West: Belgium, France, Rep. of Ireland, the Netherlands, the UK	28.3	13.8	0.4	10.6
North West: Denmark, Finland, Norway, Sweden	13.8	6.2	0.3	3.1
Central-West: Austria, Switzerland, Germany, Luxembourg	22.0	10.1	0.2	4.9
South West: Greece, Spain, Italy, Portugal	10.9	13.6	0.4	6.6
North East: Estonia, Lithuania, Latvia	6.2	4.9	0.2	2.3
Central-East: Czech Republic, Hungary, Poland, Slovenia, Slovakia	15.2	10.2	0.3	4.9
South East (EU): Bulgaria, Cyprus, Malta, Romania	7.9	5.9	0.3	3.0
South East (non-EU): Bosnia & Herzegovina, Croatia, Macedonia, Serbia, Turkey	7.7	8.6	0.4	2.5
East: Belarus, Moldova, Russia, Ukraine	8.3	5.2	0.3	2.4

** Party drugs include ecstasy, amphetamine, methamphetamines, mephadrone, GHB, ketamine and cocaine. Adapted from EMIS Network.*[28]

b See http://www.carimis.org

North America

There are no publically available national MSM drug use prevalence data for the USA: prevalence is reported only at a city or state level. This approach is appropriate in terms of influencing local harm reduction interventions but makes country-level comparison difficult. Table 4 provides a snapshot of drug use prevalence in different cities, established via multiple surveys.

Similar levels of poppers use among MSM have been observed in Canada.[35]

A significant body of research has addressed methamphetamine use among MSM in the USA. This drug is commonly associated with euphoria, decreased sexual inhibition and hypersexual behaviour.[36, 37] Analysis of data collected annually between 1996 and 2007 in Los Angeles found levels of methamphetamine use within the last 12 months varying from 11% to 53%.[38] A longitudinal study of club drug using gay and bisexual men in New York found that 64.6% of their sample reported using methamphetamine within the previous four months.[39]

Levels of IDU among MSM in both Canada and the USA have typically been very low.[2, 40, 41, 42]

South America

Between 1999 and 2002 a series of 19 sero-epidemiological cross-sectional surveys[43] were conducted among MSM in seven different South American nations: Argentina, Bolivia, Colombia, Ecuador, Paraguay, Peru and Uruguay. These surveys asked about history of drug use (ever) and analysed such usage in light of national HIV prevalence to identify significant associations. The surveys recruited a total of 13,847 MSM participants by opportunistic, community sampling, although the number of participants varied considerably between countries. Reported data from Peru appear incomplete; therefore, Peru is not included in Table 5.

Table 4: Prevalence of drug use among MSM across the USA

City/region (Year of data collection)	Methamphetamine %	Cannabis %	Ecstasy %	Cocaine %	Poppers %	Study type	Time frame of drug use	Reference
New York (2007)	6.2	27.9	8.38	12.03	24.46	Community survey of MSM (n=740)	Within the last 3 months	Carpiano et al. (2011)[32]
Chicago (2002–2003)	6	28	13	12	-	Household survey. Data from HIV-negative MSM (n=151)	Within the last 6 months	Fendrich et al. (2010)[33]
San Francisco (1999–2001)	23*	-	-	19	37	Randomised behavioural intervention of MSM accessing counselling (n=736)	Lifetime use	Colfax et al. (2005)[34]

** Includes speed and any form of methamphetamine*

Table 5: Reported drug use (ever) among MSM from six South American countries

Drug used (ever)	Colombia %	Ecuador %	Bolivia %	Argentina %	Uruguay %	Paraguay %
Cannabis	31.2	17.4	21.4	15.4	14.8	42.4
Heroin	2.4	0.6	0.0	0.4	0.2	4.3
Cocaine	14	4.9	17.2	6.7	21.9	26.4

[Adapted from Bautista et al.][43]

Broad patterns of drug use among all MSM

In reviewing this broad literature from across the globe, several patterns in MSM drug use emerge. Firstly, most drug use among MSM appears to be episodic, with weekly or monthly use far higher than daily.[15, 29, 44] This might suggest that *most* MSM who report drug use are not drug-dependent but instead use drugs for specific purposes (such as when partying, socialising or when seeking or having sex).[45] Episodic drug use may also reflect specific periods of stress or uncertainty, such as an HIV diagnosis, struggles in the process of 'coming out', or may occur in combination with periods of depression or anxiety.

Secondly, MSM, or gay men, are not a homogenous group in terms of drug use. Prevalence of use was very often higher among further marginalised or minority groups, such as ethnic minority gay men in the USA,[46-48] and is often higher among younger men.[42, 49, 50] Use of most drugs (except cannabis) tends to be higher among MSM living in large urban centres, particularly those with large gay populations such as Berlin, Sydney, London and San Francisco than it is among men in more rural areas.[26, 30]

Thirdly, polydrug use (taking more than one drug during the same session or within a fixed time frame) is common among MSM, particularly with regards to stimulants ('party drugs') such as ecstasy, cocaine, amphetamines or ketamine.[34, 51]

Fourthly, across the world, the prevalence of IDU, especially heroin, was generally very low. Other than in South Africa, reported levels of IDU in non-purposive samples rarely exceeded 5%. Previous authors[52] have suggested that the reason insufficient attention has been paid to drug use among MSM is specifically because levels of heroin use – often the focus of drug harm reduction services – have been comparatively low. In the absence of heroin-related health concerns, and those social or community harms such as crime which are often associated with problematic heroin use, the harm reduction needs of gay men have not always featured on the radar of policymakers.

Harms associated with drug use among MSM

Harms to physical and mental health

The physical and mental health harms associated with cocaine, heroin, ecstasy, cannabis, LSD and amphetamines are well documented, and are likely to be similarly represented in MSM.

Crystal methamphetamine is a super-strength amphetamine stimulant, which results in high-energy feelings of confidence, invincibility or impulsiveness. Continuous stimulation of the nervous system by crystal methamphetamine has been known to cause anxiety, depression, confusion, insomnia, psychosis and suicidal ideation,[53] and long-term use may also result in a loss of motor control or memory.[54]

GHB/GBL (Gamma-butyrolactone) is a party drug that brings a sense of euphoria. It is usually sold diluted in water, although just an extra millilitre of GBL over a moderate dose can result in an overdose, the effects of which are often unconsciousness, coma or death by respiratory depression. GBL can be addictive (although this usually only develops over longer periods of time) and, therefore, can result in significant withdrawal effects.

After-effects of inhaling poppers can include headaches, skin rashes, sinus pains and burns, but only if the liquid comes into contact with the skin. They have also been known to cause nausea and vomiting. Inhaling poppers after taking anti-impotence drugs, such as Viagra or Cialis, can result in a dangerous drop in blood pressure.[55] This may be more likely to occur if also taking a protease inhibitor as part of HIV anti-retroviral therapy (ART).

There is evidence to suggest that the use of a range of drugs, particularly methamphetamines, GBL and ecstasy, might have a detrimental impact on adherence to ART.[56, 57]

Harms to sexual health and well-being

The association between drug use (particularly methamphetamine, ecstasy and cocaine) and sexual risk behaviours is complex, and a comprehensive analysis of this literature is beyond the scope of this chapter (for a review, see Corsi et al.[58] or Romanelli et al.[59]). It is possible to say that there is a clear association between certain drug use and sex that carries a risk of HIV transmission. However, it is not clear whether this is causal or simply co-relational.

Significant attention has been paid to the role of methamphetamine in HIV transmission risk behaviours, particularly in the USA. This drug can cause feelings of hypersexualisation and is commonly utilised as part of sexual marathons (protracted periods of sexual activity) and group sex activities.[60-62] Ensuing rectal trauma facilitates the transmission of HIV. Numerous studies have suggested that the use of methamphetamine causes high-risk sexual behaviour,[63-65] perhaps via a myopic mechanism or the removal of sexual inhibitions. However, other studies have challenged this causal pathway.[66, 67]

Other associations with high-risk sexual behaviour have been identified in relation to ecstasy,[68] GHB/GBL[69] and ketamine.[70] Men who reported polydrug use in the recent past (up to three months) are more likely to report HIV risk behaviours than men who took only one drug.[44, 47]

Poppers cause blood vessels to dilate and also relax the anal sphincter muscle. This can make receptive anal intercourse more comfortable for some men. The process of vasodilatation, and the fact that sex may be rougher or last for longer while using poppers, means that their use during sero-discordant anal intercourse can increase the probability of HIV transmission by a factor of three.[71, 72]

Motivations for drug use

There has been relatively little research exploring the reasons or motivations for drug use among MSM or the personal and social context within which drug use occurs, particularly outside North America, Western Europe and Australia. Numerous authors[52, 73] have highlighted that in most settings the majority of venues to meet other men for social and/or sexual interaction are those where alcohol is served and drug use is common. Clubs and bars are the centre of most 'gay scenes', and drug use itself is normalised within this environment. Drugs often serve a very deliberate purpose in helping individuals to relax, to socialise, to mitigate social unease and to gain confidence in seeking sexual partners.[74] The value of these actions and activities should not be underestimated by those seeking to support MSM to reduce any harm that may be associated with their drug use.

Further to this, a significant body of research indicates that (crystal) methamphetamines are often used by MSM to psychologically enhance sexual experience, to maintain sexual activity over long periods of time and to facilitate sexual desires by dissipating sexual inhibitions.[75-77] Drugs may also help MSM with diagnosed HIV, in particular, to 'cognitively escape' from fear of rejection and negative self-perception and to cope with broader emotional and physical demands of living with HIV on a daily basis.[78]

The best indicator of whether drug use is problematic, or is in danger of becoming so, is if the individual concerned considers their use in this way. As already discussed, drug use among MSM in general tends to be episodic in nature, but dependency can still develop and significant harm can result. For many men, drug use becomes problematic when the costs or side-effects associated with usage impinge on their ability to live the life they are comfortable or content with.

Harm reduction interventions to meet the needs of MSM

Drug use interventions for MSM need to empower men with honest information about what the possible effects (both positive and negative) might be of taking a range of drugs. They should seek to support men, and those around them, to control or limit their use, or to limit the harms associated with such use, at times when they consider their drug use is causing harm to themselves or others. This can be accomplished in a number of ways, ranging from provision of educational information to psychotherapeutic support and pharmacological interventions. Whatever the setting, interventions should take into account each man's personal circumstances, acknowledging that drugs can serve a useful purpose in their lives, particularly in terms of mitigating psychological unease or by facilitating social or sexual contact. Health professionals should take account of these motivations and work with men to identify what level or type of drug use they are comfortable with, and help to reduce harms associated with this use.

Numerous civil society organisations in Australia, Canada, Germany, Poland, the UK and USA have developed websites or printed information booklets that explain the effects of drugs commonly used by MSM, and describe ways in which any associated harms might be mitigated. They often also include information about the legal status of each drug, and provide referral information for direct contact services if readers consider their use problematic.

Provision of psycho-therapeutic services or counselling specifically designed to address problematic drug use among MSM varies considerably across the world and within individual countries. They are known to currently exist in Australia, Canada, Germany, New Zealand, Norway, South Africa,[79] Spain, Sweden, the UK and USA. A service in Hong Kong ran between 2007 and 2009. Such therapy includes drop-in advice, motivational interviewing, support groups and cognitive behavioural therapy. Many of these interventions appear grounded in evidence from evaluations of the general population (for review, see Shearer[80]), although there have been a number of evaluations of behaviour change interventions related to methamphetamine use specifically among MSM.[81-83] In many instances, such evaluated programmes focus on reducing harms to sexual health and the likelihood of contracting or transmitting HIV, with mixed success (for review, see Rajasingham et al.[57]). In a very small number of settings, primarily the UK and USA, pharmacologic interventions exist to address methamphetamine use, but their effectiveness is still uncertain.[84, 85]

In Australia, and in many parts of Europe and North America, harm reduction services are situated within the HIV prevention sector, largely because of the association with sexual risk behaviours and because this sector is well established with strong links to the gay communities they serve. There is currently *no* provision of any harm reduction interventions specifically targeting MSM in Africa (except the Republic of South Africa), Asia, the Caribbean or South America. While MSM could access services for the general population (where they exist), previous research has reported that they often feel uncomfortable or unwelcome in such environments.[52] Drug use among MSM is frequently associated with 'gay scene' social activity or with sex, and many services for the general population may not be sufficiently knowledgeable, skilled or, indeed, accepting to help address drug use that occurs within these contexts.

Case study: antidote @ London friend

This organisation works exclusively with lesbian, gay, bisexual and transgender (LGBT) people who use drugs, the majority being gay men in their 20 and 30s, mostly employed and financially self-supporting. In the past three to four years the drug use profile of their clients has shifted towards crystal meth and GHB/GBL, with many people using them in sexual contexts. There has been a trend to inject crystal, and for GBL use to rapidly escalate to dependence levels (dosing around every two hours), so the type of intervention has had to extend to medical (mainly prescribing for GBL detox), having been mainly psychosocial. This typically involves administering benzodiazepines in high doses (often > 100mg/24hrs),[6] which they offer in partnership with the NHS Club Drug Clinic, to help clients deal with withdrawal symptoms. Dependence on GBL is an entirely new phenomenon for members of the community, who have used other drugs, often without major problems, for many years.

Most service users do not fit the typical profile of mainstream UK drug services or the typical drug patterns presenting there. By offering a targeted service they are able to remove many of the barriers of users not identifying with generic support. Being an LGBT service means that people feel less judged and more able to talk about their full range of associated problems, which they may feel inhibited to do in generic services, particularly as it may involve talking about sexual behaviours they feel ashamed of.

They work around reasons for using, dealing with cravings and trigger situations, negotiating safer boundaries and improving well-being overall; these are all typical substance misuse interventions, but it is their provision in a safe and understanding LGBT environment which sets the service apart. [c]

Conclusions

This review has highlighted the extent of drug use among MSM and summarised the range of harms that can be associated with their use**.** Drug use is common among MSM and is well established in gay social and sexual environments. Given the significant harms associated with many of the drugs that MSM use, harm reduction interventions that meet the specific needs of MSM should be prioritised in all parts of the world.

Establishing the prevalence of drug use among MSM living in Central Asian Republics, South America, the Caribbean and Africa is a research priority. Systematic population and local-level estimations for MSM populations are a necessary precursor to this. There is a need for more qualitative research in many parts of the world that explores the reasons why MSM use drugs and the personal and social context of this use.

Harm reduction practitioners should seek to understand variations in drug use among MSM in their local area and tailor interventions accordingly. They should attend to changes in such use over time, and be accepting of the social and sexual environments in which drug use often occurs. Harm reduction practitioners should also attend to ethnic or sexuality variation within MSM communities, acknowledging that further marginalised sections of the population are more likely to use drugs and for such use to be problematic. As the evidence base for prevalence, motivations, context and harms associated with drug use among MSM evolves, so it would be beneficial to develop toolkits for effective interventions for rollout in various settings.

As long as homosexuality – or acts of sex between men – is criminalised, and as long as MSM face stigma and persecution, it will remain a significant challenge to develop and deliver effective interventions to meet the complex needs that this review identifies. Legal and policy reforms relating to MSM are required in a large number of countries if prevention of HIV transmission and a reduction in other harms associated with drug use is to be realised.

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c See http://www.londonfriend.org.uk

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DRUG DECRIMINALISATION POLICIES IN PRACTICE: A Global Summary

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The authors would like to thank Damon Barrett and Joanne Csete for providing insightful feedback on an earlier version of this chapter. Thank you also to Ari Rosmarin who co-authored Release's report *A Quiet Revolution: Drug Decriminalisation Policies in Practice Across the Globe*,[1] which provided much of the information for the country summaries in this chapter.

Introduction

Decriminalisation of drug possession or use can be defined as 'the removal of sanctions under criminal law, with optional use of administrative sanctions, such as the application of civil fines or court-ordered therapeutic responses.'[2] Decriminalisation is often mistakenly understood to mean complete removal or abolition of possession offences, or confused with 'legalisation' (legal regulation of drug production and availability).[3] Under decriminalisation regimes, possession and use of small amounts of drugs are still unlawful but not *criminal* offences.

The first half of this chapter examines the harms associated with criminalising people who use drugs (PWUD) and outlines key considerations for the implementation of decriminalisation of drug possession. The second portion considers models of decriminalisation of drug possession adopted by different countries around the world. It also provides recommendations that should be taken into account when implementing decriminalisation of drug possession and highlights the growing support for adopting such a model.

International drug treaties and decriminalisation of drug possession

The modern international drug control framework was established under the 1961 UN Single Convention on Drugs,[4] but the criminalisation of personal possession was first explicitly introduced by the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychoactive Substances.[5] Article 3(2) of the 1988 convention states:
'...each Party shall adopt such measures as may be necessary to establish as a criminal offence under its domestic law, when committed intentionally, the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption.'
The commentary on the 1988 convention says explicitly that this paragraph 'amounts in fact also to a penalisation of personal consumption.' Over 180 States are parties to the three UN drug conventions (1961, 1971 and 1988), and the punitive paradigm they establish has subsequently been translated into domestic policy and law across the world.
However, the 1988 convention does not specify the nature of the sanction and additionally provides a caveat to the presumption that States must criminalise drug possession. Article 3(2) begins with the statement that any measures adopted shall be 'subject to its constitutional principles and the basic concepts of its legal systems.' State parties can, therefore, adopt a less punitive criminal justice approach to drug possession and use without breaching their international obligations.[6, a]

a For further discussion, see Bewley-Taylor D & Jelsma M (2012) The UN drug control conventions: The Limits of Latitude, *Series on Legislative Reform of Drug Policies No. 18*. Amsterdam: Transnational Institute.

Criminalisation as a risk factor in drug-related harm

The criminalisation of PWUD (directly criminalising use, or indirectly through criminalising possession) has been a central pillar of illicit drug control for over a century.

This punitive approach has come under increasing scrutiny as it has been identified as a key structural risk factor for a range of drug-related harms for people who inject drugs (PWID).[7] More commonly higher rates of HIV infection among PWID[8] are seen in environments in which injecting drug use (IDU) and other associated practices such as the provision of sterile needles are criminalised.[8] The following approaches contribute to exacerbating drug-related harms in a number of ways:

- encouraging needle sharing and hurried and higher-risk injecting – all of which increase the risk of contracting HIV, viral hepatitis and other blood-borne viruses[8]
- pushing use into unhygienic marginal environments and thus increasing the risk of infection and overdose death
- increasing the prison population of people who use and inject drugs – a high-risk environment usually with poor provision of harm reduction and HIV prevention services.[9]

Criminalisation is intended to stigmatise drug use and generate social disapproval. This has resulted in discrimination against PWUD[10] and can further increase risks by:

- undermining drug education, prevention and harm reduction efforts by alienating and marginalising key populations at higher risk of acquiring HIV, including PWID
- deterring individuals from approaching services for help or volunteering information about drug use in emergency situations such as overdose[11]
- creating informal barriers that effectively deny antiretroviral or hepatitis C treatment to people who use drugs[12, 13, 14]
- negatively impacting on wider life opportunities, including access to housing, personal finance and employment, that are all positively linked to improved health and well-being[15, b]
- justifying the continuation of counterproductive enforcement approaches, with opportunity costs for public health elements of designated drug policy budgets.

Conversely, claims for a positive deterrent effect from user-level punitive enforcement are not well supported by the limited empirical research and comparative analysis available.[16, 17] Many of the groups most vulnerable to drug-related harms

b McLaren & Mattick (2007) compared the outcomes of individuals given a non-criminal sanction in South Australia and individuals given a criminal sentence in Western Australia (pre-decriminalisation) and found that the individuals given criminal penalties were more likely to suffer negative employment, relationship and accommodation consequences as a result of their cannabis charge and were more likely to come into further contact with the criminal justice system than the (non-criminalised) individuals in South Australia.

(including young people, PWID, those from lower socio-economic backgrounds, those with existing criminal records, and those with mental health vulnerabilities) are also likely to be among the least deterred by criminalisation.[18]

Definitions of 'decriminalisation'

'Decriminalisation' is not a strictly defined legal term, but its common usage in drug policy (and the definition used here) refers to the removal of criminal sanctions for possession of small quantities of currently illegal drugs for personal use, with optional use of civil or administrative sanctions.[2] Under this definition of 'decriminalisation', possession of drugs remains unlawful and a punishable offence (albeit not one that results in a criminal record).

A distinction is also made between *de jure* decriminalisation, involving specific reforms to the legal framework, and *de facto* decriminalisation, with a similar outcome but achieved through non-enforcement of criminal laws that technically remain in force. With the exception of some of the more tolerant policies for cannabis possession (for example, in Spain, the Netherlands and Belgium), people caught in possession under a decriminalisation model will usually have the drugs confiscated.

Policy variables

There is considerable variation in how decriminalisation models function in different jurisdictions, making international comparisons and generalisations about impacts on key indicators problematic. Each of these variables can have a significant impact on the measurable outcomes. These include:[1]

Threshold quantities

Many but not all decriminalisation policies use maximum-quantity thresholds to distinguish between trafficking or supply offences and personal possession or use offences.[19] Mexico, for example, allows possession of up to 0.5g of cocaine without prosecution, while Spain allows up to 7.5g, a fifteen-fold difference.[20] Since cocaine is usually sold in 1g units, Mexico's permissible possession level of 0.5g means it is likely that virtually everyone will exceed that threshold and be liable for criminal prosecution.

Types of administrative penalties

Non-criminal sanctions in different jurisdictions include: fines, community service orders, warnings, mandatory treatment or education sessions, driver's or professional licence suspensions, travel bans, property confiscation, associational bans, mandatory reporting, mandatory drug testing, termination of public benefits, administrative arrest, or no penalty at all.

Roles of the judiciary and police

Some jurisdictions, such as the Czech Republic and the Australian states with civil penalty schemes, allow the police to issue fines in the field for minor drug offences, similar to issuing a traffic violation. Other jurisdictions, such as Brazil and Uruguay, require individuals arrested for drug offences to appear before a judge in court to determine the charge and receive an appropriate sentence, if any.

Policy implementation

Role of medical professionals and harm reduction programmes

The effectiveness of decriminalisation of drug possession is also dependent on a number of other key considerations including investment in a wide range of harm reduction and treatment options. The relationship between a country's public health and law enforcement systems can significantly change an individual's experience following an arrest for a drug offence. For example, the significant investment in Portugal's harm reduction interventions and treatment in 2001 (see Page 5), coupled with the new decriminalisation model, saw an increase in the numbers accessing services. Many commentators have highlighted that the reduced stigma associated with drug use, due largely in part to the decision not to impose criminal sanctions, contributed to this increase.[21] As the current report shows, jurisdictions also vary greatly in the resources allocated to and availability of harm reduction and treatment programmes.

Data availability and quality

Data availability and quality are important to assess the impact for a country that has adopted decriminalisation. Incomplete, inaccurate or inconsistent data on key indicators assessing the impact of decriminalisation pose important challenges to evaluation. For example, long reporting periods between national surveys on prevalence or the manner in which drug-related deaths are recorded can make it difficult to ascertain the actual impact of the policy.

Implementation challenges

Despite the existence of a statutory, judicial or regulatory decriminalisation policy, a jurisdiction's inability or unwillingness to implement that policy in practice can make it difficult to assess a policy's merits. In Peru, for example, researchers report that police regularly arrest and detain individuals for long periods without charge for decriminalised drug offences. In practice, for those in detention, such a system does not resemble decriminalisation, despite Peruvian law instructing no penalty for certain minor possession offences. Furthermore, in some jurisdictions the impact of decriminalisation has had a 'net-widening' effect, so that while the intention of the policy is to decriminalise certain behaviour, in practice more people get caught up in the system.[22]

Social, cultural, economic and religious characteristics

A community's – or individual's – relationship to drug use is impacted by much more than a country's drug laws. Public health capacity, religiosity, cultural history, employment, inequality[23] and various other measures of social and personal well-being significantly impact drug-using behaviours in a given society. It is important to recognise that impacts and implementation of drug decriminalisation policies cannot be evaluated in a vacuum.

Growing support for decriminalisation

High-level support for decriminalisation has grown in recent years in parallel with the growing trend towards its adoption by states and jurisdictions. Alongside the development of the wider mainstream drug policy reform movement (focused primarily on recreational cannabis use), support for decriminalisation of drug possession and use in the context of HIV and other blood-borne viruses among PWID has also grown significantly among key voices in the public health community. This includes journals such as the *British Medical Journal*[24] and *Lancet*,[25] non-governmental organisations (NGOs) including the Red Cross/Red Crescent[26] and International AIDS Society (IAS),[27] and high-profile individuals including Anand Grover (UN Special Rapporteur on the Right To Health),[28] Michel Sidibé (UNAIDS Executive Director),[29] Ban Ki-Moon[30] (UN Secretary-General) and Michel Kazatchkine[31] (former Executive Director, the Global Fund to Fight HIV, Tuberculosis and Malaria). Among the UN family of agencies, UNAIDS[32] and UNDP have shown cautiously worded support in principle (but remaining reluctant to overtly use the language of 'decriminalisation'). The executive summary of the 2012 UNDP Global Commission on HIV and the Law report, for example, highlights the need to:

> Reform approaches towards drug use. Rather than punishing people who use drugs but do no harm to others, governments must offer them access to effective HIV and health services, including harm reduction programmes and voluntary, evidence-based treatment for drug dependence. [33]

Even the historically conservative UN Office on Drugs and Crime (UNODC) has increasingly adopted the narrative that 'drug use is a health problem, not a crime,'[34] and in a 2012 discussion position paper the UNODC make clear that:

> Responses to drug law offences must be proportionate. Serious offences, such as trafficking in illicit drugs must be dealt with more severely and extensively than offences such as possession of drugs for personal use. For offences involving the possession, purchase or cultivation of illicit drugs for personal use, community-based treatment, education, aftercare, rehabilitation and social integration represent a more effective and proportionate alternative to conviction and punishment, including detention.[35]

One of the highest-profile public expressions of support, in terms of signatories and media coverage, has been the Vienna Declaration,[36] which states 'The criminalisation of illicit drug users is fuelling the HIV epidemic and has resulted in overwhelmingly negative health and social consequences. A full policy reorientation is needed' and includes a call on 'governments and international organisations, including the United Nations,' to 'decriminalise drug users.'

In June 2012 the Global Commission on Drug Policy launched its second report, *The War on Drugs and HIV/AIDS: How the Criminalization of Drug Use Fuels the Pandemic*.[37] It highlighted that fear of criminalisation led to increased HIV risk behaviour in certain countries and that mass incarceration fuelled HIV transmission rates within prisons. The Commission, which is made up of several former presidents and other high-profile individuals, has repeatedly called for the decriminalisation of drug possession.

Decriminalisation systems around the world[c]

It is estimated that around 25–30 countries have now implemented some form of decriminalisation. Decriminalisation approaches are found mostly in Europe, Latin America and, to a lesser extent, Eurasia, as well as some parts of the USA (cannabis only) and Australia. The precise number of countries implementing such an approach depends on which definition is used, with additional problems in quantifying more localised or informal *de facto* decriminalisation policies, as well as challenges of incomplete country data. Some Southeast Asian states, such as Vietnam, nominally espouse decriminalisation of use but are not included here because, instead of criminal sanctions, they often forcibly detain drug users in 'drug detention centres' largely indistinguishable from prisons and associated with serious human rights violations.[38, 39]

The following survey is adapted from the Release report, *A Quiet Revolution: Drug Decriminalisation Policies in Practice Across the Globe*.[1]

c This information is largely taken from the report by Release: Rosmarin A & Eastwood N (2012) *A Quiet Revolution: Drug Decriminalisation Policies in Practice Across the Globe*. London: Release.

Western Europe

- Belgium decriminalised small-scale cannabis possession in 2003.[40]
- German federal law has contained decriminalisation elements since the early 1990s.[41] There is variation between different *Länder* (German states) in application.[42, d]
- Italy first decriminalised drug possession in 1975. Since then, laws and policies around drug possession have fluctuated between harsh and lenient penalties.[43]
- Spain formally decriminalised possession and private use of small amounts of drugs in 1982, following a 1974 Supreme Court ruling.[44, 45]
- The Netherlands has had a *de facto* decriminalisation policy since 1976. While remaining technically criminal, possession offences of up to 5g of cannabis (30g prior to 1996)[46] or 'one dose' of 'hard' (non-cannabis) drugs for personal use are not prosecuted.[47]

Case Study: The Portuguese decriminalisation experience

Portugal provides a useful case study, with over a decade of detailed evaluation to draw on and a policy developed and implemented in response to a perceived national drug problem with public health priorities at the fore from the outset. Notably, Portugal coupled its decriminalisation with a public health reorientation that directed additional resources towards treatment and harm reduction.[48] Those caught in possession are referred to a 'dissuasion board' that decides whether to take no further action (the most common outcome), direct the individual to treatment services if a need is identified, or impose an administrative fine.

The useful volume of data collected during and since the reform offers considerable scope for filtering through different political and ideological lenses;[49] contrast the evaluation of Portugal's prohibitionist 'anti-drug' organisations who see it as an unmitigated disaster[50] with that of the high-profile but overwhelmingly positive Greenwald report[51] from the libertarian-leaning Cato Institute. A more rigorous and objective academic study of the Portuguese experience from 2008[2] summarises the changes observed since decriminalisation as:

- small increases in reported illicit drug use among adults
- reduced illicit drug use among problematic drug users and adolescents, at least since 2003
- reduced burden of drug offenders on the criminal justice system
- increased uptake of drug treatment
- reduction in opiate-related deaths and infectious diseases
- increases in the amounts of drugs seized by the authorities
- reductions in the retail prices of drugs.

In conclusion the authors note:

> [Portugal's experience] disconfirms the hypothesis that decriminalisation necessarily leads to increases in the most harmful forms of drug use. While small increases in drug use were reported by Portuguese adults, the regional context of this trend suggests that they were not produced solely by the 2001 decriminalisation. We would argue that they are less important than the major reductions seen in opiate-related deaths and infections, as well as reductions in young people's drug use. The Portuguese evidence suggests that combining the removal of criminal penalties with the use of alternative therapeutic responses to dependent drug users offers several advantages. It can reduce the burden of drug law enforcement on the criminal justice system, while also reducing problematic drug use.

Supporting these conclusions has been a more recent Drug Policy Profile of Portugal[48] from the European Monitoring Centre on Drugs and Drug Addiction, which observed that:

> While some want to see the Portuguese model as a first step towards the legalisation of drug use and others consider it as the new flagship of harm reduction, the model might in fact be best described as being a public health policy founded on values such as humanism, pragmatism and participation.

d For the different thresholds, see: http://www.drug-infopool.de/gesetz/nordrhein-westfalen.html.

Latin America

» Argentina's Supreme Court declared criminalisation of drug possession for personal consumption unconstitutional in 2009.[52, 53] A process of formally incorporating this decision into law is underway.[54]
» Chile decriminalised possession in 2007;[55] sentencing judges can administer fines, mandatory treatment, community service requirements and/or suspension of driver's licence.[56] Although the majority of cases end in the suspension of sentences or administrative sanctions, many people caught with small quantities do go to prison. Chile is assessing possible further changes to its laws, including full decriminalisation.[56]
» Colombia decriminalised possession following a Constitutional Court ruling in 1994.[57] This decision has been subject to more recent ongoing legal and constitutional argument between the government and Supreme Court.[58, 59, e] While these tensions leave the situation in flux, *de facto* decriminalisation continues, with a formal new government decriminalisation proposal reported.[60]
» Mexico decriminalised possession of small amounts of drugs in 2009, replacing criminal sanctions with treatment recommendations, and mandatory treatment for repeat offenders.[61] The quantity thresholds have, however, been criticised as being too low and ambiguous, leaving implementation vulnerable to police corruption.[62]
» Paraguay decriminalised small-scale possession in 1988.[56]
» Peru decriminalised drug possession in 2003,[63] but research reveals a disconnect between policy and the reality of police practices in the country.[64]
» Uruguay has never criminalised possession of drugs for personal use.[56] The principle formally entered Uruguayan law in 1974. Concerns have been raised about high levels of pre-trial detention without charge for more serious drug offences.[65]
» Decriminalisation laws are also pending in Brazil and Ecuador.[f]

Eurasia

» In Armenia possession of small quantities of drugs has been decriminalised since 2008[66] and is subject to administrative fines. However, the high level of fines (100 to 200 times the minimum wage for first-time offenders) can still result in incarceration of those unable to pay.
» In Estonia possession of small quantities of drugs for personal use has been decriminalised since 2002,[47, 67] subject to court-ordered administrative fines or 30 days administrative detention (in a local police jail).
» In Kyrgyzstan small-scale possession offences have been decriminalised and subject only to administrative responses since 1998.[68]
» In Poland since May 2011 prosecutors have had discretion not to prosecute small-scale possession offences[69] or if the individual is judged to be drug-dependent.
» The Czech Republic formally decriminalised possession of all drugs for individual use in 2010.[70]
» Russia nominally decriminalised possession in 2005. Article 228 of Russia's criminal code provides that possession of less than a 'large amount' of illegal drugs face only administrative sanctions. However, since then the threshold amount that determines a 'large' quantity of drugs has oscillated from very low thresholds to slightly higher thresholds and back again, making decriminalisation in Russia an inconsistent and effectively unrealised policy.[71]

Other countries

» Between 1987 and 2004 four Australian states decriminalised possession and use of cannabis. Two of these, Northern Territory[72] and South Australia,[73] have additional treatment diversion schemes for those found in possession of other drugs for personal use (completion of the designated programme avoids a prosecution).
» Since 1973, 14 US states and a number of other local jurisdictions have decriminalised cannabis possession.

Recommendations for implementation of decriminalisation of drug possession

When adopting a decriminalisation policy, a number of factors have to be considered to ensure the framework is meaningful in its goal of not criminalising those caught in possession of drugs for their own personal use. The following section details points for consideration in terms of the actual policy/legislation and implementation of the policy:

» **Thresholds** – where threshold amounts are adopted to determine whether someone is in possession for personal use the level needs to reflect market realities and be flexible enough to ensure that the principle of decriminalisation of personal possession is properly achieved.

e The dose is not the only factor the Court can look at when considering if drugs are for personal use.
f For updates, see: http://www.druglawreform.info/en/country-information/item/261-regional-overview-of-drug-law-reform-in-latin-america.

» **Response –** the State can either decide to take no action against someone caught in possession of drugs (for example, the Netherlands or Belgium) or can respond using civil sanctions.

If a system of fines is to be adopted, they must be set at a reasonable level and not result in the imprisonment of large numbers of people for non-payment. Other forms of civil penalties, such as seizure of passport or driving licence, should be avoided, as these can have a disproportionately negative impact on a person's life. In terms of those who are dependent on drugs, Portugal's approach, in which the police work with treatment agencies to offer an individualised referral route (with a range of treatment options available, including harm reduction), appears to be a pragmatic option. Also, failure to meet the conditions of treatment should be addressed by involving the person in their treatment programme and should certainly not result in criminal sanctions. In particular, 'drug-free' conditionality is also potentially setting up a person to fail, given the relapsing nature of drug dependence.

» **Disproportionate sentencing for cases involving possession above the threshold or supply offences –** it is critical that governments recognise the principle of proportionality in sentencing for drug offences. Too often those convicted of non-violent drug supply offences receive custodial periods which are much harsher than other violent offences, such as rape and even murder.

» **Public health interventions and treatment –** countries that wish to reduce the potential harms of problematic drug use and limit long-term health costs by introducing programmes that tackle HIV transmission and other blood-borne viruses should consider coupling the decriminalisation model with such a public health investment.

» **Net-widening –** policymakers must work to ensure that decriminalisation does not result in more people coming into contact with the criminal justice system. Whether this comes as a result of expanded police powers or low thresholds, decriminalisation policies must be targeted at reducing the number of individuals who suffer from the consequences of a criminal conviction, not merely the enactment of decriminalisation in name only.

Discussion

Given the wide variation in models around the world, there are relatively few general conclusions that can be made about the impacts of decriminalisation beyond the observation that it does not lead to the explosion in use that many fear. Critics of decriminalisation will often cite drug tourism as a risk associated with the introduction of such a policy. However, there is no evidence to suggest that this occurs. More often than not, countries or states that have adopted this approach will see similar rates of prevalence as their neighbours.[22, 74-77, g]

Research from Europe,[78] Australia,[72] the USA[22] and globally[17] suggests changes in intensity of punitive user-level enforcement appear to have only a marginal influence on determining prevalence of use, although, as noted earlier, there are significant impacts on risk behaviours.

Increasingly, more countries are joining the drug policy reform debate. Latin and Central American countries such as Colombia[79] and Guatemala[80] are some of the leading proponents calling for a reform of drug laws. Australia[81] has set up a new enquiry to consider the implementation of decriminalisation of possession of all drugs. It is not surprising that this growing momentum for change is occurring; the harms caused by criminalising those who use drugs are well documented, but added to this is a global economic crisis which is seeing cuts in police budgets all over the world. In California the decriminalisation of cannabis saw the total cost of enforcement decline from $17 million in the first half of 1975 to $4.4 million in the first half of 1976.[22]

Some research has shown that beyond ending the criminalisation of PWUD there can be other positive benefits. In Portugal, the increased numbers in treatment have been linked to the reduced stigmatisation created by a non-criminal approach to drug use.[82] Research from Australia compared individuals who had been criminalised for cannabis possession against those who had received a non-criminal response. It found that individuals given criminal penalties were more likely to suffer negative employment, relationship and accommodation consequences as a result of their cannabis charge and were more likely to come into further contact with the criminal justice system.[15]

Decriminalisation is clearly no 'silver bullet'; it can only aspire to reduce harms created, and costs incurred, by criminalisation in the first place and does not reduce harms associated with the criminal trade on which it has little direct impact. If inadequately devised or implemented, decriminalisation will have little impact, even potentially creating new problems such as net-widening.[1, 83] A more critical factor appears to be the degree to which decriminalisation is part of a wider policy reorientation and resource reallocation away from harmful punitive enforcement and towards public-health-oriented and human-rights-based approaches targeted at PWUD, particularly young people and PWID. Decriminalisation can be seen as a part of a broader harm reduction approach, as well as a key to creating an enabling environment for other public health interventions.

g These studies showed that there were no statistically significant differences in prevalence of cannabis use in states throughout Australia, even though three states had decriminalised cannabis possession and cultivation.

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HARM REDUCTION AT THE CROSSROADS:
Case examples on scale and sustainability

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The authors would like to thank Gerry Stimson and Annette Verster for reviewing an earlier version of this chapter, and Catherine Cook for her editorial guidance and insights.

Introduction

In the 25 years since the development of the first harm reduction programmes, a harm reduction approach has been adopted in policy or practice to varying degrees in 94 countries worldwide.[a] The majority of these countries, however, do not have comprehensive harm reduction programmes[1] operating at the scale necessary to impact on HIV,[2] or even more challenging, hepatitis C epidemics. Those countries that are containing or reducing HIV epidemics among drug-injecting populations are largely high-income and overwhelmingly European. There are notable successes in implementation in a variety of political, religious and economic contexts, but the vast majority of low and middle-income countries around the world lack adequate harm reduction responses.[2]

Threats to sustained harm reduction responses are multiple and vary within and across countries, but the financial and political contexts are often the underlying factors that determine the life or death of a programme. Although harm reduction interventions are evidence-based,[3] cost-effective[b] and a fundamental element of the international HIV response,[4] government investment in low and middle-income countries remains limited.[5] Of the $160 million estimated to be invested in HIV-related harm reduction in low and middle-income countries in 2007, approximately 90 per cent came from a small number of international donors[5] (see the Global Overview section of this report for a more in-depth analysis of global financing for harm reduction). Bilateral and multilateral funding for harm reduction has been crucial to introducing and sustaining the response to some of the most severe HIV epidemics among people who inject drugs (PWID) around the world. However, reliance on international funds is becoming increasingly insecure as the global economic crisis impacts upon development and HIV funding. Middle-income countries with large numbers of PWID and governments hostile to harm reduction have been left particularly vulnerable. With recent developments at the Global Fund, and depleting funds available from several other major donors, the sustainability of harm reduction is under threat like never before.

Political support for harm reduction remains key to ensuring that investments are strategic and proportionate to need, particularly in the current financial environment. Many countries continue to emphasise drug control over public health, resulting in policy and legal contexts which hinder public health responses, increase potential for infections and lead to overburdened prison systems. While this approach is being questioned and openly debated by governments more than ever before, poor political backing for harm reduction remains one of the most crucial barriers to an effective response to epidemics among PWID. In addition to the countries where political support has long been lacking, the phenomenon of regression or backsliding in support for harm reduction in policy and practice is beginning to emerge in several countries where programmes have been long established and enjoyed long-standing government support. Given this backdrop, it is important to investigate the ways in which harm reduction programmes can be scaled up, or continue to operate to scale while adapting to changing policy and funding environments.

This chapter presents a series of case studies to examine the different strategies and responses that have emerged to secure the survival of harm reduction policies and practices. It will explore, through these case studies, strategies for ensuring sustainability in harm reduction programmes. Two of the case studies focus on protecting harm reduction during periods of wider political change, while a further two examine ways of overcoming stalled implementation or 'death by pilot'. Overall they look to encapsulate the interplay between harm reduction, local and national policies and politics. The final section of the chapter summarises these developments and attempts to identify successful and innovative strategies for overcoming the barriers to the survival and scale-up of harm reduction programmes.

a As reported in Section 1 of this report, 94 countries and territories worldwide now employ a harm reduction approach (compared to 93 and 82 countries in 2010 and 2008, respectively). This support is explicit either in national policy documents and/or through the implementation or tolerance of harm reduction interventions such as needle and syringe exchange programmes (NSPs) or opioid substitution therapy (OST).

b For example: National Centre in HIV Epidemiology and Clinical Research (2010) *Return on Investment 2: Evaluating the cost effectiveness of needle and syringe programs in Australia 2009.* Sydney: University of New South Wales.

THAILAND

HIV was first reported among PWID in Thailand in the late 1980s, and the epidemic increased dramatically within this population in a few years. Despite successes in other areas of HIV prevention, the Thai response to HIV and drugs has failed to have an impact on this epidemic. The latest data indicate that between 40,300[6] and 160,528[7] people inject drugs in Thailand. HIV prevalence among PWID remains among the highest in Asia at 21.9 per cent.[8c] The majority of PWID in Thailand are living with hepatitis C (89.8 per cent).[9] The Thai government's response has focused on criminal justice approaches centred on the incarceration and compulsory detention of people who use drugs (PWUD) and characterised by several 'wars on drugs'. This case study outlines the acquisition and implementation of a Global Fund grant since 2009 and the challenges that have been faced by implementing civil society organisations operating in an environment that remains hostile to harm reduction.

Official policy language labels PWUD as patients;[10] however, practice at the community level in Thailand suggests that they continue to be treated as criminals. The government's response to drugs, guided by principles of prohibition and repression, has been consistently implemented with little regard to the health and human rights of PWUD.[11-14] Law enforcement initiatives have led to incarceration and compulsory detention with accompanying abuse of PWUD, both in community and closed settings.[15] The recently elected Pheua Thai party announced a new 'war on drugs'[16, 17d] with objectives of rehabilitating 400,000 'users' in compulsory 'treatment' centres, primarily run by military and law enforcement agencies.[18] The Thai government's reluctance to address drug-related issues through public health measures is embodied in the absence of national harm reduction policy instruments, mechanisms and measures beyond the national HIV/AIDS strategy. The Thai Office of Narcotics Control Board (ONCB) drafted a national harm reduction policy in 2010, but this has not yet been deployed. In spite of this unsupportive environment, some level of harm reduction services have been delivered in Thailand at least since 2003.

c This figure refers to men who inject drugs only.

d The 2003 campaign in particular illustrates the scale of the Thai government's approach to the war on drugs, including human rights violations and arbitrary killings that took place as a result, for more information: Human Rights Watch (2004) *Thailand: Not Enough Graves. The War on Drugs, HIV/AIDS, and violations of Human Rights*, Vol. 16, No. 8, http://www.hrw.org/reports/2004/thailand0704/thailand0704.pdf.

At present, the national response to HIV transmission among PWID is essentially limited to the CHAMPION-IDU project, supported by the Global Fund Round 8 grant and implemented by PSI Thailand alongside civil society partners including Raks Thai Foundation, the Thai AIDS Treatment Action Group, the Thai Drug Users' Network, Alden House and the Thai Red Cross. This grant is for an approved total of US$17 million for the period 2009–2014 – US$6 million for the first phase of funding, and US$11 million for 'Phase 2' – and covers 19 of the 76 Thai provinces. Earlier, in 2003, the Global Fund also provided a US$1 million grant to Thai civil society groups to address HIV transmission among PWID.[e] Without support from the Global Fund, the national response to HIV transmission among PWID would be limited to small-scale community-led programmes whose operations have been under continued threat from police and government crack-downs.

During the first two years of operations, the CHAMPION-IDU project reached over 6,000 PWID across Thailand, providing them with education, information and behaviour change communication, safer injecting kits, condoms, referrals to voluntary HIV counselling and testing (VCT), diagnosis and treatment for sexually transmitted infections (STIs), and opioid substitution therapy (OST). In parallel, over 130 health service providers and approximately 50 prison guards received training to be sensitised to the needs of PWID, while over 1500 people have participated in advocacy activities to improve the operating environment. Meanwhile, CHAMPION-IDU supports 12D – a civil society coalition working to improve the drug and HIV policy environment – in coordinating and implementing additional advocacy activities, as well as the Foundation for AIDS Rights to develop effective legal aid services for PWID. The successes of the CHAMPION-IDU project largely belong to active and recovering PWID who comprise a large proportion of the implementing field teams.

However, the sustainability of these successes is constantly under threat. There continues to be a lack of support from all government sectors for effective and evidence-based interventions to address HIV transmission among PWID, which undermines the project. Government agencies have not signed identity cards that would protect field teams from arrest, which leads to peer outreach workers being routinely harassed and arrested by law enforcement officers. There are also anecdotal reports from implementing agencies in Thailand suggesting that law enforcement officers can benefit from financial incentives for drug seizures and the arrest of PWUD, as well as penalties if quotas are not met.

A further challenge has been posed by target-setting following the CHAMPION-IDU grant's mid-term review in 2011. As the Global Fund is a funding (rather than technical)

e For a more nuanced discussion of the challenges around this grant, please refer to Kerr T et al. (2005) Getting Global Funds to Those Most in Need: The Thai Drug Users' Network, *Health and Human Rights*, 8(2) 170–186.

body, it follows the agreed normative guidance to assess the quality of programmes – in this case the UN target-setting guide for PWID.[1] However, this guidance is 'primarily intended for national target-setting'[1] whereas the CHAMPION-IDU programme is a nongovernmental initiative that operates in just 19 provinces. The guidance also states that interventions should be implemented 'in an enabling environment created by supportive legislation, policies and strategies'[1]: this is clearly not the case in Thailand. In negotiations between PSI and the Global Fund to agree targets for Phase 2, the Global Fund requested high coverage levels in the 19 provinces in line with the UN target setting guide (i.e. 60% for NSP and 40% for VCT). The performance based funding (PBF) model is based on the principle that 'to receive subsequent financing, [projects] must demonstrate results against defined performance targets'. This has raised concern that, despite its successes in health service provision, the CHAMPION-IDU programme may struggle to meet its performance targets and would therefore be rated by the Global Fund as 'inadequate' or 'unacceptable' (see Table 1).[f]

Table 1: CHAMPION-IDU key indicator targets (October 2011 – June 2014)[19]

Indicator	Phase 1 Targets	Phase 1 Performance	Phase 2 Targets	Increase between Phase 1 and 2 targets (%)
Number of PWID reached	6,574**	6,191	9,762***	148
Number of people trained (and retrained)# to implement HIV prevention activities for PWID	223**	137	258***	115
Number of condoms distributed to PWID	319,879*	170,411	986,364*	308
Number of needles/ syringes distributed to PWID	1,151,495*	319,879	5,698,315*	495
Number of PWID referred for HIV testing and counselling (and have received their results)	602*	351	6,391***	1062
Number of STI cases referred and received their diagnosis result	577*	411	8,171***	1988

In Phase 2, CHAMPION-IDU partners were allowed to count people re-trained, whereas in Phase 1, once a person received training, they could not be re-counted against indicator performance.
* Not cumulative
** Cumulative over project life
*** Cumulative annually

f See Global Fund (2012) Performance-based Disbursements, www.theglobalfund.org/en/performancebasedfunding/grantlifecycle/3.

A further concern is that the Government, already unresponsive to harm reduction efforts, could potentially use this assessment as further justification to avoid deploying future interventions to reduce HIV among PWID. The Global Fund is a leading source of international support for harm reduction programmes[20] and remains the sole and best possible option for supporting the response to HIV transmission among PWID in Thailand. In order to maximize the Global Fund's significant investment in HIV prevention among PWID in Thailand, it will be critical to balance the quantitative results of the CHAMPION-IDU project against the hostile operating environment. At the same time, it is important to provide flexibility to implementing agencies to re-program funds to support advocacy efforts towards the deployment of an evidence-based policy, while efforts are also needed to harmonize law enforcement and public health objectives so that these challenges can be transformed into genuine successes for the benefit of Thai society as a whole.

AUSTRALIA

There are an estimated 149,591 PWID in Australia.[7] Early adoption and high coverage of harm reduction interventions is often credited for the consistently low HIV prevalence among them (1 per cent).[8] This case study outlines the important role of user organisations in shaping Australia's harm reduction response, both historically and in the face of recent shifts in government policy agendas.

Australia has benefitted greatly from the early adoption of harm reduction as an effective way to reduce the impact of HIV and other blood-borne viruses such as hepatitis B and C that can result from sharing contaminated injecting equipment. Harm reduction initiatives including the implementation and rapid scale-up of NSPs and OST began in the mid- to late 1980s. These effective programmes have helped maintain low HIV prevalence of approximately 1 per cent among PWID in Australia for almost 30 years.[21]

In the early days of harm reduction, drug use was seen as a criminal issue to be stamped out by police arrests and customs seizures of imported drugs. The adoption of harm reduction shifted much of the rhetoric to one of drug use as a health issue. Language became an important way to convey ideas about 'managing drug use' and 'reducing harm'. However, the

rhetoric did not entirely reflect the reality. Examining funding for drug-related interventions in Australia reveals a very different picture of the priorities of the country's leaders. The majority of funding goes to supply and demand reduction measures, and just 3 per cent of funding has consistently been allocated to harm reduction.[22]

Despite this disparity, just one of the harm reduction measures, NSP, is recognised as one of the most cost-effective health interventions ever funded. For every $1 spent on NSP, $27 is saved just on health care costs,[23] and increased spending would result in a corresponding further reduction in blood-borne virus transmissions, other adverse health outcomes for PWID and overall health care costs, with the maximum benefit being achieved at increasing funding by 150 to 200 per cent of its current levels.[23]

To assess their impact, the Federal Department of Health commissioned two major cost–benefit analyses of NSPs in Australia. The first of these showed overwhelming evidence for the financial and health benefits of investing in NSPs in the first decade and a half of their existence. According to the second *Return on Investment Report*, published in 2010, these savings have continued to grow. Between 2000 and 2009, NSPs alone directly prevented approximately 32,000 HIV transmissions and almost 100,000 hepatitis C transmissions, and saved the Australian government over $1 billion in health care costs.[23]

Integral to the success of the Australian harm reduction response has been the involvement of PWUD in providing services, conducting formal and informal peer education, and representing the needs of PWUD in Australian policy dialogue. From the earliest days of implementing the first pre-legal NSP to today, PWUD have done everything they can to be part of Australia's harm reduction response. PWUD have challenged stereotypes by developing their own organisations, advising on policies and procedures, developing resources and working in every area relevant to PWUD, from NSPs to outreach to government health departments. They have proved that not all illicit drug use is problematic and chaotic, and that PWUD have valuable skills and care about their peers and communities. Without the voluntary and paid work of these people, and the willingness of PWUD to take the necessary steps to look after themselves and their peers, Australia's response to HIV would have had a far less successful outcome. Drug users were organising themselves even before the identification of HIV and hepatitis C as potential concerns for PWUDs. The recognition that PWUD might pose a 'threat' to the 'general community' through sexual transmission of HIV meant that the drug user organisations that had been operating voluntarily began to receive some funding.

As drug user organisations at the state and national level gained experience and proved their worth by developing successful programmes and resources, more funding was made available to allow these organisations to educate the PWUD community about blood-borne viruses. Australia, unlike many other countries, can rely on neither international donors nor philanthropic organisations to support community work. Almost all community organisations, including all harm reduction and drug treatment services, are primarily funded by the government, and the government is not very interested in funding organisations to look critically at its policies. Most of the advocacy work and lobbying for policy change remains unfunded, limiting the opportunities drug user organisations can take outside programmes to prevent transmission of blood-borne viruses.

Australia has rightly been proud of its record on implementing brave programmes in the mid-1980s that prevented an HIV epidemic. It has also been proud of what is called the 'partnership approach',[24] referring to the inclusion of affected communities such as PWUD organisations in the response to HIV. The Australian response has been promoted and modelled in Australia's aid development programmes around the world, particularly in Asia where HIV has devastating impacts on the lives of millions of PWUD and their communities.

Australian aid has funded many harm reduction programmes in Asia where the health and human rights of PWUD had previously not been considered. Meanwhile, in Australia, drug user organisations have despaired at government and community attitudes to PWUD and the lack of forward movement in our own programmes. More frightening is the fact that Australia appears to be going backwards towards denial and abstinence-oriented programming.

An 11-year conservative rule of the country from 1996, led by Prime Minister John Howard, produced the 'Tough on Drugs' strategy. Howard portrayed himself as a strong conservative, frequently talking about the evils of drugs and what he wanted to do about it. The 'Tough on Drugs' strategy emphasised supply reduction measures and language that pandered to stigma about PWUD. Increasing stigma is obviously damaging, particularly for already marginalised and criminalised communities such as PWUD. However, the 'Tough on Drugs' rhetoric was accompanied by continued harm reduction funding, and in some cases increased funding, although few new harm reduction programmes.

It was hoped that the election of a Labour government in 2007 might make the language and policies more progressive and compassionate. Instead, rhetoric around harm reduction and drug use has regressed further. A recent report developed by prominent Australians including politicians, medical professionals and parents of children who had died of overdose called on Australia to rethink the 'war on drugs' and reform drug policy.[25] The report, entitled *The Prohibition on Drugs is Killing and Criminalising Our Children and We Are All Letting It Happen*, received a lot of media and public attention. The only people unwilling to even acknowledge the idea,

let alone engage in a conversation about drug law reform, seemed to be the politicians responsible for the well-being of its citizens. Media questions about the report were met by blanket refusals from the ruling parties to discuss either the report or the ideas contained in it. Labour's silence has created confusion about where PWUD stand, and changes to budgeting have been even worse for many PWUD and harm reduction organisations.

The 'Tough on Drugs' strategy has gone, but it is being replaced by something drug user organisations are finding equally disturbing. 'New Recovery', following an agenda implemented in the United Kingdom (UK) in recent years, seems to be the new Australian strategy. 'New Recovery' promotes many ideas that seem positive such as increasing treatment programmes for PWUD. It sounds like people will have more choices in their treatment options. However, a closer reading of the current Australian *National Drug Strategy, 2010–2015: A framework for action on alcohol, tobacco and other drugs* reveals an increasing emphasis on abstinence-based outcomes for people who use drugs. It lists demand reduction as its 'First Pillar' and supply reduction as its 'Second Pillar' for responding to issues related to drug use. It also includes ideas such as 'outcomes-based funding', and 'episodes of care', which, experience from the UK shows us, can lead to rewarding numbers rather than quality outcomes. The number of times a person is told to see a particular professional does not mean they will enjoy quality or relevant treatment for their needs.

Harm reduction is slipping further into the background. Although evidence-based programmes are frequently mentioned, the actual objectives of the drug strategy concentrate far more on programmes that have proved to be costly and ineffective such as education campaigns to prevent young people trying drugs. The language used for people who are dependent on drugs emphasises 'reducing and/ or ceasing the use of drugs (to) … help them lead more stable, healthy and productive lives'.[26]

Characterising any drug use as 'problematic' and linking drug use and mental health issues is appearing as a dominant discourse in both health and political forums. In this environment, we are seeing services and programmes for PWID moved into the mental health sector and harm reduction quickly losing its place in Australia's health sector.

We are also already seeing the first major signs of the effect such pathologising of drug use may have on the ability of drug user organisations and PWUD to be involved in the decisions being made around their lives and choices. Although drug user organisations have been a part of Australia's harm reduction response, the future is not assured. The Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) has been integral to the newest initiatives in Australia including advocating for, designing and receiving funding to run Australia's first naloxone peer distribution programme. The first training sessions for PWUD and their friends and family were held a few weeks before CAHMA was told that its 2012–2013 funding application for the organisation had been rejected by the Federal Department of Health, along with many other significant but small community organisations. It was only through intense lobbying by the national drug user organisation, the Australian Injecting and Illicit Drug Users League (AIVL), CAHMA and supportive local and national agencies that CAHMA's funding was reinstalled and its ability to implement these new programmes realised.

Australia has not yet regressed to the time when drug users could not advocate for their communities for fear of imprisonment, but complacency could have devastating effects. The pathologising of drug use seems to be dominating policy and legislation, whereas harm reduction, involvement of the people affected by the issues, and evidence-based policy used to have a much stronger place. This is a time when drug user organisations are more important than ever.

VANCOUVER

There are reported to be 286,987 PWID in Canada. HIV prevalence among them is estimated to be 13.4 per cent. Coverage of key harm reduction interventions such as NSP and OST remains lower than in Australasia and most Western European countries.[2] The current government has prioritised a law enforcement approach to drugs, which has overshadowed public health responses. Vancouver is home to two projects not only crucial for the local community of PWUD but also for their contributions to the international evidence base for two important harm reduction interventions – safer injecting facilities and heroin-assisted treatment. This case study outlines these two very different projects, the structural barriers they have encountered and the reasons why, despite substantial evidence of effectiveness, these pilots have not been scaled up in the Canadian context.

Beginning in the mid-1990s, Vancouver's Downtown Eastside neighbourhood became the focus of unprecedented levels of harms related to illicit drugs, including an explosive outbreak of HIV transmission and an extremely high fatal overdose rate.[27] In response, a broad coalition of PWID, community-based advocates, public health professionals and elected officials coalesced around support for the implementation of a broad range of harm reduction interventions,[28] most notably establishing Insite, North America's first medically

supervised safer injecting facility (SIF)[29] and conducting the North American Opiate Medication Initiative (NAOMI) study, a randomised clinical trial of heroin-assisted treatment for severe heroin addiction.[30] However, despite the impressive body of scientific evidence generated attesting to the positive impacts of these programmes on the health and well-being of local vulnerable and marginalised illicit drug users, they have yet to be scaled up or implemented in a fashion consistent with their benefits and cost-effectiveness.[31, 32]

Insite opened in 2003 in a low-threshold facility located within the epicentre of the neighbourhood's open illicit drug market. A joint initiative of a social services agency and the local health authority, Insite obtained the necessary federal government-issued exemption from criminal prosecution by being set up as a pilot project to study the effects of a SIF in the Downtown Eastside.[33] The scientific evaluation produced a wealth of peer-reviewed research describing the facility's benefits, including lower levels of syringe sharing,[34] increased uptake of addiction treatment[35] and significant reductions in fatal overdoses in the area around the facility.[36] In addition, Insite enjoys broad support from its clientele, members of the surrounding community including merchants and civic leaders, as well as the Vancouver Police Department and current and former city mayors and provincial premiers. Despite these successes, the agency operating Insite and two Insite clients were forced to take Canada's federal government to court to prevent it from shutting the facility shortly before the exemption expired in 2006. Subsequently, the Supreme Court of Canada ruled in 2011 that the facility could remain open indefinitely, and plans are underway to try to expand the service by creating supervised injecting environments elsewhere in Vancouver and in other regions in Canada.

In light of the successful implementation of heroin-assisted treatment in several European countries,[37] the NAOMI study recruited over 200 out-of-treatment long-term opioid injectors and randomly assigned them to receive standard medical care (oral methadone) or a diacetylmorphine (heroin) (DAM) plus flexible doses of methadone.[38] After 12 months, individuals in the DAM group were more likely to remain in treatment, less likely to be engaged in illicit heroin use or other criminal activity, and enjoyed greater improvements in social functioning than patients receiving methadone.[39] Additional analyses concluded that treatment with DAM was cost-effective.[31] Despite these findings, DAM has not been added as a treatment modality for opioid dependence, and all participants in the DAM group were transitioned to methadone or detoxification, making the NAOMI project the only heroin prescription study to discontinue heroin-assisted treatment upon conclusion.[40]

Although it is important to note the fundamental differences between Insite and the NAOMI trial, both interventions share similar structural barriers to implementation and scale-up. First, both interventions were the subject of numerous rules and regulations rooted in political or legal considerations. For example, the City of Vancouver restricted NAOMI participation to individuals residing within one kilometre of the study site, limiting recruitment.[38] Clients at Insite are not permitted to share drugs within the facility nor assist in injections, limiting its effectiveness for a small but vulnerable group of clients.[41] Second, both interventions exist within a federal policy environment that is explicitly hostile to harm reduction interventions.[42] First elected in 2006, Prime Minister Stephen Harper has removed harm reduction from the federal government's official anti-drugs strategy and has pursued a strict prohibitionist strategy, including the implementation of mandatory minimum sentences for minor drug offences and expansion of the correctional system. Finally, the recent history of the NAOMI trial and Insite reveal the importance of community and academic advocacy in planning and implementing interventions for illicit drug users. In many respects, the establishment and continued existence of Insite is a result of the efforts of the broad coalition of clients, researchers, advocates and officials operating within legal, political, social and cultural contexts.[43] The NAOMI investigators were not similarly engaged with the community and other supporters, and patients in this study have not benefitted from similar advocacy efforts, resulting in the NAOMI intervention being halted without public education or legal efforts to prevent this outcome.

In a recent report on their experiences prepared by the NAOMI Patients Association,[44] one participant identified the marginalised status of illicit drug users as a reason for the failure to create a permanent heroin-assisted treatment programme: *'If they give you a drug for — they're experimenting with a drug for cancer and it starts working. I mean, what are they going to do? Oh, no. You can't have it any more; we're going to back off here.'*

These examples, with the success of the Insite programme resulting from collaboration between scientists, community groups and the legal and public health communities, and the closure of the NAOMI programme in the setting of researchers working largely in isolation from external stakeholders, demonstrate the importance of coalition-building between the research community, the non-profit sector, service providers and those with legal expertise to ensure that effective harm reduction programmes and other evidence-based approaches to prevent and treat harmful substance use can expand in a sustainable way.

RUSSIA

An estimated 1,815,000 PWID live in Russia. The HIV epidemic in the country is largely driven by injecting drug use. Prevalence of HIV and hepatitis C among PWID are among the highest in the world at over 37 per cent[7] and 72 per cent,[9] respectively. This case study outlines the struggles of small-scale harm reduction programmes to continue operations in the face of increasingly staunch government opposition to harm reduction and an overreliance on international donors. It highlights various strategies used by civil society actors to attempt to overcome the considerable barriers to implementing a scaled-up and sustainable harm reduction response in Russia.

The decade between 1996 and 2005 was a time full of hope for harm reduction in Russia. The country's first pilot harm reduction projects funded by the Open Society Institute (OSI) and Médicins du Monde (MdM) opened in 1996 and delivered high-quality results.[45] In 1997, Médecins Sans Frontières (MSF) Holland and OSI launched an ambitious programme to introduce harm reduction in Russia, in cooperation with the HIV/AIDS Department of the Russian Ministry of Health. As part of the new programme, MSF trained 300 doctors and NGO representatives from all over Russia in providing needle and syringe and outreach services, and OSI funded over 30 pilots.[46] To ensure sustainability, the Russian government agreed to gradually increase co-funding of the pilots, with a view to eventually fully fund and continue to scale up the project.[46] However, this did not transpire – the government continued to postpone the takeover of harm reduction services, encouraging international donors to step in and bridge the gap.[47]

In 2001 a new donor emerged – the UK Department for International Development (DFID). Its funds intended to 'bridge' the ending OSI grant programme and to fill the gap until a looming World Bank loan to meet the country's urgent health needs was agreed and signed off.[48] The DFID support included a large research project examining the effectiveness of harm reduction in Russia; it matched the funding for the 30 existing pilot projects and provided for significant scale-up of harm reduction services in two selected Russian regions looking to prove the impact of harm reduction on the HIV epidemic. However, by the end of 2003, DFID decided to move its funding to post-war development in Iraq, changing its priorities abruptly; funds were withdrawn, and scaling up did not take place.[48]

However, there was hope that the government would support harm reduction efforts within the upcoming World Bank loan. Negotiations on the loan took place for almost five years; the World Bank conducted numerous assessments, research and consultations – all with a promise that the loan would support 30 harm reduction projects.[49] However, by the time the loan was accepted, both the government and the World Bank dismissed their written plans and agreements to take over harm reduction, reallocating the money towards purchases that were more convenient for the Russian officials, such as laboratory equipment and furniture for the state AIDS centres.[49]

In 2003 a consortium of five major NGOs took the decision to stop waiting for government support and submitted Russia's first application to the Global Fund (Round 3). The grant was successful and went on to support 22 harm reduction projects. A year later, support for 30 more projects was received through the Global Fund Round 4, and again in 2006 another 33 projects were funded through the Round 5 grant. As a result, the period between 2005 and 2008 saw the beginning of scale-up for harm reduction, with over 80 projects implemented.[50] Many of the projects, however, operated only as small-scale pilots. Scepticism was also increasing around governmental support to harm reduction, as government officials became increasingly vocal in their opposition to harm reduction. For example, government representatives unanimously refused to approve harm reduction as part of national applications to the Global Fund, meaning that the Round 5 proposal did not receive the approval of the Country Coordinating Mechanism due to its focus on harm reduction.

Unexpectedly, in May 2008, at the Eastern European and Central Asian AIDS Conference the newly appointed Russian Minister for Health, Ms Golikova, announced that the government had all the resources to fully take over harm reduction projects currently supported by the Global Fund.[51] After her announcement, the audience held their breath for a moment and then burst into applause. This was the moment harm reduction advocates had been waiting over a decade for. However, just one year later in September 2009, the same Minister, at a meeting with the President and Prime Minister in attendance declared that 'distribution of sterile needles and syringes stimulates social tolerance of drug addicts, and violates the Criminal Code.'[47] This speech marked the end of political support, if even only rhetorical, to harm reduction. The national 'Anti-Drug Policy Strategy', approved another year later, ignored significant evidence around major health challenges including HIV rates of around 37 per cent[52] and hepatitis C prevalence of between 49 per cent and 96 per cent[9] among PWID and even named harm reduction as a threat to the strategy.[53]

At the end of 2011, the last Global Fund-supported programmes ceased to function. As a result, by early 2012, only six organisations across the country were able to provide harm reduction services to PWID, all struggling for small-scale funding from independent sources.[54] This is grossly inadequate for the needs of PWID; current estimates in Russia are that nearly 2 million people inject drugs, with HIV rates around 37.15 per cent among this population and much higher in some provinces [for more information see Chapter 2.1: Harm Reduction in Eurasia].

One of these organisations, the Andrey Rylkov Foundation for Health and Social Justice (ARF), maintained its outreach services supported by the International Crystal of Hope Award. However, the organisation has been severely repressed by the government. In 2012, after multiple checks by police and prosecutors, its website was shut down by the Federal Drug Control Service citing 'drug propaganda' as its reasoning – specifically concerning materials discussing substitution treatment.[55] Through this action, the Russian government suggested that it believed that not only providing services but even discussing harm reduction was illegal.

What went wrong with harm reduction advocacy in Russia? Why were small but aspirational harm reduction pilots not scaled up by the government but, rather, fiercely opposed? Traditional advocacy has been undertaken in Russia: research and evidence-building, trainings and international study tours, publications and debate. However, so far none of these activities have had an impact on mainstreaming harm reduction into national public health strategies or services. The root of this strong ideological government resistance is hard to explain, and this opposition has never been scrutinised scientifically,[47] so more research into policy resistance is recommended to determine the causes of this ongoing phenomenon.

Advocates affiliated with the ARF have taken the decision to use legal tactics to force the government to change its policies. The organisation has taken several cases to national and international courts, claiming violations of the right to health,[56] the right to be protected from torture and inhumane treatment,[57] the right to receive information[g] and the right to benefit from scientific progress.[58] However, it remains uncertain whether this approach will be successful in bringing evidence-based programmes to PWID in Russia.

g Andrey Rylkov Foundation (2012). Information note regarding retaliation of the Government of the Russian Federation against the Andrey Rylkov Foundation for Health and Social Justice (ARF) for promoting the recommendations made by the UN Committee on Economic, Social and Cultural Rights (CESCR) to the Russian Federation in its Concluding Observations

Conclusion and recommendations

This chapter has brought together a diverse set of case studies from around the world to examine the problems of sustainability in harm reduction and to highlight successful or promising strategies for securing it. All four case studies clearly demonstrate the importance of continued advocacy, alongside sustained political support for the implementation and scale-up of harm reduction services. Although the circumstances of the four case studies differ in significant respects, there are a number of common issues that can be identified.

Each of the case studies and Vancouver, in particular highlights the importance of creating a broad and diverse coalition of advocates and supporters to ensure the survival of harm reduction services. The example of Insite demonstrates that a key element in ensuring the continuation of the facility was the broad support it received from community advocates, law enforcement officials, academics and clients, as opposed to the failed NAOMI trial which worked mostly in isolation. This case study also serves as a cautionary example, highlighting the marginal social status of PWID and the potential role this has in the 'acceptability' of rolling back on harm reduction.

The Canadian and Russian case studies highlight the importance of legal mechanisms and the value of forging connections with legal professionals to protect harm reduction. In the case of Insite the ongoing use of legal mechanisms bypassed political opposition to harm reduction and helped to ensure the survival of the project. Moreover, this ruling provided legal cover for the opening of further safer injecting facilities in other parts of Canada. Similarly in Russia the use of legal mechanisms is now being applied with the hope that it will enable NGOs to side-step political resistance to harm reduction. While these initiatives are in their early stages, it is clear from the Canadian example, in particular, that this is a strategy worth exploring further.

Several case studies highlight the fundamental role of funding (or the lack thereof) in sustaining harm reduction programmes, and the significant role of donor advocacy. The case study from Thailand emphasised the need for donors to balance performance-based quantitative indicators with less quantifiable activities such as advocacy, and for international donors to take into account hostile political environments and adjust indicators and activities accordingly. The Australian study highlighted the precariousness of government funding and the need for funding mechanisms that are independent from the state for civil society strengthening, in particular for organisations of PWUD. Autonomous funding mechanisms are clearly a common need to allow harm reduction advocates to function as 'community watchdogs'. Moreover, in Russia it is clear that international donors are the only hope for the survival of harm reduction services, not only as funders but also as independent bodies with some influence over resistant

governments to put in place evidence-based strategies for HIV prevention for PWID.

Another key theme that emerges from the case studies is the importance of involving PWUD in advocacy activities. In Australia the scale-up of harm reduction can be attributed in part to the activities of networks and organisations of drug users, including self-organising, advocating and peer support. In Vancouver the Eastside community and service users of Insite and drug user organisations such as VANDU played a vital role in keeping the facility open. In Thailand ongoing advocacy from PWUD has been vital in ensuring the expansion of harm reduction services, as well as ensuring that the regressive policies and practice of the Thai government are recorded and highlighted to donors and the international community.

The Australian case study discusses the potential threat posed by the emergence of the 'new recovery' movement. It is particularly threatening to harm reduction in Australia, as it uses the language of harm reduction yet deviates from the key principles of pragmatism, evidence-based interventions and the meaningful involvement of PWUD. It is, therefore, extremely important for harm reduction professionals internationally to ensure that harm reduction messages are delivered in clear and coherent ways to ensure they cannot be co-opted.

The Australian case study also raises concerns about mental health providers taking the lead in harm reduction services. It notes that, although mental health provision is an extremely important component of a comprehensive package for drug users, it is dangerous to subsume all drug services under this label, as it suggests that PWUD are 'unwell' and unable to make informed decisions, thereby undermining efforts to support active drug users to self-organise and advocate.

In conclusion, threats to the continued implementation of programmes at a level that can impact on epidemics among PWID are a challenge to harm reduction practitioners and advocates in various political and economic contexts. The strategies to overcome these threats are multiple and varied, but all require strong and strategic advocacy for harm reduction, particularly in the current context of uncertain international financing and wavering or poor political support for harm reduction in many parts of the world. These case studies underline the importance of donors, governments and civil society organisations themselves recognising and prioritising advocacy as key to ensuring sustainable and scaled-up harm reduction responses.

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LESSONS FROM HISTORY:
Advocating for harm reduction in challenging environments

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The authors would like to thank Gerry Stimson and Annette Verster for reviewing the chapter.

INTRODUCTION

The reasons for starting and scaling-up harm reduction services are multifaceted, compelling and well established. If policy-making were a purely scientific, objective and methodical process, harm reduction would already be the global norm. However, this is not the case. Section 1 lists 158 countries that report injecting drug use (IDU), of which 94 support harm reduction in policy and/or practice to help individuals stay safe, manage or end their drug use and avoid blood-borne viruses (BBV). The other 64 countries still do not support and/or implement harm reduction. What accounts for these variations in response? What makes one country adopt harm reduction in policy and practice, while a neighbour continues to ignore the evidence?

This chapter highlights four examples from around the world where harm reduction has been endorsed to varying degrees: from early adoption and nationwide scale-up in Switzerland and Macedonia, to opening the harm reduction debate in Malaysia and overcoming strong ideological resistance in the Caribbean. Each case study explores how harm reduction came to be accepted and documents the events and actions that were key to this process. It is hoped that this chapter will inform ongoing advocacy efforts for harm reduction elsewhere in the world and provide encouragement to those who are working to promote change in their own countries — including those in both governmental and nongovernmental positions. At the same time, it should be equally relevant for countries that are seeing their existing services come under threat (see Chapter 3.6 for a more in-depth discussion of this).

THE CARIBBEAN

Injecting drug use is reported to be rare in the Caribbean region, with the notable exception of Puerto Rico. The harm reduction response in the region remains very limited, with needle and syringe exchange and opioid substitution therapy only available in Puerto Rico. The response in the rest of the region is predominantly characterised by abstinence-based, high-threshold services. The use of illicit drugs is highly criminalised, with harsh sentencing resulting in large numbers of people who use drugs in Caribbean prisons. This case study illustrates the emergence of harm reduction advocacy in the region and describes the various efforts which have contributed to its wider acceptance.

Drug policy in the Caribbean has always been heavily influenced by the USA, and its historical antipathy toward harm reduction approaches as 'capitulation' to drug use. In the 1990s, any mention of the term 'harm reduction' would lead to the loss of US State Department funding for drug demand reduction programmes. In 1997, the European Commission contracted a situational assessment of drug treatment in the Caribbean, which remains an influential work to this day.[1] The following year, Deutsche Orden Hospitaller (DOH) International received a grant from the European Commission to expand low-threshold programmes for street-engaged people who use drugs.

In the absence of prevalent drug injecting, harm reduction in the Caribbean often refers to services that treat people who use drugs with respect and dignity: providing food, clothes, showers, referrals and a supportive, listening ear. However, when the first drop-in centres began implementing this approach, service providers were forced to label them as 'public health approaches' to address HIV among the homeless, rather than harm reduction for people who use drugs. The first drop-in centre in the Caribbean was opened in Castries (Saint Lucia) in 2000, followed by centres in Santo Domingo (Dominican Republic) in 2001, Kingston (Jamaica) in 2002 and Port of Spain (Trinidad) in 2003.

Meanwhile, work was being done by leading activists in the halls of the Caribbean Community (CARICOM) Secretariat to place harm reduction on the agendas of various Councils of Ministers. In particular, as a result of the work and advocacy efforts of a handful of researchers and service providers, there was a growing acceptance by the Pan-Caribbean Partnership Against HIV/AIDS (PANCAP), the UNAIDS Regional Office and others of an overlap between non-injecting crack cocaine use and HIV infection, with five to 10 times the national prevalence among this population.[2] This countered the common argument that 'Caribbean people do not inject, so there is no link with HIV'.

In 2001, the Foreign and Commonwealth Office commissioned an evaluation of demand reduction programmes in the Caribbean, which confirmed the link between crack smoking and unsafe sexual behaviours, leading to increased HIV infections.[3] In the Nassau Declaration on Health 2001, Caribbean Heads of Government committed to Phase II of the Caribbean Cooperation in Health Initiative, which explicitly

classified substance use as a mental health and public health issue.[4,5] A steady stream of US-funded interventions continued to undermine harm reduction by focusing solely on drug use prevention and high-threshold abstinence-based services. However, harm reduction programmes remained successful in reaching and supporting 'hidden' populations in the region.

Several events led to 2001 being a pivotal year for civil society advocacy. A number of Caribbean treatment professionals attended the International Harm Reduction Conference in Delhi, India, and the US Harm Reduction Conference in Miami later that year. At the latter event, the Caribbean Harm Reduction Coalition (CHRC) was formed during a special satellite meeting. CHRC set out to promote the emerging experiences in the region and support research to increase the evidence base for interventions. The Caribbean Drug and Alcohol Research Institute was then formed to work alongside CHRC and provide the necessary evidence to support advocacy efforts. In 2004, the Caribbean Vulnerable Communities Coalition was formed, of which CHRC was a founding member, and allowed for the expansion of harm reduction to other vulnerable groups such as sex workers and men who have sex with men.

Despite the weight of US drug policy in the region, contributions from a range of international donors and partners have proven invaluable for the success of harm reduction efforts. The original European Commission funding got the ball rolling, while support from the Open Society Foundations and the UK Department for International Development (via Harm Reduction International) enabled the exchange of information, ideas and experiences across the region and internationally. In 2008, the Caribbean Vulnerable Communities Coalition began work on a successful multi-country proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria.[6] Although injecting and opioid use is less common in the Caribbean than in many parts of the world, non-injecting crack cocaine users were included as a target population, and programmes began in 2011. As a result of a rapid assessment conducted by CHRC that documented heroin injecting, efforts are also underway to provide sterile injecting equipment and to advocate for the adoption of opioid substitution therapy (OST) interventions by Caribbean governments.

Overall, the HIV crisis in the region facilitated the emergence of harm reduction as a proven public health response. Governments were presented with a harsh economic reality: they would experience a significant drop in Gross National Product if the HIV epidemic were left unaddressed. With the establishment of the Caribbean Vulnerable Communities Coalition, CHRC became part of a Caribbean-wide movement advocating for the adoption of a human rights-based agenda to augment the public health arguments previously espoused. Although the HIV epidemic remains, responses to HIV are presently more practical and evidence-informed. Agencies that previously were resistant to adopting harm reduction strategies a decade ago began to embrace and implement variations of harm reduction adapted to the contextual realities they experienced. Trinidad adopted harm reduction as part of its national drug policy, supporting the continuation of the drop-in centre started with European Development Fund (EDF) funding in 2003. Jamaica carried this one step further when the National Council for Drug Abuse received support from the Ministry of Health to operate a mobile outreach project targeting homeless street-engaged crack smokers. As this report shows, three of the countries in the region now embrace harm reduction in policy and/or practice (see Section 1: Global Overview). Advocacy efforts are ongoing, but the Caribbean example shows how harm reduction can be promoted even under the shadow of a major global detractor such as the USA.

MACEDONIA

The timely introduction of harm reduction interventions is credited for averting an HIV epidemic among PWID in Macedonia. This case study outlines the antecedent factors which contributed to the adoption of a harm reduction approach in the country, including well-timed research and well-placed civil society actors funded to take forward research recommendations. In addition to this, international technical assistance and the continued engagement of decision-makers, civil society groups and people who use drugs have been critical factors in developing the national harm reduction response.

In Macedonia, harm reduction began with the provision of OST to a very small group of people from the early 1980s, growing into an organised state-run programme from 1990 onwards. In addition, however, two key milestones stand out in the development of broader harm reduction policies and programmes.

The first of which was the research of Jean-Paul Grund and Dusan Nolimal in 1995 entitled *The Heroin Epidemics in Macedonia*.[7] This report for the Open Society Foundations was perfectly timed — HIV had not become established in Macedonia, but research indicated that widespread high-risk injecting behaviours such as syringe sharing could drive the emergence of an HIV epidemic among people who inject drugs (PWID). One of the report's recommendations was to open needle and syringe exchange programmes (NSPs). As

a result, the first service opened in 1996 via the Macedonian Association for Socio-Culture Activities (MASKA). This move was initiated by people who use drugs and supported by the Open Society Institute in Macedonia.

The second key milestone was the founding in 1997 of the Healthy Options Project Skopje (HOPS), a nongovernmental organisation (NGO) that continued the work undertaken by MASKA. Since then, HOPS has developed or supported all 16 harm reduction programmes in 13 towns across Macedonia. Because of this work, harm reduction programmes can be seen even in towns with populations of just 20,000 people. Harm reduction programmes have also been developed for the Roma suburbs, as well as for sex workers who inject drugs.

HOPS has played a key role in promoting harm reduction in Macedonia through these services, by promoting and respecting the meaningful involvement of people who use drugs in all programmes and insisting on a wide spectrum of services being made available (beyond just needles, syringes and condoms). At present, the majority of harm reduction programmes also provide medical, social and psychiatric services, and legal aid and court representation in cases of human rights violations. Experience has shown that only this comprehensive approach can achieve the coverage and results that are needed. Annually, these programmes serve more than 3,000 PWID — approximately one-third of the estimated number of people in need.[8]

The feared HIV epidemic in the country has been avoided. This has been largely attributed to the immediate implementation of harm reduction programmes, according to the latest available evidence. Only 10 of the 142 registered HIV cases are among PWID, and there have been just two cases of HIV among PWID in the last eight years.[9] Intolerance of drug use and harm reduction programmes was overcome by engaging and bringing together decision-makers, authorities, civil society groups and people who use drugs.

A key strategy used to achieve a shift in initially hostile attitudes was the inclusion of state and local government bodies in joint project activities financed by the Global Fund and the Open Society Foundations. Cooperation with the international community was also important. Experts and agencies such as UNAIDS, WHO, UNICEF and the European Union were all involved in advocating for changes to state policies on HIV and drugs. Macedonia's EU candidacy also played a role in pushing the finalisation of the National Drugs Strategy 2006–2012 and its reflection of international guidance on harm reduction.[10] With this collective support, harm reduction was first mentioned in official government documents as part of the National Strategy on HIV/AIDS in 2003 and, subsequently, as part of the National Drugs Strategy in 2006. In 2011, for the first time, small quantities of the needles, syringes, condoms and lubricants needed for harm reduction programmes were purchased through the state budget. Another important element has been the inclusion of state and local government bodies such as the Ministry of Health, Ministry of Social Policy, the National Drug Coordinator and the Departments for Social and Health Protection in activities within local municipalities, which has helped to shift the initial attitudes to drug use and harm reduction. Local municipalities are also supportive of harm reduction approaches, including through the provision of local funding for such programmes. Slowly but surely, harm reduction is becoming ingrained within national health and social care systems.

MALAYSIA

Malaysia is home to an estimated 170,000 PWID[4], with the latest reported HIV prevalence among them being 8.7%.[4] Hepatitis C prevalence among PWID remains high at 67.1%.[11] In recent years, Malaysia has refocused efforts into scaling up harm reduction services and is now reported to have 'medium' NSP coverage and increasing OST coverage.[12] This case study catalogues developments leading to the policy shift towards harm reduction, including strong civil society advocacy, and the important approval of a harm reduction approach by Islamic scholars. Also described is the recent movement towards evidence-based treatment options in favour of drug detention centres.

For many decades, Malaysia has employed a punitive and prohibitionist drug policy, characterised by a statutory presumption of trafficking when possessing more than a certain quantity of drugs (such as 200g of cannabis and 15g of heroin), mandatory death sentences, incarceration for personal drug use offences and a vision of a drug-free nation by 2015.[13] However, since the turn of the century, there has been a policy shift toward harm reduction.[14] This was a response to HIV epidemics among PWID. At the height of the epidemic, Malaysia recorded approximately 7000 new infections in 2002, 75% of which were due to injecting.[15] The shift in approach was certainly facilitated by international and internal pressure to achieve all eight Millennium Development Goals (MDGs), the prerequisites for being categorised as a developed nation.[16] Malaysia has achieved seven of these goals, the exception being the goal related to HIV.

Although the policy decisions were made by the federal government, they were clearly influenced by strong voices from patient groups and NGOs such as the Malaysian AIDS Council (MAC). In 2002, a grant was obtained from the US National Institutes of Health for exploratory research and a rapid situational analysis on HIV and drug use.[17]

A Harm Reduction Working Group was then formed, hosted by MAC, which used the data and findings to advocate to the relevant government agencies. The Working Group also worked with Islamic scholars to obtain their buy-in, and the Institute for Islamic Understanding of Malaysia pronounced harm reduction to be a public health issue which did not violate *shariah* law.[18]

At around the same time that the MDG results were released, the case for NSPs and OST was presented to the Prime Minister, Deputy Prime Minister and a governmental committee on drugs. Approval was given for methadone treatment and later, from the Minister of Health, for needle and syringe distribution. Free antiretroviral treatment (ART) was introduced in 2004, methadone pilot projects began in 2005 (and have since been expanded nationwide to include community and prison programmes, as well as a pilot clinic within a mosque setting), and NSPs began in 2006. Between 2006 and 2010, Malaysia saw a decline in the annual number of recorded HIV cases,[19] although this cannot be solely attributed to the introduction of the harm reduction programmes. Additional factors that may have contributed to the overall decline in HIV prevalence include the decreasing purity of heroin, which has led some PWID to switch to inhaling or to consuming methamphetamine tablets or buprenorphine, the increasing influx of amphetamine-type substances from East Asia,[20] and improved coverage of awareness and prevention programmes for other key populations at higher risk of HIV.[21]

In recent years, dialogue around Malaysian drug policy has begun to move away from HIV as the sole reason for reform. Arguments are increasingly being made based on an understanding that policies focusing on incarceration and corporal or capital punishment do not work. Malaysia has seen increased cooperation between NGOs and police and anti-drug agencies, which has helped to promote the humanitarian and health perspectives of drug use and dependency. While 'hard-line' perspectives and rhetoric still obviously exist, they are being broken down over time. Even among senior members of the police force there is a growing realisation that the 'war on drugs' has failed, and an openness to discuss alternatives such as police referrals into health services. Although HIV remains a concern, it has now become easier to argue for harm reduction on the basis of the dignity, health and productivity of the individual person who uses drugs.

These approaches contributed to the introduction of state-run 'Cure and Care' clinics in early 2010 by the National Anti-Drugs Agency. These facilities are voluntary clinics which provide integrated healthcare for PWID, including methadone treatment and counselling. This represents a significant paradigm shift for an agency that has traditionally focused on compulsory detention centres (or 'Pusat Serenti'). These centres still exist across Malaysia, but the number of people held in them is in decline.

Since the introduction of harm reduction programmes, Malaysia has seen a positive shift toward evidence-based prevention and treatment for people who use drugs. These programmes have continued to expand nationwide, and have led to increased collaboration between health workers and law enforcers. Today, MAC and numerous partner organisations continue to work toward reducing HIV infections among PWID and raise awareness about harm reduction, safe sex and the destigmatisation of people living with HIV. However despite these major advances, challenges still remain amidst a legal and policy environment that continues to heavily criminalise drug use.

SWITZERLAND

There are an estimated 31,653 PWID in Switzerland.[22] The early introduction of harm reduction measures had a dramatic impact on the HIV epidemic among PWID, which in 1990, was the most severe in Europe. Switzerland now maintains a low HIV prevalence among this group at 1.4%.[23] This case study describes the factors which culminated in the development of a pioneering and committed harm reduction response, including advocacy from professionals in the health and social sectors and Swiss professionals taking opportunities to learn from international experiences.

In the 1980s, Switzerland experienced a steady rise in the number of people using drugs, the amount of seized drugs, drug-related crimes (including organised crime leading to higher drug prices, delinquency and prostitution) and deaths related to overdose.[24] By 1990, the HIV infection rate in Switzerland was the highest in Europe.[25] Despite the alarming trends, prominent psychiatrists and officials remained opposed to harm reduction.[26] This led to protests from health professionals, social workers, some politicians and the media, all of whom accused officials of exacerbating the problem. In 1985, for example, a heated debate broke out when the Chief Medical Officer in Zürich prohibited NSPs and threatened severe sanctions against any organisation that offered them. Around 300 physicians signed a declaration challenging this stance.[27] A parliamentary investigative committee also reproached the Chief General Attorney for remaining passive while crime rates and organised crime increased.[28] That same year, the Swiss AIDS Federation was founded to advocate strongly for key services,[29] and numerous attempts were made

by activists to try to improve the health and social situation of people who use drugs.

Crucially, the Federal Subcommittee on Drug Questions (EKDF) published a report in 1989 proposing various measures to reduce harm, including widespread OST.[30] The Federal Office of Public Health (FOPH) sent this report to the major stakeholders for consultation.[31] In 1990, several Swiss professionals attended the first international harm reduction conference in Liverpool, and an FOPH delegation to England, the Netherlands and Sweden further supported the roll-out of harm reduction. The well-documented harm reduction work being done in Australia was also a major inspiration.

As a result of this work, at a national drug conference in October 1991,[32] 'survival assistance/harm reduction' was confirmed as one of the four pillars of the new Swiss drug policy (alongside 'repression', prevention and treatment).[33,34] This decision was particularly informed by the measurement of various drug-related indicators to compare the efficacy of different measures.[35] During this process, EKDF helped to bridge the gap between activists, professionals and the government. Its report proposed viable solutions later adopted by the government and implemented by the FOPH, while an Advocacy Coalition Framework helped to make the decision possible.[36]

During the last two decades, harm reduction in Switzerland has been held up as an example of best practice in the field. All levels of government have entrusted public services and civil society to provide comprehensive support for people who use drugs. The first authorised drug consumption room (DCR) opened in 1986 in Berne, and similar facilities soon opened in Zürich and Basel, providing contact points, food and basic medical care.[37,38] Low-threshold OST became widely available in most of the country, and methadone prescriptions rose steadily from a few hundred in 1975 to 10,000 in 1991, and then stabilised at around 17,000 per year.[39] The various cantons (districts) offer DCRs, NSPs[40] (including in pharmacies) and night services.[41] Heroin assisted treatment is also provided (and is considered as treatment rather than harm reduction) despite initial opposition from the International Narcotics Control Board[42] and the WHO. This intervention now reaches around 1000 of the estimated 30,000 people who use heroin. The FOPH also supported the creation of projects, including safer night-life programmes, and cities and cantons have assured sustainability by integrating activities into their budgets.[43]

The results of this approach are clear, not least in the downward trend in HIV transmission – an estimated 1.4% of PWID are currently living with HIV.[44] Just 4% of new HIV infections were associated with IDU in 2007, compared with the late 1980s and early 1990s when this was the primary mode of transmission.[45] Illegal drug use in public spaces is now less of an issue, and the number of deaths from overdose has declined markedly over the last 20 years.[46,47] Whereas public health and public order arguments were the most prominent in the early stages of the Swiss debates, ethical considerations and human rights were also a key part of the discussion. Harm reduction is considered a means to save lives and support people to survive their drug use, and this overcame the convictions that drug consumption violated other fundamental values of Swiss society.[48]

More than 25 years after opening its first DCR, Switzerland has firmly embedded harm reduction within its drug policy. The actions of activists, advocates and professionals helped to mainstream this approach, while the concrete evidence and data provided by researchers empowered the public and politicians to agree on pragmatic steps. Harm reduction in Switzerland no longer faces opposition from international organisations such as the WHO, and numerous referenda and popular initiatives have confirmed continuing support from the Swiss public (the most recent being in 2008). Although many aspects of this example may be considered 'typically Swiss', there remain numerous lessons that can be applied by other countries.[49]

CONCLUSION

This chapter highlights the successes achieved in advocating for harm reduction in the Caribbean, Macedonia, Malaysia and Switzerland. There are numerous other countries that could have also been featured, but the highlighted examples successfully draw out several key themes. Across all these case studies, it is clear that scientific research and the collection and communication of data are essential to make strong and evidence-based arguments to policymakers. The role of dedicated civil society groups is also clearly pivotal. Organisations such as CHRC, HOPS and MAC have all helped to engage and convince governments and religious leaders through innovative service delivery, organising or attending key meetings and events (including the International Harm Reduction Conferences) and generating and communicating sound evidence.

In all four examples, high rates of HIV transmission among people who use drugs was a key factor in the early conversations around harm reduction, and this remains the case in many countries around the world. While some countries such as Malaysia needed to react in order to control and reverse existing epidemics, others such as Macedonia were able to generate action to avert potential crises. This latter approach may be particularly important now for sub-Saharan Africa, where injecting-driven epidemics are beginning to emerge. Crucially, dialogue around HIV vulnerability, prevention and treatment has also helped to open doors to broader conversations around human rights, the overall health and well-being of PWID and the development of supportive policy environments.

These four case studies also demonstrate the need to carefully tailor approaches to the local situation. For example, whereas Switzerland embraced heated public debates to negotiate the issue in the 1980s, a more subtle approach was taken in the Caribbean to allow services to be delivered under the watchful gaze of the USA. Effective advocacy has to reflect the local context and should ideally be driven by local groups who best understand this context (meaning that these groups should be appropriately funded and empowered to perform this role). The relevant groups, whether governmental or nongovernmental, must acknowledge and understand the factors that guide policy decisions. Interestingly, these examples also allude to a diversity in the motivations of policy makers in adopting harm reduction, including ensuring national productivity, improving public health and order, and achieving MDGs and consequent 'developing country' status. Crucially, advocates must also decide and focus on which factors they can realistically influence or control. Although the ultimate 'tipping point' may come from factors beyond their control (such as changes in political leadership), their work will lay the foundations for policy shifts for change. Finally, the four examples highlighted here also demonstrate the need for patience. In the Caribbean, Macedonia, Malaysia and Switzerland, there will undoubtedly have been times when it seemed like fighting a losing battle. The policy shifts described here happened over a prolonged period and as the result of tireless and dedicated activism and advocacy.

Factors Influencing Successful Local Advocacy for Harm Reduction

- Carefully tailor responses to local contexts
- Involvement of strong, local civil society organisations
- Innovative services opened (with or without official support or permission)
- Commissioning or conducting research
- Evidence made accessible for policymakers and the public
- Clear articulation of costs, benefits, and risks of inaction
- Empowerment and meaningful engagement of people who use drugs
- Key groups united for discussions and debate: policymakers, academics, civil society, religious groups, the media and people who use drugs
- Conferences, events and exchanges (international, regional and national)
- Support from international or regional donors and organisations
- Emphasis of international goals, commitments and targets (for public health, human rights and other issues)
- Alliances built with other fields and groups

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About this Publication

In 2008 Harm Reduction International released the Global State of Harm Reduction, a report that mapped responses to drug-related HIV and hepatitis C epidemics around the world for the first time. The report has since been published every two years.

The Global State of Harm Reduction 2012 presents the major developments in harm reduction policy adoption and programme implementation that have occurred since 2010, enabling some assessment of global progress. It also explores several key issues for developing an integrated harm reduction response, such as building effective harm reduction services for women who inject drugs, access to harm reduction services by young people, drug use among men who have sex with men, global progress toward drug decriminalisation and regulation and sustainability of services in challenging environments.

This report, and other global state of harm reduction resources, are designed to provide reference tools for a wide range of audiences, such as international donor organisations, multilateral and bilateral agencies, civil society and non-governmental organisations, including organisations of people who use drugs, as well as researchers and the media.

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