



THE GLOBAL STATE OF HARM REDUCTION 2014



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The Global State of Harm Reduction 2014

Edited by Katie Stone

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Abbreviations and acronyms

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

Foreword by David Furnish

For the last few decades, those of us in the fight against AIDS have rallied together around two powerful words: Ending AIDS. Today, we are closer to that goal than we have ever been.

And yet, alongside this optimism and hope, there's another set of words that undermines so much of our work: Left Behind.

In most communities, people who inject drugs don't have access to syringes to prevent infections, opioid substitution treatment, or naloxone to prevent overdose. Moreover, people who use drugs are denied basic health services. They have no access to non-judgmental primary care, mental health and drug treatment services, and the support they need to maintain stable, healthy lives.

And yet, harm reduction has been proven time and again to be extremely effective in curbing HIV transmission. In settings where comprehensive harm reduction has been implemented, HIV rates among people who inject drugs are low—in some cases, almost negligible.

This is why the Elton John AIDS Foundation invests heavily in harm reduction programming as a core priority in our grant making, and we are deeply proud of the achievements of our grantees. In the United States, for example, it is calculated that the grantees of the Syringe Access Fund, in which we are a lead funding partner, reach more than 30,000 people every year, with over one million clean syringes and other harm reduction services. This effort in the United States is gradually reducing the number of people acquiring HIV through injection drug use.

The Elton John AIDS Foundation was a proud sponsor of the International Harm Reduction Conference in Vilnius in 2013. We are also proud to support the work of Harm Reduction International in producing this valuable report. And at every opportunity in our foundation's global communications, we profile and applaud the many harm reduction workers and activists who are at the front lines of this struggle.

But our efforts alone are not enough. Too many people are being left behind and left out—in the Americas, in Africa, in Asia, in Eastern Europe. And there continues to be a dangerous shortfall in funding for harm reduction to reach the people who need help the most.

Every person left behind is a fellow human being – someone's child, someone's parent, someone's friend, someone's partner. Every one of them has a right to life and to health. Every one of them deserves compassion, and dignity, and love.

As we look back on all of the important progress we've made in recent years, we must remember that 'Ending AIDS' must be much more than a slogan. It must be a realistic vision, grounded in science, and funded and implemented in a manner that will reach all who are in need. That is why this report is so critical. Because to truly End AIDS, we must make sure that no one gets Left Behind.



David Furnish
Chair, Elton John AIDS Foundation

Foreword by Dr Eliot Ross Albers

This fourth edition of the *Global State of Harm Reduction* is released at a critical juncture in the evolution of the harm reduction response to the use of illicit drugs.

The cost effectiveness and power of harm reduction as a means of realising the right to the highest attainable standard of health for people who use drugs - as a rights affirming, community empowering response to our needs - has never been more widely recognised. The core harm reduction interventions of the 'comprehensive package', including the provision of sterile needles and syringes and opioid substitution therapy (OST), have been clearly demonstrated to effectively prevent the transmission of blood borne viruses amongst people who inject drugs.

Yet the funding gap to support harm reduction programming and bring it to the scale needed has never been more stark. Investment in harm reduction as part of overall prevention spending is nowhere near proportionate to the incidence of new HIV cases amongst people who inject drugs, illustrating that donor priorities are out of alignment with the epidemiological trend and burden of HIV disease. HIV is an epidemic increasingly concentrated amongst the key populations (who collectively account for approximately half of new infections globally). Yet changing donor priorities, and an inability, or lack of willingness, to pay on the part of national governments means harm reduction programmes are either downsizing, not receiving investment proportionate to infection rates amongst people who inject drugs, running at a level that is nowhere near the necessary scale or simply not being provided as multilateral donors withdraw.

The severity of the hepatitis C crisis amongst people who inject drugs is more acute than HIV by several orders of magnitude. Yet harm reduction has been so tightly tied to HIV-led imperatives that few programmes have been incentivised to provide the level or range of equipment or services needed to prevent the hepatitis C virus from being inadvertently spread. Access to HCV diagnostics, treatment and care is scandalously lacking, with people who inject drugs denied access to treatment in most countries. This is not to speak of the obscene prices being demanded for the new generation of direct acting antiviral drugs.

Since the publication of the last *Global State of Harm Reduction*, we have seen several notable statements making clear the direct causative connection between criminalisation and repressive drug control policies, and the systemic human rights abuses to which people who use drugs are subject. We have seen very welcome World Health Organization (WHO) recommendations calling for peer distribution and use of naloxone to reduce opioid overdoses, a singularly empowering recommendation for the drug using community, and a recognition of the central role that we can and must play in getting vital services into the hands of our community. This closes the cycle that saw harm reduction emerge initially from drug user activists, to a new recognition that services, if they are to be truly accessible, acceptable, and appropriate must be returned through a process of power-shifting to the communities they serve. This reclamation of harm reduction services by the drug using community is a process of empowerment, and a recognition of the vital role that we play in protecting our health, and defending our rights. The success of this agenda, however, is contingent upon investment in community systems strengthening and empowered organisations, networks, and communities of people who use drugs.

Whilst, the retreat from investment in harm reduction places the lives, health, and rights of millions of people who use drugs around the world in jeopardy, the international drug users' movement has never been stronger, having successfully fought to occupy our rightful place as a vital partner in every debate that impacts upon our lives and health on the global, regional and national stages. The wealth of knowledge contained in this new edition of the *Global State of Harm Reduction* will be a welcome addition to the advocacy armoury of drug user activists everywhere, and its publication is warmly welcomed.



Dr Eliot Ross Albers
Executive Director
International Network of People who use Drugs

Introduction

About the Global State of Harm Reduction 2014

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.⁽¹⁾ The data 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. Since then, the biennial report has become a key publication for researchers, policymakers, civil society organisations and advocates, mapping harm reduction policy adoption and programme implementation globally.

In the second and third editions, the *Global State of Harm Reduction 2010: Key Issues for Broadening the Response*⁽²⁾ and *The Global State of Harm Reduction 2012: Towards an Integrated Response*,⁽³⁾ important harm reduction issues were explored in a series of chapters on key topics, such as the response to amphetamine-related harms, harm reduction in prisons, effective harm reduction services for women who inject drugs, and access to harm reduction services by young people.

The Global State of Harm Reduction 2014 continues to map the response to drug-related HIV, viral hepatitis and tuberculosis. It also integrates updated information on harm reduction services into each regional chapter, including on needle and syringe programmes (NSPs) and opioid substitution therapy (OST) provision; harm reduction services in the prison setting; access to antiretroviral therapy for people who inject drugs; regional overdose responses; policy developments; civil society developments; and information relating to funding for harm reduction.

This report and other Global State of Harm Reduction resources can be found at www.ihra.net

Methodology

The information presented in the two sections of the report has been gathered using existing data sources, including research papers and reports from multilateral agencies, international non-governmental organisations, civil society and harm reduction networks, organisations of people who use drugs, and expert and academic opinion from those working on HIV, drug use and harm reduction. Harm Reduction International has also enlisted support from regional harm reduction networks and researchers to gather qualitative information on key developments¹ and to review population size estimates, data on the epidemiology of HIV and viral hepatitis among people who inject drugs, and the extent of NSP and OST provision.

Quantitative data for the tables at the beginning of each chapter in Section 2 have been obtained from a variety of sources and are referenced in each regional update. These data reflect the most recent available estimates for each country at the time of the data collection exercise (June to October 2014). Where no source was available, the data were unpublished or their reliability were questioned by civil society organisations, researchers or other experts, we have sought expert opinion to identify additional sources and verify their reliability.

Where information in the tables is dated, we have provided footnotes with a year of estimate. Unless Harm Reduction International has been able to identify more recent data, prevalence figures for viral hepatitis have been sourced from the review of reviews published by Nelson and colleagues in 2011.⁽⁴⁾ Data from Western Europe and some countries in Eurasia has been sourced from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2014 Statistical Bulletin, unless otherwise stated in the text. Footnotes and references are provided for all estimates reported, together with any discrepancies in the data.

Figures published through international reporting systems, such as those undertaken by the United Nations Office on Drugs and Crime (UNODC), the World Health Organization and the Joint United Nations Programme on HIV/AIDS (UNAIDS), may differ from those collated here due to the varying scopes of monitoring surveys and reliability criteria, and a focus on regions that may include different country classifications.

Regions have been largely identified using the coverage of regional harm reduction networks. Accordingly, this report examines Asia, Eurasia (Central and Eastern Europe and Central Asia), Western Europe, Caribbean, Latin America, North America, Oceania, Middle East and North Africa, and sub-Saharan Africa. All regional updates have been peer reviewed by experts in the field (see Acknowledgements).

Data quality

For global population size estimates of people who inject drugs and HIV epidemiology, Harm Reduction International has presented the UN Reference Group⁽⁵⁾ data where these are the most recent available estimates, and provided data from other sources where it is reliable. These include national global AIDS progress reports submitted to UNAIDS in March 2014, bio-behavioural surveillance reports, systematic reviews and academic studies. Other experts have been consulted for information on the most recent number of NSP and OST sites.

We have sought input from harm reduction networks, researchers, academics and other experts to inform our reporting on the existence and coverage of harm reduction. Where no updates were available, data from *The Global State of Harm Reduction 2012: Towards an Integrated Response*⁽³⁾ has been included, with footnotes provided on dates of estimate where necessary.

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

Our data on epidemiology and coverage represent the most recent, verifiable estimates available. However, a lack of uniformity in measures, data collection methods and definitions for the estimates provided make cross-national and regional comparisons challenging.

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

Limitations

The report aims 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 quality of the services that are in place, although where possible, it does highlight areas of concern regionally.

While *The Global State of Harm Reduction 2014* aims to cover important areas for harm reduction, it focuses primarily on public health aspects of the response. The report does not document all the social and legal harms faced by people who use drugs, nor does it cover all the health harms related to substance use, including those related to alcohol and tobacco.

Report structure

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

Section 2 contains nine regional updates: Asia, Caribbean, Eurasia (Central and Eastern Europe and Central Asia), Latin America, Middle East and North Africa, North America, Oceania, sub-Saharan Africa and Western Europe. These examine developments in harm reduction since 2012.

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GLOBAL OVERVIEW

1.1

Global Update: Behind the numbers



Global Update: Behind the numbers

This report is the fourth in the biennial 'Global State of Harm Reduction' series tracking developments in HIV and hepatitis C related harm reduction worldwide. The 'Global State' has become a go-to source for researchers and advocates since the first edition in 2008 when it provided, for the first time, an at-a-glance snapshot of global harm reduction responses.

Throughout that time there has been slow but steady progress in the acceptance of harm reduction in national policies and in the establishment of new services. The response to HIV and hepatitis C related to unsafe injecting, however, remains poor overall.

Injecting drug use has been documented in at least 158 countries and territories worldwide.⁽¹⁾ Population size estimates for people who inject drugs, however, are challenging to ascertain and as such the global estimate for injecting drug use is a range of 8.9-22.4 million.⁽¹⁶⁾ Similar challenges for HIV incidence and prevalence data are evident with a range of the number of people who inject drugs living with HIV of 0.9 – 4.8 million.⁽¹⁸⁾ It is strongly recommended that an independent, transparent peer reviewed mechanism is put in place to determine and review estimates related to injecting drug use and HIV.

There is urgent concern regarding the global target to reduce HIV incidence by 50% among people who inject drugs by 2015. While HIV incidence has declined slightly in recent years from 110,000 (range: 97,000 – 123,000) in 2010 to 98,000 (range: 85,000 – 111,000) in 2013, this is a reduction of only 10%⁽³⁷⁾ and indicates the necessity of significantly increased harm reduction service provision. Of the 158 countries reporting injecting drug use 91 of these include harm reduction in national policy, while needle and syringe exchange programmes (NSPs) and opioid substitution therapy (OST) are available in 90 and 80 countries or territories respectively (see Table 1.1.1). Two countries have recently introduced OST programmes (since 2012), Burkina Faso and Turkey, and five countries or territories globally have newly introduced NSPs since 2012. Worryingly, NSP provision in prisons has significantly decreased since 2012, with only eight countries globally providing this harm reduction intervention.

The global state of harm reduction, however, cannot be represented solely by numbers. Behind the numbers are day to day struggles and incredibly complex dynamics at local, national and regional levels. This is why these reports have never presented the data alone, absent in-depth commentary on emerging challenges, unmet needs and policy developments. Crucially, *The Global State of Harm Reduction* has always been a civil society partnership, including developments in activism and

service provision alongside the data. What these reports show, in addition to the urgent case for harm reduction scale up top line data, is the energy and innovation of civil society and community-based organisations.

In the few places where harm reduction has been brought to sufficient scale and quality it has had a significant impact in reducing HIV transmission. The core harm reduction package endorsed by the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Office on Drugs and Crime (UNODC) and the World Health Organization (WHO) is vital for global responses to the epidemic. Nonetheless, harm reduction is facing a crisis. International and national funding for essential services is disastrously short of need in low- and middle-income countries. Unless fundamental changes are made in donor priorities, matters are set to worsen.

US\$ 2.3 billion annually is estimated by UNAIDS to be required to fund HIV prevention among people who inject drugs in 2015.⁽³⁸⁾ At last estimate, only US\$ 160 million was invested by international donors; approximately 7% of what is required.⁽³⁹⁾ Behind these numbers is the spread of preventable disease and lives risked and lost. But again civil society is taking action. Networks such as the Eurasian Harm Reduction Network have taken a lead on advocacy for filling the resourcing gap, a challenge that disproportionately affects the Eurasian region.

The money required is significant, but attainable. One tenth of the estimated annual global expenditure on drug enforcement - thought to exceed \$100 billion⁽⁴⁰⁾ - would cover the \$2.3 billion price tag four times over.

Addressing this imbalance requires more than merely moving funds. It necessitates a change in government priorities in drug control as a prerequisite for those funds being reinvested. It is for this reason that harm reduction advocacy, alongside frontline service provision, remains absolutely essential. This also faces severe funding shortfalls.

The numbers present a clear public health and human rights challenge. They demonstrate results where harm reduction is scaled up, serious harms where it is not, and identify where major investments are needed. Behind those numbers are the civil society frontline workers and activists driving change; and a funding crisis in harm reduction setting the agenda for advocacy in the coming years.

The global harm reduction response

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

| 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 |
| China | ✓ | ✓ | ✓ | x |
| Hong Kong | ✓ | x | ✓ | x |
| India | ✓ | ✓ | ✓ | x |
| Indonesia | ✓ | ✓ | ✓ | x |
| Laos PDR | ✓ | ✓ | x | x |
| Macau | ✓ | ✓ | ✓ | x |
| Malaysia | ✓ | ✓ | ✓ | x |
| Maldives | ✓ | x | ✓ | x |
| Mongolia | ✓ | ✓ | x | x |
| Myanmar | ✓ | ✓ | ✓ | x |
| Nepal | ✓ | ✓ | ✓ | x |
| Pakistan | ✓ | ✓ | x | x |
| Philippines | ✓ | ✓ | x | x |
| Taiwan | ✓ | ✓ | ✓ | x |
| Thailand | ✓ | ✓ | ✓ | x |
| Vietnam | ✓ | ✓ | ✓ | 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 |

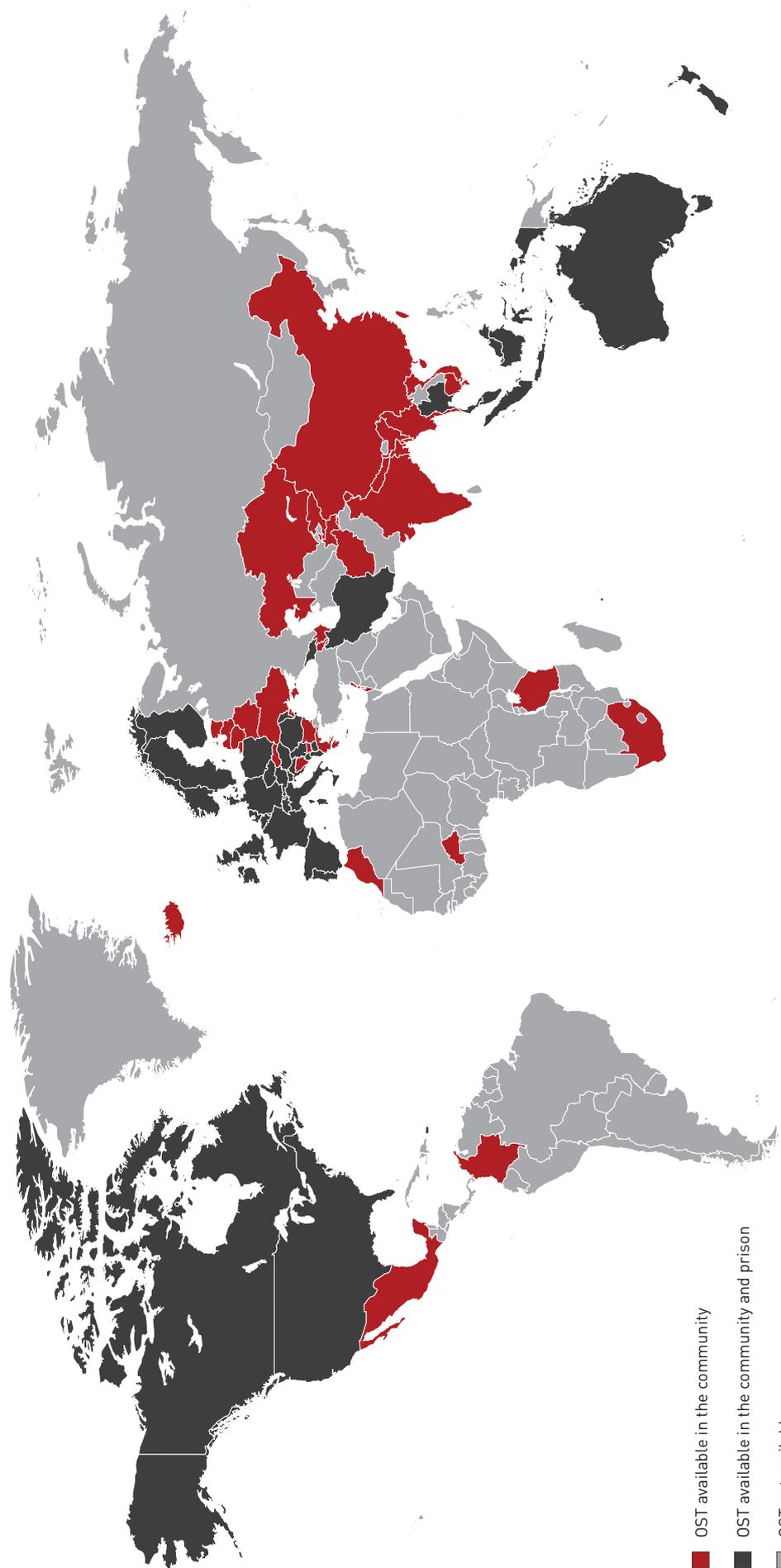
| Country or territory | Explicit supportive reference to harm reduction in national policy documents | Needle exchange programmes operational | Opioid substitution programmes operational | Drug consumption room(s) |
|--------------------------|--|--|--|--------------------------|
| EURASIA continued | | | | |
| Romania | ✓ | ✓ | ✓ | x |
| Russia | x | ✓ | x | x |
| Serbia | ✓ | ✓ | ✓ | x |
| Slovakia | ✓ | ✓ | ✓ | x |
| Slovenia | ✓ | ✓ | ✓ | x |
| Tajikistan | ✓ | ✓ | ✓ | x |
| Turkmenistan | x | ✓ | x | x |
| Ukraine | ✓ | ✓ | ✓ | x |
| Uzbekistan | ✓ | ✓ | x | x |
| WESTERN EUROPE | | | | |
| Austria | ✓ | ✓ | ✓ | x |
| Belgium | ✓ | ✓ | ✓ | x |
| Cyprus | ✓ | ✓ | ✓ | x |
| Denmark | ✓ | ✓ | ✓ | ✓ |
| Finland | ✓ | ✓ | ✓ | x |
| France | ✓ | ✓ | ✓ | x |
| Germany | ✓ | ✓ | ✓ | ✓ |
| Greece | ✓ | ✓ | ✓ | x |
| Iceland | nk | x | ✓ | x |
| Ireland | ✓ | ✓ | ✓ | x |
| Italy | ✓ | ✓ | ✓ | x |
| Luxembourg | ✓ | ✓ | ✓ | x |
| Malta | ✓ | ✓ | ✓ | x |
| Netherlands | ✓ | ✓ | ✓ | ✓ |
| Norway | ✓ | ✓ | ✓ | ✓ |
| Portugal | ✓ | ✓ | ✓ | x |
| Spain | ✓ | ✓ | ✓ | ✓ |
| Sweden | ✓ | ✓ | ✓ | x |
| Switzerland | ✓ | ✓ | ✓ | ✓ |
| Turkey | ✓ | x | ✓ | x |
| United Kingdom | ✓ | ✓ | ✓ | x |
| CARIBBEAN | | | | |
| Puerto Rico | x | ✓ | ✓ | x |
| Dominican Republic | x | ✓ | x | x |
| Trinidad & Tobago | ✓ | x | x | x |

| 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) |
|-------------------------------------|--|--|--|--------------------------|
| LATIN AMERICA | | | | |
| Argentina | ✓ | ✓ | x | x |
| Brazil | ✓ | ✓ | x | x |
| Colombia | ✓ | ✓ | ✓ | x |
| Mexico | ✓ | ✓ | ✓ | x |
| Paraguay | ✓ | ✓ | x | x |
| Uruguay | ✓ | ✓ | x | x |
| NORTH AMERICA | | | | |
| Canada | ✓ | ✓ | ✓ | ✓ |
| United States | ✓ | ✓ | ✓ | x |
| OCEANIA | | | | |
| Australia | ✓ | ✓ | ✓ | ✓ |
| New Zealand | ✓ | ✓ | ✓ | x |
| MIDDLE EAST AND NORTH AFRICA | | | | |
| Bahrain | x | x | x | x |
| Egypt | ✓ | ✓ | x | x |
| Iran | ✓ | ✓ | ✓ | x |
| Israel | ✓ | ✓ | ✓ | x |
| Jordan | ✓ | ✓ | x | x |
| Lebanon | ✓ | ✓ | ✓ | x |
| Morocco | ✓ | ✓ | ✓ | x |
| Palestine | x | ✓ | x | x |
| Syria | ✓ | x | x | x |
| Tunisia | x | ✓ | x | x |
| UAE | x | x | ✓ | x |
| SUB-SAHARAN AFRICA | | | | |
| Burkina Faso | x | x | ✓ | x |
| Kenya | ✓ | ✓ | x | x |
| Mauritius | ✓ | ✓ | ✓ | x |
| Senegal | ✓ | ✓ | x | x |
| Seychelles | x | x | ✓ | x |
| South Africa | x | ✓ | ✓ | x |
| Tanzania | ✓ | ✓ | ✓ | x |
| Zanzibar | ✓ | x | x | x |

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



Needle and syringe exchange programmes (NSPs)

In 2014, 90 countries and territories implement NSPs to varying degrees. Models of provision include: fixed and specialist NSP sites, community-based outreach, pharmacy provision and vending machines. Five countries have newly implemented NSPs since 2012 –the Dominican Republic, Colombia, Jordan, Kenya, and Senegal. Newly implemented NSPs in sub-Saharan Africa indicates a steady acceptance of the necessity for harm reduction services in regions which were previously adverse to such services.

The number of operational NSP sites and the coverage provided through existing services vary widely among countries and regions. The greatest increase in NSP provision has been seen in Malaysia, Iran and Australia, where provision has nearly doubled since 2012. And a total of 29 countries have scaled up NSP services between 2012 to 2014. These include: Afghanistan, India, Malaysia, Thailand, Armenia, Azerbaijan, Bosnia & Herzegovina, Croatia, Georgia, Hungary, Kyrgyzstan, Macedonia, Romania, Austria, Belgium, Finland, France, Germany, Greece, Ireland, Luxembourg, Norway, Sweden, United States, Australia, Egypt, Iran and Morocco.

Generally, coverage is lower in low- and middle-income countries than high-income countries, with few changes in provision since 2012 in Latin America and the Caribbean. However the introduction of NSP services in Colombia and the Dominican Republic is a positive step forward. Despite the increases in provision, existing services in many low- and middle-income countries do not reach coverage levels sufficient to stabilise HIV and hepatitis C epidemics among populations of people who inject drugs, and in thirteen countries NSP provision has actually decreased. Pakistan saw a significant decrease in provision from 81 sites in 2012⁽²⁾ to 34 in 2014,⁽³⁾ and Oman's NSP service which was operational in 2012 now ceases to exist.

In 2014, 68 countries or territories with reported injecting drug use do not provide NSP services.

Opioid substitution therapy (OST)

In 2014, 80 countries and territories implement OST. Methadone and buprenorphine are the most commonly used medications, but in some countries others are also provided, including slow-release morphine and codeine, and heroin-assisted treatment (HAT). Only two countries, Burkina Faso and Turkey have newly implemented OST since 2012. OST is also now available in Bahrain, but only in rehabilitation facilities.

The number of sites providing OST and the proportion of people that receive substitution therapy, is substantially higher in high-income countries. Similar to NSP, low- and middle-income countries often have the fewest number of OST sites.

In total since 2012, 25 countries have scaled up their provision of OST services with Vietnam doubling its availability of OST to people who inject drugs (see Chapter 2.1). However provision of OST has decreased in Estonia, Lithuania, Serbia, Mexico, and Australia. And in many countries coverage of existing OST programmes remains substantially below minimum levels recommended by international guidance, and improvement in scale and quality are urgently needed to ensure that interventions achieve the greatest impact.⁽⁴⁾

In 2012, 78 countries with reported injecting drug use do not provide OST services.

Drug Consumption Rooms

In 2014 there are now 88 drug consumption rooms (DCRs) operating worldwide. DCRs form a vital part of harm reduction services in some parts of Western Europe, allowing people who use drugs to inject in a safe space and under medical supervision. Outside of Europe two DCRs are in operation, one in Australia and one in Canada.

In Western Europe, Denmark saw the implementation of five DCRs, and both Spain and Switzerland, who had previous DCRs in operation increased their site provision by six each. Between 2012-2014 a DCR was also opened in Greece but closed due to political pressures, and a reduction of DCRs has been seen in Germany with a decrease of 3 between 2012 to 2014, and the Netherlands, which saw a decrease of 10 in the same time period.

Overdose

A recent systematic review found that overdose and AIDS related mortality are the leading cases of death for people who use drugs⁽⁵⁾ and countries such as Sweden, which have a critically low harm reduction response (see Chapter 2.3) have some of the highest death rates among people who use drugs on record.⁽⁶⁻⁷⁾ In Sub-saharan Africa naloxone, a highly effective opiate antagonist used to reverse the effects of opioid overdose, is newly available in Kenya and Tanzania, but the success of this provision is yet to be evaluated.⁽⁸⁾

In the United States, as of June 2014, there are 30 states plus Washington DC that have at least one point of access for laypersons to obtain naloxone for people who use drugs, or friends and family.⁽⁹⁾ Until

point of access for laypersons to obtain naloxone for people who use drugs, or friends and family.⁽⁹⁾ Until recently naloxone distribution programmes in Canada existed only in Edmonton, Toronto and Ottawa. However, since 2012 the British Columbia Centre for Disease Control has overseen a rapid scale up of overdose prevention and response programmes this territory.

Australia's medically supervised injecting centre (also known as a DCR – please refer to Table 2.7.1), which provides sterile injecting equipment alongside a range of additional services for people who inject drugs, has been found to significantly reduce calls to ambulance-attended opioid-related overdoses in the small area of Sydney where it is located,⁽¹⁰⁾ highlighting not only the necessity of naloxone in the reduction of drug-related deaths, but also the important function of DCRs.

Prisons

The provision of harm reduction interventions in the form of NSPs and OST in prisons and other closed settings remains extremely limited compared to responses in the community. As of 2014 eight countries implement NSPs in prisons, and 43 countries provide OST in the prison setting.

NSP is markedly smaller to OST provision in prisons, and considering the high rates of injecting drug use and the complex interaction of HIV, viral hepatitis and tuberculosis in prison settings worldwide⁽¹²⁻¹³⁾ indicates an urgent need to implement and expand the provision of NSP services in these settings. In Western Europe only Spain, Switzerland, Germany and Luxembourg offer NSP provision in the prison setting, with the service in Luxembourg under review. Armenia, Belarus and Romania all saw their NSP services in prisons closed between 2012 to 2014.

In 2014 there is still no NSP or OST provision in Latin America, and provision in sub-Saharan Africa is limited to OST provision in male prisons in Mauritius. In the Middle East and North Africa NSP and OST is still only available in Iran.

All countries in Western Europe, aside from Greece and Cyprus, provide OST for people in prison, but it is Malaysia that has the greatest scale-up of OST going from 1 prison in 2012⁽²⁾ to 18 in 2014.⁽¹¹⁾

For the first time, The Global State of Harm Reduction 2014 attempted to gather information on condom provision in prisons, and found that worryingly few countries or territories supply condoms to those incarcerated. Coupled with the lack of NSP services for people who inject drugs, there is an increased need to amend the lack of health-based approaches in the prison setting.

The funding crisis for harm reduction

As a part of the Global State of Harm Reduction project, HRI began collecting data on donor investments in harm reduction in 2009. While funding has always been short, in recent years the outlook has deteriorated due to donor retreat and national government neglect.

As noted above, only \$160 million⁽³⁸⁾ of the \$2.3 billion⁽³⁹⁾ needed for HIV-related harm reduction was invested by international donors at last count. This situation is likely to get worse. International donor policy and practice is changing. Increasingly, funds are directed towards low-income countries with a high disease burden and related HIV treatment services. More countries are becoming ineligible for international donor support due to their middle-income status, regardless of epidemiological need or the willingness of the national government to step in and cover the remaining funding gaps. This is despite the fact that the majority of people who inject drugs (approximately 75%) live in these countries.

The focus on disease burden also de-prioritises prevention even though the lack of access to harm reduction services is one of the most important factors driving HIV transmission in middle-income countries and in key regions – Central and Eastern Europe and Central Asia, South and South-East Asia and the Middle East and North Africa.

Donor governments are increasingly relying on their contributions to multilateral agencies such as The Global Fund to Fight AIDS, Tuberculosis and Malaria to fulfil their commitments to key population programming. Yet Global Fund policy has also changed and now, like some of its main contributors, it favours investment in low-income countries with a high disease burden.

Meanwhile, national governments are not taking responsibility for their own key populations and their own epidemics. Even where HIV prevalence rates are increasing and harm reduction programme coverage is dismally low, many governments are not prioritising these programmes.

This is not due to a lack of money, but rather a lack of appropriate allocation of resources. At the same time as harm reduction services are lacking, these governments spend vast amounts on drug enforcement, too often targeting and harming the very people in need of support, not punishment.

A report⁽¹⁴⁾ highlighting the global crisis for harm reduction funding developed the following recommendations:

- » Keep the Global Fund global
- » Invest strategically in harm reduction
- » Increase national harm reduction investment
- » Rebalance existing resources towards health and harm reduction



The Global Fund

In 2013 donor countries pledged a record US\$ 12 billion to the Global Fund.⁽⁴¹⁾ Late the same year the Global Fund announced a major change in how it provides grants, launching the 'New Funding Model' to 'enable strategic investment for maximum impact' and to 'provide implementers with flexible timing, better alignment with national strategies and predictability on the level of funding available'.⁽⁴²⁾ The New Funding Model moves away from the competitive funding rounds that had been implemented previously. Instead, countries are assigned to one of four 'country bands' and are given funding allocations based on their income level and disease burden.⁽⁴²⁾

Despite the Global fund's continued support for harm reduction, the New Funding Model is a demonstrable threat to investments in harm reduction programming, as many of the countries with the greatest need for harm reduction investment are now either ineligible for further funding or are not receiving any 'new' resources until at least 2017, all as a result of the Global Fund's use of country income status to determine national allocations.⁽¹⁴⁾ This is likely to lead to dramatic cuts to harm reduction programmes.

Bilateral donors

The New Funding Model at the Global Fund exemplifies the broader deprioritisation of middle-income countries by donors, including those that have led the way on harm reduction resourcing. A clear example is the UK Department for International Development where, due to changes in funding priorities, overall bilateral funding for HIV has dropped by UK£ 75 million since 2010, and as a result the number of DFID-funded HIV programmes has dropped from 26 to 16.⁽¹⁴⁾ All harm reduction programmes have closed or are due to close by the end of 2014, with the exception of programmes in Myanmar (funded through the Three Diseases Fund until 2016).⁽¹⁴⁾

International policy developments

United Nations Developments

At the UN level 2013 and 2014 saw the announcements of a UN General Assembly Special Session on Drugs in 2016 (the first since 1998)⁽⁴³⁾ and a High Level Meeting on HIV to be held in the same year.⁽⁴⁴⁾ 2016 therefore looks set to be an important year for harm reduction on the international stage. However, negotiations relating to harm reduction at these events will no doubt be fraught. In March 2014, for example, a 'Joint Ministerial Statement' was adopted at the UN Commission on Narcotic Drugs. As with other such consensus documents, harm reduction was a considerable flashpoint of negotiations, creating deadlock for weeks. While ultimately remaining in the final agreed document there was even considerable controversy as to whether previously agreed General Assembly targets (a 50% reduction in HIV transmission among people who inject drugs by 2015) could be included. The evidence base for harm reduction in HIV prevention was challenged by the Russian Federation.⁽⁴⁵⁾

In 2014, a target to 'eliminate narcotic drug and substance abuse' by 2030 appeared in the draft Sustainable Development Goals, illustrating clearly the ease with which ill-thought out and counter-productive language about drugs enters into high level debates.⁽¹⁵⁾ Following some advocacy around this language, civil society organisations across harm reduction, HIV and development managed to secure important amendments to better reflect public health goals.

The ongoing inability to come to consensus on harm reduction at UN level ('harm reduction' is still an unacceptable term at the UN Commission on Narcotic Drugs), and to fully support what works in HIV prevention, is cause for considerable concern

and exposes international commitments as merely rhetorical. At the 2014 International AIDS Conference, amid visions of an end to AIDS, UNAIDS illustrated the gap between reality and rhetoric with its ‘Gap Report’. It showed clearly how people who inject drugs are being ‘left behind’, citing criminalisation, social stigma, a lack of services and a lack of funding as the lead causes.⁽¹⁶⁾

International leadership on harm reduction

New targets will be needed at the 2016 high level meeting on HIV, but this will itself require strong leadership from governments that have championed harm reduction in the past. In recent years, however, that leadership has weakened in important ways. With continued resistance to harm reduction at national level and international levels stronger leadership from all governments that have supported these interventions will be vital.

The United Kingdom, in particular, has weakened in its leadership for harm reduction in international fora in part due to changing political priorities at a national level. During the High Level Segment ahead of the 57th session of the CND the UK’s ministerial statement did not explicitly endorse harm reduction.⁽⁴⁶⁾

Canada has been weak for many years under the Stephen Harper government, but in the past two years its positions at the UN have become increasingly extreme, working at the UN to attempt to block harm reduction.⁽¹⁷⁾

There remain, however, strong champions; including Denmark, the Netherlands and Switzerland, the latter funding the 2nd European Harm Reduction Conference in Basel.⁽⁴⁷⁾ While not a development of the past year, moreover, it is important to note in this context that since President Obama took office in 2008, there has been a clear shift in US diplomacy with regard to harm reduction. While the US will not agree to the term in UN negotiations, where once it was a considerable barrier to HIV agreements relating to harm reduction, it is now a strong advocate on the international stage for the scale up of core HIV and hepatitis C services. Indeed, the new US Drug Czar, Michael Botticelli, was a keynote speaker at the 2014 Harm Reduction Conference in Baltimore, hosted by the Harm Reduction Coalition, illustrating important progress.

Within the United Nations there has been a noticeable improvement in the public statements of the Executive Director of the UN Office on Drugs and Crime. This was especially evident in the recent World Drug Report in which the Executive Director’s

The “Support. Don’t Punish” Campaign: A global show of force for harm reduction and policy reform

The “Support. Don’t Punish” campaignⁱ is a global initiative calling for investments in proven and cost-effective harm reduction responses for people who use drugs, for the decriminalisation of personal possession, and the removal of other laws that impede public health services. The campaign was launched in 2013 through the multi-partner Community Action on Harm Reduction project,ⁱⁱ and includes social media activities, an Interactive Photo Project,ⁱⁱⁱ and a ‘Global Day of Action’ on 26th June – the UN’s International Day against Drug Abuse and Illicit Trafficking.

On Thursday 26th June 2014, people in more than 100 cities participated in a range of different events and activities – including press conferences, graffiti and art displays, protests, processions, music events, workshops and seminars, flash mobs, dance displays, football matches, and even a boat show on the Nile!^{iv} Activists gathered in Australia, Belgium, Bolivia, Bosnia and Herzegovina, Cambodia, Canada, Chile, China, Colombia, Costa Rica, Denmark, Egypt, France, Georgia, Greece, Hungary, India, Indonesia, Ireland, Italy, Kenya, Lebanon, Macedonia, Malaysia, Mauritius, Mexico, Nepal, New Zealand, Nigeria, Norway, Palestine, Peru, Philippines, Poland, Puerto Rico, Romania, Russia, Senegal, Spain, Switzerland, Tanzania, Thailand, Tunisia, Ukraine, the United Kingdom, the USA, Viet Nam and Zimbabwe. The one thing that tied them all together was the campaign message – that the heightened risks faced by people who use drugs can no longer be ignored. Others took part on social media, with 350 tweets per hour using the campaign hashtag at its peak.^v

The momentum is clearly building now ahead of the UN General Assembly Special Session (UNGASS) on drugs in 2016.

i <http://supportdontpunish.org/>

ii <http://www.cahrproject.org/>

iii <http://supportdontpunish.org/photoproject>

iv <http://supportdontpunish.org/day-of-action-2014/>

v <http://idpc.net/blog/2014/07/a-global-day-of-action-for-drug-policy-reform-in-more-than-100-cities>

foreword was unequivocal “UNODC is committed to ensuring evidence-informed HIV interventions for all key populations. We have seen that countries that have adequately invested in harm reduction services have lowered remarkably HIV transmission among people who inject drugs.”⁽¹⁸⁾

Leadership has also emerged in the form of the Global Commission on HIV and the Law⁽¹⁹⁾ and the Global Commission on Drug Policy.⁽²⁰⁾ Both made up of high-level officials, including former presidents, the Commissions have made an important contribution to the reputation and visibility of harm reduction in recent years. Both have called for reforms to the international drug control system and for decriminalisation of personal use and possession to address drug related health harms.

International attention around viral hepatitis increased with a World Health Assembly resolution passed in May 2014 which commits the WHO and Member States to address the hepatitis pandemic including hepatitis C. Despite early opposition from several member states a recommendation on harm reduction was retained.⁽⁴⁸⁾

Regional policy developments

There have been some important developments within regional bodies since 2012. For example, the European Union adopted its drug strategy and action plan 2013-2020 with a renewed commitment to harm reduction, including in prisons.⁽⁴⁹⁾ This is crucial not only for European Commission funding priorities but also for EU positions as a group at the UN where it has traditionally led the way in improving harm reduction commitments.

Under the auspices of the Organization of American States (OAS) a team was established in 2013 to produce a report on ‘Scenarios for the Drug Problem in the Americas 2013-2025’. The final report, which has proven influential in the hemisphere and beyond, suggested four potential scenarios, with harm reduction being one of the lead policy principles underpinning the scenario planning process.⁽²¹⁾

During the 5th African Union Conference of Ministers of Drug Control in 2012, a new Plan of Action on Drug Control was agreed for 2013–2017. This signals an important step forward, with a balanced approach that includes (in the accompanying Implementation Matrix) an explicit commitment to implement the UNODC/UNAIDS/WHO comprehensive package of harm reduction services, as well as providing alternatives to incarceration. At the 6th Conference in 2014 – under the bold heading ‘Drugs Kill, But Bad

Policies Kill More’ – countries reviewed progress, recommitted to harm reduction, and held important discussions on drug policy reform in the region.⁽⁵⁰⁾

The Association of South East Asian Nations, in contrast to the other regional groups above, maintained a steadfast commitment to a ‘drug free ASEAN by 2015’.⁽⁵¹⁾

Human rights and harm reduction

Writing in the first edition of the Global State of Harm Reduction, Professor Paul Hunt, then Special Rapporteur on the right to health said:

‘In seeking to reduce drug-related harm, without judgement, and with respect for the inherent dignity of every individual, regardless of lifestyle, harm reduction stands as a clear example of human rights in practice. What began as a health-based intervention in response to HIV must today be recognised as an essential component of the right to the highest attainable standard of health for people who inject drugs’.⁽²²⁾

Since then support for harm reduction as a component of the right to health has strengthened considerably, as has its relationship with the right to benefit from scientific progress and its applications and the right to freedom from cruel, inhuman or degrading treatment or punishment.^{vi} Since the last edition of the Global State in 2012, there have been a number of significant developments.

In 2013, the UN Committee on the Rights of the Child included harm reduction within its General Comment on the Child’s right to health (article 24 of the Convention on the Rights of the Child). General Comments are authoritative statements of the human rights treaty monitoring bodies providing normative guidance on the content of specific internationally protected rights. It is the clearest statement to date that appropriate harm reduction services must be considered a component of the right to health for children and young people under the age of eighteen who use drugs.⁽²³⁾

Complementing this, the UN Committee on Economic, Social and Cultural rights continued to strengthen its positions on harm reduction, raising concerns with Ukraine in 2014 about “the punitive approach taken in the State party towards persons who use drugs, which results in high numbers of such persons being imprisoned”. The Committee also raised concerns about “existing regulations which restrict access to opioid substitution therapy (OST) and needle and syringe exchange (NSE)” and recommended, alongside efforts to address

vi For an overview of developments in human rights and harm reduction to 2012 see: Barrett, D. and Gallahue, P. Harm Reduction and Human Rights. Interights Bulletin. 2012;16:188.

discrimination against people who use drugs “Allocating financial resources for the proper operation of opioid substitution therapy (OST) and needle and syringe exchange (NSE) programmes and increasing their coverage, as well as ensuring better access to such programmes in prisons programmes”.⁽²⁴⁾

Professor Paul Hunt was succeeded by Anand Grover as UN Special Rapporteur on the Right to Health. Mr Grover followed on from Prof Hunt’s work, raising harm reduction issues with governments during country visits and presenting a thematic report on drug control and the right to health to the General Assembly.⁽²⁵⁾ In 2014 Mr Grover was succeeded by Dr Dainius Puras, a strong supporter of harm reduction who was very influential in improving the drugs and harm reduction recommendations of the UN Committee on the Rights of the Child during his term from 2007-2011. As such, all three of the UN Special Rapporteurs on the right to health (Prof Hunt was the first) have been champions of harm reduction.

The former UN Special Rapporteur on Torture, Prof Manfred Nowak, was also a strong harm reduction advocate in the context of places of detention.⁽²⁵⁾ His successor, Juan Mendez, appointed in 2013, has followed suit making clear his ongoing support for harm reduction in places of detention in an important thematic report on torture in healthcare.⁽²⁶⁾

A final important development was the progress on drug policy debates within the UN Human Rights Council. At the 27th session of the Council in 2014 a side event, co-sponsored by the Global Commission on Drug Policy, Switzerland, Colombia, Mexico and Guatemala was organised in which the outgoing UN High Commissioner for Human Rights made clear her office’s support for harm reduction:

“Criminalization of drug use has considerable impact on drug users’ right to health...In many States, access to proven harm-reduction measures – including syringe exchange programmes and opiate substitution therapy – is extremely limited, non-existent or banned. Failure to provide healthcare and harm-reduction programmes... facilitates transmission of diseases such as HIV and hepatitis C. In some States, laws prohibit carrying injecting paraphernalia, and this creates additional health risks for people who inject drugs.”⁽²⁷⁾

The side event was followed at the 28th session of the Council with a cross-regional statement endorsed by sixteen countries from Europe, Latin America and Africa; calling for human rights to be at the forefront of the UNGASS debates in 2016.^{vii}

Research and data collection

A well known refrain in HIV is to ‘know your epidemic’. An important question is therefore whether global, regional and national data collection and analysis is improving over time on global harm reduction developments.

Since the disbanding of the UN Reference Group on HIV and Injecting Drug Use, the Global State of Harm Reduction has become the only independent and civil society led project collating global HIV and hepatitis C related harm reduction data. Central to this effort, however, is the UNODC’s World Drug Report, which took in-house the former epidemiological data gathering function of the reference group. In 2013 the first data from this new data collection process emerged and were immediately problematic leading HRI to issue an advisory challenging the data and methodology.⁽²⁷⁾ The 2014 World Drug Report saw significant improvements and stronger sharing of information between UNODC and HRI.

In 2013, a new ‘Strategic Advisory Group’ to the United Nations on HIV and injecting drug use was established; including representatives from UN agencies, researchers as well as Harm Reduction International, the International Drug Policy Consortium, the International Network of People Who Use Drugs and the International HIV/AIDS Alliance. In April 2014, the group held its first meeting in Geneva. This and future meetings will play a key role in helping to motivate and coordinate joint working on harm reduction and related issues within the UN and its partners.

Technical guidance

In 2013 and 2014 new guidance has emerged with regard to key populations and specific groups of people who inject drugs, both from UN agencies and civil society. From UN agencies:

- » In July 2014 the World Health Organization (WHO) released new consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. The guidelines bring together all existing guidance relevant for men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers and transgender people. Importantly the guidance recommended revising laws and policies, such as decriminalising drug use to enable a supportive environment for key populations,⁽²⁸⁾ this is the first time the WHO has made such a recommendation.

- » This guidance has also led to a separate WHO guideline on the management of opioid overdose.⁽⁵⁹⁾
- » In April 2014 the WHO also developed new guidance the screening, treatment and care of viral hepatitis.⁽²⁹⁾ The guidance includes strong recommendations for the treatment rollout for people who inject drugs. An important recommendation given the current low levels of treatment access for people who use drugs.
- » In 2014 UNODC released a toolkit providing guidance on implemented needle and syringe programmes in prisons.⁽⁶⁰⁾ The toolkit aims to assist governments to set specific targets to achieve universal access for prisoners to access evidence based HIV treatment, prevention and care.

Developments for specifically vulnerable groups:

- » In recent years children and young people who use drugs have been highlighted as a particular group requiring more concerted attention with harm reduction and HIV responses. In 2013, Harm Reduction International published a report on injecting drug use among under 18s highlighting the serious data gaps relating to this age group. The report was launched at a thematic session on young people at the UNAIDS PCB in December 2013.⁽³¹⁾
- » Throughout the first half of 2014 the WHO led a process of developing guidelines on HIV and young key affected populations, including young people who inject drugs and young people who sell sex. The process involved widespread consultation with UN, civil society and academic partners. Youth RISE organised consultations with young people who inject drugs in fourteen countries whose recommendations fed into the briefing on this key population. At the time of going to print the briefs remain in draft form, a release date remains unclear.
- » A policy brief on women who inject drugs was produced jointly by UNODC, UN Women, WHO and INPUD⁽³²⁾ The brief provides recommendations, good practice and guidance tools for service providers and governments to ensure interventions that are designed and gender sensitive and meet the needs of women who inject drugs.
- » Harm Reduction International worked with sex worker advocates and researchers to develop a new report on the overlap between sex work and drug use from a harm reduction perspective.⁽³³⁾ The report was launched at the International Congress on AIDS and HIV in Asia and Pacific.
- » The WHO in partnership with UNFPA, UNAIDS and the Global Network of Sex Work Projects (NSWP) launched a new toolkit to guide the implementation of the WHO's 2012 recommendations on HIV and sex work. The guide recommends the implementation of peer led programmes and urges countries to work towards the decriminalisation of sex work.⁽³⁴⁾ A similar toolkit to support the implementation of the UNAIDS/UNODC/WHO technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users is currently being developed by WHO, UNAIDS, UNODC, UNFPA and INPUD, it is expected to be released in 2015.
- » A toolkit to help care workers in HIV handle ethical dilemmas when working with key populations and their children i.e. people living with HIV, people who use drugs, sex workers, transgender people, gay men, and other men who have sex with men was launched at AIDS 2014 in Melbourne.⁽⁶⁰⁾ This innovative publication was developed by the Coalition for Children Affected by AIDS in collaboration with global key population networks, ethicists and care workers.

Community Action on Harm Reduction

Community Action on Harm Reduction (CAHR) is a five year project led by the International HIV/AIDS Alliance and funded by the Dutch Ministry of International Affairs (BUZA). The project aimed to significantly improve the lives of people who inject drugs in China, India, Indonesia, Kenya and Malaysia. Over a five year period the project exceeded its targets reaching over 250,000 people who inject drugs, their partners and children. An independent review concluded that access to HIV prevention and treatment and care had improved in all five countries as a result of this highly successful project. The project involved a strong focus on building the capacity of people who use drugs in the development, implementation and evaluation of services in country. Due to the success of the project CAHR will extend for one year through 2015 with a continued on the same five countries with the addition of Myanmar.

Civil society action

Additional to the efforts already noted above, there have been a number of important initiatives from civil society groups.

Civil society played a leading role in securing important reductions in the cost of ground breaking new hepatitis C medications. At the AIDS 2014 conference in Melbourne, activists stormed the stage to protest Gilead's pricing of new HCV drug Sovaldi currently costing USD 84,000 per course.⁽³⁵⁾ Civil society led advocacy in Egypt, India⁽³⁶⁾ and Georgia⁽³⁷⁾ has seen the cost of new medications reduced.

In February 2013, UNODC established a civil society group on HIV and people who use drugs. The group consists of regional and global harm reduction and drug user networks and aims to improve UNODC's collaborative work with civil society on HIV and drug use. The group has developed a joint work plan and meets face to face once a year and is facilitated by a civil society secretariat.

Civil society action around the world led to a successful replenishment for the Global Fund to Fight AIDS, TB and Malaria. In particular after concerted civil society efforts in the UK, a record UK £1 billion was pledged by the Government.⁽³⁸⁾

A new project to address the growing HIV epidemic in Asia started in 2012. Entitled "Asia Action," it seeks to increase the evidence and build support for harm reduction approaches among key policy makers in six countries - China, Cambodia, Vietnam, Malaysia, Indonesia and India. The project is implemented by a consortium of partners, led by the International HIV/AIDS Alliance, which include Harm Reduction International (HRI), the International Drug Policy Consortium (IDPC) and six national civil society organisations: AIDS Care China (China), Rumah Cemara (Indonesia), KHANA (Cambodia), India HIV/AIDS Alliance (India), Malaysian AIDS Council (Malaysia) and Supporting Community Development Initiatives (Vietnam) An advocacy focused project, it seeks to focus on areas such as developing gender sensitive guidelines for harm reduction programmes, developing community based alternatives to compulsory drug detentions centres and advocating for the meaningful engagement of people who use drugs in advocacy and service delivery.

Harm reduction networks continue to operate in every region of the world and make important contributions at national, regional and international levels.

Global Networks that include harm reduction as a key part of their focus continue to operate at the international level. These include YouthRISE, International Network of People who Use Drugs (INPUD), International Doctors for Healthy Drug Policies (IDHDP), International Centre for Science in Drug Policy (ICS DP), Law Enforcement and HIV Network (LEAHN), Women's Harm Reduction Network (WHRN) and the International Drug Policy Consortium (IDPC).

Regional networks include the Caribbean Harm Reduction Coalition (CHRC), Eurasian Harm Reduction Network (EHRN), European Harm Reduction Network (EuroHRN), Middle East and North African Harm Reduction Network (MENAHRN) and Intercambios Asociacion Civil (Latin America).

Since 2012, there have been significant developments in the visibility of networks of people who use drugs. Regional networks have been established in Asia, Eurasia, Europe, MENA and most recently in the United States. National level networks have also developed with new networks being initiated in countries such as Greece, Tanzania and Lithuania.

The International Network of People who Use Drugs has continued to strengthen since 2012 and has increased capacity and staff. This has allowed the network to actively engage in international forums such as the CND and UNAIDS Programme Coordinating Board (PCB).

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REGIONAL OVERVIEW

2.0

Regional Updates

| | |
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REGIONAL OVERVIEW

2.1

Asia



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 | HIV prevalence among people who inject drugs (%) | Hepatitis C (anti-HCV) prevalence among people who inject drugs (%) | Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%) | Harm reduction response | |
|--|--|--|---|---|-----------------------------|----------------------------------|
| | | | | | NSP ⁱ | OST ⁱⁱ |
| Afghanistan | 20,000 (18,000–23,000) ⁽¹⁾ | 4.4 ⁽²⁾ⁱⁱⁱ | 31.2 ⁽²⁾ | 6.6 ⁽²⁾ | ✓[31] ⁽³⁾ | ✓[1] ⁽³⁾ |
| Bangladesh | 21,800–23,800 ^{(4)iv} | 1.1 ⁽⁴⁾ | 39.6 ^{(5)v} | 9.4 ⁽⁶⁾ | ✓[88] ⁽⁴⁾ | ✓[3] ⁽⁴⁾ [M] |
| Bhutan | nk | nk | nk | nk | x | x |
| Brunei Darussalam | nk | nk | nk | nk | x | x |
| Cambodia | 1,300 (1,200–2,800) ⁽⁷⁾ | 24.8 ⁽⁷⁾ | nk | nk | ✓[2] | ✓[1] |
| China | 2,580,000 ^{(8)vi} | 6.3 ⁽⁹⁾ | 67 ⁽⁶⁾ | 10 ⁽⁶⁾ | ✓[898] | ✓[763] [B, M] |
| Hong Kong | nk | nk | nk | nk | x | ✓ |
| India | 177,000–180,000 ^{(10)vii} | 7.14 ⁽¹¹⁾ | 41 ^{(6) viii} | 10 ⁽⁶⁾ | ✓[295] | ✓[145] ⁽¹²⁾ [B, M, O] |
| Indonesia | 74,326 (61,901–88,320) ⁽¹³⁾ | 36.4 ⁽¹⁴⁾ | 77.3 ⁽⁶⁾ | 2.9 ⁽⁶⁾ | ✓[194] | ✓[85] [B, M] |
| Japan | nk | nk | 64.8 (55–74.5) ⁽⁶⁾ | 3.2 (2–4.3) ⁽⁶⁾ | x | x |
| Korea (Republic of) | nk | nk | 54 ⁽⁶⁾ | 4 ⁽⁶⁾ | x | x |
| Laos PDR | 1,700 ⁽¹⁵⁾ | nk | nk | nk | ✓[4] ^{(15)ix} | x |
| Macau | 238 ⁽¹⁶⁾ | 1.32 ⁽¹⁷⁾ | 80.4 ⁽¹⁸⁾ | 10.7 ⁽¹⁸⁾ | ✓[4] ⁽¹⁸⁾ | ✓[4] ⁽¹⁸⁾ [B, M] |
| Malaysia | 170,000 ⁽¹⁹⁾ | 18.9 ⁽²⁰⁾ | 67.1 ⁽⁶⁾ | ? | ✓[728] ⁽²⁰⁾ | ✓[811] ⁽²⁰⁾ [B, M] |
| Maldives | 793 (690–896) ⁽²¹⁾ | 0 ⁽²¹⁾ | 0.7 ⁽²²⁾ | 0.8 ⁽²²⁾ | x | ✓[1] ⁽²³⁾ [M] |
| Mongolia | nk | nk | nk | nk | ✓[1] ⁽²⁴⁾ | x |
| Myanmar | 75,000 ⁽²⁵⁾ | 18.7 ⁽²⁶⁾ | 79.2 ⁽⁶⁾ | 9.1 ⁽⁶⁾ | [40] ⁽²⁵⁾ | ✓[18] ⁽²⁵⁾ |
| Nepal | 52,174 ⁽²⁷⁾ | 6.3 ⁽²⁸⁾ | 87.3 (80.5–94) ⁽⁶⁾ | 5.8 (5.5–6) ⁽⁶⁾ | ✓[40] | ✓[12] ⁽²⁸⁾ |
| Pakistan | 91,000 ⁽²⁹⁾ –423,000 ^{(30)x} | 27.2 ⁽²⁹⁾ | 85 (75–92.9) ^{(6)xi} | 6.8 (6–7.5) ⁽⁶⁾ | ✓[34] ⁽³¹⁾ | x |
| Philippines | 12,304–16,607 ^{(32)xii} | 41.6 ⁽³³⁾ | 70 ⁽⁶⁾ | nk | ✓ ^{xiii} | x |
| Singapore | nk | nk | 42.5 ⁽⁶⁾ | 8.5 ⁽⁶⁾ | x | x |
| Sri Lanka | nk | nk | nk | nk | x | x |
| Taiwan | 60,000 ^{(34)xiv} | 17.7 ⁽³⁴⁾ | 41 ^{(6)xv} | 16.7 ⁽⁶⁾ | ✓[1,103] ^{(22)xvi} | ✓[90] ⁽²²⁾ [B, M] |
| Thailand | 40,300 ⁽³⁵⁾ | 25.2 ⁽³⁶⁾ | 89.8 ^{(6)xvii} | nk | ✓[38] ⁽³⁶⁾ | ✓[147] [M] |
| Vietnam | 271,000 (100,000–335,000) ⁽³⁷⁾ | 10.3 ⁽³⁷⁾ | 74.1 ^{(6)xviii} | 19.5 ⁽⁶⁾ | ✓[297] ⁽³⁷⁾ | ✓[80] ⁽³⁷⁾ |

i This includes all operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers.

ii (M) = methadone, (B) = buprenorphine, (O) = any other form (including morphine and codeine).

iii Prevalence varies from 0.3% in Mazar city to 13.3% in Herat city.

iv Data from 2009, and only for men who inject drugs.

v Based on data from Dhaka.

vi Figure indicates the number of registered people who use drugs that have been recorded by the police. There are an estimated 10 million people who use drugs thought to exist in China.

vii Data from 2008, with civil society organisations believing the actual figure to be much higher.

viii HCV prevalence varies greatly across the region, from 90% in Manipur to 1% in Bihar, but no national data is collected.

ix These are pilot NSPs in four districts of Houaphanh and Phongsaly province.

x 91,000 figure based on a mapping methodology in 2009 in hotspots where people inject drugs. The 423,000 figure was derived from an epidemiological survey. Civil society recommended a range between both figures.

xi Figure from 2003.

xii Figure relates to adult males only.

xiii Needles and syringes are distributed regularly to people who inject drugs but only at a health facility, thus limiting coverage.

xiv Based on longitudinal data from two prison cohorts.

xv Figure from 2001.

xvi Figure from 2005; no updated information on NSPs or OST in Taiwan.

xvii Figure from 2000.

xviii Figure from 2003.

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



Harm reduction in Asia

An estimated 3–5 million people who inject drugs live in Asia,⁽³⁸⁾ with an estimated 1.3 million opioid users residing in China.⁽³⁹⁾ Since 2012, new population size estimates are available for people who inject drugs from Cambodia, China, Indonesia, Nepal, Philippines and Vietnam. However, data quality and greater concentrations of people who use drugs in certain geographical areas limit the scope of these estimates, and can often hinder accurate assessments of required harm reduction service coverage.⁽⁴⁰⁾

Unsafe injecting drug use is a major driver of the HIV epidemic in many Asian countries, including Indonesia, Pakistan and the Philippines, where HIV prevalence among people who inject drugs continues to grow rather than stabilise.⁽³⁸⁾ Overlaps between people who inject drugs and other key population groups, including sex workers and men who have sex with men, have also been detected in several countries in the region, and require increased attention.⁽⁴⁰⁾ In 2013, UNAIDS reported that in 11 countries across Asia less than half of sex workers and men who have sex with men surveyed reported using a condom with their last sexual partner.⁽³⁸⁾

HIV prevalence among people who use drugs ranges from over 40% in Pakistan and the Philippines to under 10% in China, India, Macau, Malaysia Maldives and Nepal (see Table 2.1.1). However, national figures can often hide significant regional and sub-national variations. For example, national figures in Indonesia appear to be declining, with 36.4% HIV prevalence among people who inject drugs.⁽¹⁴⁾ However, in urban centres such as Jakarta and Surabaya, 2013 HIV prevalence estimates were 56.4% and 48.8% respectively.⁽⁴¹⁾ A 2011 study of 16 cities in Pakistan found an overall prevalence of HIV among people who inject drugs of 27.2%, but this ranged from 3.3–52.5% depending on the city.⁽⁴²⁾ These differences highlight the importance of multi-site studies in countries to ensure that targeted and appropriate harm reduction services are scaled up.

Although harm reduction is becoming increasingly accepted across the region, a largely punitive policy and legal environment remains firmly in place, undermining access to life-saving harm reduction programmes, and directly blocking progress towards United Nations 2011 Political Declaration on HIV/AIDS targets to reduce the transmission of HIV among people inject drugs by 50% by 2015.⁽⁴³⁾ There are 11 countries that still have compulsory centres for people who use drugs, and 15 that still have the death penalty for drug-related offences.⁽³⁸⁾

In certain countries, the early implementation of harm reduction services in the form of needle and syringe programmes (NSPs) and opioid substitution therapy (OST) contributed to a significant drop in HIV

prevalence among people who inject drugs. Nepal, for example, saw rates of HIV prevalence decline drastically from 68% in 2002 to 6.3% in 2011.⁽³⁸⁾ However, because coverage of services fell well below the recommended levels in these countries, it is possible that mortality related to HIV, tuberculosis (TB) and hepatitis C (HCV) was also a contributing factor to the decline. However, examples such as this are few, and although harm reduction coverage has been increased in Bangladesh, China, India, Indonesia, Malaysia Myanmar, Taiwan and Vietnam, the pace and scale up has been too slow to have a significant impact on reducing HIV transmission among people who unsafely inject drugs.⁽⁴⁰⁾ In Mongolia, the main non-governmental organisation (NGO) working on drug issues, the Association to Protect Citizens from Drugs and Narcotic Substances, which implements a small-scale NSP mainly for morphine users, states that people who inject drugs are extremely difficult to reach due to the punitive environment.⁽²⁴⁾

Stimulant use across the region has also greatly expanded,⁽⁴⁴⁾ and several countries have already seen a trend for amphetamine-type stimulants (ATS) far exceed use of opiates.⁽⁴⁴⁾ Few countries, however, report the existence of harm reduction services in response to the growing use of ATS. There is an urgent need for research and monitoring of ATS use in order to develop targeted harm reduction services – a gap that UNODC's Global SMART (Synthetics Monitoring: Analyses, Reporting and Trends) Programme is helping to fill.⁽⁴⁵⁾ In a study undertaken as far back as 1999 of 32 survey respondents in a treatment centre in Japan, 53.8% used methamphetamine as their drug of choice, of whom 82.1% reported needle sharing.⁽⁴⁶⁾

Developments in harm reduction implementation

Needle and syringe exchange programmes (NSPs)

A total of 17 countries in Asia have NSP provision to varying degrees (see Table 2.1.1), a number that appears to have remained stable rather than increased since *The Global State of Harm Reduction 2012*.⁽²²⁾ NSPs operate to differing degrees within the region, from small-scale projects in countries such as Laos PDR, Macau and Mongolia, to higher provision in India, Indonesia and Malaysia. Between 2012 and 2014, five countries reported scaling up NSP provision – Afghanistan, India, Indonesia, Malaysia and Thailand – with Malaysia seeing the steepest increase, from 297 sites in 2012⁽²²⁾ to 728 in 2014.⁽²⁰⁾ During this period, four countries reported a decline in NSP services: Bangladesh, China, Pakistan and Vietnam. In Vietnam, coverage has reduced

significantly, and the average number of needles and syringes provided to people who inject drugs has dropped from 180 in 2012⁽²²⁾ to 98 in 2014.⁽³⁷⁾ In China, the number of NSP sites has decreased from 941 sites across 17 provinces⁽²²⁾ to 898 sites across 15 provinces.⁽⁹⁾ In Thailand, NSP coverage remains low, with only 12 syringes distributed per person who injects drugs per year.⁽³⁶⁾ Afghanistan's NSP service provision is also limited, reaching only eight provinces in the country and providing an average of 92 syringes per person who injects drugs per year.⁽¹⁾ For countries with limited geographical coverage or low service provision, there is an urgent need to scale up NSPs to reduce the transmission of HIV and viral hepatitis through unsafe injecting.

Models of NSP service delivery differs from country to country in the region. In Indonesia, NSPs are provided through government-run community health centres (known as *puskesmas*) and civil society organisations.⁽⁴⁸⁾ NSPs in Malaysia are also provided through government-run health clinics and civil society organisations, with the majority being delivered by civil society (79%), and the remainder government run (21%).⁽⁴⁸⁾ In Lao PDR the situation is rather different, with a community-based NSP pilot project initiated on the border with Vietnam being the only NSP service in the country.⁽¹⁵⁾

Although NSP provision exists in a number of Asian countries, there are many barriers to accessing these services for people who inject drugs. In Indonesia, for example, although NSP provision exists for people who inject drugs who are using OST, they can be forbidden to access NSP services by certain

OST clinics. Coupled with this is a lack of human resources to run the services and inflexible hours of service providers. There are further barriers for women and young people who inject drugs, who can be uncomfortable about accessing existing NSP services, especially where these are provided via government-run *puskesmas*.⁽⁴⁸⁾ In Malaysia, although there has been a large increase in NSP provision, partly due to increased funding but also improved government and stakeholder relations, people who use drugs still face structural barriers in terms of law enforcement agencies.⁽⁴⁸⁾ A recent survey of Malaysian police officers found that the majority seized needles and syringes even if no arrest was made,⁽⁴⁹⁾ serving to increase the risk of unsafe injecting and associated harms.

As reported in 2012,⁽²²⁾ Bhutan, Brunei-Darussalam, Hong-Kong, Japan, Republic of Korea, Maldives, Singapore and Sri Lanka still have no NSP sites in operation.

Opioid substitution therapy (OST)

OST provision has continued to be scaled up in several Asian countries, with an estimated 297,000 people who inject drugs accessing these services.⁽³⁸⁾ Between 2012 and 2014, Bangladesh increased from 1 site to 3 sites,⁽⁴⁾ India from 72 to 145 sites,⁽¹²⁾ Malaysia from 674 to 811 sites,⁽²⁰⁾ Myanmar from 10 to 18 sites,⁽²⁶⁾ Nepal from 3 to 12 sites,⁽²⁸⁾ China from 738 to 763 sites,⁽⁸⁾ Vietnam from 41 to 80 sites⁽³⁷⁾ and Indonesia from 74 to 85 sites. There is low-level coverage (less than 20% of people who inject drugs using services) of OST in Afghanistan,

Asia Action on Harm Reduction

A successful response to HIV among people who use drugs cannot be realised in a punitive policy environment, where evidence and rights-based approaches are blocked, service access is restricted, and the meaningful participation of people who use drugs in decision-making and service delivery is undermined or simply not allowed.

Asia Action on Harm Reduction (Community alternatives to the war on drugs: community advocacy for harm reduction) is a European Union-funded project running between 2013 and 2016 that seeks to empower civil society organisations, and increase the evidence and build political support for harm reduction among key policymakers in Cambodia, China, India, Indonesia, Malaysia and Vietnam. The project is implemented by a consortium of partners, led by the International HIV/AIDS Alliance, which include Harm Reduction International (HRI), the International Drug Policy Consortium (IDPC) and six national civil society organisations: AIDS Care China (China), Rumah Cemara (Indonesia), KHANA (Cambodia), India HIV/AIDS Alliance (India), Malaysian AIDS Council (Malaysia) and Supporting Community Development Initiatives (Vietnam). The project works on advocacy areas, including enhancing law enforcement engagement with rights-based harm reduction approaches in Malaysia; assessing the harm reduction advocacy capacity of state-level drug user forum members and mapping stakeholder support of harm reduction policies in India; advocating for access to treatment in pre-trial detention and other closed settings in Malaysia; and documenting the implementation of diversion policy to drug treatment as opposed to prison for people arrested for drug-related offences in Indonesia.⁽⁴⁷⁾

India, Myanmar, Sri Lanka and Vietnam, and it is recommended that OST provision in these countries should be scaled up as a matter of urgency.⁽⁴⁰⁾ In Cambodia, OST provision remains limited to only one clinic, which provides methadone to approximately 200 people. It has been reported that the drop-out rate has increased to 48% because clients are required to visit the clinic on a daily basis due to a lack of takeaway doses.⁽⁵⁰⁾

Since 2012, OST has been approved and/or newly piloted in both Pakistan and Bhutan.⁽⁴⁰⁾ In Pakistan, a pilot feasibility study was initiated at one site in 2013, implemented by the Institute of Psychiatry and the Narcotics Control Division, in coordination with the National AIDS Control Programme (NACP), UNODC, WHO and UNAIDS.⁽⁴⁰⁾ While the pilot was a positive development, it ended in 2013 and OST remains unavailable for large numbers of opioid-dependent individuals. Introduction and scale up of OST in Pakistan is critical, not only to provide evidence-based drug dependence treatment for all who need it, but also to halt ongoing transmission of HIV among people who inject and their sexual partners, as well as to facilitate adherence to antiretroviral therapy (ART) among HIV-positive people who inject drugs.

In Bhutan, the ministry of health, the Narcotic Control Agency and the government have endorsed OST, earmarking three centres for pilot projects.⁽⁵¹⁾ A pilot drop-in centre in Thailand has also been initiated by Population Services International, to ensure OST is available for people who inject drugs living in remote locations with difficulty accessing government OST services. Implementing community-based OST was made possible through staff collaboration with community leaders, peer volunteers, and local public health staff, with results in the first six months showing a relapse rate of 8% compared to 92% in traditional government programmes.⁽³⁶⁾

Methadone is the main medicine used for OST in the region.⁽⁴⁰⁾ However, Indonesian ministry of health plans to release a specific decree to regulate use of buprenorphine during 2014, which is presently only available in private clinics.⁽⁴⁸⁾ In Lao PDR, where OST is not provided, tincture of opium capsules are used for detoxification and treatment among opium users.⁽¹⁵⁾ In Sri Lanka, although meetings on issues concerning people who use drugs have reportedly been held, no consensus has been reached on OST provision. However, a literature review has been conducted to decide on the initiation of OST, with plans to move on to a pilot study in the near future.⁽⁵²⁾

As with NSPs, OST provision in Asia is hindered by legal and policy barriers that restrict or prohibit its implementation and scale up. For example, in Malaysia, recent punitive enforcement and coercive action means that people who inject drugs have reduced trust in OST programmes, and therefore underuse them because of fear of arrest.⁽⁴⁹⁾ OST procedure and protocol across the region also appears unclear; for example, concerning terms and conditions on how to use OST, take-home dosages, and tapering off from treatment. There is also often a perspective from service providers that OST is an exit strategy and cannot be used in conjunction with NSP services.⁽⁴⁸⁾ Additional barriers, including limited hours of operation, specific requirements for women in some regions (for example, in Indonesia written permission is required from husbands to access OST), and limited financial commitment of governments and donors for maintaining and expanding programmes, mean there is still much work to be done to ensure an appropriate and enabling environment for OST.

Viral hepatitis

A systematic review in 2011 found that the region contained the largest number of people with viral hepatitis who inject drugs, with an estimated 300,000 having the hepatitis B surface antigen (HbsAg)^{xix} (range 100,000–700,000) and approximately 2.6 million having HCV (range 1.8–3.6 million).⁽⁶⁾ In 2014, HCV infection has become an urgent issue among people who inject drugs across Asia, and there is a critical need for diagnostic and treatment services to be scaled up across the region and integrated into HIV testing and treatment services.⁽⁴⁰⁾ The limited data that is available suggest that 60–90% of people who use drugs who live with HIV in Asia and the Pacific also have HCV co-infection.⁽³⁸⁾

In Afghanistan, it is estimated that 1.5% of people who inject drugs are co-infected with HIV and HCV.⁽⁵³⁾ However, there is still no policy or strategy to address the problem of HCV among people who inject drugs.⁽¹⁾ In Vietnam, guidance for treatment of HCV has been made widely available, but health insurance coverage excludes antiviral treatment.⁽³⁷⁾ Bhutan reports having a prevention and control programme that includes people who inject drugs and those living with HIV.⁽⁵⁴⁾

Significant efforts have been made by civil society organisations and people who use drugs in Indonesia to scale up the government response, with a recently developed set of guidelines on HCV treatment becoming available, care and support among people who inject drugs in place, and plans to integrate HCV

xix HbsAg indicates active (either acute or chronic) infection. Approximately 95% of adults with acute HBV infection clear the virus and develop anti-HBv and hepatitis B (HBV) surface antibodies (anti-HBs). People who inject drugs have lower clearance rates for HBV than the general population because more people who inject drugs may be chronically infected. For more information, see Nelson PK, Mathers BM, Cowie B, Hagan H, Des Jarlais D, Horyniak D, et al. Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews. *Lancet*. 2011;378(9791):571–83.

into national surveillance among people who inject drugs as of 2015.⁽⁵⁵⁾

However, treatment of HCV still remains out of reach for most people who inject drugs in the region due to exorbitant prices. In Indonesia, the test to diagnose HCV costs upwards of \$650, and although tests are available and technically covered by national health insurance schemes, people with a history of drug use are excluded from universal health insurance via the Presidential Decree 2012/13.⁽⁴⁸⁾ Urgent measures are needed in Asia to ensure that access to diagnosis and treatment for people who inject drugs improves.

Tuberculosis

Similar to HIV and viral hepatitis, people who inject drugs in Asia have a high rate of TB infection, with southeast Asia accounting for nearly 15% of the global burden of new cases of HIV–TB co-infection.⁽⁵⁶⁾ Data on TB for people who inject drugs in the region is sparse, but individual studies indicate that there is high prevalence of TB among people who inject drugs. Pakistan ranks fifth among TB high-burden countries worldwide, accounting for 61% of TB cases in the WHO Eastern Mediterranean region.⁽⁵⁷⁾ Although TB treatment in Pakistan is free for people living with HIV, Pakistan is estimated to have the fourth highest prevalence of multi-drug resistant TB (MDR-TB),⁽²⁹⁾ and as far as we are aware there is no TB testing and treatment service specifically for key populations, including people who inject drugs.

In Malaysia, TB remains a public health challenge, with approximately 16,000–20,000 new cases reported annually.⁽⁴¹⁾ The government currently conducts routine TB–HIV screening for all new detainees in closed settings, such as prisons and drug rehabilitation centres, and findings indicate that TB–HIV co-infection reported nationwide increased from 6 to 1,477 cases between 1990 and 2013.^(20,58) However, these figures do not relate specifically to people who inject drugs. In China, TB testing is often provided for people who inject drugs who are in detention.⁽⁶⁾ Although rates of TB among people who inject drugs in China is unknown, an estimated 84.9% of people received TB testing, with the rate of treatment for people co-infected with TB–HIV increasing from 35.6% in 2011 to 57.2% in 2013.⁽⁹⁾ TB treatment is integrated into HIV programmes in Bhutan, Cambodia, India, Indonesia and Nepal, but whether services are designed for people who inject drugs again is unknown.

The primary barriers to TB testing and treatment in the region include a lack of integration into harm reduction programmes, stigma and discrimination against people who use drugs among service providers, a lack of awareness of TB referral systems

between criminal justice and healthcare (particularly in China), and limited testing and treatment opportunities provided at NSP and OST sites.⁽⁴⁰⁾ It is therefore clear from the limited data on people who use drugs and TB prevalence that further research should be undertaken, and greater integration of TB services into existing harm reduction initiatives is required.

Antiretroviral therapy (ART)

In 2013, UNAIDS reported that in Asia and the Pacific more than two-thirds of people who inject drugs do not know their HIV status,⁽³⁸⁾ and in 2013 only 18% of the total number of people living with HIV who were eligible for ART accessed treatment in the region.⁽³⁸⁾ With the HIV testing indicator among people who inject drugs now included in routine Global AIDS Progress reporting, it is hoped that monitoring of HIV testing access among people who inject drugs will improve.

In Vietnam in 2013, WHO supported the Vietnam Administration of HIV/AIDS Control (VAAC) to provide evidence of the benefits of integrating OST, HIV testing and counselling, and ART. The study, conducted in Hanoi and Can Tho, showed that men living with HIV who were receiving OST were more likely to be enrolled in care, start ART and have higher retention rates than men not receiving OST.⁽³⁷⁾ The findings of this study have helped support and promote the integration of OST and ART service delivery in Vietnam.

Several barriers are still documented to HIV testing and access to ART treatment for people who inject drugs in the region. In India, HIV testing among people who inject drugs is limited, with some states not providing any form of ART.⁽⁵⁹⁾ In Malaysia, people who use drugs often feel stigmatised by healthcare staff, and a lack of confidentiality discourages people who use drugs from coming forward for early diagnosis and treatment.⁽⁴⁸⁾ In Nepal, HIV testing is not initiated at NSP sites, and there is a recommendation for drug treatment facilities to enable capacity for testing and treatment.⁽⁶⁰⁾

Reductions in HIV prevalence among people who use drugs in certain countries in the region have been largely attributed to the early implementation and scale up of key harm reduction programmes such as NSPs and OST,⁽⁶¹⁾ although HIV-related mortality may also have played a contributing role in this period. HIV prevalence rates have decreased significantly in Nepal, where prevalence among people who inject drugs in Pokhara was 4.6% in 2011 compared to 22% in 2003.⁽²⁸⁾ Although early implementers of NSPs and OST have seen a decline in HIV prevalence among people who inject drugs, much more needs

to be done in the region to integrate testing and treatment services for HIV, viral hepatitis and TB.

Harm reduction in prisons

Injecting drug use is common in prisons and other places of detention across Asia. However, there is often insufficient surveillance reporting on HIV in the prison setting, and the limited information indicates a need to increase greatly the scale of HIV prevention and treatment, including the initiation of NSPs and OST services.⁽⁶²⁾ In a study undertaken in Indonesia on prisoners incarcerated for drug-related crimes, almost 90% had consumed an illicit drug, and more than one-third had injected heroin.⁽⁶³⁾ In another study undertaken in Afghanistan, 92.9% of people who inject drugs had previously spent time in prison, with 17.2 reporting injecting in prison.⁽⁶⁴⁾ As drug detention and rehabilitation centres remain widespread across the region, and punitive approaches to drug use remain the dominant policy, there is an urgent need for harm reduction measures to be made more readily accessible.

At present, only Malaysia and Indonesia provide OST in prison, with no NSP available in prisons in any country in the region. However, although OST has been expanded in prisons in Malaysia, increasing from 1 prison in 2008 to 18 by 2013,⁽²⁰⁾ methadone is currently unavailable in pre-trial police detention, which can cause interruptions in service access during arrest. In Indonesia, there are currently 10 prisons providing OST, which is made available for new clients without prior history of OST use. *The Global State of Harm Reduction 2012*⁽²²⁾ reported that plans were underway to initiate harm reduction services in prisons in the Maldives, although as far as we are aware this has not yet begun.

There are some signs of increasing political commitment, and certain countries in the region have made important efforts to review and gradually shift from a punitive approach to a voluntary, rights-based approach to drug treatment.⁽⁴⁰⁾ For example, Malaysia has transformed eight compulsory detention centres into voluntary Cure and Care centres or clinics, widely praised as examples of best practice for the region.⁽³⁸⁾ There have also been indications of increasing political commitment in Vietnam, with the approval of the Law on Handling of Administrative Violations in June 2012. As a result of this law, 80 of the 107 compulsory detention centres will be reformed to provide voluntary and friendly detoxification, with possible OST provision also planned.⁽³⁷⁾

While these steps are a positive development, it is crucial to ensure that voluntary treatment is also community based, and includes strong referral systems to other harm reduction interventions, as well

as to HIV treatment and support services.⁽⁴⁰⁾ In 2014, UNODC produced specific guidance for community-based treatment in southeast Asia.⁽⁶⁵⁾ In March 2012, a group of 12 United Nations agencies – including UNODC, WHO, UNAIDS and the Office of the High Commissioner for Human Rights – released a joint statement “call[ing] 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”.⁽⁶⁶⁾ In November 2014, the Global Fund called for the closure of compulsory drug detention centres, making a public commitment not to provide funding for programmes in such centres.⁽⁷⁴⁾

A further area of concern for people who inject drugs who are incarcerated or placed in detention centres is their limited access to ART provision in some prisons and closed setting in Asia. While ART is technically available in prisons in Indonesia, provision is based in the hospital with an assigned healthcare worker who takes care of the procurement and dosing. Detainees have to pay the prison officer for accessing ART medication on a monthly basis, which is a further barrier to access.⁽⁴⁸⁾ In Malaysia and Cambodia, ART is available for people who are incarcerated, and some prisons in China have ART provision although the exact coverage figures are unknown. In Pakistan, fewer than 100 prisoners were accessing ART in 2014.

Overdose

Data on the extent of drug-related overdose, prevention and management is limited across Asia. No countries in the region collect and routinely monitor drug-related overdose deaths. The response is largely small scale and local, with activities implemented by civil society organisations and networks of people who use drugs.⁽⁴⁰⁾ For example, in two states in northeast India (Manipur and Nagaland), the community has taken substantive steps towards addressing the management of overdose by forming a crisis response team that provides naloxone.⁽⁵⁹⁾ In Indonesia, a regulation exists that overdose programmes should be made available in OST sites. However, in practice this regulation is not implemented consistently. Instead, overdose responses consist of limited awareness activities among activists, and there is no comprehensive programme including naloxone provision. While China has no national programme for overdose prevention, AIDS Care China, with support from the European Commission-funded Asia Action project, has recently started to operate naloxone peer distribution programmes in Yunnan and Sichuan provinces.⁽⁹⁾ By the end of May 2014, 4,361 naloxone kits had been distributed by AIDS Care China to 1,900 people who

inject drugs, and 119 people had been saved from fatal overdose.⁽⁶⁾

Although there is no national programme for overdose in Nepal, civil society organisations providing harm reduction services raise awareness about overdose among the community. The lack of availability of naloxone in countries such as Nepal remains a barrier to effective overdose prevention, and implementation and scale up of naloxone peer-led services should be increased to ensure effective overdose prevention for people who inject drugs in Asia.

Policy development for harm reduction

In 2014, 19 Asian countries or territories identified people who inject drugs as a target population for the HIV response, and explicitly included harm reduction in their national plans and drug policies (see Table 1.1.1). These include Afghanistan, Bangladesh, Cambodia, China, Hong Kong, India, Indonesia, Macau, Malaysia, Maldives, Mongolia, Myanmar, Nepal, Pakistan, Laos PDR, Philippines, Taiwan, Thailand and Vietnam. Since 2012, no new countries in the region have explicitly referenced harm reduction in policy documents.⁽²²⁾

Despite policies that have facilitated implementation and scale up of harm reduction services in the region, the existence of national policy on harm reduction does not inevitably equate to provision of an adequate response in either scope or quality. For example, although Cambodia's Drug Control Law 2012 states that a person who injects drugs and is arrested for a drug-related offence should be referred to treatment and related services,⁽⁵⁰⁾ in practice, efforts to reduce HIV transmission among people who inject drugs have been hampered by the current legal and policy environment, with legal provision of referral not implemented.⁽⁷⁾

In Vietnam, despite the introduction of a new law in October 2012 that enabled people who use drugs to go through a trial process via court hearings and have legal representation,⁽⁶⁷⁾ there are still many examples of people who use drugs being placed in compulsory detention. However, a decree on substitution treatment for opioid dependence, which was approved in 2012, has simplified the administrative procedures needed to increase accessibility to OST treatment services. Nevertheless, inconsistencies remain in the legal framework for harm reduction in Vietnam, and its heavy dependence on external donors requires innovative financing strategies if provision is to expand.

In Singapore, with some of the most punitive drug laws in the region, parliament passed legal reforms that took effect in 2013, allowing those facing the

death penalty the opportunity to ask for resentencing under certain circumstances. Since then, nine prisoners have applied for resentencing and have had their sentences reduced to life imprisonment rather than death.⁽⁶⁸⁾

Civil society and advocacy developments for harm reduction

Over the last two years, the European Commission-funded Asia Action on Harm Reduction project has played an important role in supporting civil society advocacy on harm reduction and drug policy in six Asian countries. As of August 2014, Asia Action has supported AIDS Care China to scale up naloxone training and dissemination among people who inject drugs in two provinces through 24 project sites, including compulsory detoxification centres.⁽⁴⁰⁾ In addition, the first community-based drug treatment programme was piloted in China in 2014, which aims to provide an alternative to compulsory detoxification centres implemented throughout the country.⁽⁶⁾

In Cambodia, KHANA, supported by Asia Action and AusAID's HAARP programme, has worked with police to offer a more enabling environment in order to increase access for people who inject drugs to treatment and health services, and reduce human rights violations.⁽⁵⁰⁾ In Indonesia, Rumah Cemara supported by Asia Action and in collaboration with the Indonesian Drug Users' Network, is conducting research documenting the implementation of Indonesia's 2011 diversion policy, which stipulates that people arrested on drug-related offences with personal possession under a stated weight should be referred to treatment rather than imprisoned.⁽⁶⁹⁾

In July 2014, issues relating to women who inject drugs were highlighted at the global level in Nepal when the Red Ribbon Award 2014 went to Dristi Nepal. This is an organisation run by women with a history of drug use that is dedicated to reducing drug-related harms through advocacy, treatment and support to women currently using drugs.⁽⁷⁰⁾ Dristi Nepal is one of two drug-user led civil society organisations in Asia – both organisations run by people who use drugs, with a focus on promoting better access to harm reduction and evidence-based drug policies – to win the prestigious Red Ribbon Award for 2014–2015.⁽⁷¹⁾ The other organisation is Persaudaraan Korban Napza Indonesia, a leading national network representing the joint priorities of 25 self-organised drug user groups across 19 provinces in Indonesia. The network, which was established in 2006 to address the stigma, violence, discrimination and human rights violations experienced by people who use drugs, has grown significantly in the last

two years.⁽⁷¹⁾ The Red Ribbon Award, a joint global effort by United Nations agencies, is presented every two years to ten organisations around the world at the International AIDS Conference. The award honours community-based organisations for outstanding initiatives that show leadership in reducing the spread of HIV.

India HIV/AIDS Alliance also continues to showcase best practice, reaching out to women who use drugs and the sexual partners of men who inject drugs,⁽⁷²⁾ including through the involvement of female outreach workers in the programme. Based on evidence produced by civil society organisations, NACP Phase IV: 2014–2017 has gone on to include this staff position in their strategy document.⁽⁵⁹⁾ Under the NACP Phase IV initiative, a national consultation took place in December 2014 on the HIV response to women who inject drugs and the sexual partners of men who inject drugs, in order to inform the national programme.⁽¹²⁾

The Support. Don't Punish⁽⁷³⁾ campaign represents the largest national-level and regional campaign to be implemented simultaneously across a number of countries in Asia, including activities in Thailand, Malaysia and Vietnam. In 2014, the campaign included press conferences, concerts, street protests, meetings with policymakers and other stakeholders, and the distribution of harm reduction materials in 10 countries in the region.^(40, 73) Other civil society developments have been the Indian Drug Users' Forum meeting on including HCV in the national HIV/AIDS programme,⁽⁵⁹⁾ the Indonesian Drug User Network's engagement with HCV price reduction, drug policy reform, and the renewal of national harm reduction guidelines.⁽⁴⁸⁾ In Cambodia, the Support! Reduce harm of drug use campaign, run by KHANA and the local drug user network, targeted police, local authorities and service providers to change their attitudes towards people who use drugs, portraying them as victims of drugs who they should support rather than criminals.⁽⁵⁰⁾

Mobilisation of people who use drugs in Asia

The Asian Network of People who Use Drugs (ANPUD), established in 2008 and registered in 2010, remains the only regional network in Asia that unifies and represents the voices of communities of people who use and inject drugs. Since 2012, the network has grown to include the voices of Thai and Malaysian people who use drugs, in addition to community representatives from Cambodia, India, Indonesia, Nepal and Vietnam.

ANPUD advocates for evidence-based changes in punitive drug laws and policies that negatively affect the lives of people who use drugs. It focuses on key areas, such as HCV testing and treatment access, alternatives to compulsory detention and rehabilitation centres, decriminalisation of drug possession for personal use, and improving the coverage and quality of harm reduction services in the region. To broaden the reach of its advocacy, ANPUD's 2014–2016 strategic plan prioritises partnerships with law enforcement agencies, research institutions and national networks of key affected populations.

Efforts are now underway to support and strengthen national networks of people who use drugs in Cambodia, Malaysia and Myanmar. During the 11th International Congress on AIDS in Asia and the Pacific (ICAAP) in 2013, ANPUD launched a module for network strengthening and development. The module, now available in English, Vietnamese and Khmer languages, is aimed at building organisational capacity in the areas of governance, networking, resource mobilisation, leadership and monitoring and evaluation.

The participation of women ANPUD members in regional and International forums and the network's decision-making process has also increased over the years, with two of the current executive board members now being women.

Funding: developments for harm reduction

Although the need for harm reduction funding is a key priority in a number of countries in the region, several international donors are gradually withdrawing.⁽⁴⁰⁾ Information on most countries is limited, and HIV prevention, treatment and care budgets are not disaggregated to provide information on funding for harm reduction interventions, meaning assessments are largely based on anecdotal information from civil society.

In Indonesia, the National Drug User Network has tried to build evidence around the need to improve the quality of harm reduction programming and use this as a tool to advocate for continued support. In 2013, Perssaudaraan Korban Napza Indonesia, in collaboration with UNAIDS, held a training for members on budgeting advocacy to raise awareness and enable the drug-using community to better understand funding and budgeting mechanisms in the country.⁽⁴⁸⁾ In Cambodia, funding challenges include the HAARP programme finishing in December 2015, and the Global Fund decreasing its financial support towards harm reduction, in particular OST programmes.⁽⁵⁰⁾ In Pakistan, reports have indicated that after the closure of the Enhanced HIV/AIDS Control Programme in 2010, availability and coverage of services for people who inject drugs declined significantly.⁽²⁹⁾

Multilaterals such as UNODC, UNAIDS and the World Bank support several civil society organisations in the region. In Indonesia, the Community Action on Harm Reduction project (CAHR), run by the International HIV/AIDS Alliance through Rumah Cemara, and Bridging the Gap programme, run by Mainline Foundation/Dutch government have supported civil society organisations in some areas of Indonesia to fill harm reduction intervention gaps.⁽⁴⁸⁾ Although these projects have contributed to an increasing focus on harm reduction in Indonesia, CAHR is ending in December 2015 and no new funding has yet been established.

In India, the new national programme funds harm reduction activities, including NSPs, OST, voluntary counselling and testing, and ART, but no funding is available for advocacy activities. Only the European Commission-funded Asia Action project supports this, although it is limited to three states.⁽⁵⁹⁾ In both China and Indonesia, anecdotal evidence from civil society indicates that funding for harm reduction has actually decreased,^(8,48) but no figures are available to confirm this. In 2014 in Malaysia, the government announced more funding for drug control, but this is likely to be devoted to abstinence-based programmes and primary prevention rather than harm reduction.⁽⁴⁹⁾

Although few countries in the region receive national government funding support for harm reduction, Malaysia and India are examples of where the government supports an almost fully fledged harm reduction programme. Similarly, national government investment in China has supported harm reduction for several years, including OST and NSPs, although that investment continues to reduce.⁽⁶⁾

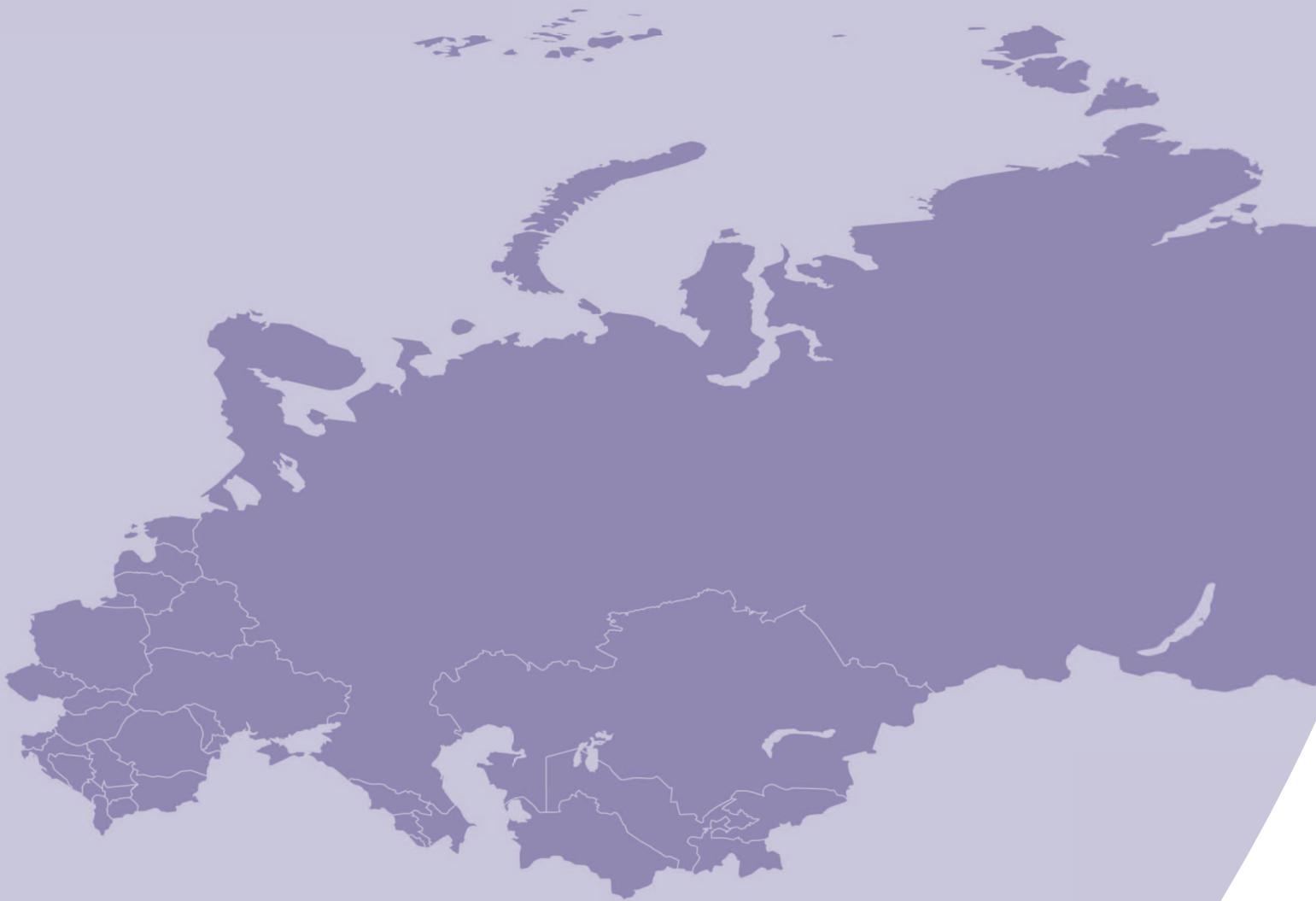
Since few Asian countries have accurate and up-to-date estimates for key affected populations such as people who inject drugs, it is difficult to ascertain whether current figures on spend accurately represent epidemiological need, as data limitations seriously hamper any rigorous assessment of whether national government investment is adequate. Further work on the cost and scope of harm reduction in this region is greatly needed.

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REGIONAL OVERVIEW

| | |
|-----|---------|
| 2.2 | Eurasia |
|-----|---------|



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 ⁽¹⁾ | HIV prevalence among people who inject drugs (%) ⁽¹⁾ | 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 ⁽¹⁾ | |
|--|--|---|--|--|--|-------------------------------------|
| | | | | | NSP ⁱ | OST ⁱⁱ |
| Albania | 4,000–6,000 | 0.5 | 28.8 | 11.5 | ✓ 2 | ✓ 6 (M) |
| Armenia | 12,700 ⁽²⁾ | 6.3 | nk | nk | ✓ 12 | ✓ 4 (M) |
| Azerbaijan | 71,283 ⁽²⁾ | 9.5 | 62.8 | 10.9 | ✓ 17 | ✓ 2 (M) |
| Belarus | 75,000 ⁽²⁾ | 17.1 ⁽²⁾ | 13.3 | 39 | ✓ 33 | ✓ 14 (M) |
| Bosnia and Herzegovina | 9,500–15,500 (12,500) ⁽⁹²⁾ | 0.3 | 12–43.4 ⁱⁱⁱ | 2–3 | ✓ 28 | ✓ 8 (B,M) |
| Bulgaria | 19,000 ⁽⁹³⁾ | 10.6 ⁽³⁾ | 67.8 | 5.7 | ✓ 102 | ✓ 31 (B,M) |
| Croatia | 6,251 | 0.48 | 39.30 | 6.5 | ✓ [102] | ✓ (B,M) |
| Czech Republic | 38,700 (38,450–38,900) | 0.0–0.7 | 18.6 | 15.1 | ✓ [106] (P) | ✓ [372] ⁽⁴⁾ (B,M, BN) |
| Estonia | 13,801 (8,178–34,732) | 50–60 ^{(5)iv} | 75 | 21.3 | ✓ [36] | ✓ [7] (B,M) |
| Georgia | 45,000 ⁽⁴⁾ | 3.0 | 53 | 7.2 | ✓ [14] | ✓ 18 (BN,M) |
| Hungary | 5,699 | 0.0 | 24.1 | 0.5 | ✓ [29] | ✓ 12 (BN,M) |
| Kazakhstan | 11,6840 ⁽⁴⁾ | 4–4.8 | 60.3 | 7.9 | ✓ [155 – 168] | ✓ [10] ⁽⁴⁾ (M) |
| Kosovo | 3,000–5,000 | 0 | 36.5 | 1 | ✓ | ✓ [3] (M) |
| Kyrgyzstan | 25,500 ⁽⁷⁾ | 12.4–14.6 | 50 | nk | ✓ [53] | ✓ [17 – 20] (M) |
| Latvia | 18,000 ^(4, 8) | 20.3 ^(4, 8) | 74.2 | 1.6 | ✓ [18] | ✓ [4] (B,M) |
| Lithuania | 6,056 ⁽⁸⁾ | 4.6 ⁽⁸⁾ | 70.3–89.7 | 3.3–8.9 | ✓ [11] | ✓ [19] (B,M) |
| Macedonia | 15,000–20,000 ^v | 0 | 70 | nk | ✓ [16] | ✓ [12] (M, B) |
| Moldova | 31,562 ⁽⁹⁾ | 7.9 ⁽⁴⁾ | 70.2–72.8 ⁽⁴⁾ | 3.4–14.2 | ✓ [23] ^{vi} | ✓ [11] (M) |
| Montenegro | nk | 0.3 | 53.6 | nk | ✓ [13] | ✓ [3] (M) |
| Poland | 15,119 (10,444–19,794) | 5 | 70 | 2.5–3.8 | ✓ [12] | ✓ [25] (BN,M) |
| Romania | 19,265 ⁽²⁾ | 24.90 ^{vii} | 79 ⁽¹⁰⁾ | 5 | ✓ [7] | ✓ [13] ⁽¹⁰⁾ (B, BN, M) |
| Russia | 1,815,000 ^{viii} | 18–31 ⁽¹¹⁾ | 72.5 ⁽¹²⁾ | 9 | ✓ [4] ⁽¹³⁾ | x |
| Serbia | 30,383 (12,682–48,083) ⁽¹⁴⁾ | <5 ⁽¹⁵⁾ | 61 ⁽¹⁵⁾ | 68.95 [60.5–77.4] ^{(16)ix} | ✓ [13] ⁽¹⁵⁾ | ✓ [29] (B, BN, M) ⁽¹⁵⁾ |
| Slovakia | 18,841 (13,732–34,343) ^x | 0.3 ⁽¹⁷⁾ | 37.8 | 28.1 | ✓ [28] | ✓ [7] (BN, B, M) |
| Slovenia | 6,100 (5,580–6,750) | 1.9 | 28.5 | 2 | ✓ [17] ⁽⁴⁾ (P) | ✓ [20] ⁽⁴⁾ (BN, B, M, O) |
| Tajikistan | 25,000 (20,000–30,000) | 13.5 ⁽¹⁸⁾ | 36.2 | nk | ✓ [9] | ✓ [34] (M) |
| Turkmenistan | nk | nk | nk | nk | ✓ [2] ⁽¹⁹⁾ | x |
| Ukraine | 310,000 | 19.70 ⁽²⁰⁾ | 27.1 ^{xi} | 4.5 | ✓ [1667] | ✓ [169] (B, M) |
| Uzbekistan | 80,000 ^{xii} | 7.3 ⁽²¹⁾ | 20.9 | nk | ✓ [235] | x |

i This includes all 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.

ii (M) = methadone, (B) = buprenorphine, (O) = any other form (including morphine and codeine).

iii Based on a study conducted in five cities.

iv Based on a study conducted in two cities.

v Data from EMCDDA 2010 based on people who inject drugs in Skopje.

vi Figure relates to regions rather than cities.

vii Civil society believe this figure to be higher.

viii Figure from 2007.

ix Based on findings from two cities.

x Figure includes high-risk drug users.

xi Year of reporting: 2012 for both HCV and HBV, Global Fund Round 6 Programme monitoring, Alliance Ukraine.

xii Year of estimate: 2006. EMCDDA Country Profile: <http://www.emcdda.europa.eu/publications/country-overviews/uz#pdu>

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



Harm reduction in Eurasia

The large and diverse Eurasian region is home to an estimated 3.1 million people who inject drugs, with two of the largest populations living in Russia (1.8 million)⁽²²⁾ and Ukraine (310,000).⁽²³⁾ Eastern Europe and Central Asia is one of two regions globally where rates of HIV infection are continuing to rise. Approximately 1.3 million adults and children are living with HIV in the region (range 1,000,000–1,700,000).⁽²⁾ However, it should be noted that this figure has been strongly disputed by civil society, and population size estimates for people living with HIV in the region should be treated with caution.⁽⁴⁾ One in three new cases of HIV were reported to be attributed to a lack of access to sterile injecting equipment between 2006 and 2010.⁽²⁴⁾ A recent systematic review suggested that one in two people who inject drugs are living with HIV in parts of Estonia, Russia and Ukraine.⁽²⁵⁾

Prevalence of hepatitis C (HCV) is extremely high across the region for people who inject drugs, although it should be noted that robust data is lacking for many countries. Where data is available, high rates are reported in Russia (up to 90%), Romania (82.4) and Lithuania (70.3–89.7%).⁽¹⁾ Rates of HCV are exacerbated in prison settings, with around 91% of prisoners in Kazakhstan living with HCV–HIV co-infection⁽²⁶⁾ and 38% of prisoners in Kyrgyzstan having been exposed to HCV.⁽²⁷⁾ Given that 90% of people who inject drugs in the region will experience incarceration at some point in their lives,⁽²⁸⁾ it is likely that rates of HCV prevalence in prisons among people who inject drugs will be extremely high. Tuberculosis (TB) prevalence in the region varies but is also generally high, with some of the highest rates of multi-drug resistant TB (MDR-TB) in the world reported in Kazakhstan, Uzbekistan, Tajikistan and Kyrgyzstan.⁽²⁹⁾

Overdose continues to be a major cause of morbidity and mortality for people who inject drugs across Eurasia. A recent review found that overdose remains the leading cause of death for people who inject drugs globally.⁽³⁰⁾ While comparable data across the region is lacking, where evidence is available rates of overdose have been described as “alarming”, with between 21–24% of people who inject drugs in Central Asia reporting having experienced a non-fatal overdose in the past year.⁽³¹⁾

Although service provision across the region has expanded since 2012, coverage levels continue to remain lower than internationally recommended targets.¹ Needle and syringe programmes (NSPs) exist in all 29 countries of the region, but coverage varies widely, ranging from two sites in Albania to 1,667 in Ukraine (see Table 2.2.1). Regionally, only 10% of people who inject drugs in Eastern Europe and 36% in Central Asia access NSPs.⁽¹³⁾ The coverage of harm

reduction programmes in Eastern Europe and Central Asia is less than 1% of the estimated number of people who inject drugs.⁽¹¹⁾

Opioid substitution therapy (OST) is available in 26 countries of the region, with only three countries reporting evidence of injecting drug use not providing OST: Russia, Turkmenistan and Uzbekistan.⁽²⁵⁾ However, it should be noted that coverage levels are low across the region, with the Czech Republic having the highest coverage, with 372 sites. The European Union part of the region represents only 5% of the total number of people accessing OST in the European Union, while 20% of people who use opiates live in these countries.⁽³²⁾

Civil society continues to play an important role in advocating for the scale up of harm reduction in the region. The appointment of Michel Kazatchkine as United Nations Secretary-General’s Special Envoy for AIDS in Eastern Europe and Central Asia has brought much-needed attention to harm reduction and HIV in the region. The Eurasian Network of People who Use Drugs (ENPUD) has continued to strengthen, and now includes members from Armenia, Azerbaijan, Belarus, Georgia, Latvia, Lithuania, Moldova, Kazakhstan and Kyrgyzstan, Russia, Tajikistan, Ukraine and Uzbekistan. Several important events have also taken place in the region recently, including the 23rd International Harm Reduction Conference in Vilnius in 2013, and regional conferences in Ukraine and Moldova organised by the Eurasian Harm Reduction Network (EHRN).

However, the most significant development affecting the state of harm reduction in the region is that of the changing donor landscape. The region is overly reliant on international donors, with approximately 15% of financial resources coming from domestic budgets.⁽³³⁾ In particular, the Global Fund’s New Funding Model, with its new focus on disease burden and income level, is likely to further threaten investments in harm reduction, as many countries in the region are now either ineligible or will not receive “new” resources until 2017.⁽³⁴⁾

In response to this growing crisis, EHRN became the recipient of the region’s first regional grant from the Global Fund. This project seeks to build an enabling environment for harm reduction funding in the region and to develop the capacity of people who use drugs to advocate for the availability and sustainability of harm reduction services to meet their needs. The regional programme is implemented in five countries: Belarus, Georgia, Kazakhstan, Moldova and Tajikistan.

Developments in harm reduction implementation

Needle and syringe exchange programmes (NSPs)

In the past few years, the number of programmes providing needles and syringes increased (an increase documented from 13 countries, compared to a decrease in 6 countries for which updated data is available; see Table 2.2.1). Since we reported in *The Global State of Harm Reduction 2012*,⁽¹⁹⁾ the most significant increases have been observed in Bosnia and Herzegovina, Croatia and Ukraine, while the most significant decrease occurred in Poland. However, overall coverage of services remains low in all countries.

In 2012, the Eastern Europe and Central Asia part of the region had the lowest number of syringes distributed per person – a rate of around 50 syringes per person who injects drugs – which represents a further decrease from 2011.⁽²⁾ According to global AIDS progress reporting in 2012, the Czech Republic and Kyrgyzstan reached a rate of more than 200 syringes per person, with Tajikistan significantly expanding coverage from 88 to 199 per person in a year.⁽²⁾ The most significant decrease was in Hungary (from 74 to 14 syringes per person), with Azerbaijan, Belarus, Moldova, Poland, Romania, Serbia and Macedonia delivering fewer than 50 syringes per person.⁽²⁾

Coverage estimates vary significantly between countries (for example, 50% in Kazakhstan,⁽¹⁾ 22% in Tajikistan,⁽¹⁾ 21% in Slovakia,⁽¹⁾ 10% in Poland⁽¹⁾). In Romania, services are limited mainly to the capital Bucharest, and in Lithuania rates dropped below the 2008 rate.⁽¹⁾ Hungary documented a decline of over 30% in syringes distributed, despite availability across the country using diverse distribution systems.⁽¹⁾

Changing patterns of drug use are documented in the eastern part of Europe, including Ukraine,⁽³⁵⁾ Russia and Georgia in the Caucasus.⁽³⁶⁾ In Budapest, a rise in injecting of legal highs (mephedrone-like substances) has been documented.⁽³⁷⁾ This not only suggests the need to scale up existing services, but also points to the challenges in adapting them to address the changing needs of people who inject drugs. For example, in the Czech Republic, NSPs have begun providing gelatine capsules to stimulant users to encourage transitioning from injecting to oral use.^(38,39)

Inadequate funding remains the key constraint to accessible and high-quality services, particularly in the non-European Union part of the region that has been affected by changing donor priorities. Other barriers include unequal coverage between urban

and rural settings, a lack of legislative regulation of services, the criminalisation of people who use drugs, restricted opening hours and poor-quality equipment.⁽⁴⁾ Additional barriers to accessing NSPs for specific groups include age restrictions for those under 18 years and a lack of gender-sensitive services for women who use drugs.⁽⁴⁾ Political hostility towards harm reduction is also a growing concern, and has led to the closure of the biggest NSP programme in Hungary, providing around 40% of the country's clean needles⁽⁴⁰⁾ – a decision criticised by Hungary's Commissioner on Fundamental Rights.⁽⁴¹⁾

Opioid substitution therapy (OST)

OST is provided in various forms and on different scales in 26 countries of the region. It remains illegal in Russia and Turkmenistan, and Uzbekistan did not renew its programme that closed in 2009. With support from the Global Fund, Kosovo initiated a pilot OST programme in mid-2012, and by the end of the year, 55 people were receiving methadone.⁽⁴⁾

Since 2012, a number of countries have removed barriers, facilitating access and improving the quality of OST programmes. In Latvia, new regulations to legalise OST provision resulted in a 28% increase in patients in 2012.⁽³⁷⁾ In Bulgaria, buprenorphine was approved for the treatment of HIV-positive or high-risk people under 18 years, enabling OST to become accessible to this age group.⁽³⁷⁾ Ukraine also removed a number of barriers, including a weakening of age restrictions for legal minors, which resulted in expanded access.⁽⁴²⁾

Countries that have scaled up OST include Armenia, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Macedonia,⁽¹⁹⁾ Tajikistan and Ukraine.⁽¹¹⁾ However, the most significant progress is being made in the Czech Republic, which has the highest coverage rates in the region, of approximately 40–45% of people who inject drugs.⁽⁴³⁾ A steady increase in coverage is also reported from Ukraine, where the number of OST patients at the beginning of 2014 reached 7,784.⁽⁴⁴⁾ Elsewhere, progress is slow and OST coverage remains limited. Despite the increased access mentioned above, Latvia remains the country with the lowest OST coverage in the European Union,⁽³⁷⁾ with only 2.3% of all opiate users receiving OST.⁽¹⁾ In Estonia, coverage remains below 15%.⁽¹⁾ Belarus reported a steady increase in OST patients, from 79,2 to 107,7 between January 2012 and 2014, although this is only a small proportion of the estimated 75,000 people who inject drugs in the country.

A 30% decrease in OST access has been documented in Romania,⁽⁴⁵⁾ the limited geographical reach of programmes in Estonia, Hungary and Lithuania has been recorded, and a significant

reduction in the number of treatment slots available in Bulgaria noted.⁽³²⁾ Although 11 countries in the European Union part of the region have legalised buprenorphine,^{xiii} three of these (Bulgaria, Estonia, Lithuania) are reported not to provide it in practice,^{xiv} and Slovakia enrolled only two people by the end of 2012.⁽⁴⁶⁾

Gender-based discrimination in access persists, and women are often excluded from OST treatment. For example, in Georgia less than 1% of women who inject drugs have access to OST.⁽⁴⁷⁾ Other barriers affecting the scale and quality of OST in countries across the region include centralisation of access,⁽³²⁾ stigma,⁽⁴⁸⁾ lack of a legal framework⁽⁴⁹⁾ and cost of treatment.

Viral hepatitis

Prevalence rates for viral hepatitis are generally far higher than HIV rates for people who inject drugs across the region, although limitations on the data for both hepatitis B (HBV) and HCV make it difficult to assess changes in the epidemic accurately. Despite this, prevalence rates of HCV infection among people who inject drugs appear to be extremely high in many

countries, with rates of 50% or higher in at least 17 countries (Azerbaijan, Bosnia and Herzegovina, Bulgaria, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Montenegro, Poland, Romania, Russia, Serbia, Tajikistan, Ukraine). In Russia, Lithuania and Romania, HCV rates have been observed of 70–90% of people who inject drugs.

Access to hepatitis treatment remains generally low. For example, although Ukraine has the highest prevalence of HCV among adults in Europe (1.2 million), only 80 courses for treating adults infected with HCV were procured between 2011 and 2013.⁽⁵⁴⁾ The high cost of hepatitis treatment remains a key obstacle to access in most countries. While some countries provide partial public funding for treatment (Armenia, Belarus, Bulgaria, Croatia, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Macedonia, Moldova, Montenegro, Poland, Russia, Serbia and Slovenia),⁽⁵⁵⁾ access remains low. However, some significant progress in reducing treatment costs has been achieved since 2012 through civil society advocacy. In Ukraine, a substantial reduction in price announced in 2013 has provided HCV treatment for 100 patients with HIV–HCV co-infection who inject drugs.⁽⁵⁴⁾

The HIV epidemic and the battle for harm reduction in Ukraine

The scale up and investment in HIV and harm reduction programming in Ukraine has made it one of the largest harm reduction programmes in the world. It is also one of the most significant successes, with rates of HIV decreasing among people who inject drugs in the country.⁽⁵⁰⁾

It is estimated that around 50% of people who inject drugs (200,000 people) are reached by these services annually, including large-scale, peer-driven interventions; pharmacy-based NSPs; new programming for people who use stimulants; and services for women who use drugs.

However, the Global Fund's New Funding Model has resulted in changes in allocations for Ukraine, leading to a projected 53% reduction in support for harm reduction programmes between 2014 and 2015. Programme managers predict that plans to scale up access to OST will cease, along with funding for legal services and sexually transmitted infection (STI) testing and treatment, and that outreach programmes will have a reduced reach. While it is hoped that a small increase in funding will be allocated through the next round of Global Fund support in 2016, if further reductions are experienced there is likely to be an overall cut of 72% in harm reduction programmes by 2017.⁽⁵¹⁾

In 2014, after the annexation of Crimea by Russia, all substitution programmes operating there were discontinued, resulting in around 800 patients no longer receiving OST since Crimea was now subject to Russian law, under which OST is illegal. While the health and welfare of these former patients is largely unknown, it was reported that 10 people died between March and May 2014⁽⁵²⁾ and approximately 200 people were displaced because of the discontinuation of OST. Since the unrest, OST provision is also under threat in eastern regions. Donetsk and Luhansk in particular are at risk of being cut off from essential medical supplies, including methadone and buprenorphine.⁽⁵³⁾

According to the UNAIDS representative in Ukraine, Crimea's OST provision was considered an example of best practice. Among the 800 people formerly enrolled in OST in Crimea, 38% were living with HIV and 50% of them were receiving antiretroviral therapy (ART).⁽⁵²⁾

xiii Bulgaria, Czech Republic, Croatia, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia, Slovenia.

xiv EMCDDA. Table HSR-3. Estimated number of clients in methadone treatment and of all clients receiving any opioid substitution treatment (OST). [Online]. 2012. Available from: <http://www.emcdda.europa.eu/stats12/hsrtab3b> [Accessed 28 November 2014].

In 2014, the Georgian government negotiated a significant 60% price reduction in treatment courses,⁽⁵⁶⁾ leading the government to announce that 10,000 people, including those in prison, will receive treatment.

Political commitment on these issues is generally low, with only five countries reporting national HCV strategies (Bosnia and Herzegovina, Latvia, Lithuania, Slovenia and Ukraine).⁽⁵⁷⁾ Stigma and discrimination related to drug use, as well as widespread misconceptions among treatment specialists about a lack of adherence to treatment by people who use drugs, create further barriers to treatment. Many countries have restrictive admission criteria for people who use drugs, which range from abstinence requirements in some countries (Hungary and Macedonia) to systematic exclusion in others (Bulgaria and Romania).⁽⁴⁾ A recent report covering six countries (Georgia, Kazakhstan, Kyrgyzstan, Lithuania, Russia and Ukraine) found that treatment is unavailable due to a lack of guidelines prioritising modern, internationally agreed HCV diagnostic and treatment protocols, with some existing guidelines recommending medications of questionable value whose effectiveness has been insufficiently proven.⁽⁵⁸⁾

Overdose

Overdose remains a major cause of avoidable death in the region. Although data is sparse, where available it is clear that overdose-related mortality is increasing in many parts of the region. For example, it has been estimated that around 100,000 people die from overdose every year in Russia.⁽⁵⁹⁾ Rates in Estonia are also particularly high; a trend associated with changing drug patterns, particularly the use of fentanyl (a family of highly potent synthetic opioids).⁽⁴⁵⁾ However, it is difficult to assess the true scale of overdose morbidity and mortality, as inconsistent reporting and differences in surveillance systems has led to systematic undercounting of overdose events. Accordingly, there is a lack of data to effectively inform overdose prevention programmes.⁽⁶⁰⁾

The overdose epidemic among people who inject drugs remains unacknowledged as an urgent political issue at a regional level. However, some progress has been made since 2012, with both Estonia⁽⁶⁰⁾ and Kyrgyzstan specifically referencing overdose in their national anti-drug strategies.⁽⁴⁾

The Global Fund has played an important role in supporting the scale up of peer workers in overdose prevention programmes in Kyrgyzstan.⁽⁴⁾ Further scale up of services is expected in Georgia and Moldova following inclusion of overdose in recent Global Fund proposals.⁽⁴⁾

Naloxone, a highly effective opioid antagonist used to reverse the effects of opioid overdose, is registered in the essential medicines list in all countries in the region with the exception of Albania.⁽⁶¹⁾ However, harm reduction programmes providing naloxone are extremely limited, with only Georgia, Kyrgyzstan, Russia, Tajikistan and Ukraine reporting implementation.⁽⁶⁰⁾ Of the 11 European Union member states within Eurasia, only Estonia provides takeaway intranasal naloxone.⁽⁶²⁾

The most significant progress has been made in Central Asia, where a regional project has been initiated to make naloxone available through pharmacies using a voucher system. In Tajikistan, home to some of the region's first overdose projects, local and international non-governmental organisations (NGOs) were successful in advocacy to the ministry of health to allow harm reduction programmes to store naloxone legally on site, enabling a significant increase in the distribution of naloxone.⁽⁶⁰⁾ In 2014, the Georgian government amended legislation that required medical services to report drug overdose cases to the police, removing a large barrier to overdose prevention.⁽⁶³⁾

Barriers to accessing naloxone in the region include extensive regulations for management of naloxone by non-medical staff, while simultaneously provision through medical personnel is restricted by overregulation.⁽⁶⁴⁾ Moreover, intense stigma and discrimination create additional barriers for people who inject drugs, coupled with structural and legal barriers such as harsh penalties for drug use and possession, and high threshold criteria for acquiring naloxone – often only available through medical personnel. Furthermore, those limited services that are able to provide naloxone are usually inadequately funded, meaning that programmes are frequently limited to small-scale pilot projects. This financial instability has led to interruptions in naloxone supply in some countries.⁽⁶⁰⁾

Tuberculosis

Throughout the region, TB testing and treatment services are not generally tailored to the needs of people who inject drugs, being rarely linked to HIV or drug treatment services. However, some countries have taken positive steps forward, including Belarus and Ukraine, where TB testing is offered at some harm reduction sites. Despite this, take up is low as concerns around lengthy hospital stays without access to OST and other drug treatment interventions deter testing.⁽⁴⁾

Prisons and other correction facilities, such as pre-trial detention centres, have some of the highest rates of MDR-TB in the region. In Russia, MDR-TB rates

among prison populations have ranged from 12–55% in previously treated patients.⁽⁶⁵⁾

Key barriers in TB diagnostics, treatment and care include a lack of political will and sustainable funding. A large proportion of TB services in communities and prisons are supported by the Global Fund. However, due to the changing nature of eligibility criteria, a number of countries, including Azerbaijan, Belarus and Romania, will no longer be eligible for Global Fund support for TB programmes. Although Azerbaijan has the third-highest MDR-TB rate in the world,⁽⁶⁶⁾ the current Global Fund grant supporting TB programmes is due to end in 2015. Following cancellation of Round 11, Belarus became ineligible to apply for continued support through the Transitional Funding Mechanism.⁽⁶⁷⁾ Equally, in Romania, where 27% of all TB cases in the European Union occur and 19% of previously treated cases are now multi-drug resistant,⁽⁶⁸⁾ the government has yet to allocate sufficient funding to address the issue. Although the government demonstrated willingness in 2012 to fund the TB response, pledging €5.75 million, parliament has failed to allocate the funds so far.⁽⁶⁷⁾ Service provision for prisoners is particularly dependent on international sources of funding, with an estimated 90% of countries in Eastern Europe and Central Asia funding TB services with grants from the Global Fund.⁽⁶⁹⁾

Antiretroviral therapy (ART)

Across the region ART coverage remains extremely low, with around 20% of people who inject drugs who are living with HIV able to access treatment.⁽²⁵⁾ In Russia, 35% of people who are living with HIV inject drugs,⁽⁷⁰⁾ but just 1 in 10 access ART.⁽²⁾ Such disproportionately poor access to ART is likely to be even more pronounced among subgroups such as people living with HIV who inject drugs and women who are pregnant. For example, a prospective cohort study in Ukraine among pregnant women with HIV showed that the mother-to-child transmission rates of HIV were almost twice as high among women who injected drugs as among women who did not.⁽⁷¹⁾

Despite these reported low coverage levels, some progress can be seen. For example, between 2010 and 2012, the number of people receiving ART increased by 50% in Azerbaijan and Tajikistan.⁽⁷²⁾ Since 2008, the Ukraine government has significantly increased investments in providing ART. Resources allocated for HIV treatment in the central state budget covered 43,790 people living with HIV at the end of 2013; an impressive increase from 12,751 people receiving treatment on 1 January 2010.⁽⁷³⁾ Romania and Georgia have also achieved ART rates of over 60%.⁽⁷⁴⁾

Key barriers include stigma and discrimination, unavailability of low-threshold testing and counselling services, and a lack of comprehensive care and treatment, including evidence-based drug treatment. Currently, ART is financed through a combination of domestic budget allocations and out-of-pocket spending. However, in cases where treatment is covered by the state, people who inject drugs face heightened barriers to access. For example, around 30–50% of people who inject drugs in Estonia do not have healthcare insurance and are therefore unable to access ART.⁽⁷⁵⁾ Other barriers include limited geographical reach of service provision (for example, in Belarus under 20 medical professionals can prescribe ART), poor case management, and a lack of joined-up service provision between drug treatment services and HIV clinics, as well as TB and hepatitis issues.⁽⁴⁾

HIV diagnosis and AIDS-related mortality remain high, particularly for people who inject drugs. Between 2006 and 2011 there has been a reported 58% rise in AIDS-related deaths in the region.^(70,74) There is a critical need to scale up integrated HIV and drug treatment services, in particular OST, which has been shown to improve adherence to ART among people who inject drugs. The implementation of OST provision has been projected to reduce new HIV infections by 54%.⁽⁷⁶⁾

Harm reduction in prisons

The region has a high prison population, with Russia alone incarcerating 850,000–1 million people each year – the second highest prison population in the world.⁽⁷⁷⁾ A repressive legal environment and an over-reliance on punitive drug laws in many countries ensure that a large proportion of the prison population are likely to be people who use drugs.⁽⁷⁸⁾ In Central Asia it has been estimated that 90% of people who inject drugs have been imprisoned at some point in their lives.⁽²⁷⁾

NSPs in prisons are available in three countries (Kyrgyzstan, Moldova, Tajikistan). Prison NSP programmes that previously had been established in Armenia, Belarus and Romania have now ceased to operate. Although the programme in Tajikistan is a pilot, the response in Kyrgyzstan and Moldova is more robust, with NSPs available in 16 and 9 prisons respectively.⁽⁷⁹⁾

Civil society reports that OST in prison or detention settings exists to some extent in 19 countries in the region (see Table 1.1.1). However, regulation, coverage and quality differs substantially, with some countries allowing people to maintain OST in prisons if they were accessing it before arrest (Albania, Bulgaria, Croatia, Czech Republic, Estonia,

Kyrgyzstan, Macedonia, Moldova, Montenegro, Poland, Romania, Serbia, Slovenia), while others use methadone for detoxification only (Georgia), allow it in policy but have not implemented it in practice (Hungary), or have made it available in some cases in police lock-up only (Ukraine). Slovenia has scaled up OST in prison settings and is now reaching over 10% of the prison population.⁽⁷⁵⁾

Civil society confirms the availability of ART in prisons in at least 13 countries (Albania, Azerbaijan, Belarus, Bulgaria, Czech Republic, Georgia, Hungary, Kyrgyzstan, Macedonia, Poland, Romania Slovakia and Ukraine). A number of countries (for example, Bulgaria, Latvia and Romania) reportedly practice mandatory HIV testing within prisons.⁽⁷⁵⁾

Policy developments

Within the region, 26 countries or territories have national HIV or drug policies explicitly supporting harm reduction.⁽¹⁹⁾

Positive policy developments have been observed in Albania, where the newly adopted National Strategy Against Drugs 2012–16 consists of a balanced approach, including harm reduction. In Kyrgyzstan, the anti-drug programme that was adopted at the beginning of 2014 acknowledges harm reduction, including OST and naloxone. Furthermore, it specifically identifies the importance of creating a conducive legal environment for implementing a comprehensive package of services that meet international standards.

However, drug policy across the region is marked by an overreliance on criminalisation, and political hostility towards harm reduction is common. For example, in Uzbekistan and Ukraine, possession of very small amounts of drugs, equal to the residue found in a used syringe, can lead to imprisonment.⁽⁶⁰⁾ This zero tolerance policy shift is also supported by the national anti-drug strategy called “Clear Consciousness, Sobriety and the Fight Against Drug Crime”, with aims for a drug free Hungary by 2020. In January 2014, a new Criminal Code bill was introduced in Bulgaria that is looking to recriminalise drug use. If approved, fines for minor possession will be replaced with imprisonment.⁽⁶¹⁾

The Russian Federation continues to implement a zero tolerance approach to drug use.⁽⁶²⁾ In recent years, the Russian government has used anti-propaganda laws to suppress harm reduction services and advocacy,⁽⁶³⁾ as well as considering the recriminalisation of drug use. In 2013, the United Nations Special Rapporteur on torture and other forms of cruel, inhuman, degrading treatment or punishment, Juan E Méndez, released a report

equating the denial of OST to cruel, inhuman or degrading treatment and, in some cases, torture, and advised “similar reasoning should apply to the non-custodial context, particularly in instances where Governments impose a complete ban on substitution treatment and harm reduction measures.”⁽⁶⁴⁾

Civil society and advocacy developments for harm reduction

Civil society has continued to play a strong and important role in the region in advocating for harm reduction in Eurasia and internationally.

Regional initiatives have included a clear focus on the lack of sustainable funding for harm reduction in the region. EHRN became the principle recipient for the first regional HIV/AIDS grant in Eastern Europe and Central Asia. The programme Harm Reduction Works: Fund it! is now set to focus on strengthening civil society in the region to advocate for sustainable funding for national harm reduction programmes, covering Belarus Georgia, Kazakhstan, Moldova and Tajikistan.

Since 2012 a number of online interactive campaigns have been launched. In 2012, over 6,000 people signed the EHRN Hepatitis C Treatment Waiting List, which highlighted the lack of access to treatment for people who use drugs. In the same year, in partnership with ENPUD, EHRN launched the ‘I am the Evidence’ campaign, recording personal testimonies advocating for naloxone provision. In 2014, the Women against Violence campaign was launched, aiming to document cases of violence against women who use drugs and raise awareness of the heightened vulnerability to violence many women experience.⁽⁶⁵⁾

Several international meetings held in the region between 2012 and 2013 helped to facilitate debate on harm reduction and dialogue between policymakers, international organisations, and harm reduction and drug user activist groups. In July 2012, EHRN and the International HIV/ AIDS Alliance in Ukraine organised the AIDS forum ‘Ensuring That Our Voice is Heard’ in Ukraine. Over 100 participants attended from 11 Eastern European and Central Asian countries, more than half representing communities of people who use drugs. The 2012 International AIDS conference was held in the USA, where visa restrictions meant that many representatives of people who use drugs could not attend. EHRN organized the AIDS Hub as a pre-conference for community members from Eastern Europe and Central Asia. In June 2013, the 23rd International Harm Reduction Conference was held in Vilnius, Lithuania, ensuring wide regional focus and dialogue between government representatives, harm

reduction organisations, and people who use drugs. ENPUD has also continued to grow, and currently has approximately 100 members representing the majority of Eastern European and Central Asian countries.

A number of successful harm reduction advocacy campaigns have been carried out at a national level, including securing the development of take-home naloxone by the drug user-led Association of the Substitution Treatment Advocates of Ukraine (ASTAU); the opening of a new OST site in Tajikistan by the OST patients' group Choice; and removing barriers to OST access in Armenia. Here, the drug user activist group Awakening Power successfully advocated for removal of police representatives from medical commissions evaluating a individual's readiness to undergo OST. In Hungary and Romania, civil society groups are working towards establishing drug consumption rooms. In Kyrgyzstan and Ukraine, groups of people living with HIV and people who inject drugs have joined forces to advocate for reduction of HIV and HCV treatment prices.

Funding: developments for harm reduction

Funding for the majority of harm reduction programmes in Eastern Europe and Central Asia is mainly reliant on international sources, primarily the Global Fund. The Global Fund has allocated \$688.5 million^{xv} for financing programmes for 2014 and beyond. Currently the largest funding allocation within the region is to Ukraine (28%), followed by

Uzbekistan (10%) and Georgia (9%).⁽⁸⁸⁾

A period of instability from 2011 to 2012, during which the Global Fund cancelled Round 11⁽¹⁹⁾ and offered only limited funds for “essential services”, was followed by a Transitional Funding Mechanism⁽⁸⁹⁾ in 2013, and finally the New Funding Model was adopted. According to new eligibility criteria, more than half of countries (16 out of 29) within this region will become ineligible for funding from 2014.⁽⁹⁰⁾

The New Funding Model may threaten investments in harm reduction, as many of the countries with the greatest need are now either ineligible for further funding or are not receiving any “new” resources for harm reduction, and national sources are expected to fill the gap. However, across the region governments have shown little “willingness to pay” for harm reduction programmes.⁽⁹¹⁾

All countries except Armenia, Bulgaria, Moldova and Montenegro provide some domestic funding for harm reduction. However, the degree of domestic financing varies substantially. Available data for 2009–2012 indicate that out of 21 countries in the region, the largest proportion of funding (over 90%) for harm reduction in Croatia, Czech Republic, Estonia, Hungary, Latvia, Lithuania and Poland comes from domestic sources.⁽²⁾ However, as harm reduction coverage estimates show, adequate scale is achieved only in the Czech Republic. In Armenia, Azerbaijan, Belarus, Bulgaria, Moldova, Montenegro, Romania, Russia, Tajikistan, Ukraine and Uzbekistan domestic funding varies from 0% (Armenia, Bulgaria, Moldova, Montenegro) to 12% (Belarus).⁽²⁾

Successful campaign to reduce prices for hepatitis C treatment in Georgia

According to available data, 6.7% of Georgia's adult population (around 200 000 people) live with the HCV. The prevalence level is twice as high as the global average.⁽⁸⁶⁾ It has been estimated that around 20,000 people,⁽⁵⁶⁾ or around one in ten, in need of treatment have undergone a course in Georgia. One course of treatment can cost up to US\$15,000. This exorbitant price ensures it is almost inaccessible for most people in the country, where the average monthly wage is around US\$400.

A campaign to improve access to HCV treatment was initiated by the Georgian Harm Reduction Network (GHRN) in partnership with patients' groups. The cornerstone of the campaign was to make people living with HCV visible in order to create a demand for treatment. In 2012, a campaign ‘We Need Treatment NOW’ was organised, targeting policymakers at national and local levels, followed by an innovative campaign telling pharmaceutical companies it was ‘Time for Sale’. In parallel, GHRN and patient groups led a number of meetings with the health and justice ministries in order to develop national hepatitis strategy. The partnership between the harm reduction groups and patient groups was crucial to presenting treatment access as an urgent public health issue and to ensuring a non-discriminatory approach.

As a result of three years of advocacy, a significant price reduction was achieved, from US\$246 to US\$93 per vial for Pegintron, allowing 10,000 people to undergo treatment at a reduced price. The price reduction has also enabled the government to expand treatment to prisoners living with HCV.⁽⁸⁷⁾

In Kazakhstan and Kyrgyzstan, the gap between domestic and external source is lowest in the region (see Table 1).

In Kyrgyzstan, public spending for HIV between 2010 and 2012 more than doubled, indicating the progress made by the country in taking over the financial burden of HIV, and the total share of harm reduction funding in HIV support from international sources is

now below 6% (see Table 1). In all other countries for which data is available (Albania, Georgia, Lithuania, Moldova, Romania), domestic spending on HIV decreased between 2011 and 2012^{xvi}. According to UNAIDS, the influx of domestic resources into the HIV response directly correlates with country income level, with higher investments in higher-income countries.⁽²⁾

Table 1: The proportion of domestic versus external spending for harm reduction and share of harm reduction in domestic and external HIV spending*

| Country | Year | Harm reduction spending for IDUs from domestic sources (%) | Harm reduction spending for IDUs from international sources (%) | Share of harm reduction spending in the total HIV / AIDS spending (%) | Share of harm reduction spending in HIV/AIDS spending from domestic sources (%) | Share of harm reduction spending in total HIV/AIDS spending from international sources (%) |
|----------------|------|--|---|---|---|--|
| Armenia | 2012 | 0 | 100 | 20.5 | 0.0 | 26.7 |
| Azerbaijan | 2011 | 6 | 94 | 10.2 | 0.9 | 31.8 |
| Belarus | 2011 | 12 | 88 | 16.8 | 3.2 | 40.8 |
| Bulgaria | 2011 | 0 | 100 | 10.2 | 0.0 | 15.3 |
| Croatia | 2009 | 100 | 0 | 32.1 | 32.1 | 0.0 |
| Czech Republic | 2009 | 96 | 3 | 22.3 | 22.3 | 25.3 |
| Estonia | 2010 | 100 | 0 | 46.9 | 46.9 | 0.0 |
| Georgia | 2012 | 39 | 42 | 59.7 | 64.1 | 48.2 |
| Hungary | 2009 | 100 | 0 | 2.1 | 2.1 | 0.0 |
| Kazakhstan | 2012 | 36 | 64 | 35.3 | 28.6 | 40.6 |
| Kyrgyzstan | 2012 | 40 | 60 | 5.4 | 4.9 | 5.8 |
| Latvia | 2010 | 100 | 0 | 3.7 | 4.1 | 0.0 |
| Lithuania | 2012 | 100 | 0 | 43.5 | 43.5 | 0.0 |
| Moldova | 2012 | 0 | 100 | 35.5 | 0.0 | 56.6 |
| Montenegro | 2009 | 0 | 100 | 22.0 | 0.0 | 22.0 |
| Poland | 2009 | 99 | 0 | 4.2 | 5.5 | 0.0 |
| Romania | 2011 | 7 | 93 | 23.1 | 6.0 | 29.3 |
| Russia | 2008 | 2 | 98 | 2.9 | 0.1 | 29.2 |
| Tajikistan | 2011 | 5 | 95 | 25.8 | 7.2 | 30.8 |
| Ukraine | 2010 | 4 | 96 | 23.3 | 1.7 | 50.1 |
| Uzbekistan | 2012 | 6 | 94 | 7.9 | 0.8 | 17.6 |

The table is based on UNAIDS. *AIDSinfo*. [Online]. 2013. Available from: <http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/> [Accessed 28 November 2014].

The table summarising information for countries of the region, and an interactive maps, is available at: Eurasian Harm Reduction Network. *Harm reduction funding in EECA*. [Online]. <http://www.harm-reduction.org/issues/funding-harm-reduction/map> [Accessed 28 November 2014].

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REGIONAL OVERVIEW

2.3

Western Europe



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 ⁽¹⁾ | HIV prevalence among people who inject drugs (%) ⁽²⁾ | Hepatitis C (anti- HCV) prevalence among people who inject drugs (%) ⁽³⁾ | Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%) ⁽²⁸⁾ | Harm reduction response | | |
|--|---|--|---|--|---|---|--|
| | | | | | NSP ⁽⁴⁾  | OST ⁽⁵⁾ ⁱⁱ  | DCR ⁽⁵⁷⁾  |
| Andorra | nk | nk | nk | nk | x | x | x |
| Austria | 17,500 (12,000–23,000) ⁱⁱⁱ | 0.7–5.3 | 44.3–59.9 | nk | ✓[40] | ✓(B,M,O) | x |
| Belgium | 24,810 (18,286–36,896) | 0.0–8.3 | 17.1–75.1 ^{iv} | 3.0 ^v | ✓[102] | ✓(B,H,M) | x |
| Cyprus | 231 (192–3,010) | 0–1.3 | 55.4 | 2.4 | ✓[1] | ✓(1) B,O | x |
| Denmark | 12,754 (10,066–16,821) | 5 ⁶ | 52.5 | 1.3 ^{vi} | ✓ | ✓(B,H,M) | 5 |
| Finland | 15,650 (12,200–19,700) ^{(7)vii} | 0.9 | 60.5 | nk | ✓[42] | ✓(B,M,O) | x |
| France | 122,000 ^{(8)viii} | 7.2 | 41.7 ^{ix} | 4.8 ^{(9)x} | ✓[583] | ✓(19,484) (B,M,O) | x |
| Germany | 94,250 (78,000–110,500) ⁽⁸⁾ | 3.9–5.6 ^{xi} | 56.0–71.6 ^{xii} | 7.2 ^{xiii} | ✓[391] | ✓(2,786–6,626) (B,H,M) | 24 |
| Greece | 7,651 ⁽¹⁰⁾ | 5–8 ^{(10)xiv} | 59.6–73.4 | 1.3–3.3 | ✓[14] | ✓(17)(B,M,O) | x |
| Iceland | nk | nk | 63 ^{(9)xv} | nk | x | ✓(B,M) | x |
| Ireland | 6,289 (4,694–7,884) ^{(8)xvi} | nk | 74.6 (72.3–76.9) ^{(9)xvii} | nk | ✓[91] | ✓(332)(B,M,O) | x |
| Italy | 326,000 ^{(8)xviii} | 11.5 | 61.0–64.8 ^{xix} | nk | ✓ | ✓(B,M,O) | x |
| Luxemburg | 1907 | 2.4 | 70.3–89.7 ^{xx} | 5.1 ^{xxi} | ✓[10] | ✓(B,M,O) | 1 |
| Malta | (1,524–2,301) | 0 | 40.8 | nk | ✓[7] | ✓(≥2) (B,M) | x |
| Monaco | nk | nk | nk | nk | x | x | x |
| Netherlands | 2,390 (2,336–2,444) | 0.0–3.7 ^{xxii} | 86.2 ^{(9)xxiii} | 3.0 ^{xxiv} | ✓[175] | ✓(B,H,M) | 30 |
| Norway | 9730 (8,299–11,757) | 2.32 | 65.8 | 1.2 ^{xxv} | ✓[44] | ✓(B,M) | 1 |
| Portugal | nk | 4.9– 6.5 | 83.8 | 4.9 | ✓[1,270] | ✓(B,M) | x |
| Spain | 7,393 (7,098–7,886) | 33.6 | 79.6 (73.3–85.9) ^{(9)xxvi} | 3.6 ^{xxvii} | ✓[2,386] | ✓(497–2,229) (B,H,M) | 13 |
| Sweden | nk | 4.4 | 75.1 (62.0–88.2) ^{(9)xxviii} | 2.3 | ✓[4] | ✓(B,M) | x |
| Switzerland | 31,653 (24,907–38,399) ^{(8)xxix} | 7.3 | 78.3 ^{(9)xxx} | 4.0 ^{xxxi} | ✓ | ✓(B,H,M,O) | 13 |
| Turkey | nk | 0.3 | 50.1 | 8.6 | x | ✓(B) | x |
| UK | 133,112 (126,852–143,278) | 1.2 | 43 | 8.9 | ✓[1,523] ^{(59)xxxiii} | ✓(B,H,M,O) | x |

i. Figure is based on total number of fixed sites (including specialist agency sites, vending machines, pharmacy-based services and prison-based services) combined with total number of mobile sites (outreach workers and services carried out by a van). Data is from 2012 unless otherwise stated.

ii. Year of estimate: 2011.

iii. Year of estimate: 2000.

iv. Estimate is based on sub-national data.

v. Year of estimate: 2008. See reference 9.

vi. Year of estimate: 2007. See reference 9.

vii. Civil society argues that figures are greater than stated by UNODC.

viii. Year of estimate: 1999.

ix. Estimate is based on sub-national data.

x. Year of estimate: 1992–1995.

xi. Figure is based on sub-national data.

xii. Estimate is based on sub-national data.

xiii. Year of estimate: 1992–94. See reference 9.

xiv. Figure is based on sub-national data.

xv. Year of estimate: 1990–1993.

xvi. Year of estimate: 1996.

xvii. Year of estimate: 2001–3.

xviii. Year of estimate: 1996.

xix. Figure is based on sub-national data.

xx. Figure is based on sub-national data.

xxi. Year of estimate: 1990–93. See reference 9.

xxii. Figure is based on sub-national data.

xxiii. Year of estimate: 2008.

xxiv. Year of estimate: 2000. See reference 9.

xxv. Year of estimate: 2008. See reference 9.

xxvi. Year of estimate: 2003.

xxvii. Year of estimate: 2003. See reference 9.

xxviii. Year of estimate: 2007.

xxix. Year of estimate: 1997.

xxx. Year of estimate: 2002.

xxxi. Year of estimate: 1996. See reference 9.

xxxii. Year of estimate: 1996–2000. See reference 9.

xxxiii. Year of estimate: 2010.

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

In most of Europe, HIV rates among people who inject drugs appear to be stable or declining⁽¹¹⁾ as a result of early scale up of harm reduction measures. However, recent severe outbreaks of HIV among people who inject drugs in Greece and Romania prompted the European Centre for Disease Prevention and Control (ECDC) and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) to undertake a risk assessment in 2013. They concluded that five countries in Western Europe are of concern for HIV risk: Estonia, Greece, Latvia, Lithuania and Romania.⁽¹¹⁾

There have been few notable changes in the dynamics of drug use in Europe since 2012. The rate of opioid use in Europe, including in new European Union member states, is estimated to be around 0.4% among people aged 15–64 (approximately 1.3 million users).⁽¹¹⁾ While heroin use is slightly declining, use of other opioids, including fentanyl, methadone and buprenorphine, is growing. Injecting drug use has also been declining since 2006, including among people who use opioids,⁽¹²⁾ and the number of new users of opioids also appears to be declining.⁽¹²⁾ At the same time, Europe's drug-using population is ageing, particularly in the countries of Western Europe that experienced heroin epidemics in the 1980s and 1990s.⁽⁶⁰⁾

Amphetamine use has remained relatively low and stable, with less than 2.5% of the population using in most countries.⁽¹²⁾ Although amphetamines are often taken orally or snorted, injection is also common in some communities.⁽¹²⁾ Stimulant injecting poses challenges for needle and syringe programme (NSP) coverage, since more frequent injection requires more syringes, and adapted outreach is needed to reach stimulant users.⁽¹¹⁾ Use of amphetamine-type stimulants (ATS) in conjunction with risky sexual behaviour (described as “chem sex” in a 2013 study on amphetamine use among men who have sex with men in London⁽¹³⁾) is believed to be contributing to rising rates of HIV among men who have sex with men in many countries. New psychoactive substances and ‘legal highs’ are also getting increasing attention, but the discourse is often focused on supply reduction and law enforcement issues rather than understanding and managing the impact on health and rights.

A myriad of factors, including criminalisation, stigma and inadequate medical and social services, contribute to disproportionately high mortality and morbidity among people who use drugs in Europe, with overdose remaining the main cause of mortality. People who inject drugs in Europe face a mortality rate of 1–2% per year and are 10 times more likely to die than their non-using peers of the same gender

and age,⁽¹²⁾ with women who use opioids facing a risk that is 30 times greater.⁽¹²⁾ Although the majority of the mostly high-income countries of Western Europe remain among those countries in the world with the best-controlled HIV epidemics among people who inject drugs, HIV prevalence within this population is still high (greater than 5%) in France, Greece, Italy and Spain.⁽¹⁴⁾ In Austria, Belgium, Cyprus, Denmark, Finland, Germany, Luxemburg, Malta, the Netherlands, Norway, Sweden and the UK⁽¹⁴⁾ it is moderate (1–5%), low (less than 1%) or stable, and in Finland, Germany and Sweden, HIV prevalence among people who use drugs is declining.⁽¹⁴⁾ The relatively low and/or declining prevalence reported in most of these countries is generally attributed to the scope and quality of their harm reduction programmes.

The World Health Organization (WHO) estimates that there may be as many as 1.2 million people who inject drugs living with hepatitis C (HCV) in the European Union/Free Trade Agreement region,⁽³⁾ with an estimated HCV prevalence of approximately 44% among people who inject drugs.⁽³⁾ Increases in HCV prevalence among people who inject drugs have been seen in Belgium, Cyprus, Greece and Turkey.⁽¹¹⁾ Problematically, access to HCV treatment and prevention for people who inject drugs remains low.

Data on tuberculosis (TB) prevalence in Western Europe is still very limited. In European countries, the disease is predominantly concentrated among high-risk groups, such as migrant populations, homeless people, people who use drugs and people in prison.⁽¹⁵⁾ People who are living with HIV and who inject drugs are two to six times more likely to develop TB than non-injectors, and commonly have co-morbidities with hepatitis B (HBV) and HCV infection. Among people who inject drugs who develop TB, at least one in three will also have HIV, and two out of three will have HCV antibodies. They are also at increased risk of criminalisation and incarceration.⁽¹⁶⁾

Although the availability of health data on people who use drugs and harm reduction programming in West European Union countries is better than in other regions, there are some important gaps. For example, although previous ECDC reports on implementation of the Dublin Declaration on HIV/AIDS in Europe and Central Asia have noted that data was needed on access to antiretroviral treatment (ART) for people who inject drugs, this is still very limited. However, in 2012 the ECDC did report that availability of population size estimates for people who inject drugs has improved,⁽¹⁴⁾ and that more countries are now reporting on availability of needles/syringes per person.⁽¹⁴⁾ There has also been an improvement in data on HIV prevalence among people who inject

drugs.⁽¹⁴⁾ In 2013, a major report on HIV in the European region was also launched, synthesising evidence on the HIV epidemic among key populations and the effectiveness of responses to it.⁽¹⁷⁾

Developments in harm reduction implementation

Needle and syringe exchange programmes (NSPs)

In most Western European countries, the annual number of syringes distributed per person who injects drugs approaches WHO's recommendation of 200.⁽¹⁸⁾ However, the number of syringes distributed (the key indicator for NSP coverage) has been in flux. Between 2007 and 2012, increases were seen in Austria, France, Finland, Greece, Malta and the UK (Northern Ireland),⁽¹²⁾ while there were decreases in Belgium, Ireland, Luxembourg, Norway, Portugal, Spain, Sweden and the UK (Scotland).⁽¹²⁾ Belgium, France and Turkey have particularly low NSP coverage (less than 100 syringes per person who injects drugs per year),⁽¹¹⁾ while moderate to high coverage (distribution of more than 100 syringes per person per year) is reported in Austria, Finland, Hungary, Luxembourg, Malta, Norway, Portugal, Spain and Sweden.⁽¹⁴⁾ For some countries, data on the number of syringes distributed are lacking or do not reflect the situation fully. Germany, for example, is not on the list of countries with high or moderate coverage, and this is most likely due to nationwide data being unavailable. There are nearly 1,000 NSP services in Germany but there is no central processing of information.

In many cases where decreases were seen, this has been attributed to financial strains. In Greece, where a new initiative to scale up NSP access was launched in 2011, implementation was slowed due to funding constraints.^(10,14) Restrictions such as these, together with changing financing mechanisms, may jeopardise quality as well as coverage. In Finland, for example, there are fears that new tendering procedures for NSP service provision could lead to compromised quality, as providers undercut each other in order to win the tender.

Even in countries with relatively good levels of coverage, important gaps exist. In many countries, provision of services to young people aged under 18 is a challenge. Reaching out to migrants, especially undocumented migrants, is also difficult, and NSP provision in rural communities is often underdeveloped. In many Western European countries, rates of sharing injecting equipment have also been documented as high,⁽¹⁴⁾ increasing the risk of transmission of HIV and viral hepatitis.

Various approaches to NSP are employed in Europe, including through fixed sites and outreach and mobile units, as well as pharmacies and vending machines.

Vending machines are used in Austria, France, Germany, Luxemburg and the UK, and there is significant distribution of sterile syringes through pharmacies in Belgium, France, Ireland, the Netherlands, Portugal, Spain and the UK.⁽⁴⁾ Among other interesting innovations in NSP service provision, Luxemburg introduced low dead space syringes in 2014, responding to evidence that these may reduce transmission of HIV and viral hepatitis. Also, in Finland in 2012, the A-Clinic Foundation's drop-in needle exchange started to offer home visits from peer workers and health and social services professionals. During its first two years, the service reached 700 clients, more than half of them female.⁽¹⁹⁾

Opioid substitution therapy (OST)

Over half of opioid users in Europe access opioid substitution therapy (OST),⁽²⁰⁾ with an estimated 734,000 receiving OST in 2012⁽¹²⁾ – a slight rise compared to 2011. The most significant increase in OST between 2011 and 2012 was in Turkey, which saw an increase of 250% from 8,000 to 28,656, followed by Greece, which saw an increase of 45% to 9,878.⁽¹²⁾ One country, Italy, saw a substantial decrease in access, with the total number of people accessing OST falling from almost 110,000 in 2011 to 98,460 in 2012.⁽⁶¹⁾

In some countries, national rates of access to OST may be adequate, in accordance with WHO recommendations, while in sub-national regions or for some populations in those countries, levels of access may remain inadequate. In Germany, 77,300 people (30–50% of the entire population who inject drugs) receive OST,⁽²¹⁾ but advocacy for expanded access in some areas, especially in rural settings, is ongoing.

While access to OST in Europe has been expanding slowly and steadily, there are areas of concern. In England and Wales, growing focus on abstinence-based treatment models is jeopardising programme quality by making programmes higher threshold, limiting dosing and requiring programmes to progressively lower doses to push clients towards drug-free outcomes.

Approximately two-thirds of OST clients in Europe receive methadone, while around 20% receive buprenorphine.⁽²⁰⁾ Approximately 6% of OST programmes use slow-release morphine. Heroin-assisted treatment (HAT) programmes are in place in Belgium, Denmark, Germany, the Netherlands, Spain and the UK, and low-release morphine programmes in Austria, Luxemburg and the UK.⁽²⁰⁾ HAT programmes in Germany are funded by health insurance,⁽²²⁾ the result of advocacy by Junkies Ehemalige Substituierte (JES), an organisation of people who use drugs, in partnership with Deutsche AIDS-Hilfe.

Viral hepatitis

There are approximately 1.2 million people who inject drugs living with HCV in the European Union/Free Trade Agreement region, representing approximately 44% of people who inject drugs in the region.⁽³⁾ As with HIV, there is a significant gap in data related to access to HCV treatment for people who inject drugs, but available data suggests that access is “alarmingly low”.⁽²³⁾ Of 16 Western European countries submitting data to a study, eight had national strategies that included people who inject drugs and nine had treatment guidelines that included people who inject drugs.⁽²⁴⁾ The treatment gap for people who inject drugs is in part related to a legacy of treatment recommendations that excluded people who are currently using drugs. The European Association for the Study of the Liver (EASL) published a revision of its guidelines in 2013 that recommends providing treatment to people who inject drugs providing that they want it and are able to regularly attend follow-up visits to a multidisciplinary medical service.⁽²³⁾ However, many doctors remain unwilling to treat people who inject drugs, and many people who inject drugs do not come forward for treatment.⁽²³⁾

The advent of direct acting antivirals (DAAs) – new medicines approved by the European Commission in January 2014, with cure rates of up to 98% – is potentially a revolution in HCV treatment. However, the pharmaceutical industry has priced the drugs beyond the reach even of the relatively well-resourced healthcare systems of Europe, with Gilead’s DAA, Sofosbuvir, vending at \$84,000 for each 12-week course. Significant progress will probably be impossible until pharmaceutical companies are pushed to reduce the price. There is growing momentum in Europe and globally to fight for access to HCV treatment and services, including for people who inject drugs (see box *Hepatitis C: momentum for change*).

Some countries in Europe demonstrate good HCV practice. For example, Scotland has a well-funded HCV action plan that is credited with reducing HCV prevalence.⁽²⁵⁾ The programme makes testing available in low-threshold settings and provides treatment to people who inject drugs using a multidisciplinary approach. The action plan was implemented locally by managed care networks that involved governmental as well as voluntary sector representatives.⁽²⁶⁾ The experience of the German non-governmental NSP service Fixpunkt suggests that NSPs can have an important role in providing information, support and materials to prevent HCV transmission, and to encourage testing and treatment.⁽²⁷⁾

Hepatitis C: momentum for change

Demand for access to HCV prevention and treatment is growing. There is broad consensus among global, regional and national civil society that the HCV epidemic is a health emergency. In response, civil society actors, including people who use drugs, are working hard to force their governments to implement the historic HCV resolution they signed in May 2014 at the World Health Assembly, and to pressure the pharmaceutical industry to lower the exorbitant price they have set for lifesaving DAAs.

The Correlation Network’s European Initiative on Hepatitis C and Drug Use⁽²⁸⁾ brings together more than 30 organisations to share information and engage in advocacy. In September 2014, it released a supplemental edition of the journal *BMC Infectious Diseases* devoted to ‘Viral Hepatitis and Drug Use in Europe’, containing a series of 18 articles by leading European thinkers on HCV service access, including by people who use drugs.⁽²⁹⁾ In October 2014, it hosted the European Conference on HCV and Drug Use and launched a petition to the European parliament calling for urgent action on HCV. The initiative is also supporting sharing practical information on clinical aspects of HCV treatment and related low-threshold services.

Regional momentum on HCV in Europe is matched at national level. Current good practice in Scotland, where there is a national hepatitis strategy and relatively good access to testing and treatment for people who inject drugs, came about in part due to calls from civil society.⁽²⁶⁾ In Helsinki, an awareness symposium entitled ‘HCV is Preventable and Curable: Act Now on this Public Health Emergency!’ was held in May 2014, and the Finnish government is now developing a policy on HCV.⁽¹⁹⁾ In Ireland, a HCV strategy was adopted in September 2012 following pressure from civil society groups,⁽³⁰⁾ and action is being taken not only to advocate for national change but to provide direct help to individuals as well.

Tuberculosis

Data on TB prevalence in Western Europe is still very limited. In European countries, the disease is predominantly concentrated among high-risk groups, such as migrant populations, homeless people, people who use drugs and people in prison.⁽¹⁵⁾ People who are living with HIV and who inject drugs are two to six times more likely to develop TB than non-injectors, and commonly have co-morbidities with HBV and HCV infection. Among people who inject drugs who develop TB, at least one in three will also have HIV, and two in three will have HCV antibodies. They are also at increased risk of criminalisation and incarceration.⁽¹⁶⁾

Antiretroviral therapy (ART)

Rates of HIV testing among people who inject drugs are generally high in Western Europe, except in Malta and Greece, where the ECDC reports that they are inadequate.⁽¹⁴⁾ The ECDC notes that countries with higher levels of access to NSPs and OST tend to have higher levels of access to testing.⁽¹⁴⁾ Countries with particularly good access to HIV testing for people who inject drugs include Finland, Luxembourg, the Netherlands, Portugal, Spain and the UK.¹ Low access to testing (less than 30%) was reported in Malta and Turkey.⁽¹⁴⁾ Although ART is available in principle in all countries, the 2013 ECDC Thematic Report identified inadequate ART coverage among people who inject drugs in several countries, including Greece, Italy, Portugal, Spain and Sweden.⁽¹⁴⁾ Late presentation (where people learn their HIV status at the point when their immune system is already significantly compromised) is often more common among people who inject drugs, and was specifically reported in Belgium, France, Italy and the Netherlands.⁽¹⁴⁾ In Italy, for example, 61% of people who inject drugs and test positive are late presenters.⁽³¹⁾ In Ireland, the proportion of people who inject drugs who were diagnosed late was 63%.⁽³²⁾ The European AIDS Treatment Group (EATG) began to prioritise the demedicalisation of HIV testing in 2013 in order to promote testing in low-threshold settings. In Germany, programmes offering HIV testing in low-threshold services are being piloted.⁽³³⁾

There is little information available about levels of access to ART among people who inject drugs in Western Europe, although the region is considered to have largely achieved universal access to HIV prevention, treatment and care. Data also suggests that improvements may be needed in social and adherence support for people who inject drugs. A Swiss study of over 6,500 people living with HIV conducted between 2007 and 2013 found that people who use drugs had poorer treatment outcomes and

lower rates of survival than study participants who did not use drugs.⁽³⁴⁾ This finding, however, was not true for people in OST programmes who did not use street drugs, but did apply to people who were in OST programmes and also used street drugs. Treatment interruptions, missed appointments and drug-related deaths contributed to these outcomes.⁽³⁴⁾

Harm reduction in prisons

With the exception of Portugal, where possession of amounts of drugs for personal use is decriminalised, drug use in Europe remains a criminal offence. It is estimated that around half of the prison population in Europe have used drugs,⁽³⁵⁾ while a survey of 15 European countries found that 15–30% of prisoners reported ever having injected drugs.⁽³⁶⁾

In 1990, the United Nations General Assembly called for equivalence between health services, including harm reduction, inside and outside of prison, and this was reiterated in the 2013 WHO policy brief *Good Governance for Prison Health in the 21st Century*.⁽³⁷⁾ The 2009–12 EU drugs action plan also called for the development and implementation of prevention, harm reduction and treatment services in prison that are equivalent to services outside of prison,⁽³⁸⁾ but levels of access to harm reduction interventions in prisons continue to lag behind those outside.⁽³⁷⁾ France, Italy, Norway, the United Kingdom, some Swiss cantons and two autonomous regions of Spain have taken steps toward addressing health inequities in prison by transferring the responsibility for the healthcare of prisoners from ministries of justice or the prison administration to health ministries, and Finland is currently considering doing the same.⁽³⁷⁾

NSPs are only available in prisons in Spain (38 prisons), Switzerland (seven prisons, dependent on political decisions in some cantons) and in Germany (one female prison in Berlin). A pilot programme in Portugal was stopped in 2013 as prisoners did not participate due to lack of confidentiality, and an NSP programme in Luxembourg (one prison) is currently under review.⁽³⁹⁾

Almost all European countries have now introduced OST in prison.⁽⁴⁰⁾ Greece and Cyprus are the only countries where prison doctors are not allowed to prescribe long-term substitution treatment.⁽⁴⁰⁾ Access to OST is generally high in Denmark, Ireland, Luxembourg, Slovenia, Spain and the United Kingdom. Coverage is lower in countries with less experience of OST delivery and countries that limit OST provision to prisoners who had started it prior to imprisonment.⁽⁴¹⁾ The rate of overdose-related deaths following release from prison is also high,⁽⁴²⁾ with approximately six out of ten deaths occurring in the first 12 weeks after release being drug related.⁽⁴⁰⁾

In Scotland, evidence suggests that giving naloxone kits to prisoners on release from prison reduces opioid-related deaths within the first four weeks after release.⁽⁴³⁾

Rates of HIV, viral hepatitis and TB in many countries are significantly higher among prison populations than the general population.⁽³⁷⁾ HIV prevalence in prisons ranges from 0.2% in Finland to up to 39.7% in Spain.⁽²⁾ HCV prevalence is also extremely high in prisons,⁽⁴⁴⁾ with the highest reported HCV level among people who inject drugs in prisons recorded in Luxembourg at 90.7%.⁽⁴⁵⁾ Data on TB among prisoners who inject drugs is scarce, but WHO suggests that TB rates in prison are up to 84 times higher than among the general population.⁽⁴⁶⁾

Overdose

Overdose continues to be a major cause of death among young people in Europe, accounting for 3.5% of all deaths in adult males under 40 years of age.⁽⁴⁷⁾ Overdose is the leading cause of death for people who use drugs,⁽⁴⁷⁾ who face mortality rates of 1–2% per year.⁽¹²⁾ In 75% of overdose deaths, opioids were present.⁽¹²⁾ In its 2014 *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations*, WHO recommends that people likely to witness a drug overdose (including peers of people who inject drugs) should have access to naloxone and training in how to use it. Europe is home to an example of excellent practice in this respect. Scotland's nationwide take-home naloxone programme is estimated to have saved at least 500 lives since it began in late 2011, according to a 2014 evaluation⁽⁴⁸⁾ (see box *Saving Lives with take-home naloxone in Scotland*).

However, most countries in Europe still do not practice this highly effective,² and cost-effective,⁽⁴⁹⁾ means of saving lives. In many countries, there are still administrative barriers to implementation of peer-modulated naloxone programmes, as naloxone is only available either by prescription or when it can be administered by medical personnel. Civil society representatives often cite “medical power” (medical personnel do not believe that laypeople can administer naloxone effectively) as a barrier. For many harm reduction advocates, the historical focus of harm reduction services on preventing transmission of infectious diseases leaves the issue of overdose neglected. However, since 2012 there have been important national and regional advocacy efforts. Overdose prevention was a key issue in the European Harm Reduction Network (EuroHRN)'s 2014 conference. The ‘I am the Evidence!’ campaign, led by the Eurasian Harm Reduction Network (EHRN) in partnership with EuroHRN, aims to map good practice in countries implementing peer-led naloxone distribution, including Denmark, France, Italy and Scotland, and to document the experiences of people who use drugs through a video campaign that collects their life-saving stories.⁽⁵⁰⁾

Other approaches proven to reduce drug-related deaths, such as OST⁽⁵¹⁾ and drug consumption rooms (DCRs),⁽⁵²⁾ are available to varying degrees in Europe. As noted above, OST programmes are relatively accessible in most of Western Europe but are insufficient, even at good levels of access, to prevent overdose from being the leading cause of death for people who inject drugs. DCRs are still not widely available. In 2013, EuroHRN conducted an organisational review of DCRs in Europe, finding that of the 33 that responded to the study, all provided spaces for injection and two-thirds allowed smoking.⁽⁵⁷⁾ Thirteen DCRs stated that they were

Saving lives with take-home naloxone in Scotland⁽⁴⁸⁾

Scotland is the first country in the world to implement a national take-home naloxone programme. Following pilots in 2007 and 2009 that showed the feasibility of take-home naloxone, the Scottish government decided that the approach should be rolled out nationwide. An extensive training, a naloxone distribution system was set up targeting people who were in contact with drug services, including NSP and OST programmes, along with voluntary and statutory sector personnel and pharmacy staff. Since the programme's launch in April 2011, a total of 5,830 naloxone kits have been distributed, reaching approximately 8% of Scotland's 59,510 people who inject drugs, with 1,461 kits also distributed in prisons. Between the programme launch in November 2010 and an assessment in March 2013, 365 overdose reversals using the naloxone kits were reported, with conservative estimates suggesting that at least 500 lives have been saved.

In 2014, an extensive evaluation of the programme was carried out. It offers a wealth of practical guidance that will be valuable not only for improvement and scale up of Scotland's programme, but for other countries as they modernise their approach, bringing it into line with WHO recommendations by implementing full-scale take-home naloxone programmes.⁽⁴⁸⁾

challenged to reach certain groups, including young people who use drugs, people using alternative drug administration methods, people using different substances, and migrants/non-locals.

Currently, there are 86 DCRs across seven countries in Europe, including Denmark, Germany, Luxembourg, Norway, Spain and Switzerland, while in France, Portugal and the UK work is underway to open pilot DCRs. However, there is political resistance. In Greece, a DCR opened and was closed within a year due to political pressures. However, the EHRN study showed a clear increase in acceptance of DCRs among treatment, shelter and police staff, as well as neighbours, over the time that the DCRs had been functioning. In addition, while the review did not measure improvement in health status, it did show that the facilities improved access to other services. For example, 100% of DCRs surveyed reported that they facilitated improved access to primary healthcare.

Policy development for harm reduction

On the whole, Western European HIV policy frameworks address harm reduction. For example, harm reduction is specifically addressed in the European Union Action Plan on HIV/AIDS in the EU and Neighbouring Countries: 2014–2016,⁽⁵³⁾ which is itself harmonised with the WHO-led European Action Plan for HIV/AIDS 2012–2015,⁽⁵³⁾ in which harm reduction is also covered.

Attention to harm reduction in European drug policy frameworks is also improving. The EU Drugs Strategy (2013–2020)⁽⁵⁴⁾ and EU Drugs Action Plan (2013–2016)⁽³⁸⁾ address harm reduction, human rights, civil society engagement and transparency more than in previous European Union policy documents, and compare positively with policy frameworks in other regions. Advocacy and policy work by civil society had a positive impact on support for harm reduction in these processes.

In 2014, the European Commission announced that by 2015 the Drugs Unit will have moved from the Directorate-General for Justice to the Directorate-General for Home Affairs. This is expected to be a positive change, given that the Directorate-General for Home Affairs has a role in promoting human rights. At the same time, the Drug Prevention and Information programme, which previously funded some harm reduction initiatives, is shifting its focus away from health. This is expected to impact negatively on financing for civil society initiatives that exchange and transfer best practice across the European Union, including EuroHRN.

Legal and regulatory barriers can inhibit the implementation of some essential harm reduction services. In most countries, there are still regulatory obstacles to low-threshold HIV and HCV testing and to community naloxone programming. Most significantly, people who use drugs remain criminalised in nearly every country in Europe, with the exception of Portugal. Punitive law enforcement in Europe has the same unfortunate consequences for health and rights as it does globally, exacerbating the HIV⁽⁵⁵⁾ and HCV⁽⁵⁶⁾ epidemics, increasing stigma, and resulting in human rights violations, fear of accessing health services and all of the added risks associated with incarceration, among others.

Many European countries champion harm reduction internationally, with the Netherlands, Norway and Switzerland boldly supporting harm reduction during the Commission on Narcotic Drugs (CND). Sweden and Italy continue to oppose harm reduction, but through the Civil Society Forum on Drugs, civil society organisations are working together to advocate for a European Union position supportive of harm reduction in the 2016 United Nations General Assembly Special Session (UNGASS) on drugs.

Civil society and advocacy developments for harm reduction

There have been significant developments in civil society mobilisation and advocacy around harm reduction in recent years, both at regional and national levels.

While HIV policy has benefited from transparent and constructive interaction between governmental structures and civil society, the same has not been true historically for drug policy. The positive changes described above in the way civil society engagement and harm reduction were addressed in Europe's drug policy were brought about only through active and coordinated wielding of influence by civil society. The European Civil Society Forum on Drugs, modelled after Europe's Civil Society Forum on HIV, is a diverse group representing civil society organisations engaged in service provision and advocacy relating to prevention of drug use, drug-related treatment, social support services and harm reduction. The Forum put forward 20 recommendations as the EU Drugs Strategy (2013–2020) was being developed, many of which were taken into consideration.

As discussed above, there has also been growing momentum to call for access to HCV treatment and prevention, including for people who use drugs. The 'I am the Evidence!' campaign for community naloxone programming has raised awareness of the gap between the evidence base related to

preventing overdose deaths and practice in most countries. There have also been efforts to increase understanding of and support for harm reduction for people who inject drugs through the ‘Support don’t Punish’ campaign.

Until now, EuroHRN has brought together people who use drugs and those involved in harm reduction to promote harm reduction approaches. However, with the European Union Drug Prevention and Information programme now focusing less on health and rights issues, the network secretariat has lost its funding. EuroHRN intends to continue to function on a voluntary basis.

The meaningful involvement of people who use drugs in policy development and service delivery in Europe continues to improve. Following a meeting of 30 representatives from 13 countries in 2011, the European Network of People who Use Drugs (EuroNPUD) was formally established, including a steering committee consisting of one representative from each country. The committee is the decision-making forum for the network and is actively fundraising for work on priority issues, in particular access to HCV services.⁽³³⁾

In 2014, the German organisation JES will celebrate its 25th anniversary – it is one of the oldest networks of people who use drugs in the world. JES, in partnership with Deutsche AIDS-Hilfe, was successful in advocating for the non-voting representation of people who use drugs in the Federal Joint Committee, the highest decision-making body for Germany’s associations of physicians, dentists, hospitals and insurance funds, linking them with the ministry of health. In France, people who use drugs have been represented since 2012 on the National Narcotic Commission (Commission Nationale des Stupéfiants). Throughout Europe, there are increasing examples of representation of civil society and people who use drugs in decision-making bodies and processes at organisational, sub-national and national levels.

Several important regional events took place in recent years including the 2nd European Harm Reduction Conference which took place in Basel, Switzerland. The Conference was supported by the Swiss Government and co-organised by the European Harm Reduction Network. It attracted over 700 delegates with a focus on innovative harm reduction, cooperation with stakeholders and a day dedicated to drug policy reform.

Funding: developments for harm reduction

Stigmatisation and criminalisation continue to drive health and rights inequities for people who inject drugs in Western Europe. While the EU Drugs Strategy (2013–2020) recommends harm reduction services, continued vigilance is necessary in order to ensure national implementation and to bring about the policy reforms needed to end criminalisation of people who use drugs and related health and rights inequities.

The impact of the global financial crisis is also hindering the implementation of effective strategies in Western Europe. A survey by the European Union Civil Society Forum on Drugs in late 2013 revealed that over 60% of civil society organisations engaged in harm reduction and other drug-related service and policy work had experienced a significant decrease in funding, and 24% had reduced the drug services they provided within the four years preceding the survey. At the same time, several European governments do provide essential funds for harm reduction in low- and middle-income countries. These include the UK Department for International Development (DFID), the Netherlands Ministry of Foreign Affairs, the Norwegian Agency for Development Cooperation (Norad), GTZ (Germany) and the Swedish International Development Cooperation Agency (Sida). However, in this sector, too, budgets are becoming tighter.

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REGIONAL OVERVIEW

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|-----|-----------|
| 2.4 | Caribbean |
|-----|-----------|



Caribbean

Table 2.4.1: Epidemiology of HIV and viral hepatitis, and harm reduction responses in the Caribbean

| Country/ territory/ with reported injecting drug use | People who inject drugs ⁱ | HIV prevalence among people who inject drugs (%) | Hepatitis C (anti- HCV) prevalence among people who inject drugs (%) | Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%) | Harm reduction response | |
|--|---|---|--|--|--|---|
| | | | | | NSP ⁱⁱ  | OST ⁱⁱⁱ  |
| Bahamas | nk | nk | nk | nk | x | x |
| Bermuda | nk | nk | nk | nk | x | x |
| Dominican Republic | 200,000–350,000 ^{(1)iv} | 11 ^v | 3.4 ⁽¹⁾ | 3.1 ⁽¹⁾ | ✓(1) | x |
| Haiti | nk | nk | nk | nk | x | x |
| Jamaica | nk | nk | nk | nk | x | x |
| Puerto Rico | 30,000 | 22.9 ⁽²⁾ | 89% ^{vi} | nk | ✓(6) ^{vii} | ✓(8) ^{viii} (M, B, O) |
| Suriname | nk | nk | nk | nk | x | x |

ⁱ In 2008, the United Nations 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. However, civil society suggests this information is no longer up to date.

ⁱⁱ This includes all operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers.

ⁱⁱⁱ (M) = methadone, (B) = buprenorphine, (O) = any other form (including morphine and codeine).

^{iv} Figure is not representative of people who inject drugs, rather the total number of people who use drugs in the Dominican Republic.

^v Figures taken from <http://www.housingworks.org/community/detail/housing-works-expands-hiv-aids-prevention-services-to-the-dominican-republi>

^{vi} Figure is sub-national and relates to San Juan only.

^{vii} Each of these has multiple sites; for example, one syringe programme has 15 sites.

^{viii} This includes six fixed sites and two mobile units.

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



Harm reduction in the Caribbean

The Caribbean has the second highest HIV prevalence after sub-Saharan Africa,⁽³⁾ although the region has seen the most pronounced decline in rates of infection globally since 2001, with a 49% drop.

⁽⁴⁾ HIV in the Caribbean is predominantly transmitted through unprotected sex,⁽⁵⁾ and injecting drug use is thought to be rare.⁽⁶⁾ The exceptions are Puerto Rico, where an estimated 30,000 people inject drugs, and the Dominican Republic, where an estimated 200,000–350,000 people use drugs (including injecting and non-injecting).⁽⁷⁾ Currently, only 7 out of 18 countries in the region have reported injecting drug use.⁽⁸⁾ However, it is important to note that data on the Caribbean is sparse, and some of the data regarding drug use has been produced through research criticised as theoretically and methodologically weak.⁽⁹⁾

In 2013, three islands in the region had an adult HIV prevalence rate of greater than 1%.⁽⁴⁾ HIV prevalence in the Bahamas for 2012 was 3.1%.⁽¹⁰⁾ In Jamaica, HIV prevalence among homeless people and people who use drugs went down from 12% in 2010 to 4.02% in 2013.⁽¹¹⁾ A recent report has noted the high rate of HIV in Haiti, accounting for approximately 55% of all people living with HIV in the Caribbean.⁽¹²⁾

Reliable data for HIV prevalence among people who inject drugs is only available for Puerto Rico and, to some extent, the Dominican Republic, where a lack of access to sterile injecting equipment has been identified as a significant contributor to the HIV epidemic. In the Dominican Republic, unsafe injecting drug use is thought to account for 1% of HIV transmission,⁽¹³⁾ although civil society queries the accuracy of this figure.⁽¹⁴⁾

The most recent estimate indicates that there are approximately 30,000 people who inject drugs in Puerto Rico, 22.9% of whom are living with HIV. This appears to be an increase on earlier estimates (*The Global State of Harm Reduction 2012* reported HIV prevalence among people who inject drugs as 12.9%⁽¹⁰⁾) but, as noted in the introduction to this report, much of the data should be viewed critically. The 2012 estimate for Puerto Rico refers to information gathered between 1998 and 2001, so is now over a decade old. The most recent estimate is therefore deemed more reliable.

In 2012, the Dominican Republic opened its first needle and syringe programme (NSP), while Puerto Rico introduced a harm reduction response in the form of NSPs and opioid substitution therapy (OST) in 2007. The positive effects of this harm reduction programme in Puerto Rico are already apparent. In 2011, 22.9% of new HIV infections were transmitted through unsafe injecting,⁽²⁾ a decrease of 17.1% from 2007.⁽¹⁵⁾

The Caribbean is one of two regions (the other being Latin America) in which the use of cocaine remains disproportionately high,⁽¹⁶⁾ with a reported link between the sexual transmission of HIV and the use of crack cocaine on many of the islands.⁽¹⁷⁾ Nearly 2% of the Jamaican population have experienced a period of crack cocaine use,⁽¹⁸⁾ and non-injecting use of crack cocaine has been associated with HIV transmission in the Bahamas.⁽¹⁹⁾ Reported HIV prevalence among people who use crack cocaine is 7.5% in St Lucia and 5% in Jamaica,⁽²⁰⁾ although these figures date from 2008. At the time of writing, no recent data relating to the use of cocaine and/or crack cocaine have been released, even after the Joint United Nations Programme on HIV/AIDS (UNAIDS) recommendation in 2006 to document HIV prevention programmes for people who use crack cocaine.⁽²⁰⁾

The harm reduction response in the Caribbean remains extremely limited. NSPs and OST exist predominantly in Puerto Rico, together with one NSP in the Dominican Republic. Drug treatment services for people who use drugs in the rest of the region are primarily abstinence focused, and outreach programmes providing hot meals and shelter for people who use drugs may often be faith based.⁽¹⁸⁾ In Jamaica, the Tek it to Dem initiative takes services to homeless crack cocaine users, providing a mobile delivery of care packages, hot food, peer education and transportation of people who use drugs to healthcare services and treatment centres.⁽¹⁸⁾ Trinidad has a government-supported drop-in centre offering assessment, referral and rehabilitation for homeless people who use drugs,⁽²¹⁾ and St Lucia has a small number of drop-in centres.⁽¹⁷⁾ Although injecting drug use is considered low overall in the region, the delivery of services where HIV and drug use have been associated, such as in Puerto Rico, is often restricted to urban areas and is underused due to police intolerance. In other areas of the Caribbean, services focused on homelessness and drug use are often combined illogically.

Developments in harm reduction implementation

Needle and syringe exchange programmes (NSPs)

Only two countries in the Caribbean provide NSPs. A study in 2012 of people who inject drugs in the Dominican Republic found that more than 40% shared syringes and more than 40% used discarded syringes found on the ground.⁽²²⁾ In 2012, the Dominican Republic opened its first NSP supported

by Centro de Orientación e Investigación Integral (COIN).⁽¹⁴⁾ Since its inception, over 1,000 people have accessed its Open Doors programme, and between June and December 2012, 4,000 syringes were distributed, 20% of them to females who inject drugs.⁽²²⁾

Puerto Rico has the largest NSP service in the region, with six active NSP sites based in communities around the capital city of San Juan. However, police interference is currently one of the main obstacles to successful implementation. In the absence of a national policy on NSPs, the Puerto Rican police department's campaign *Golpe al Usuario* (Striking the Drug User)⁽²³⁾ is leading to NSP programmes being underused. There are also anecdotal reports of law enforcement authorities entering *hospitalillos* (shooting galleries) and destroying the available sterile injecting equipment.⁽¹⁰⁾ Coupled with this, the poor transportation infrastructure on the island means that people who inject drugs are often unable to travel and access the limited number of harm reduction services.⁽²⁴⁾ Despite these obstacles, sterile injecting equipment can be purchased in pharmacies, and it has been reported that many people who inject drugs obtain needles and syringes in this way.⁽¹⁰⁾

In the Dominican Republic, the legal framework is also presenting barriers to the implementation of an NSP service, as any amount of substances found are considered as drug trafficking, including small quantities left over in used syringes.⁽²⁵⁾

Emerging trends: Xylazine and steroid use in the Caribbean

The use of xylazine, an injectable veterinary anaesthetic often mixed with heroin, has become an emerging trend in Puerto Rico, predominantly among males.⁽²⁶⁾ The associated harms related to this new drug are still under-researched. However, studies have shown that chronic xylazine use can lead to open skin ulcers.⁽²⁷⁾ These ulcers, which omit a strong odour and are painful, often mean that xylazine users are denied access to NSP services⁽²⁷⁾ due to the stigmatising nature of the abscesses/ulcers.⁽²⁷⁾ With its increasing popularity among people who inject drugs in Puerto Rico, more research into tracking xylazine use and associated harms, alongside advocacy and education, are needed to ensure the provision of appropriate responses within harm reduction services for xylazine users.

Opioid substitution therapy (OST)

Puerto Rico remains the only territory in the Caribbean providing OST. However, the first OST pilot has now been approved in the Dominican Republic and should be in place towards the end of 2014.⁽²⁵⁾ At present, there are six fixed sites, two mobile units and one prison-based programme in Puerto Rico. In 2007, there were an estimated 5,570 people receiving methadone, representing 19% of people dependent on opiates.⁽⁸⁾ Buprenorphine provision had also begun to be scaled up in collaboration with non-governmental organisations (NGOs) in Puerto Rico, but since changes in government leadership this has now stopped.⁽²⁴⁾ Although OST is available in Puerto Rico, high levels of bureaucracy are required to secure and retain a place on the programme, meaning that people with a lower socio-economic status or without health insurance can struggle to gain access.⁽²⁴⁾ However, in contrast to many countries outside of the Caribbean, there are currently no legal age restrictions preventing access to NSP and OST services.⁽¹⁰⁾

Harm reduction for people who use crack cocaine

Crack cocaine is the main stimulant used in the region.⁽¹⁴⁾ Despite this, there are only a small number of drop-in centres in the Dominican Republic, Trinidad, Jamaica and St Lucia that provide specific services for this group.⁽¹⁷⁾ The Castries facility in St Lucia 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.⁽¹⁷⁾

In Jamaica, Tek it to Dem 2 takes services to homeless crack cocaine users who are reluctant to access zero tolerance or total abstinence programmes. The initiative provides peer education on HIV and sexually transmitted infection prevention and risk, alongside hot food, accompaniment and transportation.⁽¹⁸⁾

Although several UNAIDS reports in 2012 included people who use crack cocaine as a vulnerable population, the 2014 UNAIDS reports do not discuss either crack use or cocaine in the region.

Viral hepatitis

There is very little information on hepatitis C (HCV) among people who inject drugs in the region. Similarly, data relating to hepatitis B (HBV) infection, including among those who do not inject, is limited to anecdotal reports.⁽²⁸⁾ National HCV prevalence among people who use drugs in the Dominican Republic is 3.4%.⁽¹⁾ However, this does not disaggregate for people who inject drugs, and there are no testing programmes and no access to treatment for those who use drugs.⁽²⁵⁾ National HCV prevalence data for people who inject drugs in Puerto Rico is not available, although sub-national data for San Juan in 2005 indicated that HCV prevalence among people who inject was 89%.⁽²⁹⁾ Although this 2005 figure is extremely high, no recent studies, so far as we are aware, have been undertaken to track HCV or HBV prevalence.

HCV testing and treatment is rarely offered to people who use drugs in the Caribbean,^(14, 24) with most diagnosis of HCV in Puerto Rico occurring in prisons, where testing and treatment is provided.⁽²⁴⁾ Treatment for those outside of the prison system and in the other islands remains in the hands of private healthcare providers, with prohibitive costs restricting access for most people.

Tuberculosis

There is a dearth of information on the extent of tuberculosis (TB) infection rates among people who inject drugs in the Caribbean. In 1999, one study in Puerto Rico found that TB incidence was highest among people living with HIV who inject drugs.⁽³⁰⁾ Whether in response to this data or for reasons of best practice, all drug treatment centres in Puerto Rico now require TB testing prior to admission, with treatment then available at health centres.⁽²⁴⁾ It is estimated that 17.4% of TB patients in the Caribbean are living with HIV, but how many of them also inject drugs is unknown.⁽⁴⁾

Antiretroviral therapy (ART)

There are 80,190 adults reported to be receiving ART in the Caribbean.⁽⁴⁾ ART coverage is estimated to be 72%, the second highest coverage globally among low- and middle-income countries.⁽⁴⁾ However, this rate is based on a baseline CD4^{ix} count of 350, and in June 2013 the World Health Organization (WHO) raised the rate to a CD4 count of 500,⁽³¹⁾ meaning coverage in the Caribbean fell to approximately 40%.⁽¹⁴⁾ While there are programmes in place on

some islands to provide ART adherence support for people who use drugs, there are no estimates on the number of either injecting or non-injecting drug users receiving ART in the Caribbean.⁽⁸⁾ Out of nine Caribbean islands, four have adequate healthcare facilities providing integrated HIV and TB treatment services (Antigua and Barbuda, Dominican Republic, Haiti, St Lucia) while five are seen to have inadequate treatment services (Barbados, Dominica, Grenada, Jamaica and Trinidad and Tobago).⁽⁴⁾ Although all national programmes acknowledge the need to focus on ARVs for key population groups, only a limited number actually report on these, and it is thought that there is a low utilisation of existing services by key population groups.⁽¹⁴⁾

Barriers to ART include ease of testing and hours of operation in the clinics.⁽¹⁴⁾ In Puerto Rico, people who use drugs are often inadequately targeted by HIV testing and ART. Overall, there is little information on coverage testing and ART for people who inject drugs in the region,⁽²⁴⁾ even though a regional synthesis of UNAIDS progress reports from 2008 emphasised the need for the Caribbean to quickly increase the meaningful involvement of its most vulnerable populations in its HIV response.⁽²⁰⁾

Harm reduction in prisons

Drug use is highly criminalised across the region and incurs severe sentences. Due to these stringent criminal laws, large numbers of people who use drugs are incarcerated. The risk of HIV transmission in prisons is further heightened by the criminalisation of sex between men, the lack of condom availability in prisons,^(14, 24) and the absence of prison-based harm reduction services. Puerto Rico is still the only country in the region that has OST operating in prison, and although promising, this service is limited to one prison and so far has not been scaled up.⁽²⁴⁾

At present, there is no systematic data on access to HIV prevention, treatment, care and support in prisons in the region, but indications are that service provision remains limited. In one recent study looking at healthcare practices and associated needs among incarcerated men in Puerto Rico, it was found that 73.8% had a history of drug use, 83.8% received their first HIV screening in prison, 55.6% were undertaking ART and 83.8% had been co-diagnosed with HCV.⁽³²⁾ It is estimated that approximately 6.9% of the incarcerated population in Puerto Rico present with HIV infection.⁽³³⁾ In Jamaica, it is standard practice to provide opt-out screening for HIV and syphilis, with anyone testing positive offered follow-up care.⁽¹¹⁾

ix A CD4 count is a measurement of HIV infection in the body to which initiation of antiretrovirals can be determined. See: www.aidsmap.com/CD4-cell-counts/page/1254931

Overdose

The Caribbean currently has a limited overdose response, with no naloxone peer distribution and no overdose programmes operating in the region. In Puerto Rico, opiate overdose prevention education is offered by only 1 service across 15 sites, and naloxone can only be prescribed by the medical director.⁽²⁴⁾ Anyone who calls the emergency services to respond to an overdose is liable to arrest or intimidation by the police.⁽³⁴⁾

One cross-sectional survey in Puerto Rican prisons found that almost half of the incarcerated population had witnessed an overdose in prison, and one-third had known someone to have died of an overdose while incarcerated.⁽³⁵⁾ Of those reporting injecting drug use prior to incarceration, 60.6% had witnessed an overdose incident and 44.9% had known of an overdose death.⁽³⁵⁾

The only territory in the region to have reliable information on overdose is Puerto Rico. Further investigation into overdose prevention and reversal, including law and policy reform, is recommended across the region.

Policy development for harm reduction

Since the publication of *The Global State of Harm Reduction 2012*,⁽¹⁰⁾ there have been few developments in harm reduction policy at either national or regional levels. New legislation to decriminalise cannabis appears to be the primary step forward.^(14, 24) Moves towards decriminalising the use of cannabis for medicinal purposes are in process in Puerto Rico, and a debate on the decriminalisation of cannabis has been initiated in Jamaica.⁽¹⁴⁾ There has been a small increase in awareness of harm reduction observed in the press in Puerto Rico, in part influenced by the discourse around cannabis consumption and decriminalisation.⁽²⁴⁾

Harm reduction was included in Trinidad and Tobago's National Anti-Drug Plan for 2008–2012 as a key component of the national response to drugs,⁽³⁶⁾ although this appears to be the sole national policy relating to HIV and drug use that includes harm reduction. A report from the Dominican Republic has noted that the legislative framework needs to be amended to be more harm reduction friendly, as it is discouraging people from accessing health services and therefore increasing the risks they face.⁽²²⁾ Among recommendations for the new National Strategic Plan on HIV and AIDS in the Dominican Republic is the introduction of harm reduction for people who use drugs.⁽²⁵⁾

UNAIDS has set new targets for 2020 for reducing HIV in the Caribbean, named 90-90-90: increasing to 90% the proportion of people living with HIV who know their diagnosis; increasing to 90% the proportion of people living with HIV receiving ART; and increasing to 90% the proportion of people on HIV treatment who have an undetectable viral load.⁽³⁷⁾ There is no mention of people who inject drugs as a key population within these overall goals.

Civil society and advocacy developments for harm reduction

The majority of drop-in centres that operate drug treatment services, although primarily abstinence based, are implemented by civil society organisations (CSOs). A harm reduction coalition, the Coalicion Puerorriqueña de Reduccion de Daños (CoPuReDa), is being established in Puerto Rico, comprising all the NSPs operating in the country,⁽²⁴⁾ and the Dominican Republic's NSP was established by people who use drugs.⁽²²⁾

Civil society advocacy is predominantly led by a Jamaican coalition of civil society actors, named the Caribbean Vulnerable Communities Coalition (CVC), the Dominican Republic-based COIN, and the Dominican Republic Foundation for Harm Reduction (FUNDOREDADA). These organisations work to challenge the structural drivers of the epidemic, focusing on socially marginalised populations affected by HIV.

Although harm reduction in the Caribbean remains embryonic and fragile, it is an approach that is slowly gaining recognition.^(14, 24) The Caribbean Harm Reduction Coalition (CHRC), founded in 2001, implemented harm reduction and drug policy training in Guyana, Trinidad and Tobago and Jamaica in 2014, and is currently leading advocacy for the revision of all national drug and HIV strategies to include issues related to the sexual transmission of HIV among people who use drugs and their sexual partners.⁽¹⁴⁾

In 2011, a Caribbean HIV conference was held in the Bahamas to discuss a sustainable response to the regional epidemic. The conference attracted more than 2,000 participants from across the region, including individuals from key population groups, members of community organisations and representatives of regional and international governments.⁽³⁸⁾

Funding: developments for harm reduction

The Caribbean, like other regions, is heavily affected by the global funding crisis for harm reduction.⁽³⁹⁾ Although the Global Fund Round 9 signified an important advance for harm reduction in the Caribbean, with a substantial grant of US\$29,812,507,⁽⁴⁰⁾ this funding is now coming to an end. In Jamaica, it is estimated that the cost of implementing the national HIV and AIDS programme between 2013 and 2016 will be US\$116.8 million. In response to the withdrawal of funding by the Global Fund, the Jamaican government must take greater responsibility⁽¹¹⁾ although the feasibility of this is questionable. USAID funding of the National Council on Drug Abuse in Jamaica ended in 2012, and Global Fund monies were secured only until March 2013.⁽¹⁸⁾

Round 9 of the Global Fund has supported a regional project, with Pan Caribbean Partnership Against HIV and AIDS (PANCAP) as principal recipient. As a sub-recipients of that grant, CVC and COIN plan to undertake an assessment of harm reduction in six countries (Jamaica, Dominican Republic, Trinidad and Tobago, Surinam, Guyana and Haiti), which will provide a clearer indication of the future needs.⁽¹⁴⁾ However, funding for people who use drugs in the Dominican Republic, donated by the Centres for Disease Control and Prevention (CDC), came to an end in September 2014, and as yet no alternative funding for prevention and harm reduction strategies has been sourced.⁽²⁵⁾

In Trinidad and Tobago and Jamaica, governments have taken over funding certain programmes as donors begin to retreat. However, assuming the financial responsibility of private funders is too great a burden for Caribbean countries. In Puerto Rico, funding cuts to the health sector have affected NGOs providing services to people who inject drugs, leaving organisations to seek assistance from private foundations to keep their services running.⁽²⁴⁾

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2.5

Latin America



Latin America

Table 2.5.1: Epidemiology of HIV and viral hepatitis, and harm reduction responses in Latin America

| Country/ territory with reported injecting drug use | People who inject drugs | 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 ⁱ | |
|---|---|--|--|---|--|--|
| | | | | | NSP  | OST  |
| Argentina | 65,829 (64,500– 67,158) ⁽²⁾ⁱⁱ | nk ⁱⁱⁱ | 4.8 ^{(3)iv} | 1.6 ⁽³⁾ | ✓(25) (P) ^v | x |
| Bolivia | nk | nk | nk | nk | x | x |
| Brazil | 540,500 ^{vi} | 5.92 ⁽⁴⁾ | 63.9 ^{vii} | 2.3 | ✓(150-450) ^{viii} | x |
| Chile | 21,783 ^{(3)ix} | nk | nk | nk | x | x |
| Colombia | nk | 1.35-2.72 ⁽⁵⁾ | nk | nk | ✓ | ✓(7) ^x |
| Costa Rica | nk | nk | nk | nk | x | x |
| Ecuador | nk | nk | nk | nk | x | x |
| El Salvador | nk | nk | nk | nk | x | x |
| Guatemala | nk | nk | nk | nk | x | x |
| Honduras | nk | nk | nk | nk | x | x |
| Mexico | 141,690 ^{(6)xi} | 2.5 ⁽⁶⁾ | 96 | nk | ✓ ⁽¹⁾⁹ | ✓(18) (M) ^{xii} |
| Nicaragua | nk | nk | nk | nk | x | x |
| Panama | nk | nk | nk | nk | x | x |
| Paraguay | nk | 9.35 (3.7–15) ⁽²⁾ | 9.8 ^{xiii} | nk | ✓ ⁽³⁾ | x |
| Peru | nk | 1 ⁽⁷⁾ | nk | nk | x | x |
| Uruguay | nk | 0.2 ⁽⁸⁾ | 21.5 ⁽⁹⁾ | 19.5 ⁽⁹⁾ | ✓ | x |
| Venezuela | nk | nk | nk | nk | x | x |

i Unless otherwise stated, data has been sourced from Mathers BM, Degenhardt L, Ali H, Wiessing L, Hickman M, Mattick RP, et al. HIV prevention, treatment and care services for people who inject drugs: a systematic review of global, regional, and national coverage. *Lancet*. 2010;375(9719):1014-28.

ii This estimate was taken from 1999 and injecting drug use is thought to have reduced significantly since this date.

iii Although estimates exist, they range from 11.9% to 49.7%, and there is no agreed figure.

iv Local studies undertaken in Buenos Aires indicate higher prevalence, although civil society argues that these are not representative of countrywide HCV prevalence.

v Figure is taken from 2012, but we do not have data on how many NGOs are presently providing NSP services. (P) indicates needles and syringes being available for purchase in pharmacies.

vi Figure is taken from 2003, and as far as we are aware no recent estimate of people who inject drugs in Brazil has been published.

vii Figure is taken from 2000/2001 and no recent estimate is available.

viii Figure is taken from 2012, but we do not have data on how many NGOs are presently providing NSP services.

ix Civil society organisations believe this figure to be an overestimate.

x In Colombia, OST is being developed in Armenia, Bogota, Bucaramanga, Cali, Cucuta, Medellin and Pereira, but exact numbers of sites are unknown.

xi This figure includes all opiate users and does not differentiate between people who inject opiates.

xii Of the 18 OST sites, 17 are private clinics and 1 is government run.

xiii Figure is taken from 2006.

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

Harm reduction in Latin America

Although prevalence of injecting drug use in Latin America remains low, unsafe injecting is thought to be a significant route for both HIV and viral hepatitis transmission, particularly in the region's southern cone.⁽¹⁰⁾ In 2008, the Reference Group to the United Nations on HIV and Injecting Drug Use (which has now ceased to operate) estimated that over two million people inject drugs in the region, with the largest proportion (540,000) in Brazil.⁽²⁾ However, civil society sources note that drug use in the region primarily centres on cocaine and its derivatives (especially smoking crack cocaine and pasta base^{xiv}), so the figures included in Table 2.5.1 may not reflect the overall prevalence of drug use across the region.⁽¹¹⁻¹³⁾

Where data on HIV prevalence among people who inject drugs are available, the rates vary greatly between countries. In Peru, according to data collected in 2010, HIV incidence among people who inject drugs was reportedly 1%,⁽⁷⁾ with Brazil reporting the highest incidence in the region at 5.92%.⁽⁴⁾ However, reliable figures on incidence of HIV, viral hepatitis and tuberculosis among people who inject drugs are limited. In addition, the injecting of opiates is thought to be diminishing in the region^(11,14) and where data are available these tend to place greater emphasis on people who use predominantly cocaine-based substances.

In Colombia, although the key population most at risk of HIV infection is the transgender community,⁽⁵⁾ people who inject drugs have been highlighted as a priority group at-risk of HIV transmission, and recommendations have been developed to increase services for this population.⁽¹⁵⁾ Opioid substitution therapy (OST) sites are in existence in Colombia and are being scaled up,⁽¹⁴⁾ and needle and syringe programmes (NSPs) are also now operating in the country. A pilot NSP programme, supported by the Pan American Health Organization (PAHO) and involving 100 people who inject drugs in the city of Pereira, has led to the development of three mobile centres called Centros de Atención Móvil para Drogodependientes (CAMAD). Several CAMAD initiatives were launched in Bogotá in 2012,⁽¹⁶⁾ and it is hoped that 20 further sites will be established.⁽¹⁴⁾

In Argentina, 90% of HIV infections are sexually transmitted, and approximately 50% of these are attributed to men who have sex with men.⁽¹⁷⁾ Injecting drug use exists in the country, mostly involving injection of cocaine. The majority of studies have been undertaken in Buenos Aires,⁽¹¹⁾ where HIV prevalence among people who inject drugs is reported to be 1.9% among men, 0.7% among

women⁽¹⁷⁾ and 6.3% among intranasal cocaine users and smokers.⁽¹⁸⁾ Although the figures indicate that unsafe injecting does occur, since 2012 NSP service provision has diminished in Argentina and there is currently no OST service provision.⁽¹¹⁾ Brazil also has no OST provision, but NSP services are available. In a study undertaken in 10 Brazilian cities, there was thought to be a low number of people who inject drugs.⁽¹⁹⁾ While a study in Bolivia found drug use among the lesbian, gay, bisexual and transgender community, there are presently no harm reduction services for people who use drugs in the country.⁽²⁰⁾

Although Latin America is at the forefront of a growing global movement to decriminalise drug use, harm reduction initiatives remain limited, and epidemiological research on people who inject drugs is sparse. Civil society advocacy has been instrumental in bringing about preliminary changes in national drug policy, and civil society is the primary provider of harm reduction initiatives, but there continues to be a lack of support for harm reduction services from governments.⁽¹¹⁾

Developments in harm reduction implementation

Needle and syringe exchange programmes (NSPs)

NSP services for people who inject drugs in Latin America continue to be extremely limited, and up-to-date information on provision is unavailable. *The Global State of Harm Reduction 2012* reported extremely low coverage, with only 2% of people who inject drugs accessing NSP services across the region, and only 0.3 syringes distributed per person per year.⁽²¹⁾ Of the 12 countries in the region that report injecting drug use, only five currently operate NSP services (see Table 2.5.1). Brazil offers the most extensive coverage, with between 150 and 450 sites. However, this estimate is from 2012, and it is thought that due to a decreasing number of people injecting drugs in the country, services have been scaled back.⁽¹¹⁾ NSP provision in the four remaining countries (Argentina, Mexico, Paraguay and Uruguay) is limited relative to the numbers of people who inject drugs, with Argentina believed to have scaled back its NSP services, similar to Brazil, in response to declining injecting drug use.⁽¹¹⁾

In Mexico coverage is improving, thanks to Global Fund programmes which currently provide 77.6% of all syringes supplied to people who inject drugs.⁽⁶⁾ State funding is also available for NSP provision in the form of subsidies and there has been an increase of

xiv Also known as paco and basuco, pasta base is a paste that is produced in the intermediate stages of cocaine preparation, and is marketed as a cheaper alternative to pure cocaine in a number of Latin American countries.

8.1% in the number of syringes distributed per person per year. However, NSP provision remains under-resourced and insufficient relative to the numbers of people who are unsafely injecting drugs in the country. Although drug use has been decriminalised in Mexico,⁽²²⁾ the threshold quantities are believed to be so low that drug laws continue to serve as a barrier to people accessing NSP services.

In Colombia, NSP services for people who inject drugs have been initiated recently, following a pilot study with 100 people who inject drugs in the city of Pereira, supported by PAHO.⁽¹⁴⁾ Three mobile assistance centres were developed in 2014 in Pereira, with the first launched in Bogotá in 2012, and a further 20 planned for the city. These serve a wide-range of people who use drugs rather than specifically those who inject since, as mentioned previously, injecting drug use has become less prevalent than inhalation of cocaine-based substances.

In the countries that do offer NSP provision, many people who inject drugs are deterred from accessing services because of restricted opening hours, long waiting times, insufficient resources, criminalisation of drug use and inadequately trained service providers.^(11,13) Further research, advocacy and service provision is necessary in the region to ensure that

people who use drugs have appropriate access to safe injecting equipment.

Opioid substitution therapy (OST)

Opioid use is thought to be rare in Latin America. At present, Mexico and Colombia are the only countries in the region that provide OST to people who inject drugs and/or use opiates (see Table 2.5.1), with approximately 18.6% of opiate users receiving OST in Mexico.⁽⁶⁾ According to figures deriving from a press report in June 2013, there were thought to be 17 private OST facilities and one government facility providing methadone to people who use drugs in Mexico.⁽²³⁾

In Colombia, there are currently OST sites operating in seven cities: Bogotá, Medellín, Cali, Pereira, Armenia, Cúcuta and Bucaramanga.⁽²⁴⁾ However, the number of sites in these cities is unknown. In Argentina, although opiate use is reportedly rare, some services in public hospitals, such as the toxicology service of the Fernández Hospital in Buenos Aires City, can prescribe methadone.⁽²⁵⁾ It is unclear however whether people who inject drugs are accessing this service.

Cocaine and transmission of HIV and viral hepatitis in Latin America: an increased harm reduction response

Research is increasing into harms related to non-injecting drug use in Latin America, as it is now widely acknowledged that drug use in the region is predominantly non-injecting of cocaine and its derivatives.^(10,11) In a systematic review of key populations in Brazil, HIV prevalence among people who use drugs was found to be 23.1%,⁽²⁶⁾ while in an earlier study looking at pooled data over a ten-year period in Brazil, people who inject drugs and people who smoke crack illustrated similar levels of risk for HIV infection.⁽²⁷⁾ Although much of the research is emerging from Brazil, a study in Montevideo, Uruguay published in 2013 also found an increased risk of HIV among cocaine smokers, with an estimated 6.3% HIV prevalence rate.⁽²⁸⁾ Growing recognition of HIV prevalence and hepatitis C (HCV)⁽²⁹⁾ among people who use cocaine and its derivatives has increased the harm reduction response for people who use drugs in parts of Latin America. For example, in Brazil, the non-governmental organisation *É de Lei* of São Paulo has successfully distributed new crack pipes⁽³⁰⁾ in an attempt to reduce viral hepatitis transmission through sharing pipes. In São Paulo, the *Bracos Abertos* (Open Arms) programme offers people in the favelas who use crack cocaine healthcare, information on treatment, paid work and three meals a day. The programme has already made a significant impact on health outcomes, as well as on lowering the levels of stigma and discrimination associated with drug use in the area.⁽³¹⁾

A study in Bahia, Brazil, also observed the use of 'pitolho' (the co-smoking of crack and marijuana in a cigarette-like form) and identified several key reasons why crack users have adopted the pitolho as a harm reduction tool, including a reduction in the negative behavioural and physical effects of crack cocaine, and greater control over a potential vulnerability to violence.⁽³²⁾ Oral HIV tests are also being offered in Brazil in areas where there is believed to be intense use of crack cocaine, both as a harm reduction measure and to help increase awareness of HIV and viral hepatitis transmission through sharing drug paraphernalia such as straws and pipes.⁽³³⁾ Although recognition, implementation and research into harm reduction initiatives for people who use cocaine is a positive step towards reducing transmission of HIV and viral hepatitis in Latin America, further initiatives for people who use drugs are needed.

Viral hepatitis

Data on viral hepatitis among people who inject drugs in Latin America is sparse and often out of date. Argentina is believed to have the lowest prevalence of HCV among people who inject drugs in the region, at 4.8%⁽³⁾ and Mexico the highest, at 96%.⁽¹⁾ However, these figures stem from data published in 2009 and 2005 respectively, and as far as we are aware, there are few updated estimates available for most countries in Latin America. In Brazil, transmission rates for HCV were recorded as 28.9% among people who inject drugs in 2011.^(3,4)

In a 2002 study in Buenos Aires and Montevideo, HCV and HIV prevalence among non-injecting cocaine users were 8.8% and 7.9% respectively.⁽³⁵⁾ This work highlighted the vulnerability to infection among people who use drugs but do not inject through practices such as sharing straws, and emphasised the need for harm reduction services tailored to them as key populations at risk in Latin America. Although injecting drug use has been reported, we have been unable to source information on HCV or hepatitis B (HCB) prevalence rates. In 2011, the Buenos Aires provincial ministry of health launched the Programme for Prevention and Detection of Viral Hepatitis to work in conjunction with the HIV/AIDS and Sexually Transmitted Infections (STIs) Programme. However, civil society organisations contest the levels of access to HCV testing and treatment said to be available across the country.⁽³⁶⁾ In 2012 we reported that the ministries of health and social security in Costa Rica and Panama pledged to guarantee access to testing and treatment services for HIV and viral hepatitis for all.⁽³⁷⁾ However, it has not been possible to corroborate whether these promises have been fulfilled.

Tuberculosis

Previous evidence has suggested that tuberculosis (TB) rates in countries such as Brazil are extremely high, with 48 cases per 100,000 people in 2010.⁽³⁸⁾ However, the WHO reported in 2012 that Brazil has shown a sustained decline in TB over the past 20 years.⁽³⁹⁾ Although research on TB prevalence among people who use drugs in Latin America is lacking, there is evidence to suggest that they are associated with elevated TB infection rates.⁽³⁸⁾

Where TB rates are reported in the region, they often appear with HIV co-infection. In Peru, the proportion of people receiving TB treatment also receiving antiretroviral therapy (ART) was 64%.⁽⁷⁾ Uruguay reported 852 cases of TB in 2013, 14% of them involving co-infection with HIV.⁽⁶⁾ Venezuela estimated the percentage of TB incidence among people with HIV as 18% in 2012,⁽⁴⁰⁾ Mexico had 512 people

receiving both TB and ART treatment in 2013,⁽⁶⁾ and Bolivia reported 168 people co-infected with TB and HIV.⁽²⁰⁾ Most Latin American countries offer HIV testing to anyone presenting with TB. However, as in other regions, prevalence figures do not detail what proportion of infections are among people who use drugs or who inject drugs. Moreover, while diagnosis services are available across the region, access to these is inconsistent for people who use drugs⁽¹¹⁾ and we are unaware of any TB services in Latin America that specifically target this community.

Antiretroviral therapy (ART)

Latin America has the highest international and domestic public spend on ART among low- and middle-income countries, at just under \$US800 million.⁽⁴¹⁾ In 2010, it was reported that ART was being provided to 521,000 of the 820,000 people in need of treatment, representing 63% coverage for the region.⁽¹⁰⁾ 14 of 31 countries and territories in the region reported at least one shortage of ART drugs in 2012, with prices varying by up to 77 times more depending on the country.⁽⁴³⁾

In 2013, Brazil reported 718,000 people living with HIV, with an estimated 5.82% HIV prevalence rate among people who inject drugs.⁽⁴⁾ Although Brazil has a well-documented treatment system with high coverage rates and free ART, a 2011 study noted that many people who inject drugs had failed to initiate ART due to lack of access to HIV testing and stigma surrounding injecting drug use⁽⁴²⁾. The criminalisation of drug use continues to greatly restrict access to services and treatment adherence among people who inject drugs, although figures relating to rates of service provision among key populations are severely lacking. Further research on the availability of ART for people who use drugs in Latin America is urgently needed.

Harm reduction in prisons

In most Latin American countries, the cultivation, distribution and personal use of drugs remain heavily criminalised. The pervasive 'war on drugs' in the region has led to large numbers of people who use drugs being incarcerated in severely overcrowded prisons. While there is a lack of data on the prevalence of HIV, viral hepatitis and TB in Latin American prisons, it is clear that prison populations are at increased risk of infection. In Peru, the estimated HIV prevalence rate among prison populations is 4.03% compared to 0.4% among the general population, and in Bolivia HIV prevalence is reported as 10% among prisoners compared to 0.2% among the general population.⁽⁴⁴⁾ In Argentina, TB patients with a history of incarceration were between

6 and 18 times more likely to test positively for HBV and HCV respectively.⁽⁴⁵⁾

Systematic research is required to provide a more accurate analysis of current HIV, viral hepatitis and TB epidemics and drug use in Latin American prisons. The available data suggests that there are currently no prison-based harm reduction services operating in the region.

Overdose

Data on the prevalence of overdoses in Latin America is extremely limited. Research in Colombia in 2012 in the cities of Pereira and Medellín reported that 25% and 33.3% respectively of people who inject drugs had experienced a non-fatal heroin overdose.⁽¹⁵⁾ In both cities, six out of ten people revealed that they would not access healthcare services if they had another overdose episode for fear of referral to law enforcement authorities.⁽¹⁵⁾

There are currently no overdose prevention programmes established in the region.⁽¹¹⁾ Naloxone is registered in a number of Latin American countries, including Argentina, Brazil, Chile, Mexico, Paraguay, Peru, Uruguay and Venezuela. However, it is not yet available to people who use drugs 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 is included in regional healthcare plans.⁽¹¹⁾

Prevailing laws and the criminalisation of drug use continue to hamper the introduction of overdose prevention and treatment initiatives in the region, and further work on naloxone availability for people who use drugs is recommended.

Policy development for harm reduction

As reported in 2010⁽⁴⁶⁾ and 2012,⁽³⁷⁾ six Latin American countries include harm reduction in their national policies on HIV and/or drugs: Argentina, Brazil, Colombia, Paraguay, Peru and Uruguay. In 2013, Argentina made provision for a harm reduction approach in the National Mental Health Act 2013.⁽¹¹⁾ As a result, the only national public institution dedicated to drug treatment, the Network Hospital Specialized in Mental Health and Addiction (formerly CENARESO), has now included both risk and harm reduction services within its programmes.⁽¹¹⁾ In Brazil, the Federal Drug Laws of 2000 and 2006 explicitly refer to harm reduction. Mexico also has an official statement that includes harm reduction strategies,⁽⁴⁷⁾ although it is claimed that few harm reduction initiatives are orientated towards people who use drugs but who do not inject.⁽⁴⁸⁾

Although there has been little progress in explicitly including harm reduction in national policies across the region, there has been a notable increase in debate on drug policy at national and international levels. Countries such as Chile, Colombia, Costa Rica, Guatemala and Mexico have all declared the need for a new approach to drug policy, with greater emphasis on health principles rather than criminal sanctions.⁽¹¹⁾

A major policy development occurred in Latin America in 2012 when Bolivia denounced the 1961 Single Convention on Narcotic Drugs, and then re-acceded in 2013 with a reservation which would allow traditional uses of coca leaf domestically, enabling indigenous communities to legally cultivate and use the leaves, for example for chewing.⁽¹¹⁾ In 2013, the Government of Uruguay passed legislation to regulate state-controlled sales of cannabis.⁽¹¹⁾

A meeting hosted by AIDSTAR-One in Antigua, Guatemala, in September 2012, and supported by the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Latin American and Caribbean Bureau of the United States Agency for International Development (USAID), helped raise awareness of the need for policy change in Latin America. During the technical consultation, entitled 'Substance use and HIV prevention, care and treatment in Latin America', collaborating international agencies – including the United Nations Office on Drugs and Crime (UNODC), PAHO, the Joint United Nations Program on HIV/AIDS (UNAIDS), the Guatemalan department of health and human services, the Substance Abuse and Mental Health Services Administration (SAMSHA), the National Institute on Drug Abuse (NIDA) and the United States Centers for Disease Control and Prevention (CDC) – sought to improve planning for programmes related to substance use among key populations in Latin America.

Civil society and advocacy developments for harm reduction

Civil society organisations in Latin America have played an increasingly important role in drug policy reform at both regional and national levels. In 2009, the first Latin American Conference on Drug Policy was organised by Intercambios Civil Association in Buenos Aires, as a platform for discussing solution-orientated proposals for drug policy in the region. The fifth Latin American Conference on Drug Policy and the first Central American Conference on Drug Policy took place in September 2014 in Costa Rica, organised by the Asociación Costarricense para el Estudio e Intervención en Drogas (ACEID) and the consortium CONFEDDROGAS, which is composed of

six civil society organisations committed to significant change in drug policy.

In October 2012, the Latin American Network of People Who Use Drugs (LANPUD) was formed.⁽¹¹⁾ In 2013, the 10th Hemispheric Forum of Civil Society and Social Actors held a special session with the Committee on Inter-American Summits Management and Civil Society Participation in the Organization of American States (OAS), and produced recommendations on harm reduction.⁽⁴⁹⁾ OAS plays an active role in promoting debate on drug policy in Latin America, publishing two reports in 2013 that called for open discussion on drug policy across the region.^(50,51) In two successive declarations, the Declaration of Antigua adopted in June 2013, and the Declaration of Guatemala agreed in September 2014^(11,52), OAS has also called for balanced drug policy that is respectful of health and human rights. Civil society organisations have been actively engaging with and influencing these regional processes.⁽¹³⁾

In November 2013, an open letter signed by 52 Latin American civil society organisations was handed to ministers at the Fourth Meeting of Ministers of Public Security of the Americas, urging them to get involved in the search for alternatives to current drug policy in the region, and calling for human rights, a reduction in violence and a minimisation of harm for people who use drugs.⁽⁵⁴⁾ Seventeen civil society organisations in the region also requested a hearing at a meeting of the Inter-American Commission on Human Rights (IACHR) in March 2014 in Washington D.C. to analyse the serious impact of current policies on human rights.⁽⁵⁵⁾ The International Federation of Catholic Universities (IFCU) policy brief *Drug Policy in Latin America and Asia: Towards the Construction of Responses Focused on Human Rights* also makes an important contribution to harm reduction in Latin American, and is signed by academics from Catholic universities in Bolivia, Brazil, Colombia, India, Indonesia, Lebanon, Philippines and Thailand, together with Intercambios Civil Association.⁽⁵³⁾

Funding: developments for harm reduction

Multilateral agencies and international donors have continued to support harm reduction initiatives in Latin America. As in other regions, the Global Fund has allocated resources for harm reduction programmes in Argentina, Mexico, Paraguay and Uruguay,⁽¹¹⁾ and more recently Open Society Foundations, a key donor for harm reduction, has added harm reduction work in Latin America to its portfolio.⁽⁵⁶⁾ Caritas (Germany) has supported the activities of the Red Americana de Intervención en Situaciones de Sufrimiento Social (RAISSS) network, and the Levi Straus Foundation has continued its support for projects in Argentina. However, with donors including the Global Fund increasingly restricting resources for middle-income countries, the sustainability of many projects in Latin America is at risk.

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 becomes an integral part of drug policy and public health responses.

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REGIONAL OVERVIEW

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| 2.6 | North America |
|-----|---------------|



North America

Table 2.6.1: : Epidemiology of HIV and viral hepatitis, and harm reduction responses in North America

| Country/ territory with reported injecting drug use ⁱ | People who inject drugs ⁱ | HIV prevalence among people who inject drugs (%) | Hepatitis C (anti- HCV) prevalence among people who inject drugs (%) | Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%) | Harm reduction response | | |
|--|---|---|--|---|--|---|--|
| | | | | | NSP ⁱⁱ  | OST ⁱⁱⁱ  | DCR ^{iv}  |
| Canada | 286,987 (220,690– 375,173) ^{(1)v} | 11.2 ^{(2)vi} | 68 ⁽²⁾ | nk |  |  |  |
| United States | 6,612,488 (4,583,188– 8,641,788) ⁽³⁾ | 2.1 ⁽³⁾ | 43.13 ⁽³⁾ | 11.8 [3.5–20] ^{(4)vii} |  (194) ^{(5)viii} |  (>1,400) ⁽⁶⁾ (B, BN, M) |  |

ⁱ There are no identified reports of injecting drug use in Greenland.

ⁱⁱ 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.

ⁱⁱⁱ The number in brackets represents the number of operational OST sites, 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).

^{iv} DCR = drug consumption room, also referred to as a safer injecting facility (SIF).

^v Year of estimate: 2004.

^{vi} Figure is based on 11 sentinel sites.

^{vii} Year of estimate: 1992.

^{viii} These services operate in 33 of the 50 states, which include Puerto Rico (see page 68).

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



Harm reduction in North America

The USA, after China and Russia, has one of the highest estimated populations of people who inject drugs in the world,⁽¹⁾ with the combined total from all states estimated to be 46% of people who inject drugs globally.⁽²⁾ In Canada, 17% of new HIV infections are attributed to unsafe injection drug use, and HIV prevalence among people who inject drugs ranges from 3–21%.⁽⁷⁾ The HIV epidemic among people who inject drugs in both the USA and Canada mirrors broader disparities in the HIV epidemic, with racial and ethnic minorities in the USA and Aboriginal people in Canada disproportionately affected.^(8,9)

Although key harm reduction services 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. *The Global State of Harm Reduction 2012: Towards an Integrated Response*⁽¹⁰⁾ reported increased overdose prevention and response programmes, including distribution of community-based naloxone – a response that has continued to grow most dramatically in the USA. However, prison harm reduction remains underdeveloped in both countries. While OST provision is widely (if unevenly) available in both federal and provincial prisons in Canada, access is limited in the USA. Prison NSPs remain unavailable in North America. Canada still operates the only drug consumption room in North America, the INSITE project in Vancouver, British Columbia, with other cities stating their intention of opening these in the near future.

Civil society organisations in the USA and Canada have actively engaged in activities around harm reduction and drug policy reform, and have been instrumental in the growing overdose prevention and community naloxone distribution programmes in both countries since 2012. Networking and activism among people who use drugs has also been growing stronger, particularly in the USA, where a new national umbrella association of drug user activist groups has been formed.

Developments in harm reduction implementation

Needle and syringe exchange programmes (NSPs)

NSPs are available in both countries. A 2014 review of coverage in the USA by the North American Syringe Exchange Network (NASEN) found 194 NSPs operating in 33 states, the District of Columbia, the Commonwealth of Puerto Rico and the Indian Nations.⁽⁵⁾ However, this data should be interpreted with some caution. The political climate and punitive legislation in a number of states discourages some

programmes from making their information public. NSPs are available across Canada, although civil society reports that coverage varies from region to region, and even within regions, due to the unstable means by which the programmes are funded. While large urban centres tend to have strong networks of harm reduction services, rural areas, smaller centres and Aboriginal communities often face difficulties in establishing and maintaining services. For example, only six communities in Alberta have NSPs, and they are also unavailable in large parts of Manitoba and Ontario.⁽¹¹⁾ As in Canada, most NSPs in the USA are located in urban centres, with suburban and rural access being much less common.⁽⁵⁾

National-level estimates of NSP coverage are not collected in Canada or the USA, making it difficult to monitor service provision levels accurately. The last available data, as reported in *The Global State of Harm Reduction 2012*, indicate that an average of 23 syringes are distributed per person who injects per year across North America, amounting to low coverage compared to international targets.⁽¹²⁾ This places North America behind other high-income regions such as Western Europe (59 syringes) and Australasia (202 syringes).⁽¹³⁾ A 2012 survey of 142 NSPs in the USA found a total of 39.2 million syringes distributed in that year by the 108 projects for which data was provided.⁽⁵⁾

Civil society reports continue to suggest that funding is one of the most significant barriers to service provision and scale up in both countries. Since in the USA individual states determine the legality of syringe exchange or distribution, some states have only underground NSPs or none at all, which is largely the case throughout the southern region.⁽¹⁴⁾ In Canada, the lack of federal support for NSPs means that harm reduction services are currently delivered by community agencies, non-governmental organisations (NGOs), municipalities, provinces and territories.

The limited geographical reach and opening hours of available sites also pose barriers to access, especially for women who inject drugs, who also experience added stigma and fear of exposure to authorities because of strict child custody and welfare laws.⁽¹⁵⁾ 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.

Canada still operates the only drug consumption room in North America, the INSITE project in Vancouver, British Columbia. Following the failure of the federal government's appeal to the Supreme Court in 2011 to force closure of the facility, other cities have approved proposals to establish safe injecting programmes, including Toronto and

Montreal.^(16,17) However, establishing the projects will still require approval of the current conservative federal government. In 2014, the federal government introduced legislation, Bill C-2, which would make it more difficult for local governments to set up drug consumption rooms (see page 94, Policy development for harm reduction).

Opioid substitution therapy (OST)

OST is available in both countries, although access is by no means universal. Over 2,418 licensed facilities provide OST in the form of methadone, buprenorphine and buprenorphine–naloxone combination across the USA.⁽¹⁸⁾ 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).⁽⁶⁾ 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.⁽¹⁹⁾ Only one of three Canadian territories provides MMT, and buprenorphine is not widely used due to its prohibitive cost.⁽¹⁹⁾ In Canada, there has also been an increase in demand, including in First Nation communities and prisons.⁽¹⁹⁾ However, the lack of doctors who can prescribe methadone, and limited provision through low-threshold services, remain a significant barrier to addressing the increasing demand for MMT in Canada.

Limited funding options and budget cuts threaten the quality of service provision in Canada. Additional obstacles to OST access include geographical distance from sites, stigma and misconceptions around drug dependence at every level of the treatment system. As with NSPs, confidentiality issues present a further obstacle, especially in small cities and remote areas. Moreover, 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. 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 among First Nation communities. Some attempts are being made to increase the availability of OST through low-threshold programmes.

The clinical trial ‘Study to Assess Longer-term Opioid Medication Effectiveness’ (SALOME) is currently underway in Vancouver.⁽²⁰⁾ The trial is investigating the effectiveness of hydromorphone (the active ingredient

in heroin) compared to injectable medical-grade heroin (diacetylmorphine) for people with chronic opioid dependence for whom other maintenance treatments have been unsuccessful. In late 2013, a group of patients who had left the SALOME project, along with their doctors, lodged a constitutional challenge seeking to allow them to continue to access prescription heroin even though they were no longer part of the project. In 2014, the plaintiffs won the case, and the doctors began prescribing heroin in November 2014⁽²¹⁾ (see page 94, Policy development for harm reduction)).

In the USA, growing concerns about the diversion of buprenorphine⁽²²⁾ have the potential to decrease access to the medication. Restrictions arising from these concerns include mandatory counselling and urine toxicology tests, as well as requirements by insurance companies for prior approval of each patient, placing greater time demands on doctors who administer buprenorphine maintenance therapy.⁽²²⁾ Additional barriers to OST access in the USA include uneven Medicaid coverage across states, leaving many uninsured people who use drugs unable to access the medication, as well as many doctors opting to 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 of 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 childcare difficulties and increased stigma.

Viral hepatitis

Viral hepatitis prevalence rates among people who inject drugs are high in both the USA and Canada. A systematic review published in 2011 reported prevalence rates of hepatitis C (HCV) among people who inject drugs of over 60% and 70% in Canada and the USA respectively.⁽⁴⁾ Although in 2014 HCV is believed to have declined in the USA (see Table 2.6.1), the rate of infection among this population group is still extremely high. For example, in the USA, people who inject drugs continue to account for up to 50% of new HCV infections⁽²³⁾ and approximately 80% of new HCV infections in Canada.⁽²⁴⁾ Both countries have significant numbers of people co-infected with HIV and HCV.⁽²⁵⁾

The extent of testing and treatment for viral hepatitis among people who inject drugs is unclear. 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, lack of an effective test that can determine current infection status instead of history of exposure, and in some cases the requirement that a person must be abstinent from drug use in order to qualify for treatment.⁽²⁶⁾ 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. A 2011 study estimated that approximately 137,000 people who inject drugs will experience HCV-related disease each year until 2026, and it will cost C\$3.96 billion to provide them with treatment. This highlights the urgent need to develop targeted HCV prevention strategies and ensure adequate allocation of resources for future treatment needs in Canada.⁽²⁷⁾

In 2014, a new national viral hepatitis action plan was released in the USA that supports the provision of both NSP and OST as part of a comprehensive HCV prevention package. This includes support for increased access to HCV prevention, care, and treatment services in prison.⁽²⁸⁾ In Canada, there is no national hepatitis strategy, although there is a 2009 strategic framework for action sponsored by the Public Health Agency of Canada. However, community-based organisations have called for the development of a true national HCV strategy that goes beyond the limitations of and gaps in the current framework.⁽¹¹⁾

Tuberculosis

Integration of tuberculosis (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 people who inject drugs, coupled with a lack of awareness of the relevance of TB as an issue, hinder many from seeking these services. The US Centers for Disease Control and Prevention (CDC) 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. The impacts of this initiative are yet to be determined.

Antiretroviral therapy (ART)

An estimated 40,334 people who inject drugs in Canada and 308,208 in the USA were living with HIV in 2008.⁽⁶⁾ In the USA, 9% of new HIV infections are among people who inject drugs.⁽⁹⁾ Racial disparities

in HIV infection among people who inject drugs are evident in both countries. According to the CDC, African-Americans are ten times more likely to be diagnosed with HIV than white people who inject.⁽¹⁴⁾ In Canada, aboriginal people (composed of First Nations, Inuit and Métis) are more likely to acquire HIV via unsafe injecting than non-Aboriginal people, and unsafe injecting drug use accounts for more HIV cases among Aboriginal women than among aboriginal men.⁽²⁹⁾ Among aboriginal Canadians, the estimated proportion of new HIV infections in 2008 attributed to unsafe injecting was 66%; almost four times higher than among the Canadian population as a whole.⁽³⁰⁾

There are no national-level data on antiretroviral therapy (ART) coverage among people who inject drugs in either Canada or the USA. Differing approaches, targets and implementation structures across states, provinces and jurisdictions have an impact on 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.⁽²⁵⁾ Most of these individuals represent key populations at higher risk of HIV, including people who inject drugs. Although recent data indicate that 85.5% of people who are injecting drugs took an HIV test and received their results in the past 12 months,⁽³¹⁾ this proportion is substantially lower among sub-groups at higher risk, such as aboriginal people and women who inject drugs.^(9,29)

Civil society reports in the USA cite the lack of access to antiretroviral drugs as a major barrier to people who inject drugs starting ART, especially in the southern region where there is a growing waiting list for the AIDS Drug Assistance Program.⁽³²⁾ Additionally, some doctors are reported to initiate treatment only when the patient abstains from drug use. In Canada, the cost of HIV treatment is heavily subsidised, if not completely covered, by provincial governments. However, accessibility to ART for people who inject drugs is uneven across the country.⁽¹¹⁾

Harm reduction in prisons

The USA has the highest prison population rate in the world, with a recorded 2.24 million people incarcerated.⁽³³⁾ Despite the high rate of detention, the highest estimated population who inject drugs, and one of the highest prevalence rates of HIV among this population, harm reduction initiatives in the prison setting remain extremely limited. Although Canada's prison harm reduction programmes are more extensive in some respects, they still fall far short of a comprehensive response.

High rates of HIV, viral hepatitis and TB among inmates in the USA have been recorded, particularly among those who are released from prison and re-incarcerated.⁽³⁴⁾ This suggests the urgent need for harm reduction provision to be made available. In Canada, HIV and HCV prevalence in prison is at least 10 and 30 times higher, respectively, than in the drug user community as a whole. Injecting drug use is common, with one in six people in federal prisons reporting injecting in prison within the previous six months. Of those people who injected drugs in prison, half used someone else's used syringe and one-third shared a needle with someone with HIV, HCV or unknown infection status.⁽³⁵⁾

OST provision is available in only a small number of US prisons and jails, including Rikers Island (New York), the Metropolitan Detention Center (New Mexico) and jails in Baltimore and Rhode Island.⁽³²⁾ In 2013, indicative of a gradual shift in policy, the US Department of Justice and the Bureau of Justice Assistance co-sponsored a cross-disciplinary training manual on OST for offender populations designed to increase knowledge and awareness.⁽³⁶⁾ Then in early 2014, the Substance Abuse and Mental Health Service Administration (SAMHSA) released a report, *Medication-Assisted Treatment and the Criminal Justice System*, three years after hosting an expert committee on the issue.

Unlike the USA, OST is widely available in Canadian federal and provincial prisons. In most jurisdictions, OST continuation is available to prisoners who were prescribed it prior to their arrest. Only the federal prison system and one province currently enable prisoners to initiate OST treatment while incarcerated,⁽³⁷⁾ although civil society reports note that difficulties remain in initiating OST even in those jurisdiction that allow it.⁽¹¹⁾

There are no NSPs operating in prisons in either Canada or the USA, although in 2012 a legal challenge was launched in Canada by a former prisoner and four HIV organisations to the failure to make sterile injecting equipment available in prisons (see box below). The distribution of bleach for cleaning used syringes has been in place since 1996 in the Canadian federal prison system, and is also available in some provincial systems,⁽³⁷⁾ although this is a suboptimal harm reduction response to the risk of sharing syringes.

Prisons in both Canada and the USA have ART provision. Condom provision is also common although uneven across the Canadian federal and provincial prisons, with most jurisdictions providing condom access to some degree, although concerns

have been raised about barriers to access.⁽³⁷⁾ Condoms are largely unavailable in US prisons and jails, with only a handful of jurisdictions or individual institutions allowing access.⁽³⁸⁾

Legal action on prison needle exchange in Canada

In September 2012, a former Canadian prisoner and four community-based HIV organisations launched a joint lawsuit against the federal government to challenge the failure to provide access to sterile injecting equipment in prisons. The lead plaintiff in the case is Steven Simmons, a former prisoner who contracted HCV while incarcerated between 1998 and 2010. The NGOs supporting the lawsuit are the Canadian HIV/AIDS Legal Network, Prisoners with HIV/AIDS Support Action Network (PASAN), the Canadian Aboriginal AIDS Network (CAAN) and CATIE, a national HIV and HCV information service. The lawsuit, filed in Ontario's Superior Court of Justice, claims that the failure of the state to provide access to NSPs in prisons constitutes a violation of the Canadian Charter of Rights and Freedoms. The plaintiffs are seeking a judicial order that would compel the government to make prison NSPs available across Canada. As part of the suit, the Canadian HIV/AIDS Legal Network will submit affidavits and testimonials from 50 current or former federal prisoners from across the country, documenting their experiences of injecting drug use and needle sharing in prisons. Their perspectives will provide evidence of the harm prisoners experience when they are denied healthcare services that other citizens can access. Developments in the lawsuit can be followed at www.prisonhealthnow.ca.⁽³⁹⁾

Overdose

The Global State of Harm Reduction 2012 revealed a steady increase in reported drug-related overdose in the USA,⁽¹⁰⁾ and it is still the leading cause of death by injury in the country, with 114 people dying as a result of a drug overdose every day.⁽⁴⁰⁾^{ix} In 2010, naloxone (an opioid antagonist) was delivered in 188 opioid overdose prevention programmes in the USA.⁽⁴¹⁾ Collectively, these have trained over 50,000 individuals in naloxone use, resulting in 10,071 reported overdose reversals between 1996

ix This includes unintentional, intentional (suicide or homicide) and cases of undetermined intent.

and 2010.⁽⁴⁰⁾ As of June 2014, there are 30 states plus Washington DC that have at least one point of access for laypersons to obtain naloxone for people who use drugs, or friends and family,⁽³²⁾ with over 600 distribution sites and 13 states that have at least one naloxone co-prescription in place.⁽³²⁾ Co-prescription refers to the practice of prescribing naloxone to someone who is receiving opioid pain medications from their doctor for a chronic pain condition, or for a patient who the prescribing doctor otherwise feels may be at risk of overdose. The prescription for naloxone is filled through the pharmacy. This new development is intended to reach prescription opioid users that traditionally have not been well served by existing naloxone programmes, which are primarily reaching people who use heroin and people who inject who use NSPs.⁽¹⁰⁾ A 2012 survey of NSPs in the USA found that half of the programmes distributed naloxone (60% provided injectable naloxone only, 14% intranasal only and 26% provided both).⁽⁵⁾

Over the past few years there has been a significant increase in the number of US states passing laws enhancing the overdose response. Between 2012 and 2014, 19 states passed laws providing immunity to healthcare workers or layperson responders administering naloxone, making a total of 27 states with such legislation.⁽⁴²⁾ In addition, 24 states now have passed Good Samaritan laws providing legal protections for people who call emergency services for help in the event of an overdose. This is an increase of 14 states since 2012.⁽⁴³⁾

Until recently, naloxone distribution programmes in Canada existed only in Edmonton, Toronto and Ottawa. However, since 2012 there has been a rapid scale up of overdose prevention and response programmes in British Columbia, sponsored by the BC Centre for Disease Control. The agency has initiated programmes at 45 sites in the province, with 1,215 naloxone kits being distributed and more than 2,200 people trained to recognise and respond to an opioid overdose.⁽⁴⁴⁾ Similar community-based programmes have now been initiated in medium and large urban centres across Ontario, and one is under development in Montreal, Quebec. Although these programmes are not yet supported by the federal government, the scale up and initiation of naloxone is a positive move towards fewer deaths by overdose, and also serves to increase awareness of the issue. National-level data on drug overdoses is unavailable in Canada.⁽¹¹⁾

Policy development for harm reduction

Since *The Global State of Harm Reduction 2012* there has been significant legislative progress in the USA on the issue of overdose prevention. As described above, 19 states have passed laws since 2012 providing immunity to healthcare workers or layperson responders administering naloxone, and 14 states have passed Good Samaritan laws providing legal protections for people who call emergency services for help in the event of an overdose.^(42,43) In April 2012, the director of the Office of National Drug Control Policy (ONDCP) for the first time voiced public support for the distribution of naloxone,⁽⁴⁵⁾ and since that time ONDCP and other federal agencies have continued to support naloxone programmes. In 2014, the National Drug Control Strategy was released that contains supportive language for both naloxone and NSPs.⁽⁴⁶⁾ In the same year, the Law Enforcement Naloxone Toolkit was released by the Bureau of Justice Assistance and the Opioid Overdose Prevention Toolkit⁽⁴⁷⁾ by SAMHSA, both in response to the opioid overdose epidemic.

State referenda on the legal regulation and sale of cannabis were adopted in Washington and Colorado in the 2012 elections, and similar ballot initiatives were passed by voters in Oregon, Alaska and the District of Columbia in 2014. These referenda have heightened the national debate on drug policy reform within the USA.

In 2013, a group of patients and doctors initiated a constitutional court challenge to proposed changes to Health Canada's Special Access Programme, which enabled access to prescription heroin for those who had participated in the SALOME heroin trial in Vancouver. The plaintiffs sought the right to continue to access prescribed heroin, even though they were no longer participants in the SALOME study. In November 2013, a court case challenging the new federal regulations was launched by the Providence Health Care Society and four former participants in the trial, who were represented by the Pivot Legal Society. In May 2014, the British Columbia Supreme Court granted an injunction to the participants, exempting them from new federal regulations. Then in November 2014, doctors began prescribing heroin, making Vancouver the first city in North America where prescription heroin is available to people outside of a clinical trial.^(48,49)

In Canada, there have been further developments on the issue of drug consumption rooms. Following the Canadian federal government's failed 2011 attempt at the Supreme Court to close down the INSITE project in Vancouver, it has introduced legislation that would substantially limit the ability of other municipalities to

open similar safe injecting facilities. The legislation, known as Bill C-2, would create significant barriers to local health authorities seeking to establish drug consumption rooms in their own cities.⁽⁵⁰⁾ According to the Canadian HIV/AIDS Legal Network, “Bill C-2 would introduce an unnecessary series of obstacles and a biased process replete with opportunities for misinformation and stigma to block needed health services.” The bill is currently working its way through parliament, although it has yet to be approved. Civil society organisations have been actively opposing the proposed law.⁽⁵¹⁾

Civil society and advocacy developments for harm reduction

Civil society organisations working for harm reduction and drug policy advocacy in North America have been increasingly active since 2012, both nationally and internationally. Grassroots initiatives have played a significant role in expanding access to naloxone in both the USA and Canada. The Harm Reduction Coalition (HRC) has been a key national voice in the USA, not only in supporting the development of harm reduction services but also in successfully engaging the Obama administration on key issues, and working with international partners at the annual Commission on Narcotic Drugs meetings and on preparations for the 2016 United Nations General Assembly Special Session (UNGASS) on drugs. HRC also hosts the biennial national harm reduction conference, the major meeting place for harm reductionists and drug user activists from across the USA. The 2014

event was notable for a keynote speech delivered by the US ‘drug czar’ Michael Botticelli, ONDCP director, in which he explicitly voiced support for harm reduction and naloxone – the first time a high-level US administration official has addressed the harm reduction conference.

In Canada, the leading national organisations include the Canadian Drug Policy Coalition, an independent civil society network of organisations and individuals advocating to improve Canada’s drug policies; the Canadian HIV/AIDS Legal Network, a national organisation actively engaged in advocacy on legal and human rights issues surrounding HIV; and 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. Both the Canadian Drug Policy Coalition and the Canadian HIV/AIDS Legal Network have been particularly active, engaging policymakers and the media at the national level on issues such as opposition to Bill C-2, drug law reform and harm reduction in prisons. The Canadian Drug Policy Coalition and the Canadian HIV/AIDS Legal Network are also active on the international stage, working with partners at United Nations forums such as the Commission on Narcotic Drugs.

In Canada, the Pivot Legal Society is also a central player in promoting legislative change to support harm reduction and drug policy reform. Pivot is a legal advocacy project committed to using the law to address the root causes of poverty and social exclusion, and it has been centrally involved in a number of key court decisions in recent years,

United States Alliance of Drug User Unions

Drug user unions began to form in the USA during the early 1990s, and the drug user union movement has grown slowly since then, connected to the international drug user movement via the International Network of People who Use Drugs (INPUD).

In 2012, following a drug user pre-conference at the 9th National Harm Reduction Conference in Portland, Oregon, five US drug user unions held the first meeting of the American Federation of Drug Users (AFDU). The groups involved were the San Francisco Drug Users Union, VOCAL-NY, the New York Users’ Union, the Urban Survivors’ Union (Seattle) and the New England Users Union. At this meeting, each union nominated a representative to serve as a link person between AFDU and their member organisation. AFDU’s first formal gathering was held in 2013 in Denver at the Drug Policy Alliance Conference, where a decision was made to change the name of the group to the United States of America Drug Users Unions (USADUU).

USADUU is working to build a “national drug user peer-based organisation promoting drug user rights and health, de-stigmatisation and de-criminalisation across America”. Among its core objectives are “to unify and empower Drug User Unions across America to collaborate, thus providing a united platform giving a voice to American drug users to address the harm created by the war on drugs at both a national and international level” and “to present drug users and the drug user agenda as an organised, strong, and unified front against the war on drugs”.

At the 10th National Harm Reduction Conference in Baltimore in 2014, USADUU held a meeting with over 30 activists from across the country.

including the INSITE case in 2011, the SALOME case (described above), and a recent successful Supreme Court challenge to Canada's prostitution laws.

Drug user organising has grown significantly in the USA since last reported in *The Global State of Harm Reduction 2012*, with well-established networks and associations operating in New York (VOCAL, New York Users' Union), San Francisco (San Francisco Drug Users Union), Seattle (Urban Survivors' Union) and New England (New England Users Union). In 2012, these five unions came together to form a national umbrella coalition, the United States Alliance of Drug User Unions (see box below).

Organisations of people who use drugs operate in a number of cities and regions in Canada, including 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 people who use drugs are small and have minimal budgets. The Canadian Association of People who Use Drugs (CAPUD) acts as an umbrella for these organisations. Formed in 2010, CAPUD's work was reinvigorated by a national meeting of members in October 2013, and it has since formed alliances with other key national partners, including the Centre for Addictions Research of BC (CARBC), the Canadian Drug Policy Coalition, the Canadian HIV/AIDS Legal Network and the Canadian AIDS Society.

Funding: 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 going 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, comprised of AIDS United, Elton John AIDS Foundation, Levi Strauss Foundation, Open Society Foundations, Tides Foundation, Irene Diamond Fund (closed in 2011) and NASEN. A 2012 survey of 142 NSPs in the USA found total funding of \$19.4 million.⁽⁵⁾

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

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REGIONAL OVERVIEW

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| 2.7 | Oceania |
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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 ⁱ | HIV prevalence among people who inject drugs (%) | Hepatitis C (anti- HCV) prevalence among people who inject drugs (%) | Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%) | Harm reduction response | | |
|--|---|---|--|---|--|---|---|
| | | | | | NSP ⁱⁱ  | OST ⁱⁱⁱ  | DCR ⁱ  |
| Australia | 89,200 ⁽¹⁾ | 1.2 ⁽²⁾ | 54 ⁽²⁾ | 18.1 ⁽²⁾ | ✓(3,000+) (P) ^{iv} | ✓(2,025) ⁽³⁾ (B, M) | 1 |
| Fiji | nk | nk | nk | nk | x | x | |
| New Zealand | 12,840 ⁽⁴⁾ | 0.2 ⁽⁵⁾ | 50% ⁽⁶⁾ | nk | ✓(192+) (P) ⁽⁷⁾ | ✓ (B, M) | |
| Papua New Guinea | nk | nk | nk | nk | x | x | |
| Samoa | nk | nk | nk | nk | x | x | |
| Timor Leste | nk | nk | nk | nk | x | x | |

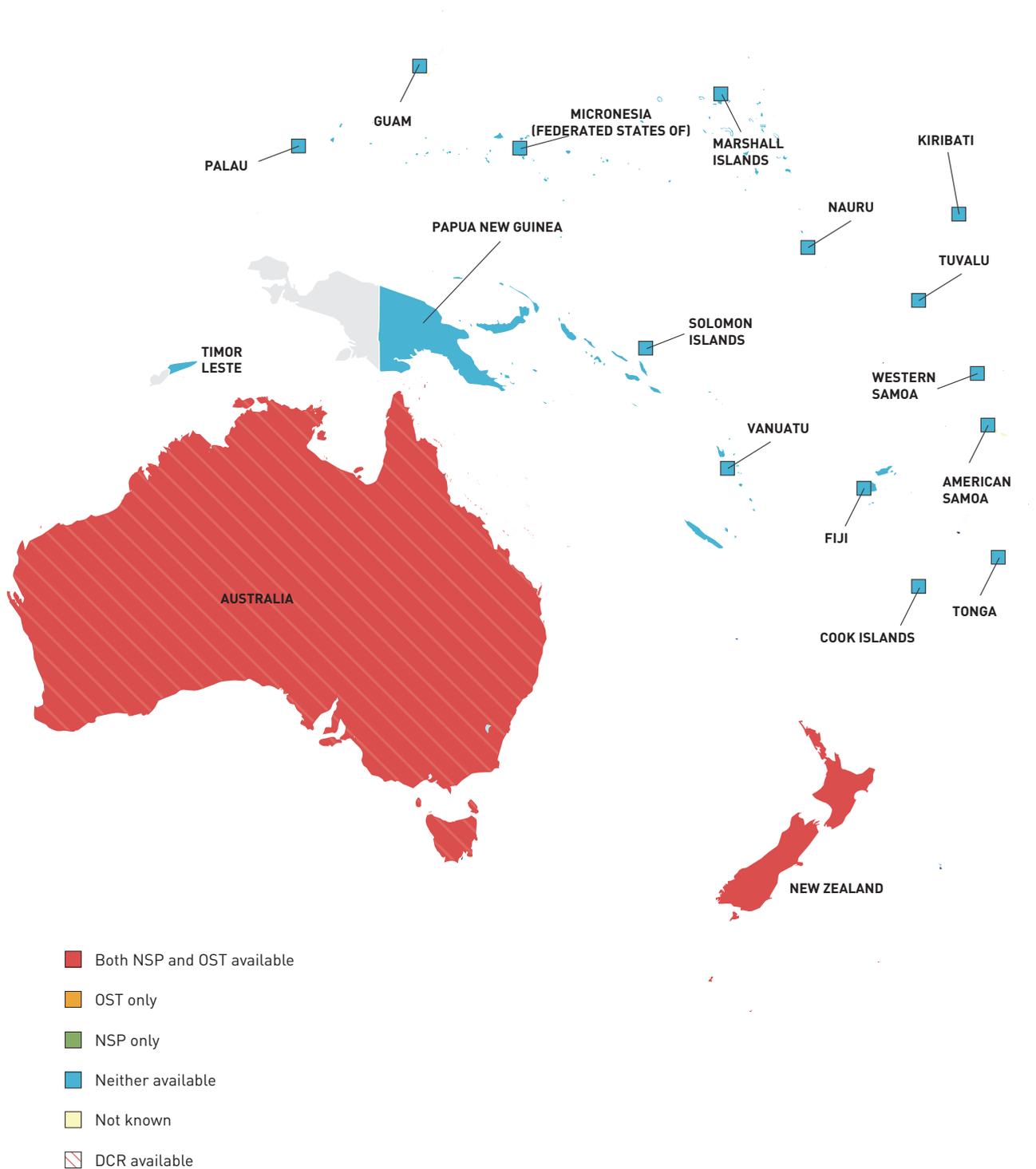
i DCR is a drug consumption room (please refer to chapter for details), also referred to as a safer injection facility.

ii This includes all operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers.

iii (M) = methadone, (B) = buprenorphine, (O) = any other form (including morphine and codeine).

iv (P) = needles and syringes reported to be available for purchase from pharmacies or other outlets.

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



Harm reduction in Oceania

The region of Oceania includes the Pacific Island countries and territories (PICTs).^v However, the regional prevalence of injecting drug use in countries other than Australia and New Zealand is unknown. Injecting drug use has been reported in the PICTs, but little research has been undertaken and no harm reduction programmes have been initiated.⁽⁶⁾ Approximately 102,040 people inject drugs in Australia and New Zealand combined,^(1,4) a decrease of approximately 70,000 on figures from 2012.⁽⁹⁾ HIV prevalence among them is relatively low (1.2%⁽²⁾ and 0.2%⁽⁵⁾ respectively). However, hepatitis C (HCV) rates have remained high, at 54%⁽²⁾ and 50%⁽⁶⁾ respectively.

Although harm reduction services in the form of needle and syringe programmes (NSPs) and opioid substitution therapy (OST) are available in both Australia and New Zealand, there is a disparity of provision and uptake among Aboriginal Australians and Torres Strait Islanders.^(10,11) This is illustrated through transmission rates among newly diagnosed HIV-positive Aboriginal people, with a far higher percentage reporting transmission through unsafe injecting drug use (13%) compared to non-Aboriginal people living with HIV (2%).⁽¹²⁾ Early implementation of harm reduction programmes in the 1980s has been widely credited with these low levels of HIV among injecting populations.⁽⁸⁾ However, there are still significant ethnic disparities and uneven coverage among affected groups.^(10, 13)

Civil society organisations report that while harm reduction services in Australia and New Zealand have been maintained, they have not been increased. Without additional scale up, and with cuts to current funding, this situation may destabilise the mechanisms that keep unsafe injecting and HIV infection rates low.^(10,13) In Australia, a key body for the alcohol and other drugs sector, the Drug Council of Australia, was defunded on 25 November 2013. Other groups, such as the Australian Injecting and Illicit Drug Users League (AIVL) and its member organisations representing people who use drugs, together with community organisations representing people living with HIV, have reported unstable funding projections for the future.⁽¹⁰⁾ The *Anex Bulletin*, a publication that supported the harm reduction workforce, has also been defunded.⁽¹¹⁾

Among the smaller islands of Oceania, HIV epidemics have remained limited.⁽¹⁴⁾ In Fiji, harmful drug use patterns and injecting drug use are reported, but there is little analysis or structural response to address the range of social- and health-related harms

documented.⁽¹⁵⁾ A rapid assessment of drug use in Papua New Guinea in 2005 found that high-potency cannabis was the main drug used.⁽¹⁶⁾ In 2012, two assessments were undertaken to explore injecting drug use, treatment, prevention and care, yet the extent and nature of injecting practices remain unclear.⁽¹⁷⁾ In Samoa, the use of hallucinogens is prominent among adolescents,⁽¹⁸⁾ and poly-drug use, particularly involving alcohol, cannabis, inhalants and amphetamine-type stimulants, can be more pervasive in the PICTs.⁽¹⁹⁾ There are presently no harm reduction services in the PICTs, with most approaches to drug use or poly-drug use being abstinence based.⁽¹⁹⁾ Further research into drug use in the PICTs needs to be undertaken.

Civil society organisations have noted a recent increase in use of amphetamine-type stimulants in both Australia and New Zealand.^(10,13) In one study looking at 15 years of HIV surveillance in Australia, 31% of people who inject drugs had recently injected methamphetamine (n=22,478), whereas 42% had recently injected heroin.⁽²⁰⁾ Another study between 2009 and 2013 showed a similar increase in methamphetamine injecting but a decrease in heroin.⁽²⁾ Further research on the use of drugs such as methamphetamine and sexual risk behaviours that have been associated with it⁽²¹⁾ should be undertaken to improve and adapt the harm reduction response.

Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

NSPs have a long history in Australia, with over 3,000 NSP outlets now in operation, including mobile outreach and vending machines.⁽⁸⁾ The low rate of HIV transmission among people who inject drugs has often been attributed to the early implementation and scale up of NSP services, which are government supported and publicly funded. However, since 2012 there has been no significant fiscal increase, meaning real funding for NSP services has decreased compared to inflation and increased cost of sterile injecting equipment.⁽¹⁰⁾ Although daily injecting decreased between 2009 and 2013 from a reported 50% of people who use drugs to 44%, there was an increase in the prevalence of injecting performance and image enhancing drugs (PIEDs) from 2% to 7% during the same time period.⁽²⁾ The number of PIEDs detected at the Australian border increased by 106% between 2009 and 2011,⁽²²⁾ indicating a need for

^v 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.

Australian NSPs to adapt their services to meet the needs of these populations.

Alongside Australia, New Zealand also has one of the highest NSP coverage rates in the world, annually distributing over 3 million clean needles to people who inject drugs,⁽²³⁾ and with 21 primary NSPs and approximately 170 pharmacies offering NSP services.⁽⁷⁾ In both countries, NSPs are the primary mode of accessing safe injecting equipment, according to epidemiological data. In New Zealand, as in Australia, the low rate of HIV infection among people who inject drugs has been attributed to the high number of NSP services available. However, also like Australia, coverage needs to be more comprehensive to ensure increased access and availability.^(10,13) Although in Australia the availability of secure dispensing units that provide sterile injecting equipment has increased since 2012, other models of NSPs have been scaled down. For example, the mobile NSP service in Victoria is no longer available 24 hours a day,⁽¹¹⁾ and there are increasing strains on funding.^(10,11)

In Australia, as previously noted, there is a disparity of service provision among indigenous communities, who have higher rates of HIV transmission through unsafe injecting drug use. Although there are some small-scale targeted services, such as dedicated peer-NSP workers, this can mean that in small communities a service provider from the same cultural background is likely to know the person accessing the service. Confidentiality issues can therefore reduce the desire for a person who injects drugs to seek out this service.⁽¹⁰⁾ A more concerted effort is needed to ensure greater provision and uptake by Aboriginal and Torres Strait Islander communities.

There is no NSP service provision in any of the PICTs. Injecting practices are thought to occur in

Timor Leste, although rates of HIV infection are unknown.⁽²⁴⁾ Research has been undertaken in Papua New Guinea but, as in Timor Leste, injecting practices are unclear.⁽¹⁷⁾ The response to drug use is based on abstinence-only interventions, and at present there are no plans to implement harm reduction services in these territories.

Opioid substitution therapy (OST)

In 2013, there were 2,025 outlets providing OST in Australia,⁽³⁾ a reduction of 107 outlets from 2012.⁽⁹⁾ The ratio of clients per OST prescriber has reduced from 26 in 2012 to 23 in 2013, and the growth in client numbers has also slowed in recent years.⁽³⁾ OST is mostly provided in the private sector (82%),⁽³⁾ with clients paying between AU\$14.70 and AU\$85 per week for medication,⁽²⁸⁾ with the average cost being AU\$35.⁽¹⁰⁾ This burden of cost can be extremely prohibitive for people who use drugs, and has yet to be addressed in the country.

Although OST provision is high in Australia, there has been little change since 2012.⁽¹⁰⁾ In New Zealand, current levels of OST provision are unclear, but in 2009 it was estimated that approximately 4,600 individuals were receiving OST, predominantly in methadone form.⁽²⁹⁾ The only forms of OST available in Australia are methadone and suboxone film. A few people in Australia are allowed to remain on subutex if their doctor agrees they cannot take suboxone for medical reasons. However, extra restrictions are often applied to subutex, such as no takeaway doses. Fewer takeaway doses are allowed for people on methadone than on suboxone in most Australian states.⁽¹⁰⁾

In both countries there are restrictions applied to OST provision, creating barriers for people who inject drugs, and service provision can be variable.^(10,13) In

Economic analysis: the value of needle and syringe programmes in Australia

Australia's approach to harm reduction in terms of NSP provision has long been credited with keeping rates of HIV low among people who inject drugs, and economic analysis has been undertaken to illustrate the cost-effectiveness of these programmes. It is estimated that between 2000 and 2009, 32,050 new HIV infections and 96,667 new HCV infections were directly averted through provision of NSP services,⁽²⁵⁾ reducing the incidence of HIV by 34–70%.⁽²⁶⁾

The figure attributed to healthcare costs saved is thought to be AU\$1.28 billion, with gross funding for NSP services costing \$243 million Australian dollars.⁽²⁵⁾ Based on these figures and the continued uptake of NSP services among people who inject drugs, the projected cost savings in terms of healthcare have been stated as AU\$340–950 million.⁽²⁶⁾ Although the figures are impressive, the average cost per person who injects drugs per occasion of service is AU\$199.96, which one study believed could be further reduced to \$93.32 Australian dollars if NSP clinics reached peak utilisation.⁽²⁷⁾

Maintaining levels of NSP funding will increase healthcare cost savings and gains in life years of the person who injects drugs.^(25,26) However, as has been noted by civil society organisations, there is some uncertainty as to whether funding pools for NSP services will remain stable.⁽¹⁰⁾

New Zealand, one of the main barriers to OST uptake is over-adherence to urine analysis, with people removed from OST treatment if their urine is found to contain illicit drugs⁽¹³⁾ – a theme also common in some Australian states too.⁽¹⁰⁾ There can also be up to a six-month wait in New Zealand to access an OST service.⁽³⁰⁾ However, it is the cost of prescriptions that is seen to be the primary factor deterring people who use drugs from turning to OST.⁽¹¹⁾

Currently, as with NSPs, there is no provision of OST in the PICTs.

Viral hepatitis

Although HIV rates among people who inject drugs in both Australia and New Zealand are low, HCV rates have remained high at 54%⁽²⁾ and 50%⁽⁶⁾ respectively, with one study undertaken in Sydney finding HCV rates as high as 62%.⁽²¹⁾ Although there is provision for HCV testing and treatment in both countries, the cost of treatment is a significant barrier in New Zealand.⁽¹³⁾ In Australia, HCV treatment is relatively affordable and available on a government pharmaceutical benefit scheme. Yet it is thought that only 1% of people living with HCV access treatment.⁽³¹⁾ As with HIV, HCV rates have also been shown to be notably higher among Aboriginal and Torres Strait Islander populations than non-Aboriginal people who inject drugs.⁽²⁵⁾ Less is known about hepatitis B in Australia, but it is estimated that approximately 50% of cases (n=207,000) are attributed to unsafe injecting drug use.⁽³²⁾

A further barrier in Australia is the waiting list for HCV treatment, which can be up to two to three years.⁽¹⁰⁾ There are also restrictions on where people who inject drugs can access these services, as they are often not tailored to key population groups.⁽¹⁰⁾ It has been noted that HCV government expenditure in Australia is inadequate, and represents less than 3% of harm reduction funding.⁽¹¹⁾ Furthermore, treatments have been linked to unpleasant side effects, meaning uptake can be low.

In New Zealand, it is thought that over 50,000 people have been exposed to HCV, many of whom contracted the virus through unsafe injecting drug use.⁽³⁰⁾ However, provision for testing and treatment remains extremely low, with a nurse specialising in HCV visiting only once a month in one area of New Zealand, and a GP testing for HCV closing down due to a lack of funding.⁽³⁰⁾ As can be seen from these data, there is strong evidence in both countries of the need for an urgent change in the way HCV is treated.

As is the case with HIV and injecting drug use, there is little to no data on hepatitis in the PICTs, and further research on this is needed.

Tuberculosis

Tuberculosis (TB) rates remain extremely low in both Australia and New Zealand, with between 5 and 6 cases per 100,000 people in Australia⁽³³⁾ and 10 cases per 100,000 people in New Zealand.⁽³⁴⁾

HIV is seen to be an insignificant contributor to TB in New Zealand,⁽²³⁾ and although it is covered to some extent in harm reduction policies,⁽¹³⁾ there is no evidence to suggest it is increasing among people who inject drugs. This finding is echoed in Australia, although there is little information on rates of TB infection among people who inject drugs both in the country and surrounding PICTs. However, TB is seen to be of increasing concern within the general population of Papua New Guinea.⁽⁸⁾

Antiretroviral therapy

The prevalence of HIV, like TB, among people who inject drugs, remains low in Australia and New Zealand, at 1.2%⁽²⁾ and 0.2%⁽⁵⁾ respectively. However, as stated previously, the proportion of Aboriginal people in Australia who have reported transmission of HIV through unsafe injecting drug use is 9% higher than non-Aboriginal people living with HIV who inject drugs.⁽¹²⁾

In New Zealand, 80% of people living with HIV are thought to be receiving antiretroviral therapy (ART).⁽²³⁾ There are thought to be 12,800 people receiving ART in Australia,⁽²⁾ although it is unclear how many of them inject drugs. Many PICTs provide access to ART, but again it is unclear how many of those who receive treatment also inject drugs, as there is little research available.

Harm reduction in prisons

Unsafe injecting practices have been widely reported in Australian prisons. In a recent study, it was shown that of 47,196 opioid-dependent people, 37% had experienced at least one episode of incarceration.⁽³⁵⁾ Approximately one in three people who inject drugs who were incarcerated reported injecting drug use in prison in all years between 2009 and 2013,⁽²⁾ and in a sample of 415 prison entrants who injected drugs, HCV was prevalent in 57.2%.⁽³⁶⁾ The prevalence of HCV has consistently been higher among respondents reporting imprisonment,⁽²⁾ highlighting an important need for harm reduction interventions in Australian prisons.

There are presently no NSP services available in prisons in either Australia or New Zealand. In one prison in Canberra, NSP funding had been provided by local government and a model had been agreed for its implementation. However, prison staff had signed a

workplace agreement that NSP services would not be implemented without their consent. Negotiations are currently ongoing with staff to assess the options for legally implementing an NSP.⁽¹⁰⁾

In Australia and New Zealand, OST, ART and condom provision are available in prisons in most states.^(10,13) There is little information on harm reduction interventions in the PICTs, but it has been reported that prisoners are not routinely screened on entry into prisons in Papua New Guinea for diseases such as TB and hepatitis.⁽¹⁷⁾

Overdose

There were 279 cases of heroin-related fatal overdose reported in Australia in 2013.⁽²⁾ Since 2012, Australia has implemented naloxone programmes on a pilot basis for people who use drugs in four states (Australian Capital Territory, Western Australia, Victoria and New South Wales), and evaluations of the peer-distribution programmes have so far shown a high degree of success.⁽¹⁰⁾ There are also models of naloxone distribution using primary healthcare workers in place.⁽¹¹⁾ However, both programmes face challenges in meeting demand.⁽¹¹⁾ Australia has a medically supervised injecting centre (also known as a DCR – please refer to Table 2.7.1), which provides sterile injecting equipment alongside a range of additional services for people who inject drugs. It has been found to significantly reduce calls to ambulance-attended opioid-related overdoses in the small area of Sydney where it is located.⁽³⁷⁾ In 2012, after more than ten years of positive evaluations, the centre has now been moved from a pilot programme to a legal entity.⁽¹⁰⁾

In New Zealand, no overdose prevention programmes exist in the form of naloxone distribution among peers. Instead, overdose prevention is handled through drug helplines and emergency services.⁽¹³⁾ In the PICTs, information on overdose and prevention is unknown.

Policy development for harm reduction

In Australia, one of the most important policy changes in recent years relates to HCV, with recognition that prevention, treatment and care provision varies for key populations, and recommendations on improving access for people who inject drugs, with particular emphasis on those within prison settings.⁽³⁸⁾ Within the 2014–2017 HCV strategy there are also recommendations for NSP services to become available in prison settings, and for further peer-led harm reduction programmes to operate among Aboriginal and Torres Strait Islander people due to a disproportionate prevalence of HIV and HCV in

these communities.⁽³⁸⁾ These policy changes are an important step towards recognising the impact of harm reduction programmes in the region, and understanding the shortcomings in Australia's approach to reducing HCV transmission among people who inject drugs.

People who inject drugs are mentioned as a priority group in Australia's national HIV strategy,⁽³⁹⁾ HCV strategy,⁽³⁸⁾ hepatitis B strategy⁽³²⁾ and Aboriginal and Torres Strait Islanders blood-borne viruses strategy.⁽⁴⁰⁾ Civil society is represented on committees working on drug strategies within the region.⁽¹⁰⁾

As detailed in *The Global State of Harm Reduction 2012*, the New Zealand Law Commission produced 144 recommendations for reforming the Misuse of Drugs Act 1975,⁽⁹⁾ and encouraged greater investment in harm reduction, education and addiction treatment, amendment of drug paraphernalia laws and decriminalisation of small amounts of drug possession.⁽⁴¹⁾

Within the PICTs, in countries such as Fiji, drug policy strategies are closely linked to mental health promotional activities,⁽⁴²⁾ and many responses to drug use have been law enforcement rather than harm reduction centred.⁽¹⁹⁾ As reported in 2012, a lack of research on injecting drug use in the region hampers policy reform.⁽⁹⁾

Civil society and advocacy developments for harm reduction

In Australia, civil society organisations continue to play a key role in the harm reduction response for people who inject and use drugs. One particular organisation, the Australian Injecting & Illicit Drug Users League (AIVL), has played an integral role in ensuring, through their involvement on government committees, that harm reduction and policy reform issues have been heard.⁽¹⁰⁾ AIVL is currently conducting research and programming on stigma and discrimination towards people who use drugs, and has developed a training module focusing on healthcare workers, social workers, university and other tertiary students, and other organisations with the potential to impact on the lives of people who use drugs.⁽¹⁰⁾

The New South Wales Users and AIDS Association (NUAA) has developed a book advocating for NSPs in prisons, incorporating interviews with people who have been imprisoned to inform their advocacy. The Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) has also been integral to advocacy for NSP services in a prison in Canberra.⁽¹⁰⁾ In addition, Australia has a national harm

reduction network, Anex,⁽⁴³⁾ established in 1995, that promotes evidence-informed policy and practice, particularly in relation to NSPs, and also a national advocacy organisation, Family and Friends for Drug Law Reform (FFDLR).⁽⁴⁴⁾

International Overdose Awareness Day, an annual initiative of the Pennington Institute in Australia, highlights the need for greater prevention awareness around the issue of drug overdose, alongside remembrance of those who have died. This event has grown since 2012 and is now known internationally.⁽¹¹⁾

In New Zealand, civil society organisations provide the majority of advocacy activities for people who inject drugs.⁽¹³⁾ In August 2013, the New Zealand Drug Foundation gathered together almost 100 people representing over 50 organisations to help reshape New Zealand's alcohol and drug policy. This culminated in the Wellington Declaration for better cooperation and collaboration between everyone affected by drugs and drug policy.⁽⁴⁵⁾

The Global State of Harm Reduction 2012 reported on the PICTs' more visible presence in civil society forums, but noted their lack of engagement in regional forums advocating harm reduction.⁽⁹⁾ Although the PICTs do have the Pacific Drug & Alcohol Research Network (PDARN), the last meeting was held in August 2011.⁽⁴⁶⁾ There has been a small increase in research in these territories, but further data gathering and advocacy should be undertaken regarding harm reduction approaches and drug use, particularly with the increase in amphetamine-type stimulants.

Funding: developments for harm reduction

Historically, financial support for harm reduction services, and organisations working with people who inject drugs, has been provided by the Australian federal government. However, support for non-governmental organisations and advisory boards has diminished since the recent change in government, destabilising the future of the harm reduction response. Furthermore, the department of foreign affairs and trade, which has now absorbed the Australian aid development programme, has recently received significant cuts to its aid budget.⁽¹⁰⁾

AIVL, the main representative of people who use drugs in Australia, has been given a six month extension of government funding for its programmes but has no guarantee of ongoing funding.⁽¹⁰⁾

International/multilateral funding also faces an uncertain future, with programmes such as the HIV/AIDS Asia Regional Program (HAARP) and the HIV Cooperation Programme for Indonesia (HCPI) now coming to an end, and nothing in place for their continuation.⁽¹⁰⁾ In a 2013 report by the National Alcohol and Drug Research Centre, it was found that actual spending on harm reduction has been greatly reduced in Australia,⁽⁴⁷⁾ a troubling fact considering its history and success in reducing the harms for people who inject drugs.

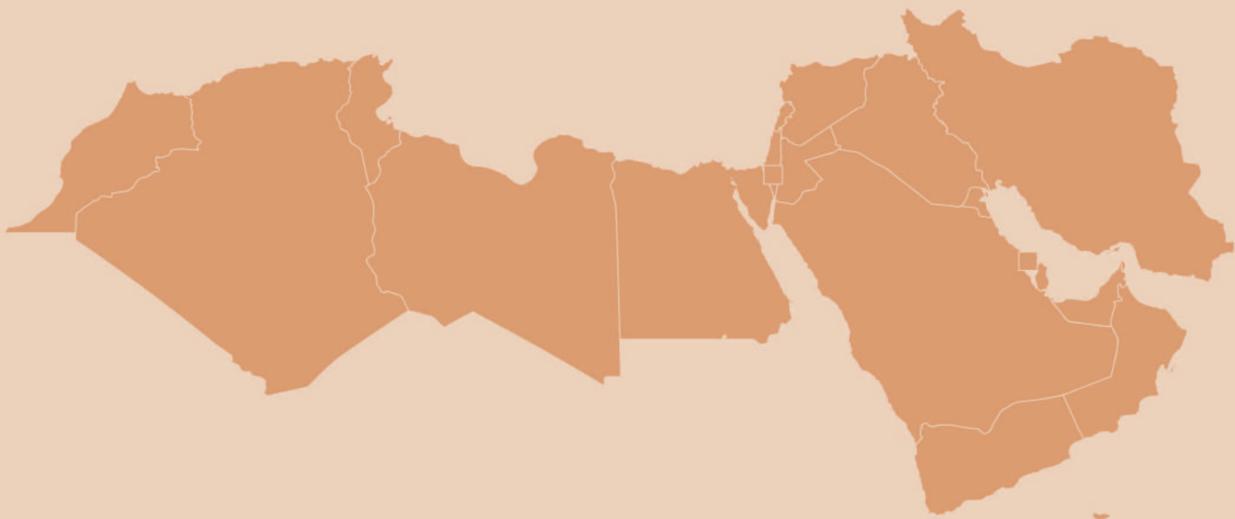
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REGIONAL OVERVIEW

2.8

Middle East and North Africa



Middle East and North Africa

Table 2.8.1: Epidemiology of HIV and viral hepatitis, and harm reduction in the Middle East and North Africa

| Country/ territory with reported injecting drug use | People who inject drugs | HIV prevalence among people who inject drugs (%) | Hepatitis C (anti- HCV) prevalence among people who inject drugs (%) ⁱ | Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%) ⁱⁱ | Harm reduction response | |
|---|----------------------------|---|---|--|---|--|
| | | | | | NSP ⁱⁱⁱ  | OST ^{iv}  |
| Algeria | nk | nk | nk | nk | x | x |
| Bahrain | nk | 55.8 ^{(1)v} | nk | nk | x | ✓(M) ^{vi} |
| Egypt | 100,000 ⁽²⁾ | 6.5–6.8 ⁽³⁾ | 49.4 (35.8–63) | 13.5 (10.9–16) | ✓(11) ^{(4)vii} | x |
| Iran | 185,000 ⁽⁵⁾ | 15.07 ⁽⁶⁾ | 50.2 (34.5–65.9) | 17.3 (3.7–30.9) | ✓(682) ^(4, 6) | ✓(4275) ⁽⁶⁾ |
| Iraq | 34,673 ^{(7)viii} | nk | nk | nk | x (P) | x |
| Israel | nk | nk | 67.6 | 2.8 (0.–5.5) | ✓(5) ⁽⁸⁾ | ✓(B.M) |
| Jordan | nk | 6 ⁽⁹⁾ | nk | nk | ✓(2) ^{(4)ix} | x |
| Kuwait | nk | nk | nk | nk | x | x |
| Lebanon | nk | 1 ⁽¹⁰⁾ | 52.8 ⁽¹¹⁾ | nk | ✓(2) ^{(4)x} | ✓ ^{xi} |
| Libya | 7,206 ^{(7)xii} | 87 ^{(12)xiii} | 94 ⁽¹²⁾ | 5 ⁽¹²⁾ | x | x |
| Morocco | 18,500 ^{(13)xiv} | 11.4 ⁽²⁾ | 51 ⁽¹⁴⁾ | nk | ✓(>8) ⁽¹⁵⁾ | ✓(6) ⁽¹⁵⁾ (M) |
| Oman | nk | 3.8 ^{(16)xv} | nk | nk | x | x |
| Palestine | nk | 0 ⁽³⁾ | nk | 1 ⁽¹⁷⁾ | ✓(1) ⁽¹⁸⁾ | x |
| Qatar | nk | nk | nk | nk | x | x |
| Saudi Arabia | 10,000 ⁽¹⁹⁾ | 3.5 ^{(20)xvi} | 49.8 (14.1–85.4) ⁽¹⁵⁾ | 18.5 ⁽¹⁷⁾ | x | x |
| Syria | 10,000 ⁽¹⁷⁾ | nk | 60.5 ⁽¹⁵⁾ | nk | x | x |
| Tunisia | 9,000 ⁽²⁾ | 3 ⁽²⁾ | nk | nk | ✓(3) ⁽⁸⁾ | x |
| United Arab Emirates (UAE) | nk | nk | nk | nk | x | ✓(M) ^{xvii} |
| Yemen | nk | nk | nk | nk | x | x |

i Unless otherwise stated, data is sourced from Nelson et al. (2011) *Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews*. *Lancet*, 378(9791) pp.571–83

ii Unless otherwise stated, data is sourced from Nelson PK, Mathers BM, Cowie B, Hagan H, Des Jarlais D, Horyniak D, et al. Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews. *Lancet*. 2011;378(9791):571–83.

iii This includes all operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers.

iv (M) = methadone, (B) = buprenorphine, (O) = any other form (including morphine and codeine).

v People who inject drugs are only reached through post-rehabilitation or prison programmes (n=244), which may not be representative of the total number of people who inject drugs.

vi Methadone is only available in rehabilitation facilities.

vii Figure does not relate to the number of sites but the 11 known organisations providing NSPs in Egypt.

viii Based on a literature review between 1998 and 2005.

ix Figure does not relate to the number of sites but the two known organisations providing NSPs in Jordan.

x Figure does not relate to the number of sites but the two known organisations providing NSPs in Lebanon.

xi OST only available in the ministry of health.

xii Based on a literature review between 1998 and 2005.

xiii Based on sub-national data in the city of Tripoli.

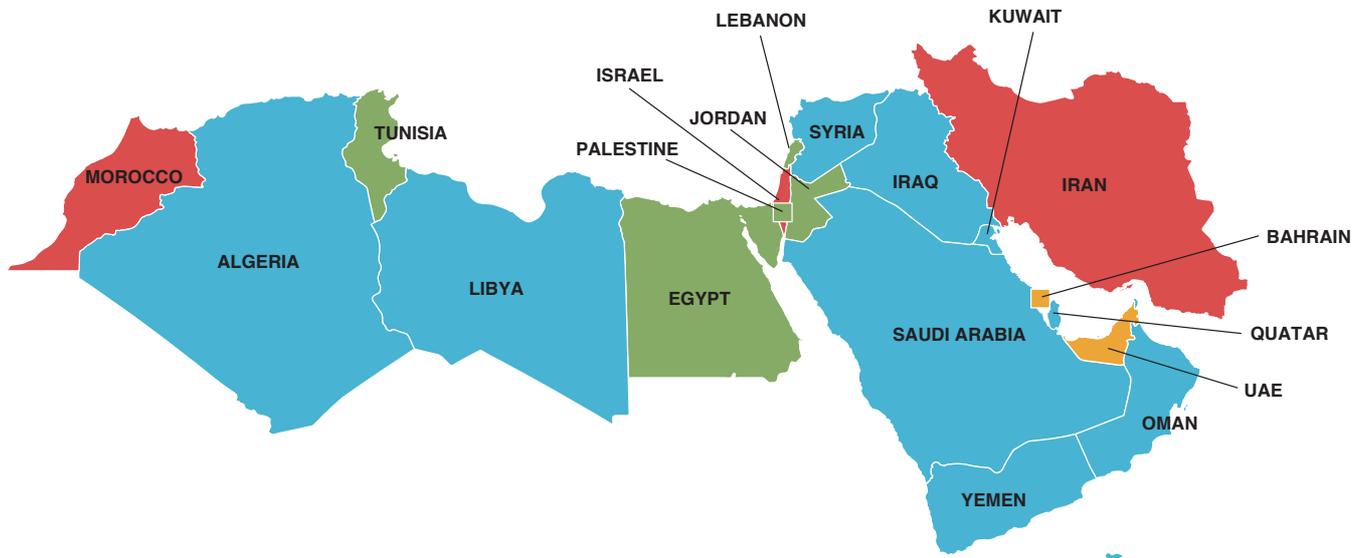
xiv This figure has been queried by civil society organisations as ranges vary from 5,000 to 18,500.

xv This figure has been queried by civil society organisations as there are great discrepancies in data published by other organisations.

xvi 2013 data from three detoxification centres in Riyadh, Jeddah and Daman, which may not be representative of the total number of people who inject drugs.

xvii Methadone is only available in rehabilitation facilities.

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 a region where HIV infections continue to rise.⁽²⁾ Within MENA, people who inject drugs, men who have sex with men and female sex workers are still the most affected groups in terms of HIV, hepatitis C (HCV) and hepatitis B (HBV) infection.⁽²⁾ Although the region has seen an increase in HIV research,⁽²¹⁾ there is still a lack of reliable size estimates for populations who inject drugs in most countries, and the availability of evidence remains weak.

An estimated 626,000 people inject drugs in MENA (range 335,000–1,635,000),⁽⁵⁾ with injecting drug use appearing as the primary mode of transmission of HIV in Bahrain,⁽¹⁾ Iran⁽⁶⁾ and Libya.⁽²²⁾ With 80% of the global opium production occurring in Afghanistan,⁽¹³⁾ and the price of heroin markedly lower than in other parts of the world,⁽¹³⁾ the geographical location of many of the surrounding territories means that injecting drug use remains high. In recognition of this, there have been significant policy developments and a scale up of harm reduction programmes since 2010, with the Middle East and North Africa Harm Reduction Association (MENAHR) being a central catalyst for increased government and civil society attention around the issue.

Although there is a high prevalence of people who inject drugs in the region, there are highly heterogeneous findings in terms of the distribution geographically in certain countries.⁽⁶⁾ For example, prevalence of drug use in Iran is the highest in the region at approximately 185,000.⁽⁵⁾ However, the figure is estimated to be 0% in some areas⁽²³⁾ and as high as 44.7% in others.⁽²⁴⁾ Libya has an extremely high rate of HIV attributed to unsafe injecting, but these figures relate only to Tripoli.⁽¹²⁾ In Morocco, many of the data relating to the prevalence of HIV among people who inject drugs is concentrated in the northern part of the country, with figures reaching 17.9%.⁽²⁵⁾ This is considerably higher than the national figure of 11.4%.⁽²⁾

The above evidence suggests that, although data gathering regarding injecting drug use and HIV/hepatitis surveillance in the region has greatly improved, there are still wide gaps in knowledge.⁽³⁾ There also appears to be a greater gender division in MENA countries than in other parts of the world, with the most common route of HIV among males (82%) in people who inject drugs in Iran, and 18.5% HIV transmission as the most common rate among men who inject drugs in Tunisia.⁽²⁶⁾ Again, this may not be representative of the whole region, but it is important to note in terms of tailored responses for women who may not be accessing services.

The sharing of needles and syringes is also highly variable within the MENA region. Although there is little information on injecting drug use in Palestine,

a bio-behavioural survey undertaken in 2010 found that among 199 people who inject drugs, 90.4% reported using sterile injecting equipment last time they injected⁽²⁷⁾ – a similar number to those in Iran, at 91.72%.⁽⁶⁾ These two countries appear in the top quartile in terms of safe injecting practices. However, in Morocco, a study undertaken in 2005 reported that 63.9% of people who inject drugs would share syringes,⁽²⁸⁾ and in Egypt only 45.5% of people who inject drugs reported using sterile injecting equipment in 2013.⁽²⁹⁾

There is currently limited data on people who inject drugs in Bahrain, with information from mandatory testing on admission to rehabilitation facilities in 2011 finding 4.6% HIV prevalence among people who inject drugs.⁽¹⁾ A survey of university students in 2006 found that 25% of a sample of 2,200 shared needles. However, there is no provision for needle and syringe programmes (NSPs) and opioid substitution therapy (OST) in the country, and current interventions for people who use drugs are abstinence based, with clean needles and syringes only available from pharmacies on prescription.⁽¹⁾ There is limited research done among key populations in Kuwait, Oman, Saudi Arabia, Syria, Yemen, Lebanon and Jordan.^(4,5) However, in places such as the Amman region in Jordan, unsafe injecting drug use is reported.⁽⁹⁾ Information from focus groups in Kuwait shows that unsafe injecting drug use is present,⁽³⁰⁾ and at the end of 2013 there was an estimated 3.8% rate of HIV prevalence among people who inject drugs in Oman.⁽¹⁶⁾ In the Daman district of Saudi Arabia, there was an estimated 3.5% rate of HIV prevalence among people who inject drugs.⁽²⁰⁾ With figures such as these emerging in MENA territories and no harm reduction interventions in place, it seems imperative that further research is undertaken alongside the scale up of harm reduction services to limit the transmission of viruses such as HIV and hepatitis.

There has been a steady increase in use of amphetamine-type stimulants (ATS) among people who use drugs noted in Iran.^(6,31) This is not only leading to health problems, but also negatively affecting the use of methadone for treatment among people who inject drugs (specifically heroin) by ameliorating some of the side effects such as psychological energy, sexual functioning and cognitive performance.⁽³¹⁾ In a study of prisoners in Iran undertaken in 2012/2013, it was found that 11.6% of prisoners had used ATS within the last month and 27.98% of those had injected.⁽⁶⁾ ATS seizures have also been reported in Jordan, Saudi Arabia, Lebanon and Syria,^(4, 13) indicating a need for further mapping and research to understand ATS use and appropriate responses to it.

Developments in harm reduction implementation

Needle and syringe exchange programmes (NSPs)

Iran has consistently experienced the highest rate of HIV prevalence in the region,^(32,33) and prevalence rates remain high in 2014.⁽⁶⁾ Although clean needle and syringe provision has doubled since 2012 (from 6,022,834 in 2012 to 12,626,021 in 2014), funding for harm reduction activities seems to have slowed down,^(4,6) which appears contradictory to coverage reports. In 2012, *The Global State of Harm Reduction* reported that coverage of needle and syringes was between 26 and 35 per person who injects drugs per year.⁽⁶⁾ This has since increased to between 55 and 77.⁽⁶⁾ This evidence therefore contradicts the steady increase in rates of HIV among people who inject drugs. Unless other factors are at play that have not been identified, such as sexual risk behaviours or an increase in refugees who inject drugs unsafely, it is difficult to ascertain the facts about infection rates among this population in Iran.

There has been no change in the number of countries providing NSP services in MENA since 2012.⁽³²⁾ Although a previous pilot NSP in Oman is no longer operating, MENAHRA initiated a pilot NSP and condom distribution service in the Jarash area of Jordan through Friends of Development and Investment Society (FDIS) in 2012. This pilot has since expanded to areas outside of the main city, as well as in Amman and other surrounding areas during 2014 through the Forearms of Change Center to Enable Community.⁽⁴⁾ In 2012, MENAHRA provided a four-month grant to the Association of Friends of HIV+ (FHIV+), an Egyptian organisation in the Minya governorate. During this period, the organisation distributed 5,995 clean needles and syringes.⁽⁴⁾ Funding in Egypt was then halted for two years while the volatile situation in the country interrupted service delivery. Then in August 2014, FHIV+ and two other organisations were funded through MENAHRA to implement NSP distribution outreach activities in the governorate of Minya and in greater Cairo.⁽⁴⁾

In early 2012, plans were underway to operate a pilot NSP service in Syria, with funding through the Global Fund,⁽³²⁾ but this has been postponed due to the security situation in the country.⁽⁴⁾ There is little published data on Lebanon, but NSP services are thought to be in operation,⁽³²⁾ with reports from Soins Infirmiers et Développement Communautaire (SIDC), a non-governmental organisation (NGO) in Lebanon providing this service, indicating that coverage was extremely low, at approximately 1.6 clean syringes per person per year.⁽⁸⁾ Between 2012

and 2014, two organisations in Lebanon, SIDC and Skoun, distributed over 16,000 syringes to people who inject drugs.⁽⁴⁾ In Tunisia, there are three NSP sites in operation, with 142 people who inject drugs accessing the service and 3,944 clean syringes distributed during a six-month period in 2013.⁽⁴⁾ NSP services also operate in Morocco,⁽³⁴⁾ Israel and Palestine, but there is limited information on these programmes. In one study of 211 people who inject drugs in Morocco, it was found that 85.2% of them shared needles and syringes,⁽³⁴⁾ highlighting the need for scale up of NSP provision.

Although the primary mode of HIV transmission in Bahrain is unsafe injecting drug use, there is no NSP provision in the country.⁽¹⁾ People who inject drugs in Bahrain are reached through post-rehabilitation or prison programmes, and the services offered are abstinence based.⁽¹⁾ In Kuwait, the rate of sharing of needles and syringes is thought to be high. However, the only services available for people who inject drugs are detoxification and rehabilitation at the Addiction and Psychiatric Hospital, which is insufficient compared to need.⁽³⁰⁾ In Qatar, according to government figures, only 18 cases of HIV have been reported among the whole population.⁽³⁵⁾ In Saudi Arabia, there is evidence of injecting drug use but there are no NSPs in operation in the country. The same is true of the United Arab Emirates, Algeria, Yemen, Iraq and Kuwait.

Barriers to accessing NSP services in countries where there is availability are similar to those found in other regions, with low coverage in rural areas, cultural stigma related to injecting drug use (particularly experienced by women who inject drugs), and a fear of arrest due to punitive laws.⁽⁴⁾

Opioid substitution therapy (OST)

Six MENA countries provide OST to different degrees: Bahrain, Iran, Israel, Lebanon, Morocco and United Arab Emirates. In some countries such as Bahrain⁽¹⁾ and the United Arab Emirates,⁽³⁶⁾ OST is only available through detoxification and rehabilitation facilities, with people who inject drugs being reached through post-rehabilitation or prison programmes. In other countries, OST provision is not based on punitive measures or rehabilitative/detoxification programmes. The best example of this is Iran, where OST is offered to people who inject drugs in 4,275 centres, 4,038 of which are privately operated.^(4,6) This represents an increase of 902 sites since 2012.⁽³²⁾ However, there remains a need to expand OST services to meet increasing demand within the country, and to find a solution to the shortage of financial and human resources for OST provision.⁽⁴⁾

In Lebanon, multiple OST services have been funded by MENAHRA since 2012 and provided through Skoun and SIDC. Since 2012, Lebanon has included OST provision for people who inject drugs within its national strategic plan, with the service dispensed by the ministry of health. There are currently over 1,000 people who inject drugs receiving OST in the form of Buprenorphine in Lebanon.^(4,37) There is limited information on OST programmes in Israel. In Morocco, there are six OST sites operational⁽¹⁵⁾ accessed by approximately 300 people who inject drugs. Since over 1,000 requests have been made,⁽³⁸⁾ a further three OST sites are planned in the country in response.⁽¹⁵⁾ Kuwait is due to begin a pilot OST service in 2014,^(4,30) and government permission has been given to begin a pilot OST service in Oman.⁽¹⁶⁾

In 2014, the United Nations Office on Drugs and Crime (UNODC) convened a national opioid substitution therapy taskforce, commissioning a feasibility study to select, approve and procure the most appropriate controlled substances for piloting OST in Egypt. In preparation for introducing this service to people who inject drugs, training of service providers across six governorates in Egypt has been initiated.⁽²⁹⁾

Although bio-behavioural surveillance of people who inject drugs has improved in the MENA region, actual coverage estimates for OST provision are still difficult to ascertain. Iran is the only exception to this, with an estimated 64,000 people receiving OST.⁽⁶⁾ Barriers to accessing OST services remain throughout the region, with fear, stigma and discrimination surrounding people who use drugs, together with criminalisation by governments.^(4,38) To combat some of the stigma that women who inject drugs may encounter, five pilot centres were established in Iran in 2007 offering the management of sexually transmitted infections (STIs), psychological counselling and harm reduction services, provided by female staff.⁽³⁹⁾ A follow-up study six months later found that those using the service had responded well and showed a reduction in HIV risk behaviour.⁽⁴⁰⁾ Although it was reported that the female-specific programmes had been expanded to 27 sites in 2012,⁽³²⁾ it is not known whether they are still in existence.

Viral hepatitis

There is little data on the prevalence of viral hepatitis, either HCV or HBV, among people who inject drugs in MENA. The figures in Table 2.8.1 date from estimates taken in 2008, with some estimates dating back to 1988/89 (e.g. Israel).⁽¹⁷⁾ Morocco has the most up-to-date HCV estimate from a study undertaken in 2010, but is based on sub-regional data in northern Morocco only.⁽¹⁴⁾ The eight countries that do have

available data, although unlikely to be representative of present rates of infection among people who inject drugs, had HCV prevalence close to 40% and above. The majority of countries in the region have a viral hepatitis policy, with the exception of Algeria, Libya and Yemen. However, only Bahrain, Kuwait and Iran specifically mention services targeted at people who inject drugs.^(4,38,41)

In the United Arab Emirates, 44% of people who inject drugs who were admitted to the national rehabilitation centre tested positive for HCV,⁽⁴²⁾ and data from the two main drug treatment centres in Jordan showed prevalence rates among people who use drugs at 5.4% for HCV and 0.6% for HCB.⁽⁹⁾ In the East Jerusalem governorate region of Palestine, a biological behavioural survey in 2010 among 199 people who inject drugs found that 40.3% tested positive for HCV.⁽²⁷⁾ However, treatment availability for people who inject drugs in these countries remains unclear. Bahrain, Egypt, Iraq, Jordan, Kuwait, Lebanon, Qatar and Syria do have publicly funded HCV treatment.⁽⁴⁾ A treatment clinic for HCV has been recently introduced at the Mubarak hospital in Kuwait,⁽³⁰⁾ but whether it can be accessed by people who inject drugs is unknown.

HCV diagnosis and treatment is a significant issue for people who inject drugs in Egypt.⁽⁴³⁾ However, with an estimated 10% of the population living with the disease (8–10 million people), and unsafe injecting practices among people who use drugs contributing to increasing numbers, WHO launched a new global injection safety initiative in December 2014.⁽⁴⁴⁾ Together with provision of new, affordable treatment, the initiative will hopefully have an impact on hepatitis rates for people who inject drugs in the region. However, an urgent need remains for data on viral hepatitis among people who inject drugs in the MENA region.

Tuberculosis

Like hepatitis, there is very little data on tuberculosis (TB) among people who inject drugs in MENA. As far as we are aware, only one recent study has been undertaken in the region looking at the burden of HIV among TB patients since 2007, finding a 3.8% rate of HIV co-infection among 3,133 patients in Iran and 1.6% HIV co-infection in Yemen.⁽²⁶⁾ In 2011, data from Libya indicated 731 new TB cases, 128 of which included HIV co-infection. In 2010, approximately 14,000 people were affected by TB, but it is not known what proportion of these cases is attributable to unsafe injecting drug use.⁽⁸⁾

According to UNAIDS 2011 Universal Access Reporting, coverage of treatment for people with TB/HIV co-infection in MENA ranges from less than 10%

in five countries, to between 25% and 55% in another four, to nearly full coverage in Oman and Algeria.⁽²⁵⁾ There is believed to be routine testing of TB in Algeria and Syria, and TB screening for people living with HIV in Bahrain, Egypt, Iran, Jordan, Morocco, Oman, Saudi Arabia and the United Arab Emirates,⁽⁴⁾ but there is little evidence on TB testing and treatment services tailored for people who inject drugs. Further data is needed on the levels of TB among people who inject drugs in MENA to assist with developing an appropriate harm reduction response that is integrated into existing services.

Antiretroviral therapy (ART)

Data on HIV prevalence, testing and antiretroviral therapy (ART) in the region is mostly based on detoxification centres, police registers and prison records. As a result, available figures in many MENA countries tend to be underestimates or susceptible to reporting bias. ART provision has not increased,⁽²⁾ despite a steady rate of HIV among people who inject drugs within the region. There are currently an estimated 19,424 adults receiving ART,⁽²⁾ although rates of ART provision among people who inject drugs is unknown.

Coupled with this is the relative lack of information on HIV prevalence among people who inject drugs. In Egypt in 2010, 6.8% of people who inject drugs in Cairo were found to have contracted HIV, and 6.5% in Alexandria were HIV infected. Lower rates of 2.4% HIV prevalence among people who inject drugs were observed in Tunisia in 2011 (0–2.7%), while surveys undertaken in Jordan, Lebanon and Palestine found no HIV cases among people who inject drugs.⁽²⁶⁾ In Morocco, people who inject drugs were thought to contribute to 7% of new HIV infections.⁽⁴⁵⁾ In Egypt 1,171 people were receiving ART in 2013,⁽²⁹⁾ but it is not known how many of them were injecting. In Kuwait, people who inject drugs are only tested for HIV when arrested or admitted to the addiction and psychiatric hospital, and an HIV diagnosis often does not result in counselling in these services.⁽³⁰⁾ In Oman, there are 15 sites at which people can access ART treatment, with an estimated 821 people receiving ART in 2013.⁽¹⁶⁾ In Lebanon, ART is not available for people who inject drugs unless they are on OST.⁽⁴⁾

Voluntary counselling and testing (VCT) is available in several MENA countries. However, most of these services do not specifically target people who inject drugs. In Algeria, 68,779 individuals were tested for HIV in 2013, but the proportion who were injecting drugs is unknown.⁽⁴⁾ In Lebanon, VCT is available through a mobile unit of the organisation SIDC, as well as 60 VCT centres around the country run by NGOs.⁽⁴⁾ VCT is also available in Egypt, and 29% of

newly reported cases of HIV in 2012 were found to be among people who inject drugs.⁽⁴⁶⁾ In Jordan, VCT is available and there are plans to offer this service within the newly implemented NSP service.⁽⁴⁾ In Morocco, VCT uptake has increased from 70 in 2010 to 385 in 2013, although VCT coverage for people who inject drugs remains limited.⁽⁴⁾

Like NSP and OST provision, even where ART or VCT services are available, people who inject drugs often face barriers to accessing them, such as a fear of breach of confidentiality and stigma related to drug use.

Harm reduction in prisons

Punitive drug laws in much of the MENA region means a high proportion of people who use drugs are incarcerated. However, information on injecting drug use among the prison population is limited. In 2005, a study found that 45.9% of people who inject drugs had a history of incarceration for drug use, and 19.8% had unsafely injected drugs while in prison.⁽²⁸⁾ In 2010, Iran reported HIV prevalence among people imprisoned for injecting drug use as 5.42%,⁽⁶⁾ yet it is the only country in the region that has an NSP service available.⁽⁴⁷⁾ It is also the only country that provides OST in prisons, with 40,000 prisoners receiving access.⁽⁶⁾ However, since an estimated 120,000 need OST, an expansion of this service is required in Iranian prisons.⁽⁶⁾ In Morocco, an OST pilot programme was initiated in one prison in 2013,⁽¹⁵⁾ and in Lebanon there are plans to initiate OST services in the prison setting^(4,10,48)

In Egypt between 2009 and 2012, a Drosos Foundation-funded project, in collaboration with the Egyptian ministries of interior affairs, health and social affairs, launched four VCT sites inside four Egyptian prisons as part a call to improve HIV prevention among prison populations.⁽⁴⁾ However, generally within the region, access to ART provision varies greatly. In Algeria, although there is testing and treatment for STIs in prisons, there is no specific mention of ART.⁽⁴⁹⁾ In Bahrain, eligible prisoners are provided with ART through a link to a central hospital,⁽¹⁾ and there is ART provision for the prison population in Jordan,⁽⁹⁾ Iran⁽⁶⁾ and Lebanon.⁽¹⁰⁾ Although ART is available in Kuwait, Oman, the United Arab Emirates and Yemen, it is uncertain whether prisoners have access to treatment. Libya also provides ART, but due to the volatile situation in the country, supplies are thought to be limited for the general population, indicating that vulnerable populations may not have access to ART.⁽⁴⁾ In terms of condom provision, as far as we are aware only Algeria and Iran supply condoms within the prison setting.^(6,49)

Overdose

Data on the occurrence of fatal and non-fatal overdose remain extremely limited in the region, and responses to overdose limited. Naloxone, a highly effective opioid antagonist that reverses the effect of overdose, is not available for peer distribution in the community in any of the MENA countries. However, isolated initiatives addressing overdose as part of broader interventions have been documented in some instances.

Policy development for harm reduction

Although monitoring of injecting drug use has improved marginally in the region, many MENA countries still make no explicit mention of harm reduction in their national strategies. Algeria's national strategic plan does not refer to harm reduction,⁽⁴⁹⁾ and it is also absent from Bahrain's national strategy.

⁽¹⁾ In Oman and Kuwait, there is also presently no mention of harm reduction, but there are plans to revise these documents to include key populations, including people who inject drugs.⁽⁴⁾ In Jordan⁽⁹⁾ and Saudi Arabia,⁽²⁰⁾ the need to strengthen HIV prevention for key populations at high risk is acknowledged but people who inject drugs are not. However, Egypt,⁽²⁹⁾ Iran,⁽⁶⁾ Morocco, Syria and Tunisia all refer to harm reduction in their national strategic plans.⁽⁵⁾

In November 2012, a technical meeting to develop an Arab AIDS strategy took place in Riyadh. The meeting was organised by the League of Arab States in coordination with UNAIDS, and served as a technical forum for facilitating the development and implementation of the strategy. The Council of Arab Ministers of Health endorsed the Arab AIDS Strategy (2014–2020) during its session at the League of Arab States.⁽⁵⁰⁾ The strategy acknowledges people who inject drugs, and urges the need to scale up HIV testing and harm reduction programmes as part of an integrated package of services for people who inject drugs.

In 2013, UNODC and partners selected 24 high-priority countries where more concentrated efforts will be focused on HIV prevention, including people who inject drugs and other key population groups.⁽⁵¹⁾ This initiative will affect three of the most-affected MENA countries – Iran, Egypt and Morocco – and hopefully will improve harm reduction efforts. In 2012, a regional technical committee on harm reduction was formed to enhance coordination among key actors working on the topic and/or engaging with people who inject drugs. The committee was led by MENAHRA and includes WHO, UNODC and UNAIDS representatives as core members.⁽⁴⁾

Harm reduction and the Regional Religious Leaders Group

In December 2012, a regional advocacy meeting on harm reduction was held for religious leaders. Eighteen participants attended, representing different religions and sects from Lebanon, Syria, Jordan, Egypt, Tunisia, Morocco and Bahrain. It was an important move forward for harm reduction in the region, as religious leaders can be important stakeholders. In addition to advocating with policymakers and government officials, advocating with religious leaders to promote acceptance of harm reduction programmes is often central to increasing tolerance of harm reduction. The religious leaders who attended had previous experience of HIV and AIDS, and most were part of the CHAHAMA network (Arab Religious Leaders Network Responding to AIDS). As a result of this meeting, participants formed a group on harm reduction and issued a declaration on the rights of people who use drugs and on harm reduction.⁽⁵²⁾ The group are presently preparing a manual, Harm Reduction for Religious Leaders, which will be completed by the end of 2014.

Civil society and advocacy developments for harm reduction

Civil society organisations in MENA have consistently played an active role in advocating and implementing harm reduction approaches. In November 2013, MENAHRA held its 2nd Regional Conference on Harm Reduction in Beirut. Hosted by the Lebanese ministry of public health, the three-day event brought together over 224 delegates from 24 countries to discuss, debate and advocate for harm reduction policies and practices. During the conference, delegates shared findings, achievements and challenges to harm reduction in MENA. A pre-conference donors' meeting highlighted MENA's harm reduction needs, ensuring that the region remains an integral part of donors' agendas. A film festival also took place over two days, during which 14 films and documentaries illustrated harm reduction issues in the region.⁽⁴⁾

MENA also has a Middle East and North Africa Network of People who Use Drugs (MENAPUD), formed at the International Harm Reduction Association's Conference in Beirut in 2011. Lacking a coordinating body, this network of people who use drugs, or who previously used drugs, at first had relatively low levels of engagement.

Then in March 2014 funds were secured by MENAHRA to appoint a coordinator and re-activate the network. Since April 2014, MENAPUD members and the coordinator have been working, with MENAHRA's support, on structuring the network through capacity-building and mentorship. In addition, the group has been involved in a number of activities to increase the representation and participation of the community of people who use drugs within the region, such as a graffiti event in Beirut.⁽⁴⁾

In February 2014, the Second Regional Consultative Meeting towards Networking of Drug Demand and Harm Reduction NGOs was held in Tehran. Multiple regional and international organisations were in attendance to help draft the network's constitution. Presentations and plenaries took place, and harm reduction, networking and advocacy issues were discussed. At the end of the meeting, the proposed constitution was approved by members and Iran was designated the network's secretariat.⁽⁵³⁾

MENAHRA also became a primary recipient of a Global Fund Round 10 grant to advocate for a conducive environment for implementing harm reduction activities, advocacy and capacity-building work in 13 MENA countries. At the end of 2013, MENAHRA underwent a round of negotiations for Phase 2 of the grant, receiving approval to initiate activities for the following three years (2014–2016).⁽⁴⁾

In 2013, Drosos funded the Network of Associations for Harm Reduction (NAHR) in Egypt, a coalition of civil society organisations and stakeholders supportive of and dedicated to harm reduction initiatives. Its aim is to strengthen collaborations among civil society organisations to improve implementation of harm reduction activities, as well as reduce stigma and discrimination experienced by key populations.⁽⁵⁴⁾

Funding: developments for harm reduction

The Global Fund is one of the most significant contributors to the funding of harm reduction in MENA. Aside from Iran, where almost 95% of OST services are provided by the private sector and civil society organisations,⁽⁴⁾ funding for harm reduction services in Morocco, Lebanon, Jordan, Egypt and Tunisia stems from MENAHRA during Phase 1 of the Global Fund grant, extended through negotiating for Phase 2 funding from the New Funding Model.⁽⁴⁾ With the Global Fund's support, advocacy and scoping missions have also been funded. In 2012, two advocacy missions were conducted in Oman and Jordan, and in 2013 two advocacy missions were conducted in Egypt and Libya. However, Jordan has recently been classified as ineligible for Global Fund grants because of its status as a middle-income country, and alternative donors must be sought.

The Global Fund, through MENAHRA, has funded knowledge hubs in Morocco and Lebanon, delivering multiple trainings on advocacy. There is also a knowledge hub in Iran called KH-INCAS, although there have been issues relating to the receipt of funds due to international sanctions placed on Iran.⁽⁴⁾ The regional Global Fund grant (Round 10) managed by MENAHRA ends in 2016. As the major source of funding for harm reduction services in a number of MENA countries, an alternative is urgently needed to ensure that services continue and that pilots begin in countries where no services exist.⁽⁴⁾ Drosos funding for NAHR in Egypt ends in 2017, and again, alternative funding must be secured before the grant ends so as to not adversely affect the harm reduction initiatives underway in the country.

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REGIONAL OVERVIEW

2.9

Sub-Saharan Africa



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 | People who inject drugs | HIV prevalence among people who inject drugs (%) | Hepatitis C (anti- HCV) prevalence among people who inject drugs (%) | Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%) | Harm reduction response | |
|---|----------------------------|---|--|--|---|--|
| | | | | | NSP ⁱ  | OST ⁱⁱ  |
| Burkina Faso | nk | nk | nk | nk | x | ✓ ⁽¹⁾ |
| Côte D'Ivoire | nk | nk | nk | nk | x | x |
| Djibouti | nk | nk | nk | nk | x | x |
| Gabon | nk | nk | nk | nk | x | x |
| Ghana | nk | nk | nk | nk | x | x |
| Kenya | 18,327 ⁽²⁾ | 18 ⁽²⁾ | 51.4 (42.2–60.6) ⁽³⁾ | 6.4 ⁽³⁾ | ✓(10) ⁽²²⁾ | x |
| Malawi | nk | nk | nk | nk | x | x |
| Mauritius | 10,000 ⁽⁴⁾ | 44.3 ⁽⁴⁾ | 97.3 ⁽⁵⁾ | 9 ⁽³⁾ | ✓(52) ⁽⁴⁾ | ✓(16) (M, O) |
| Nigeria | 11,692 | 4.2 ⁽⁶⁾ | nk | nk | x | x |
| Senegal | 1,324 ⁽⁷⁾ iii | 9.1 ⁽⁸⁾ | nk | nk | ✓(1) | x |
| Seychelles | 345 ⁽⁹⁾ | 5.8 ⁽⁹⁾ | 53.5 ⁽⁹⁾ | 0.1 ⁽⁹⁾ | x | ✓ ⁽⁹⁾ |
| Sierra Leone | nk | nk | nk | nk | x | x |
| South Africa | 67,000 ⁽¹⁰⁾ | 19.4 ⁽¹⁰⁾ | nk | nk | ✓(1) ^{iv} | ✓(M, B) ^v |
| Tanzania | 30,000 ⁽¹¹⁾ | 33.9 ⁽¹¹⁾ | 28 ⁽¹¹⁾ | nk | ✓(7) | ✓(3) (M, O) |
| Uganda | nk | 16.7 ⁽¹²⁾ vi | nk | nk | x | x |
| Zambia | nk | nk | nk | nk | x | x |

i This includes all operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers.

ii (M) = methadone, (B) = buprenorphine, (O) = any other form (including morphine and codeine).

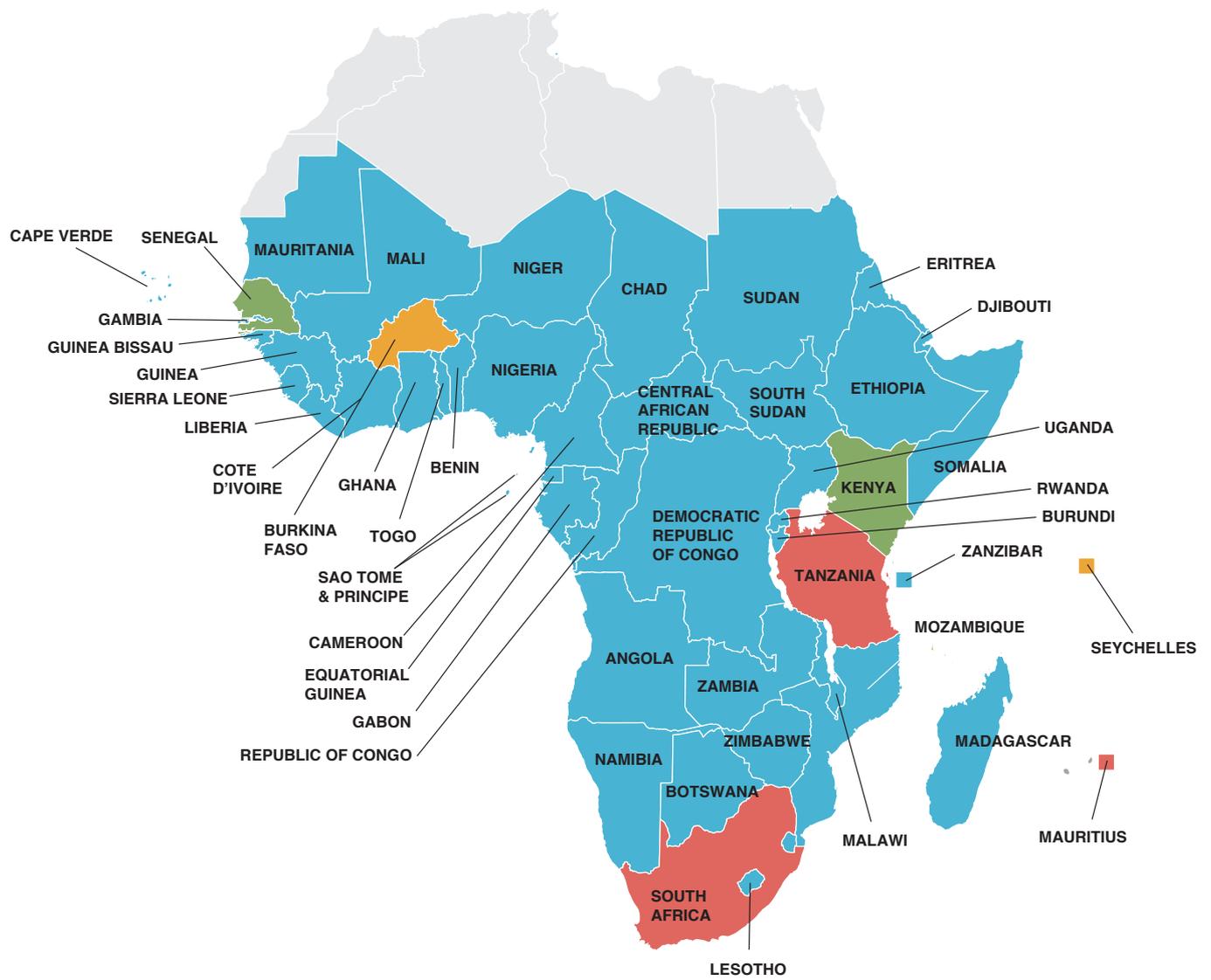
iii This is based on sub-national data from the Dakar region.

iv This is a small-scale community-based outreach programme delivering needles and syringes.

v In the Western Cape there is one government-funded OST demonstration project, but as both private and public clinics provide OST we are unable to cite an actual figure.

vi Based on a study conducted in Kampala in 2012 with a sample of 54 people who inject drugs.

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

An estimated 23.5 million people are living with HIV in sub-Saharan Africa, representing 69% of the global HIV burden.⁽¹³⁾ In 2012, 75% of all new HIV infections globally occurred in the region.⁽¹⁴⁾ Although reliable information on injecting drug use in sub-Saharan Africa is very limited, estimates suggest that there may be 1,020,000 people who inject drugs, with an extremely wide range of between 300,000 and 6,240,000,⁽¹⁵⁾ of which 5 to 10% are thought to be living with HIV.⁽¹⁴⁾

There is some understanding of HIV prevalence among people who inject drugs in certain countries in sub-Saharan Africa. However, due to the different methods of calculating prevalence, and figures often stemming from sub-national data, the numbers cited should be viewed with caution. The reported prevalence of HIV among people who inject drugs in Tanzania in 2012 was 42%,⁽¹⁰⁾ which has since dropped to an estimated 33.9%.⁽¹¹⁾ Research in Kampala, Uganda, found 16.7% HIV prevalence among people who inject drugs.

⁽¹²⁾ This is believed to be the first study of its kind to map prevalence among key populations in Uganda, producing a pledge from government to prioritise innovative approaches for people who inject drugs.⁽¹²⁾ In Senegal, HIV prevalence among people who inject drugs is approximately 9.1%.⁽⁶⁾ It has recently been reported that a small-scale community-based needle and syringe programme (NSP) has been initiated,⁽¹⁶⁾ which is the only government-run harm reduction programme in West Africa.⁽⁶⁾

Although services are generally lacking, the initiation of research and emerging harm reduction policies are positive steps forward, particularly in light of the documentation of high-risk injecting practices, including that of flashblood^{vii} occurring in Tanzania and Zanzibar.⁽¹⁷⁾ Moreover, because of the geographical location of countries such as Tanzania and Zanzibar along key transit points for the trafficking of heroin, cocaine and other drugs, there is increased availability of these drugs in this part of the region.⁽¹⁸⁾ South Africa has also seen a marked increase in stimulant use⁽¹⁹⁾ that is evidenced in research into increased risk behaviours for sexual transmission of HIV.⁽²⁰⁾ In Western Cape Province, the proportion of admissions to drug treatment facilities for methamphetamine as the primary drug used increased from 0.8% in 2001 to 52% in 2011.⁽²¹⁾

Programmatic scale up of harm reduction services in a few sub-Saharan countries has marginally improved since 2012. However, it has not grown in proportion to the HIV epidemic among people who inject drugs. NSPs have been implemented in Kenya⁽²²⁾ and scaled up in Tanzania from one site in 2012 to seven sites in 2014, including one mobile outreach programme.⁽²³⁾

The recent establishment and scale up of community-based opioid substitution therapy (OST) in Tanzania is an important step forward for the region, as the first of its kind in East Africa.

As Table 2.9.1 shows, there is a serious need to close the evidence gaps on the epidemiology of HIV and viral hepatitis among people who use drugs in sub-Saharan Africa. Ghana is set to undertake a study in 2014 on people who inject drugs to ascertain an accurate picture of trends.⁽²⁴⁾ A study in 2011 documented injecting drug use among males, but did not make reference to females who inject drugs.⁽²⁵⁾ Research is also scheduled in Somalia⁽²⁶⁾ and Senegal.⁽⁷⁾ In South Africa, the Centres for Disease Control and Prevention (CDC) have contracted civil society organisations to work on increasing services, awareness and education on harm reduction, with a demonstration project planned for Cape Town, Durban and Pretoria.⁽¹⁹⁾ However, other countries, such as Zambia, which has one of the highest HIV prevalence rates in the world,⁽²⁷⁾ have no verified data on injecting drug use and HIV, and no research planned. Other countries, such as Rwanda, claim that injecting drug use is not present and therefore do not target people who use drugs in their HIV strategy, despite data collected in 2007/2008 identifying injecting drug use.⁽²⁸⁾ However, there is a proposal from the Global Fund to increase data and research for East Africa.

Recent civil society initiatives include establishing the Kenya Network of People who Use Drugs (KeNPUD) in 2012, followed by the Eastern African Harm Reduction Network,^(22, 30) which met in March 2013 to share experiences and strengthen organisational development for a resilient regional harm reduction network.⁽³¹⁾ Also in 2013, a countrywide harm reduction network was implemented in Uganda,⁽²⁹⁾ and an advocacy group, the Tanzania Network of People Who Use Drugs (TANPUD), was introduced,⁽²³⁾ advocating and educating for the health and human rights of people who use drugs.⁽³²⁾ Most recently, in June 2014, ReAct, an independent peer-led network of people who use drugs, was established in Tanzania.⁽³³⁾

The limited services in the region, coupled with the criminalisation of drug use and minor possession, do little to reduce HIV risks faced by people who inject drugs,⁽³⁴⁾ and do not meet international recommendations. While there are significant structural factors involved beyond service provision, drug policy, criminal laws, law enforcement and political priorities relating to drugs present significant hurdles to access and scale up of programmes, with many countries continuing to focus primarily on supply reduction and law enforcement rather than public health. There is also

vii Flashblood is a high-risk blood-sharing practice that carries a very high probability of HIV transmission. One user draws blood back into the syringe after injecting heroin and then passes the syringe on to a peer, who injects the 3ml to 4ml of blood.

a need in the region to include people who use drugs in harm reduction initiatives and research in order to obtain a more accurate picture of various types of substance use.⁽³⁵⁾

Developments in harm reduction implementation

Needle and syringe exchange programmes (NSPs)

NSPs are generally unsupported both financially and politically by governments, with civil society providing the majority of services in the region.^(19, 22, 23, 30, 36)

Historically Mauritius has been the only exception, but in 2012 the Kenyan government announced the initiation of NSPs within the country,⁽²⁸⁾ resulting in 2014 in ten newly operational sites (four in Nairobi, three in Kilifi, two in Mombasa and one in Kwale) reaching 4,500 people who inject drugs.⁽²²⁾ It is estimated that 51.6% of people using NSP service provision in Kenya now report using sterile injecting equipment.⁽²⁾ There has also been a scale up of NSPs in Dar es Salaam, Tanzania, increasing from one site in 2012 to seven in 2014, with one mobile NSP visiting people who inject drugs approximately once a week.⁽²³⁾ On average, 155 syringes were distributed per person per year in Dar es Salaam, with 84.2% of people who inject drugs reporting using sterile injecting equipment in areas where there is NSP provision.⁽³⁷⁾ In South Africa, there is presently only one NSP site focused on men who have sex with men who inject drugs.⁽¹⁹⁾

By far the greatest coverage of NSPs in the region is to be found in Mauritius. On average, 44 syringes were distributed per person per year in Mauritius, with 83.8% of people who inject drugs reporting

using sterile injecting equipment in 2013.⁽⁴⁾ However, Mauritius has remained static in terms of NSP sites, and although generally people who inject drugs are moving towards OST, a growing number are injecting drugs and accessing services. Consequently, there are often insufficient facilities to meet the need, which is negatively affecting the quality of service, with long waiting times and lack of equipment.⁽³⁰⁾

In Nigeria, 9% of new HIV infections are attributed to unsafe injecting drug use⁽³⁸⁾ and there are currently no known NSPs. However, 70.89% of people who inject drugs reported using sterile injecting equipment between 2005 and 2010⁽⁶⁾ due to widespread availability via pharmacies.⁽³⁸⁾ In the Seychelles, a high percentage of people who inject drugs have reported practising unsafe injecting, and OST has been newly introduced, along with a recognition by government of a need for NSP service provision.⁽⁹⁾ In Senegal, NSP provision on a small scale has recently been established.⁽¹⁶⁾

Despite increases in the number of NSP sites in sub-Saharan Africa, coverage of existing services still remains disproportionately low compared to international coverage targets.⁽³⁹⁾ There are also numerous legal and policy barriers, coupled with intense social stigma associated with injecting drug use. This can force people who inject drugs to hide injecting equipment and engage in unsafe injecting practices. Even in areas where it is legal to purchase needles and syringes, police harassment and fear of arrest for carrying drug paraphernalia may deter individuals from accessing services.^(19, 23, 29, 30)

These barriers lead to poor health-seeking behaviour.⁽¹⁹⁾

Women who inject drugs: adapting the service response in sub-Saharan Africa

As in many other parts of the world,^(40, 41) women who inject drugs often experience disproportionately higher levels of negative health outcomes,^(11, 39, 42) with HIV prevalence for women who inject being 5 to 15% higher than their male counterparts in Nigeria⁽⁴³⁾ and 55 to 68% higher in Tanzania.⁽⁴⁴⁾ A study looking specifically at gender inequalities in harm reduction services in Dar es Salaam found that only 8% of those accessing the services were women.⁽⁴⁵⁾ In another study undertaken in South Africa, less than 20% of women who use drugs reported any awareness of drug treatment programmes.⁽³⁴⁾

Gender inequality, alongside lower purchasing power and dependence on their male partners,⁽⁴³⁾ mean that some women who inject drugs participate in extremely high-risk injecting practices. However, awareness of the heightened barriers that women who use drugs encounter in accessing services is increasing with the development of gender-sensitive services in some countries.^(22, 23) In Kenya, for example, NSP services are using community-based outreach that will enable women who do not wish to seek services publicly to access NSP provision,⁽²²⁾ and mobile units are in operation in Tanzania and Mauritius.^(23, 30) The demonstration project planned in South Africa (see page 122), although not yet implemented, has also built in harm reduction approaches for women, using female peers and other female staff members in outreach programmes to support women who are fearful of attending services.

Opioid substitution therapy (OST)

As illustrated in Table 2.9.1, OST remains largely unavailable throughout sub-Saharan Africa, with the exception of Mauritius,⁽³⁰⁾ where over 6,000 people access services, and newly initiated programmes in Tanzania. Methadone maintenance therapy has increased in Tanzania, which is a significant step forward, rising from one site to three in the city of Dar es Salaam.⁽²³⁾ This makes the OST programme in Tanzania the largest government-run programme in the region, with over 1,200 people receiving methadone in 2013 and outreach workers making contact with around 20,000 people who use drugs.⁽⁶⁾ However, takeaway doses remain unavailable, and the cost of transport to OST sites for people who inject drugs has been cited as a barrier to access. In Mauritius, people who inject drugs and wish to access OST must complete a two-week induction period, either as an inpatient or outpatient. This requirement has been cited as a barrier for those in employment, those who do not wish to disclose to their family that they inject drugs, and for women who cannot find or afford childcare.⁽³⁰⁾

In Kenya, methadone OST is in development, with funding from the US government and technical support from the United Nations Office on Drugs and Crime (UNODC), and is due to be situated in government hospitals in Mombasa, Malindi and Nairobi.⁽²²⁾ However, OST in a community setting remains unavailable, and due to a long process of service development and preparation, it is unlikely to be established in the near future. In Senegal, an OST site within a drug treatment centre is currently being built in Dakar,⁽¹⁶⁾ and OST provision is reportedly available in Burkina Faso, although limited information is available.⁽¹⁾

There are OST sites in operation in South Africa and plans to increase this service. However, available data indicates that this is restricted to just one government-funded site, with private OST provision available in clinics.⁽¹⁹⁾ While other government hospitals use methadone, it should be noted this is for detoxification services only. Due to the cost of treatment and the inability of many people who inject drugs to obtain private health insurance, coverage remains low in the country.⁽¹⁹⁾

In many of the other sub-Saharan African countries where injecting drug use has been reported, such as Nigeria and Uganda, OST has yet to be established.

Viral hepatitis

Hepatitis C (HCV) and hepatitis B prevalence in sub-Saharan Africa is generally quite high, and more elevated still among people who inject drugs. For example, Kenya reports over 50% HCV prevalence among people who inject drugs, and Mauritius over 97%.^(46, 47) However, data relating to viral hepatitis in people who inject drugs is sparse. Within the five countries where data is available, HCV prevalence is thought to be significantly higher than HIV prevalence. The estimate of HCV prevalence for people who inject drugs in Tanzania is 28%,⁽²³⁾ an increase of approximately 5% from 2012.

The cost of treatment and testing is one of the central problems in addressing HCV. In Tanzania, the cost of treatment for HCV is more than €10,000 per patient.⁽²³⁾ In Kenya, HCV treatment is also very limited. People can be referred to research institutes or government hospitals. However, referral rates are extremely low, and people who inject drugs report rarely being offered a rapid HCV test and generally having little to no access to treatment.⁽²²⁾ Barriers to access for testing, treatment and care are evident in Uganda and South Africa. In Mauritius, HIV and HCV testing are offered together, but as in most countries in the region, treatment is unavailable for people who inject drugs, even though 97% of them are HCV positive.

In 2014, Nigeria developed a programme to enable HCV testing for people who use drugs, but the policy has only recently been published and is yet to be implemented. As in most countries in the region, HCV treatment is unavailable, not only for key populations but for anyone. New HCV direct acting antiretroviral medications have been hailed as “revolutionary”, and it is hoped, will ensure greater adherence and clearance rates of HCV. However, the extremely high cost of these new drugs puts them out of reach for low- and middle-income countries. However, Gilead, a pharmaceutical company that has developed medicines suitable for treating viral hepatitis, is working with regional partners to introduce low-cost generic Sovaldi® (one of the new WHO-recommended HCV treatment drugs) for use in low- and middle-income countries.⁽⁴⁸⁾

Tuberculosis

Prevalence of tuberculosis (TB) in sub-Saharan Africa is extremely high, with more than 75% of HIV co-infection with TB based in this region.⁽¹⁴⁾ There is a paucity of data related to TB prevalence among people who inject drugs. While the majority of those who have been diagnosed will not develop active TB disease, people who inject drugs, together with prisoners, are more vulnerable to progressing to active TB due to

increased HIV co-infection among people who inject drugs, and prison conditions in some countries.⁽⁴⁹⁾

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.⁽⁴⁹⁾ Although there are services for testing and treatment of TB in most countries in the region, stigma, discrimination and treatment adherence impede any advances in tackling TB among people who inject drugs. In the Temeke district of Dar es Salaam in Tanzania, a national patient-led organisation focusing on TB and HIV, called MUKIKUTE, has been established, integrating TB and HIV low-threshold centres for people who inject drugs.⁽²³⁾ It is the only service reported that delivers coordinated TB and HIV services in Tanzania. Although TB diagnosis and treatment are available and free, the high prevalence rate among people who use drugs means that clinics may face difficulties in accepting all requests.⁽²³⁾

A similar problem is apparent in Kenya and South Africa, with treatment available but detection among people who inject drugs remaining an issue. In South Africa, however, it is hoped that this will be addressed with the implementation of a multi-site programme that came into operation during 2014 as part of national health screening.⁽¹⁹⁾ There are few TB cases in Mauritius, but diagnosis and treatment are available for people who use drugs.⁽³⁰⁾ There are no TB programmes for people who inject drugs in Nigeria, but a programme is available for the general population.⁽³⁶⁾

Antiretroviral therapy (ART)

In 2012 there were an estimated 6,991,492 adults receiving antiretroviral therapy (ART) in sub-Saharan Africa,⁽¹⁴⁾ representing 60% of those living with HIV. However, the data on numbers of people who inject drugs receiving ART within this region remain limited. In 2008, the Reference Group to the United Nations on HIV and Injecting Drug Use reported that just 38 people who inject drugs in Kenya and 138 people who inject drugs in Mauritius were receiving ART. These estimates represented less than 1% of HIV-positive people who inject drugs in Kenya and 1.1% of people who inject drugs in Mauritius receiving ART.⁽⁵⁰⁾ There is no up-to-date government data in the region on the number of people receiving ART who inject drugs, making it difficult to calculate ART coverage among this population.

In Tanzania, reports have shown that people who use drugs have been discriminated against and denied HIV testing from certain government hospitals. However, non-governmental organisations (NGOs) also provide testing services and sensitisation programmes,

and training among providers is being rolled out in government hospitals to improve access for people who use drugs.⁽²³⁾ In Kenya, all people who use drugs who have a CD4 count of less than 350 are eligible for ART; otherwise they are provided with prophylactic cotrimoxazole – an antibiotic seen to reduce morbidity in adults with HIV.^(22,51) In Mauritius, ART is available for people who inject drugs at the HIV public hospital. ART is available in South Africa, but services are not explicitly aimed at people who inject drugs.⁽¹⁹⁾

Harm reduction in prisons

The criminalisation of possession of drugs and drug use in sub-Saharan Africa contributes to a high proportion of people who inject drugs being incarcerated. Evidence suggests that the prison setting may be contributing considerably to accelerating HIV transmission with high-risk injecting practices.⁽³⁴⁾ In 2008, a study undertaken in Ghana found that 35% of people in prison reported a history of injecting drug use.⁽⁵²⁾

In Africa, OST in prisons is available only in Mauritius and is limited to male prisons.⁽³⁰⁾ In addition, men who are incarcerated on the island and who do not have ID cards are refused access to this service. There has been some improvement in OST provision in that it is now available for prisoners who were not receiving OST before they were in custody.⁽³⁰⁾ In the rest of the region, harm reduction services in the form of OST and NSPs are unavailable in prison settings. While Nigerian government objectives outline a commitment to increased access for people who inject drugs to a full range of harm reduction measures, planned services in prisons are limited to drug treatment, telephone hotlines and drop-in centres providing information and referrals.⁽⁵³⁾

ART is available in Kenyan prisons,⁽²²⁾ with approximately 77% of Kenyan detainees reporting being tested for HIV.⁽⁵⁴⁾ Uganda also provides ART to those incarcerated,⁽²⁹⁾ and South Africa is due to provide ART provision across prison settings following a court decision.⁽¹⁹⁾ In Tanzania, it has been reported that ART should be available in prisons, but it is unclear whether this service is actually being offered. In addition, the government has justified the non-availability of condoms for male prisoners by citing the illegality of sodomy. Indeed, condom provision in prisons throughout the region is limited to South Africa, where availability is inconsistent.⁽¹⁹⁾ The UK Department for International Development has published plans for a regional project aimed at making condom provision in prisons more politically acceptable in Southern Africa.⁽⁶⁷⁾

Overdose

There is little data on the prevalence of and response to overdose in sub-Saharan Africa. Data from 2011 indicated that overdose cases in Kenya were estimated to be 83–90% higher in Nairobi than in the coastal areas, and approximately 58% of people who injected drugs in Kenya reported knowing at least one person who had experienced a fatal overdose.⁽⁵⁵⁾ Naloxone, a highly effective opioid antagonist used to reverse the effects of opiate overdose, is now available in Kenya, although the success of this provision has yet to be evaluated.⁽²²⁾

Naloxone is also available in hospitals in Tanzania,⁽⁵⁶⁾ but there is still no access to overdose treatment for the wider population; for example, friends and family of the person injecting drugs. Civil society and government in Tanzania are in discussion regarding naloxone peer-distribution programmes.⁽²³⁾

Mauritius, South Africa and Nigeria currently have no overdose prevention system in operation.^(19,30,36)

Policy development for harm reduction

Since 2012, seven sub-Saharan countries have adopted a specific reference to harm reduction in national HIV policy documents. Harm reduction is currently endorsed in the Tanzanian National Strategy for Non-Communicable Diseases 2009–2015⁽⁵⁷⁾ and the Tanzania Third National Multi-Sectoral Strategic Framework for HIV and AIDS.⁽⁵⁸⁾ It is also a component of HIV policy frameworks in Kenya and Mauritius.^(30,42) The 2011–2015 National AIDS Programme in Senegal also makes explicit reference to people who inject drugs as a priority target group.⁽⁵⁹⁾ The government of Mauritius has also stated that it will re-establish a harm reduction committee, conduct frequent harm reduction awareness programmes, and aim to decriminalise the distribution and use of syringes.⁽⁴⁾

In Uganda, where there are currently no active harm reduction services, the United Nations Development Programme (UNDP) has invited the Uganda Harm Reduction Network (UHRN) to participate in consultations to develop a model for a regional framework based on HIV prevention, treatment and care among key populations.⁽²⁹⁾ The Department of Health in South Africa is also drafting operational guidelines for HIV, sexually transmitted infections and TB for key populations,⁽¹⁹⁾ and advocating for prescribed medication and substitution therapies for opiate dependence.⁽⁶⁰⁾

The Seychelles National Strategic Framework 2012–2016 for HIV and AIDS and STIs prioritises the needs of key populations at higher risk of HIV exposure, including people who inject drugs, recognising the need for harm reduction services such as NSPs on the island.⁽⁶¹⁾ In 2009, harm reduction was included in the National Policy on HIV/AIDS in Nigeria, where the government committed to “Increase access of drug users to [a] full range harm reduction measures and to service providers offering treatment for drug dependence, sexually transmitted infections, AIDS and tuberculosis.”⁽⁶²⁾

Despite these advances, policies for most countries in the region continue to focus on supply reduction and the criminalisation of drugs, overshadowing any harm reduction responses. Despite progress in implementing NSPs in Tanzania, for example, the possession of needles is still illegal in the country.⁽¹¹⁾ A small step forward was taken in Mauritius when the Dangerous Drugs Act was amended in 2013 to make provision for the decriminalisation of “synthetic Cannabinoids and their derivatives”,⁽³⁰⁾ illustrating an increased tolerance towards certain forms of drug use in the country.

During the 5th African Union Conference of Ministers of Drug Control in 2012, a new Plan of Action on Drug Control was agreed for 2013–2017. This signals an important step forward, with a balanced approach that includes (in the accompanying Implementation Matrix) an explicit commitment to implement the UNODC/UNAIDS/WHO comprehensive package of harm reduction services, as well as providing alternatives to incarceration. At the 6th Conference in 2014 – under the bold heading ‘Drugs Kills, But Bad Policies Kill More’ – countries reviewed progress, recommitted to harm reduction, and held important discussions on drug policy reform in the region.⁽⁶³⁾

In 2013, the former United Nations Secretary-General, Kofi Annan, convened the West Africa Commission on Drugs to address the issue of drugs and security in the region. The commission comprises 11 regional leaders from the worlds of politics, civil society, health, security, law enforcement and the judiciary. It is chaired by former Nigerian president, Olusegun Obasanjo.⁽⁶⁾ After 18 months of debate, outreach and consultation, the commission launched its report in 2014, recommending the adoption of a harm reduction and public health approach across the region, and the integration of harm reduction into national drug policies.⁽⁶⁾ The report also called for broad drug policy reform, including the decriminalisation of people who use drugs, and for a balanced approach to drug policy that prioritises health and human rights.

Civil society and advocacy developments for harm reduction

With the emerging scale up of harm reduction services in Tanzania and Kenya, and a plan to initiate these in Uganda, civil society organisations in the region have helped to secure small but vital improvements in harm reduction provision. Through the Community Action on Harm Reduction (CAHR) programme, additional funding for the NSP programme was secured from the Open Society Foundations and Mainline.⁽⁶⁴⁾ In the continuing absence of local government support, the inception of the Eastern African Harm Reduction Network may have the potential to contribute to a coherent regional harm reduction strategy, with the synergy of civil society organisations giving harm reduction a stronger voice in a part of the world where for too long it has been muted.

Collectif Urgence Toxida (CUT), the national harm reduction network in Mauritius, together with the Kenyan AIDS NGOs Consortium (KANCO) and other national actors, TanPUD, Youth RISE Nigeria, ZDCLU in Zimbabwe and KenPUD have used the 'Support. Don't Punish' campaign⁽⁶⁵⁾ as a platform for people to talk publicly about drug policy reform.^(23,29,30) This has helped to draw attention to the need for harm reduction services, harm reduction funding, and drug policy reforms across the region.

In South Africa, the CDC has contracted civil society organisations to set up a pilot programme providing medication-assisted treatment to people who are dependent on heroin. The demonstration project planned for Cape Town, Durban and Pretoria (see page 122) will provide a package of services for people who inject drugs. It aims to reach 50% of this population in the areas where the project is initiated, although only a few areas of these municipalities will be targeted.⁽¹⁹⁾ Closer collaboration with government authorities is also evident in Uganda, where UHRN has been selected to represent the interests of people who use drugs on a ministry of health national technical committee.⁽²⁹⁾ And in March 2013, an inception meeting to formulate the Eastern Africa Harm Reduction Network was convened, with an application put forward to the Global Fund to support both initiation and scale up of harm reduction.

Funding: developments for harm reduction

Multilateral agencies and donor NGOs provide the majority of HIV and AIDS funding in sub-Saharan Africa. In Tanzania, Médecins du Monde-France received a grant from the Elton John AIDS Foundation (EJAF) to scale up harm reduction programmes in Dar es Salaam.⁽²³⁾ The Open Society Foundations have also been supporting capacity-building and advocacy in the country, and funding from the French Development Agency has continued to assist harm reduction programmes in Dar es Salaam.⁽²³⁾ CDC has also supported OST in Tanzania. In 2014, the Tanzanian government formed a resource mobilisation committee to raise awareness of harm reduction, mobilise resources and hold a workshop with mayors and councillors from Dar es Salaam, in the hope of increasing harm reduction funding. At present, there is no available data on the contribution of government funding for harm reduction in Tanzania. However, the Tanzanian government does provide HIV tests and condom distribution, with more funds being released to build a centre specifically aimed at key population groups.

Kenya received a one-year extension to continue harm reduction programming through the Dutch-funded CAHR project implemented by the International HIV/AIDS Alliance in December 2014.⁽²²⁾ The Global Fund has taken over funding of some activities.⁽¹⁶⁾ The Kenyan government began a major initiative in 2014 to introduce OST to people who inject drugs in order to prevent HIV and increase their access to HCV treatment and ART, while promoting respect for their human rights. This initiative is the result of a unique partnership between the ministry of health, country governments in Nairobi and coastal provinces, UNODC and USAID.⁽⁶⁶⁾ However, without a sustainable plan to continue the funding stream, any progress made in Kenya for provision of sterile injecting equipment and OST is likely to be reversed. A similar outcome is probable in Mauritius, which to date has received US\$9,668,292 in harm reduction funding from the Global Fund, as funding will cease over the coming two to three years. The Mauritian government has pledged to invest in some national projects, but it is unclear if civil society (currently funded through the Global Fund) will benefit from this support.

In Uganda, funding for harm reduction has generally been viewed as a low priority by government, although there has been an increased focus from multilaterals and donor NGOs. The International Treatment Preparedness Coalition (ITPC) has also provided US\$20,000 for two years in Uganda.⁽²⁹⁾ Multilaterals, including UNODC, UNAIDS, WHO, and agencies such as PEPFAR, have been working alongside civil society organisations in South Africa to raise harm reduction awareness, but large funding gaps remain.⁽¹⁹⁾

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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 data 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. Since then, the biennial report has become a key publication for researchers, policymakers, civil society organisations and advocates, mapping harm reduction policy adoption and programme implementation globally.

The Global State of Harm Reduction 2014 continues to map the response to drug-related HIV, viral hepatitis and tuberculosis. It also integrates updated information on harm reduction services into each regional chapter, including on needle and syringe programmes (NSPs) and opioid substitution therapy (OST) provision; harm reduction services in the prison setting; access to antiretroviral therapy for people who inject drugs; regional overdose responses; policy developments; civil society developments; and information relating to funding for harm reduction.

This report, and other global state of harm reduction resources, are designed to provide reference tools for wide range of audiences, such as international donor organisations, multilateral and bilateral agencies, civil society and non-governmental organisation, including organisations of people who use drugs, as well as researchers and the media.

If you would like to find out more about Harm Reduction International and how you can support our work, please contact us at:

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