The Global State of Harm Reduction 2016

20 YEARS

HARM REDUCTION INTERNATIONAL

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Contents

The Global State of Harm Reduction 2016

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Abbreviations and acronyms

2CB	2,5-dimethoxy-4-bromophenethylamine
AIDS	Acquired immunodeficiency syndrome
ANPUD	Asian Network of People who Use Drugs
APCOM	Asia Pacific Coalition on Male Sexual Health
ART	Antiretroviral therapy
ASEAN	Association of Southeast Asian Nations
ATS	Amphetamine-type stimulants
BBV	Blood-borne virus
CAHR	Community Action on Harm Reduction
CCDU	Compulsory centres for the treatment and rehabilitation of people who use drugs
CDC	Centers for Disease Control and Prevention (US)
CEDD	Colectivo de Estudios Drogas y Derecho
CELAC	Community of Latin American and Caribbean States
CND	Commission on Narcotic Drugs
DAA	Direct-acting antiviral
DCR	Drug consumption room
EC	European Commission
ECDA	European Centre for Disease Prevention and Control
EECA	Eastern Europe and Central Asia
EHRN	Eurasian Harm Reduction Network
EJAF	Elton John AIDS Foundation
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ENPUD	Eurasian Network of People Who use Drugs
EU	European Union
EuroNPUD	European Network of People Who Use Drugs
HAT	Heroin assisted treatment
HBsAg	Blood marker indicating active HBV infection
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HLM	High-Level Meeting
HRI	Harm Reduction International
IBBS	Integrated Biological Behavioral Surveillance Survey
INPUD	International Network of People who Use Drugs
LANPUD	Latin American Network of People Who Use Drugs
LGBT	Lesbian, gay, bisexual and transgender
LSD	Lysergic acid diethylamide
MDG	Millennium Development Goal
MdM	Médecins du Monde
MDMA	3,4-Methylenedioxymethamphetamine (ecstasy)
MENA	Middle East and North Africa
MENAHRA	Middle East and North Africa Harm Reduction Association
MENAPUD	Middle East and North Africa Network of People who Use Drugs
MMT	Methadone maintenance treatment
MSM	Men who have sex with men
NGO	Non-governmental organisation
NSP	Needle and syringe programme
OST	Opioid substitution therapy
PDARN	Pacific Drugs and Alcohol Research Network
PEPFAR	US President's Emergency Plan for AIDS Relief
PICTs	Pacific Island Countries and Territories
PWID	People who inject drugs
RANAA	Regional Arab Network Against AIDS
SIF	Safer injecting facility
SIS	Safe injection site
STI	Sexually transmitted infection
STD	Sexually transmitted disease
TB	Tuberculosis
TNI	Transnational Institute
TSF	Technical Support Facility (UNAIDS)
UAE	United Arab Emirates
UK	United Kingdom of Great Britain and Northern Ireland
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
US	United States of America
USAID	United States Agency for International Development
WHO	World Health Organization

Foreword

By John-Peter Kools and Rick Lines

We are pleased to welcome you to the 2016 Global State of Harm Reduction.

This year marks two important milestones for us: the 10th anniversary of the Global State project and the 20th anniversary of the founding of the International Harm Reduction Association, now known as Harm Reduction International.

Since it began in 2006, the Global State has emerged as one of the key resources for those working on harm reduction issues around the world. It stands alone as the only independent, civil-society led project monitoring global progress on harm reduction, and on important related developments in national and international law, policy and advocacy.

Although this report bears HRI's name, behind the scenes it is the product of dozens of colleagues working on harm reduction in all regions of the world, who collaborate with us in collecting data, sharing case studies and providing critical peer-review to ensure our information is as accurate as we can make it. In particular we must acknowledge the work of Catherine Cook, the author of the first edition of the Global State who has overseen the project from its inception.

Reflecting back over the ten years of the Global State, there is no doubt that the harm reduction approach has continued to grow year after year in country after country. Indeed, harm reduction is accepted (or tolerated) in more than half of the countries of the world where injecting drug use has been reported. Despite the well documented gaps in access and quality in many parts of the world, it can be said that harm reduction is present in the majority of countries where injecting is present. No longer can our critics suggest our shared philosophy and approach to addressing the harms of drug use and drug policy is a fringe position.

Over the last ten years we have also seen other important developments. When we started this project in 2006, the focus of the report (and indeed much of the harm reduction sector) was on HIV prevention among people who inject opioids. Since that time we have seen the development of critical programmes addressing viral hepatitis, overdose prevention and harm reduction among people who use stimulants, developments that have become an increasingly important part of our report. Over the last decade we have also seen major developments in organising and networking by people who use drugs, which has made a critical contribution to national, regional and global advocacy.

Despite this progress, we all know the many problems that remain. Harm reduction programmes are too few, too vulnerable and too underfunded in most parts of the world. International donor support for harm reduction is under sustained threat. The United Nations appears to be turning its back on the issue of injecting drug use. Despite the growth of support for harm reduction around the world, criminalisation and prison continues to be the dominant paradigm of drug control, fueling ill-health and human rights abuses around the world. People are continuing to die needlessly, because too many governments are addicted to prohibition.

Harm reduction saves lives. Promotes health, human rights and dignity. Saves money. The harm reduction movement, and the movement of people who use drugs, are on the right side of the issue, and the right side of history. As we prepare for another milestone next year, our 25th international conference to be held in Montreal, we are reminded of the words of the late Jack Layton, Canadian political leader and long-time harm reduction supporter. 'My friends, love is better than anger. Hope is better than fear. Optimism is better than despair. So let us be loving, hopeful and optimistic. And we'll change the world.'

John-Peter Kools
Chair

Rick Lines
Executive Director

Introduction

About the Global State of Harm Reduction 2016

In 2008, Harm Reduction International (HRI) released the *Global State of Harm Reduction,* a report that mapped responses to drug-related HIV and hepatitis C epidemics around the world for the first time.[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. Since HRI first began reporting, the harm reduction response has increased globally with harm reduction programmes now operating at some level in more than half of the 158 countries in the world where injecting drug use has been documented. Harm reduction is now the majority response in the international community.

The Global State of Harm Reduction 2016 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 prisons; access to antiretroviral therapy (ART) for people who inject drugs; overdose responses; policy developments; civil society developments; and information relating to funding for harm reduction. With changing patterns in drug use, the 2016 report also reflects the use of, and harm reduction response to, amphetamine type stimulants (ATS).

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

Methodology

The information presented in the two sections of the report has been gathered using existing data sources. These include 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 developments and to review population size estimates, prevalence data on 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 (March to October 2016). 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 outdated, we have provided footnotes with a year of estimate. Unless HRI 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.[2] Data from Western Europe and some countries in Eurasia has been sourced from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2016 Statistical Bulletin, unless otherwise stated in the text.[3-6] 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, the Caribbean, Latin America, North America, Oceania, the 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

Since the dissolution of the UN Reference Group on HIV and Injecting Drug Use, there have been no updates on their independent peer-reviewed global epidemiological or service coverage systematic reviews. For some countries, the estimates published by the UN Reference in 2008 and 2010 remain the most recent available and reliable estimates.[7, 8] More recent data, where reviewed to be reliable, has been included from various sources. For Western European countries and some countries in Eurasia, EMCDDA has continued to be a crucial source of reliable data for this edition of the *Global State* as in past editions. Other sources include global AIDS response progress reports submitted by governments to UNAIDS in 2014/2015/2016, data published by UNODC in the World Drug Report in 2016, bio-behavioural surveillance reports, systematic reviews and academic studies.

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 2014*[9] 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 it 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 regional concern.

While *The Global State of Harm Reduction 2016* 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, 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. These examine developments in harm reduction since 2014.

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Global Overview

1.1 Global Update: Behind the numbers

Global Overview

Global Update: Behind the numbers

This report is the fifth in the biennial *Global State of Harm Reduction* series tracking developments in harm reduction worldwide. The '*Global State*' has become a vital source for researchers and advocates since the first edition in 2008, when it provided the first global snapshot of harm reduction responses.

Injecting drug use is a global phenomenon, documented in at least 158 of the world's countries and territories.[1] Using primarily government reported data, UN estimates for 2014 found that 11.7 million people injected drugs worldwide, with 14% living with HIV, 52% living with hepatitis C and 9% living with hepatitis B.[9][a] The harm reduction response, while in place to some degree in a majority of the world's countries, falls far short of reaching most people who inject drugs worldwide. In 2016, 90 countries implement needle and syringe programmes (NSPs) to some degree and 80 have at least one opioid substitution programme (OST) in place.

Perhaps the most striking statistic to emerge from this year's *Global State of Harm Reduction* is that since 2014, there has been no increase in the number of countries implementing - the first time that this has happened since the inception of the *Global State* in 2008. Of 158 countries and territories where injecting drug use has been reported, 68 still have no NSP in place, and 78 have no provision of OST.

Behind these numbers is a gap between the international commitments made over the last two years and the levels of financial and political leadership being shown by both national governments and international agencies. In 2015, as part of the Sustainable Development Goals (SDGs), the UN General Assembly agreed a global target to end AIDS by 2030.[2] This year, member states at both the UN General Assembly Special Session (UNGASS) on Drugs and the High Level Meeting on HIV and AIDS committed to "minimising the adverse public health and social consequences of drug abuse", and endorsed harm reduction interventions including "medication assisted therapy", "injecting equipment programmes", "antiretroviral therapy" and "opioid receptor antagonists".[3] Yet as this year's *Global State* shows, in many countries coverage of NSP and OST remains substantially below the minimum levels recommended by international guidance[4] and is insufficient to prevent HIV and hepatitis C epidemics among people who inject drugs. There are also an alarming number of countries where coverage of NSP and OST has decreased.

Underpinning the data is a deepening funding crisis facing harm reduction. Even in Europe, the region traditionally most supportive of harm reduction, a drop in government funding has resulted in service closures. International donor funding for the HIV response is in decline, and this problem is increasingly pronounced in middle-income countries (MICs) where harm reduction is most needed.[5] The Global Fund for AIDS, tuberculosis (TB) and Malaria has warned MICs to "begin or build upon transition preparations during the 2017-2019 period", and has listed 24 countries that will become ineligible for GFATM support in the coming years.[6] With international financing disappearing, harm reduction advocates in MICs are uncertain about what will replace it. The assumption from international agencies appears to be that national governments will fill this vacuum and invest. In May 2016, UNAIDS released "global" harm reduction resource needs estimates which did not include high-income countries and assumed that all upper MICs would fund their own responses.[7] In doing so UNAIDS has left behind some three quarters of people who inject drugs globally,[b] covering countries such as the US, Russia, Greece, Hungary, Bulgaria, Thailand, China, Mauritius and Belarus, where harm reduction programmes are severely limited even after decades of local advocacy.

One of the greatest challenges behind the *Global State of Harm Reduction* at present is the global leadership gap. The 2011 Political Declaration on HIV included a historical target to halve HIV transmission among people who inject drugs by 2015,[8] but this was missed by more than 80%. The 2016 UNGASS on Drugs and High Level Meeting on HIV had the potential to deliver a wholesale shift in priorities, but instead we saw only modest advances in harm reduction language and no commitment to address the funding crisis or to redirect funding away from enforcement approaches. HRI's '10 by 20' campaign calls on governments to redirect 10% of the estimated US$100 billion currently spent on drug control to harm reduction. Research by HRI and the Burnet Institute has shown that such a redirection has the potential to virtually end AIDS among people who inject drugs.[5]

[a] Results of independent academic systematic reviews to update global data on injecting drug use, HIV, hepatitis B and C prevalence, along with harm reduction coverage estimates are due for release in 2017.

[b] HRI unpublished calculations using national population size estimates from the Global State of Harm Reduction 2014 categorised by country-income status.

Alongside the high level obstacles, a range of practical challenges are emerging or intensifying on the ground. This year's *Global State* reports increased injection of amphetamine-type stimulants (ATS) in every region of the world. Although in some countries there are bespoke harm reduction services for people who use ATS, these are few and small-scale. Amidst the UNODC funding cuts, long anticipated guidance on HIV and stimulant use have again been stalled. There is an urgent need for these guidelines and for adapted harm reduction responses.

Further measures are also needed to respond to the phenomenal increase in overdose and rates of drug related deaths that have been documented in countries such as the US, Canada and the UK.[9-13] These include scaled-up distribution of naloxone (an opioid antagonist) and the removal of restrictive policies that prevent people who use drugs and their peers and families from accessing this life-saving medication.

In relation to hepatitis C, important advances have recently occurred through the development of more effective medicines (known as direct-acting antivirals or DAAs) and through efforts to make affordable generic versions of these drugs available. Price remains a central barrier as drug companies have not offered generic drugs to many countries with a high burden of hepatitis C, while stigma and discrimination against people who use drugs further restricts access.

Moreover, the provision of harm reduction services in prison settings continues to be woefully inadequate. In 2016, only 8 countries implement NSPs in at least one prison, with NSPs entirely unavailable to prisoners in seven out of the nine regions reviewed in the *Global State* report. OST is provided in prisons in 52 countries, representing a 21% increase since the *Global State* last reported, but quality and other barriers remain. Prisoners also continue to face a heightened risk of overdose. This is despite the fact that the provision of harm reduction in prisons is not a policy option but a legally binding human rights obligation that must be urgently prioritised – and resourced - by political leaders.

Behind these numbers remains a landscape of political neglect where harm reduction advocates and people who use drugs are struggling to fill the gap governments are leaving behind. Civil society is relied upon to deliver services, gather data, advocate for funding and fight for the rights of people who use drugs. Underfunded and politically ignored, it is no wonder that the harm reduction response is facing stagnation and in some cases regression.

At the 2015 International Harm Reduction Conference, ahead of the UNGASS on drugs, the harm reduction sector called for a harm reduction decade with a new approach to drug use rooted in science, public health, human rights and dignity. It truly is time for governments and international agencies to rethink the objectives of global drug policy and revisit the means by which they measure their success, to encompass coverage of services, reduction of harms, and lives saved. Diplomats, UN agencies and civil society organisations are already embarking on the process to develop the next Political Declaration on Drugs in 2019. If that process is to be worth even the time already invested, it must secure a new decade of drug policy with harm reduction as a guiding principle.

The Global Harm Reduction Response

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

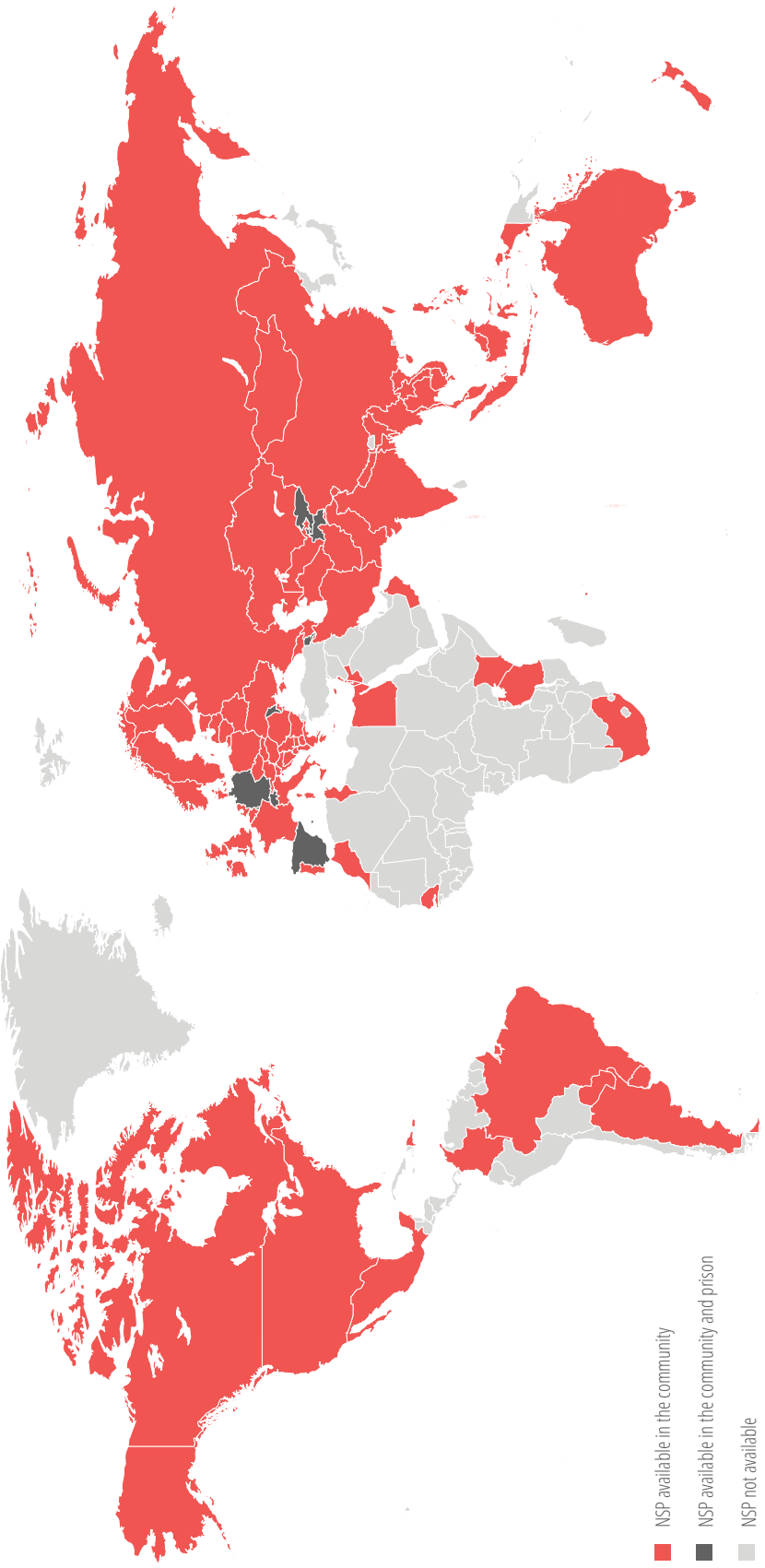
Country or territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid substitution programme operational	At least one drug consumption room	OST in at least one prison	NSP in at least one prison
ASIA						
Afghanistan	✓	✓	✓	✗	✗	✗
Bangladesh	✓	✓	✓	✗	✗	✗
Cambodia	✓	✓	✓	✗	✗	✗
China	✓	✓	✓	✗	✗	✗
Hong Kong	✓	✗	✓	✗	✗	✗
India	✓	✓	✓	✗	✓	✗
Indonesia	✓	✓	✓	✗	✓	✗
Laos PDR	✓	✓	✗	✗	✗	✗
Macau	✓	✓	✓	✗	✓	✗
Malaysia	✓	✓	✓	✗	✓	✗
Maldives	✓	✗	✓	✗	✗	✗
Mongolia	✓	✓	✗	✗	✗	✗
Myanmar	✓	✓	✓	✗	✗	✗
Nepal	✓	✓	✓	✗	✗	✗
Pakistan	✓	✓	✗	✗	✗	✗
Philippines	✓	✓	✗	✗	✗	✗
Taiwan	✓	✓	✓	✗	✗	✗
Thailand	✓	✓	✓	✗	✗	✗
Vietnam	✓	✓	✓	✗	✓	✗
EURASIA						
Albania	✓	✓	✓	✗	✓	✗
Armenia	✓	✓	✓	✗	✓	✓
Azerbaijan	✗	✓	✓	✗	✗	✗
Belarus	✓	✓	✓	✗	✗	✗
Bosnia & Herzegovina	✓	✓	✓	✗	✓	✗
Bulgaria	✓	✓	✓	✗	✓	✗
Croatia	✓	✓	✓	✗	✓	✗
Czech Republic	✓	✓	✓	✗	✓	✗
Estonia	✓	✓	✓	✗	✓	✗
Georgia	✓	✓	✓	✗	✓	✗
Hungary	✓	✓	✓	✗	✗	✗
Kazakhstan	✓	✓	✓	✗	✗	✗
Kosovo	✓	✓	✓	✗	✗	✗
Kyrgyzstan	✓	✓	✓	✗	✓	✓
Latvia	✓	✓	✓	✗	✓	✗
Lithuania	✓	✓	✓	✗	✓	✗
Macedonia	✓	✓	✓	✗	✓	✗

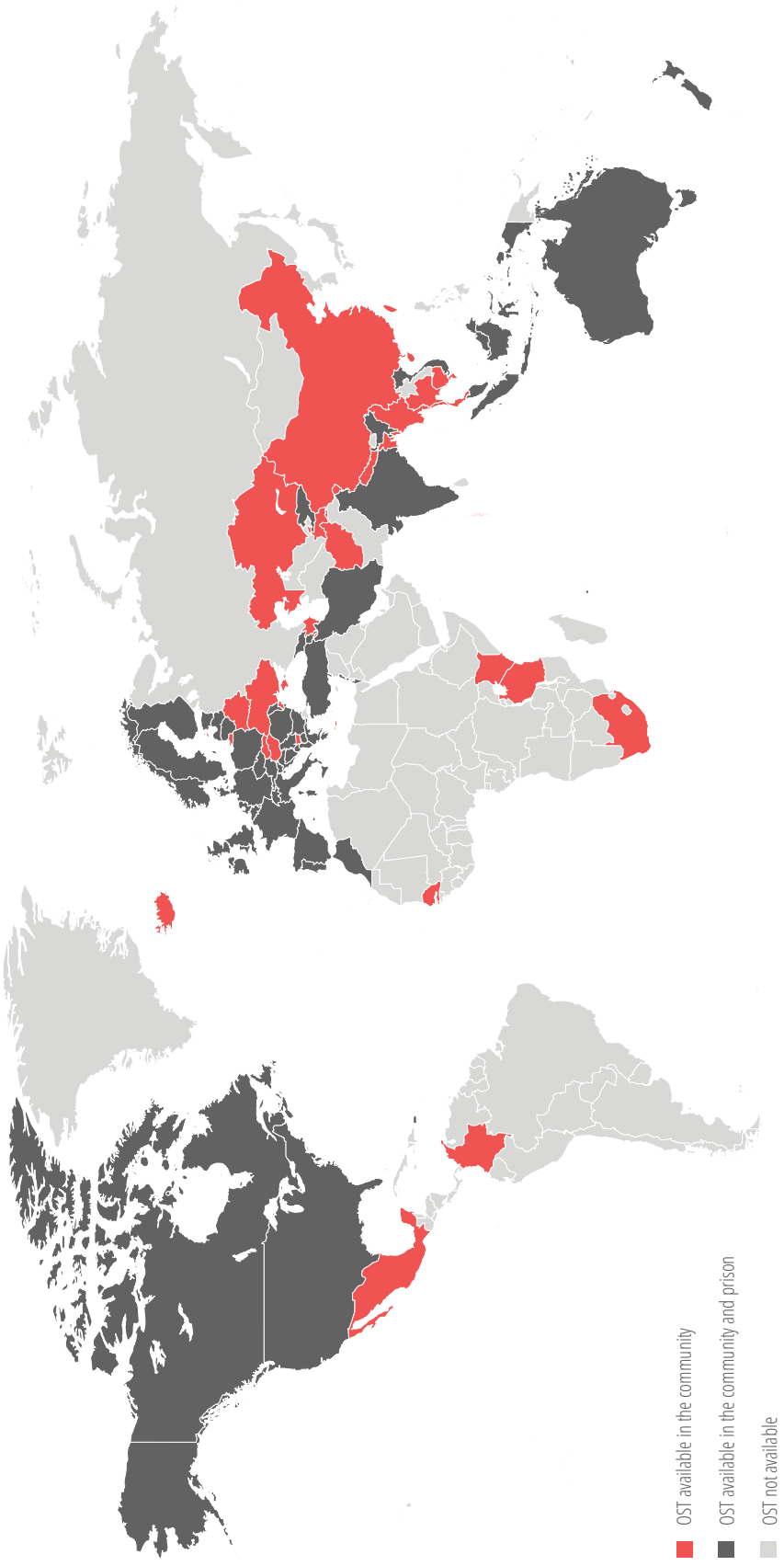
[c] The countries and territories represented in the table are those for which data are available. Those for which no data are available are not listed.

Country or territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid substitution programme operational	At least one drug consumption room	OST in at least one prison	NSP in at least one prison
EURASIA continued						
Moldova	✓	✓	✓	✗	✓	✓
Montenegro	✓	✓	✓	✗	✓	✗
Poland	✓	✓	✓	✗	✓	✗
Romania	✓	✓	✓	✗	✓	✗
Russia	✗	✓	✗	✗	✗	✗
Serbia	✓	✓	✓	✗	✓	✗
Slovakia	✓	✓	✓	✗	✗	✗
Slovenia	✓	✓	✓	✗	✓	✗
Tajikistan	✓	✓	✓	✗	✗	✓
Turkmenistan	✗	✓	✗	✗	✗	✗
Ukraine	✓	✓	✓	✗	✗	✗
Uzbekistan	✓	✓	✗	✗	✗	✗
WESTERN EUROPE						
Austria	✓	✓	✓	✗	✓	✗
Belgium	✓	✓	✓	✗	✓	✗
Cyprus	✓	✓	✓	✗	✗	✗
Denmark	✓	✓	✓	✓	✓	✗
Finland	✓	✓	✓	✗	✓	✗
France	✓	✓	✓	✓	✓	✗
Germany	✓	✓	✓	✓	✓	✓
Greece	✓	✓	✓	✗	✓	✗
Iceland	nk	✗	✓	✗	✗	✗
Ireland	✓	✓	✓	✗	✓	✗
Italy	✓	✓	✓	✗	✓	✗
Luxembourg	✓	✓	✓	✗	✓	✓
Malta	✓	✓	✓	✗	✓	✗
Monaco	nk	✓	nk	nk	✗	✗
Netherlands	✓	✓	✓	✓	✓	✗
Norway	✓	✓	✓	✓	✓	✗
Portugal	✓	✓	✓	✗	✓	✗
Spain	✓	✓	✓	✓	✓	✓
Sweden	✓	✓	✓	✗	✓	✗
Switzerland	✓	✓	✓	✓	✓	✓
Turkey	✓	✗	✓	✗	✓	✗
United Kingdom	✓	✓	✓	✗	✓	✗

Country or territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid substitution programme operational	At least one drug consumption room	OST in at least one prison	NSP in at least one prison
CARIBBEAN						
Puerto Rico	✗	✓	✓	✗	✓	✗
Dominican Republic	✗	✓	✗	✗	✗	✗
Trinidad & Tobago	✓	✗	✗	✗	✗	✗
LATIN AMERICA						
Argentina	✓	✓	✗	✗	✗	✗
Brazil	✓	✓	✗	✗	✗	✗
Colombia	✓	✓	✓	✗	✗	✗
Mexico	✓	✓	✓	✗	✗	✗
Paraguay	✓	✓	✗	✗	✗	✗
Uruguay	✓	✓	✗	✗	✗	✗
NORTH AMERICA						
Canada	✓	✓	✓	✓	✓	✗
United States	✓	✓	✓	✗	✓	✗
OCEANIA						
Australia	✓	✓	✓	✓	✓	✗
New Zealand	✓	✓	✓	✗	✓	✗
MIDDLE EAST AND NORTH AFRICA						
Egypt	✓	✓	✗	✗	✗	✗
Iran	✓	✓	✓	✗	✓	✗
Israel	✗	✓	✓	✗	✓	✗
Jordan	✗	✓	✗	✗	✗	✗
Lebanon	✗	✓	✓	✗	✓	✗
Morocco	✓	✓	✓	✗	✓	✗
Palestine	✗	✓	✗	✗	✗	✗
Syria	✓	✗	✗	✗	✗	✗
Tunisia	✓	✓	✗	✗	✓	✗
SUB-SAHARAN AFRICA						
Ghana	✓	✗	✗	✗	✗	✗
Kenya	✓	✓	✓	✗	✗	✗
Mauritius	✓	✓	✓	✗	✓	✗
Senegal	✓	✓	✓	✗	✗	✗
Seychelles	✗	✗	✓	✗	✗	✗
South Africa	✓	✓	✓	✗	✗	✗
Tanzania	✓	✓	✓	✗	✗	✗
Zanzibar	✓	✗	✗	✗	✗	✗

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 programmes (NSPs)

In 2016, 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. Since the last edition of the *Global State* was published in 2014, there has been no change in the number of countries implementing NSPs. This is the first time since the inception of the *Global State* in 2008 that there has been no increase to report in the number of countries adopting this life-saving intervention.

The number of operational NSP sites and the coverage provided through existing services varies widely among countries and regions. According to available data, a total of 17 countries have scaled-up NSP services between 2014 and 2016. These include: Nepal, Taiwan, Belarus, Czech Republic, Georgia, Hungary, Latvia, Lithuania, Moldova, Poland, Romania, Ireland, Sweden, Egypt, Kenya, South Africa and the US. The greatest increase in NSP provision has been seen in Taiwan, where 1,254 NSP sites now operate.[14] However, it is important to note that while the data in the *Global State* 2016 represent the most robust available estimates, these are not always recent, and improvements in data surveillance regarding service provision are needed.

In many low- and middle-income countries, NSP coverage continues to be insufficient to prevent HIV and hepatitis C epidemics among people who inject drugs. Worryingly, in 20 countries NSP provision has decreased since 2014, these include: Afghanistan, China, India, Malaysia, Thailand, Kyrgyzstan, Slovakia, Slovenia, Austria, Belgium, Finland, Germany, Greece, Luxembourg, Norway, Spain, Iran, Morocco, Mauritius and Tanzania.

Even in countries with good levels of NSP coverage, important gaps continue to exist. Reaching migrant communities, especially undocumented migrants, is difficult and many services still do not allow the provision of needles for people under the age of 18, which is now an explicit recommendation within UN technical guidance.[15] Further reported issues hindering effective NSP provision are limited after-hours services, geographic access and stigma and discrimination experienced by people who inject drugs accessing harm reduction services in some settings.[16]

Of 158 countries and territories where injecting drug use has been reported, 68 still have no needle and syringe programmes in place.

Opioid substitution therapy (OST)

In 2016, 80 countries and territories implement OST. Although this figure is the same as reported in 2014, OST has been newly implemented in Monaco (including within prisons), Senegal and Kenya. In 2014, the *Global State* reported that OST was available in Burkina Faso which has since been disproved. Although the United Arab Emirates and Bahrain do provide OST, this service is available for detoxification purposes only and is therefore not categorised as a harm reduction response.

Methadone and buprenorphine are the most commonly used OST medications, but in some countries others are also provided, including slow-release morphine and codeine and heroin-assisted treatment.[17] The number of sites providing OST and the proportion of people that receive opioid substitution therapy remains substantially higher in most high-income countries. Similar to NSP, low-and middle-income countries often have the fewest number of OST sites.

Since 2014, 16 countries have scaled-up their provision of OST services, including: China, Indonesia, Malaysia, Myanmar, Nepal, Taiwan, Vietnam, Belarus, Estonia, Hungary, Kyrgyzstan, Latvia, Macedonia, Montenegro, Iran and Mauritius, with Iran increasing provision by 1,708 sites. However, provision of OST has decreased in several countries in Eurasia, with fewer sites reported in Moldova, Romania, Serbia, Slovenia and Tajikistan.

As previously reported in 2014, coverage of existing programmes in many countries remains substantially below minimum levels recommended by international guidance. Improvement in scale and quality are urgently needed to ensure that interventions achieve the greatest impact.[4]

Of 158 countries and territories where injecting drug use is reported, 78 have no provision of opioid substitution therapy in place.

Hepatitis C treatment access for people who inject drugs

Approximately 80 million people are living with hepatitis C worldwide, with an estimated two-thirds of cases found among people who inject drugs.[18] In 60-80% of cases, the hepatitis C infection becomes chronic and approximately 700,000 people with chronic hepatitis C die untreated each year.[18]

Prior to the development of direct-acting antivirals (DAAs), hepatitis C treatments based on interferon had cure rates of less than 50%. DAAs have transformed cure rates to 90% and are not only much more effective, but are a far less aggressive form of treatment.[18] One of the central barriers to DAAs access is price. In Brazil, a 28-day supply of one of the generic DAAs (sofosbuvir) is US$2,292. In Romania the same drug costs US$16,368,[18] and in Japan a 12 week course of sofosbuvir is US$37,729.[19] Gilead Sciences, which owns a 20-year patent on sofosbuvir (marketed as Sovaldi®), is able through the effective monopoly granted by the patent, to charge any price that it estimates a given market can bear.[19]

Asia is one of the regions disproportionally affected by hepatitis C with approximately 70% of people who inject drugs in the region living with the virus.[20] In 2015, Gilead Sciences (one of a number of companies who produce hepatitis C medicines) issued voluntary licences to 11 Indian generic producers, allowing them to produce and market generic sofosbuvir to selected markets with a 7% royalty payment to Gilead.[21] The 101 countries chosen by the company that can benefit from this scheme include Afghanistan, Bangladesh, Bhutan, Cambodia, Indonesia, India, Malaysia, Mongolia, Myanmar, Nepal, Pakistan, Sri Lanka, and Vietnam.[22] Generic sofosbuvir can potentially be sold in these countries for as little as US$300 per month,[23] but countries need to register to create regulations for its use, and this is taking time in some settings. In 2015, Georgia launched a new hepatitis C elimination programme, with an exceptional donation of free Sovaldi,® which Gilead announced as an experiment to show the impact of access to the medicine in an entire small country. This initiative should extend coverage from 5,000 to 20,000 in the coming years and will include people who use/inject drugs.[18]

In March 2016, the Australian government made directly-acting antiviral treatments for hepatitis C available free of charge without restriction relating to drug use or disease stage – only the second country in the world to do so.[24] The availability of these new treatments through the Pharmaceutical Benefits Scheme (PBS) has seen an estimated 26,360 people initiating treatment between March to September 2016, compared with 7,296 in 2015.[25]

Gilead and other companies have not offered the possibility of generic drugs to many middle-income countries, like China, with a high burden of hepatitis C.[26] In some countries, the high cost of the medicines becomes one more reason to justify inaction around a disease that threatens the lives of people who inject drugs.[26] Although progress has been made in some countries, there is still a great way to go to ensuring treatment services are accessible, including for people who inject drugs who are disproportionally affected by the virus.

Price, however, is not the only barrier to treatment access. 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, despite clinical trials showing that tailored services for people who inject drugs have high adherence and retention rates.[27, 28] In October 2016, a report by the World Health Organization (WHO) highlighted that special efforts must be made to ensure treatment services are accessible to people who inject drugs, through adopting enabling policies and guidelines and decentralising care. Involving people who inject drugs in the development, implementation and oversight of hepatitis C services is also essential.[18]

Amphetamine-type stimulants (ATS)[d]

It has been estimated that between 13.9 million and 54.8 million people use amphetamines worldwide,[29] with more than 60% of global ATS use thought to be concentrated in Southeast Asia.[30] The wide-ranging global figures reflect the current lack of accurate data on amphetamine use. Data collection methods often vary from country to country, and some countries do not collect or analyse data at all, meaning that data are extremely limited and obtaining an estimate of global use is challenging. However, according to reports from civil society, academics, NGOs and international agencies ATS use is increasing in countries in every region of the world.

In Australia, for example, there has been a rise in methamphetamine use between 2010 and 2014, with methamphetamine reported as the last drug injected by one-third of respondents in the 2014 Australian Needle and Syringe Program Survey (ANSPS).[31] More than 200,000 people are reported to be using crystalline methamphetamine (commonly known as 'ice') in Australia, an increase of 100,000 since last reported in 2007.[32] Increased ATS injecting, and high levels of marginalisation have been common factors in a number of the recent HIV outbreaks in some countries in Western Europe.[33] Crystalline methamphetamine is reported to be increasing in availability, including in countries where methamphetamine use has not been commonly reported in the past, such as Germany.[34] The Czech Republic has seen an increase in methamphetamine use from an estimated 20,000 people using methamphetamines in 2007, to over 36,000 in 2014, with injecting being the primary route of admission.[35]

Very few harm reduction interventions are tailored towards people who use ATS and there is an urgent need for adapted harm reduction responses given the increase in ATS injecting.[36]

Drug Consumption Rooms

In addition to other effective harm reduction approaches such as OST[37] and NSP[38] provision, ten countries around the world operate drug consumption rooms (DCRs), also known as supervised injecting facilities (SIFs), or Medically Supervised Injecting Centres (MSIC).[39] All but two of these services are found in Western Europe – the exceptions being in Vancouver, Canada, and Australia. DCRs are professionally supervised healthcare facilities where people can consume drugs in safe conditions. DCRs aim to attract hard-to-reach populations who may usually use drugs in risky and unhygienic conditions. One of the primary goals is to reduce morbidity and mortality by providing a safe environment and by training people on safer drug use. DCRs initially evolved as a response to health and public order problems linked to open drug scenes and drug markets in cities where a network of harm reduction services already existed but where difficulties were encountered in responding to the needs of people who use drugs.[40]

In 2016, there are 90 DCRs operating worldwide in Canada, Australia, Denmark, France, Germany, Luxembourg, Netherlands, Norway, Spain and Switzerland. In October 2016, a DCR was introduced in Paris, France, and an increase in DCR sites has been seen in the Netherlands and Canada since the *Global State* last reported. However, both Switzerland and Spain have reduced the number of sites by one. At the time of reporting, both Ireland and Scotland plan to introduce supervised injecting facilities during 2016/7.[41, 42]

Overdose

In 2013, a systematic review found that overdose and AIDS related mortality were the leading causes of death for people who use drugs.[43] In its 2014 *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations,* the World Health Organization recommends that people likely to witness a drug overdose (including people who inject drugs and their families and friends) should have access to naloxone and training on how to use it. Naloxone, a highly effective opioid antagonist, is still unavailable outside of hospitals in many countries around the world. More countries are now implementing peer-distribution of naloxone, but on a global scale this remains limited.

North America continues to have the highest drug-related mortality rate in the world, contributing to an estimated 25% of drug-related deaths globally.[9] In the United States, the rate of fatal drug overdose has increased by 137% since 2000, with more people dying from drug overdoses in 2014 than during any previous year on record, 61% of which were opioid-related.[9, 10] Across the border in Canada, drug overdose deaths have jumped 327% since 2008.[11] Overdose also continues to be a major cause of death among people who use drugs in Western Europe, with more than 6,000 deaths among this population each year, many involving opioids.[44] And in the UK, there has been a 64% increase in drug-related deaths linked to heroin and morphine in the last two years, now the highest ever recorded in the country.[12, 13]

[d] Although amphetamines are often grouped with ecstasy in the category amphetamine-type stimulants, this report limits its scope to amphetamine, methamphetamine, cathinone and methcathinone.

The reasons behind these rises in fatal overdose are unclear but a number of factors may be involved including: increased heroin availability and prevalence of its use, higher purity, the increased levels of morbidity linked to an ageing cohort of people who use opioids, as well as changing consumption patterns, including the use of highly potent synthetic opioids and medicines.[45]

Developments have taken place in North America in response to this epidemic. In the US, 37 states and the District of Columbia have now enacted some form of Good Samaritan laws to protect people from arrest or prosecution for drug possession when they call for help in the event of an overdose.[46] Additionally, as of May 2016, naloxone programmes for law enforcement had begun in at least one municipality in 35 states.[47] In Canada, the federal government removed naloxone from the prescription drug list in March 2016 to allow its emergency use, without a prescription, outside of hospital settings.[48, 49] In a further move to make naloxone more accessible, Canada's health Minister officially authorised naloxone nasal spray for non-prescription use in October 2016.[50]

Unlike hepatitis C treatment, it is restrictive policies and scheduling naloxone as a prescription-only drug in many countries, rather than price, that limit its availability. However, given the increasingly high overdose rates documented, it is urgent that naloxone distribution is scaled-up to meet need.

Prisons

Despite some momentum around decriminalisation in the last years, the global response to drugs remains predominantly punitive.[51] As a result, around 1 in every 5 prisoners worldwide are being held on drug-related charges.[9] UNAIDS estimates that 56-90% of people who inject drugs will be incarcerated at some stage.[52] Injecting drug use continues to be consistently documented in prisons around the world and the prevalence of HIV, HCV and TB remain substantially higher inside than outside of prisons.[53] A recent comprehensive review of the global disease burden in prisoners found that of the approximately 10.2 million people incarcerated at any given time, an estimated 3.8% are living with HIV, 15.1% with HCV, and 2.8% with active TB.[53] Findings from this year's *Global State* reveal that the provision of harm reduction services in prison settings continues to be inadequate and far behind that of the wider community.

In 2016, only 8 countries implement NSPs in at least one prison – Armenia, Germany, Kyrgyzstan, Luxembourg, Moldova, Spain, Switzerland, and Tajikistan. Civil society report that since 2014, Iran has ceased to make NSPs available to prisoners, signalling the end of NSP provision in prison settings in the MENA region.[54] NSPs are entirely unavailable to prisoners in seven out of the nine regions reviewed in the *Global State* report. Important legal and policy developments in France and Nepal, however, could – with a little political courage – see the introduction of NSPs in prisons in both countries soon.

At present, some form of OST is provided in prisons in 52 countries, representing a 21% increase since the *Global State* last reported. Notably, in the past two years OST has been initiated in at least one prison in India, Lebanon, Macau, Morocco, and Vietnam, while the service has been expanded to two more prisons in both Greece and Moldova. Guidelines on OST in prisons have also been developed in Tajikistan, although actual implementation of the service is still under consideration. Despite this important progress, the quality of prison-based OST varies considerably and serious barriers, including stigma and discrimination, unnecessary restrictions and long waiting times persistently impede access to this essential service where it does exist.

Despite a continued lack of systematic monitoring on the availability, accessibility and quality of diagnostics, treatment and care for HIV, HCV and TB in the world's prisons, existing data suggest that these also continue to fail to meet prisoners' needs in most countries.[53] At the same time, the fact that prisoners face a heightened risk of overdose following their release remains a very serious, yet almost universally neglected, issue in practice.[55] In 2016, it appears that only England, Scotland, Wales, Estonia, Norway, Spain, some parts of Canada and the United States provide varying degrees of overdose prevention training and naloxone to prisoners on or prior to their release.

Prison-based harm reduction continues to be extremely vulnerable to budget cuts, financial crises, and changes in political environments globally. Regional overviews paint a bleak picture: harm reduction in prisons is either absent or plagued by restrictions, inconsistency and uncertainty. The provision of good-quality and accessible harm reduction, both inside and outside of prisons, is not a policy option but a legally binding human rights obligation.[56] It must be urgently prioritised – and resourced - by political leaders and prison authorities, and national, regional and international prison monitoring mechanisms should systematically examine issues relating to harm reduction during their prison

visits.[57] At the same time, efforts to provide alternatives to prison for people who use drugs must be intensified.

International policy developments

United Nations Developments

The United Nations General Assembly Special Session on Drugs (UNGASS) took place in New York from 19–21 April, 2016.[58] This event was the first such Special Session since 1998. It was originally scheduled to take place in 2019, to coincide with the completion of the 2009 Political Declaration on drugs,[59] but the governments of Colombia, Mexico and Guatemala called for this meeting to be brought forward to reflect the urgent need for debate and review[60] – a proposal that was supported by 95 member states at the UN General Assembly.

Harm reduction civil society groups viewed the UNGASS on drugs as an important moment to make progress in securing international recognition of harm reduction, and to move beyond the diplomatically ambiguous language of "related support services" that was eventually agreed in the 2009 Political Declaration.

Ahead of the UNGASS itself several UN agencies inputted submissions into the process which explicitly supported harm reduction including UNAIDS,[7] WHO,[61] UNDP,[62] the UN University[63] and the Office of the High Commissioner on Human Rights (OHCHR).[64] Other intergovernmental bodies such as the European Union and African Union also supported harm reduction through submissions to the process.[58]

In February 2016, an Informal Interactive Stakeholder Consultation was held in New York to solicit views from civil society and UN agencies about what the UNGASS outcome document should include. HRI and other NGOs called for a strong endorsement of harm reduction and for member states to redirect funding from drug enforcement to harm reduction programmes, in line with our '10 by 20' campaign.[65]

Despite promises that the preparatory process for the UNGASS would be held in an inclusive and consultative manner,[58] the final outcome document was negotiated by member states during 'informal meetings' to which UN agencies and civil society had no access. The final outcome document[3] was adopted without plenary discussion on the first day of the UNGASS on Drugs meeting and was followed by member states' statements and five thematic round tables.[66]

The UNGASS outcome document secured a commitment from member states to 'minimising the adverse public health and social consequences of drug abuse'[65] and invites national authorities to consider specific interventions including 'medication assisted therapy', 'injecting equipment programmes', 'antiretroviral therapy' and 'opioid receptor antagonists' such as naloxone for the treatment of overdose. It also urges states to provide these interventions in prisons and other custodial settings. In addition, the UNGASS document welcomes the Sustainable Development Goals (SDGs) and commits (in line with SDG target 3.3) to end AIDS and tuberculosis by 2030 and to "combat" viral hepatitis and other communicable diseases among people who use and inject drugs.[3]

The term 'harm reduction' itself is not mentioned in the UNGASS outcome document, despite this being agreed language at the UN General Assembly level. While the mention of harm reduction interventions and the call to provide these in prisons can be seen as a step forward, civil society groups remain disappointed that the term harm reduction was not included in the final document. 46 member states did, however, endorse or mention the need for harm reduction during the thematic round tables or in their plenary statements.[67] The Czech Republic, Estonia, Latvia, Lithuania, Poland, Romania and Slovenia all made statements in explicit support of harm reduction.[68] The European Union's common position, which included Macedonia, Serbia, Ukraine, Albania, Bosnia & Herzegovina, Moldova and Georgia, also stated that harm reduction, as a proven effective measure in preventing overdose and the transmission of blood borne diseases, should be further promoted and implemented.[68] In the Latin America region, Brazil, Costa Rica, Colombia and Uruguay all made statements in support of harm reduction, but several Asian nations failed to lend their support. Australia, a previous world leader in harm reduction, made no reference to harm reduction in their statement. Although still refusing to mention the words 'harm reduction' in national policy and international forums, the US government is beginning to adopt more of a public health approach to drugs and continues to endorse harm reduction interventions.[47] At the UNGASS it specifically urged Member States to scale-up their public health responses to drugs and to adopt evidence-based interventions such as OST and NSPs.[69]

The UNGASS document also includes the strongest human rights provision ever adopted in a UN drug control resolution,[70] with Paragraph 4(o) calling on member states to adopt "practical measures to uphold

the prohibition of arbitrary arrest and detention and of torture and other cruel, inhuman or degrading treatment or punishment and to eliminate impunity".[3] It is the only human rights provision which urges states to bring drug enforcement activities in line with international human rights obligations without making any concession to national law.

A High Level Meeting (HLM) on Ending AIDS also took place in 2016, from 8 – 10 June in New York. The preparatory process was led by Zambia and Switzerland. While some elements of civil society engagement were improved ahead of the HLM, such as a funded Civil Society Task Force (CSTF),[71] 22 organisations representing key population groups such as LGBT groups, sex workers and people who use drugs were excluded from the process by a group of member states including Russia, Cameroon and Tanzania.[72]

While it has the usual caveats to national legislation, paragraph 43 of the Political Declaration[73] explicitly admonishes the lack of progress in expanding harm reduction services, mentions the need to remove restrictive laws and advocates a focus on women, young people and prisons. This is the first ever UN Political Declaration to advocate for the provision of harm reduction in prisons and other custodial settings.

Paragraph 62 (d) also includes a reference to "minimising the adverse public health and social consequences of drug abuse", using the weaker UNGASS language.[73] It is HRI's understanding that during the negotiations, conservative states would only accept one reference to harm reduction.

Global leadership on harm reduction

As described above, the UNGASS on drugs and the HLM on Ending AIDS secured clear commitments to provide harm reduction services, largely thanks to a number of champion governments. While there were important references, there were also significant gaps. For instance, the 2011 Political Declaration on HIV included a specific target to reduce transmission of HIV among people who inject drugs (PWIDs) by 50% by 2015.[8] A new target to reduce HIV among people who inject drugs was not included in either of the 2016 documents,[74] suggesting a decline in global political leadership on harm reduction over the last two years, particularly from UNAIDS. In his review of the 2011 Political Declaration, the UN Secretary General reported that there had been "mixed progress" in halving new HIV infections among people who inject drugs,[2] when in reality the world has failed to meet this target by more than 80%.

This is one of several recent examples where UN agencies, and in particular UNAIDS, have missed an opportunity to hold governments who refuse to support even basic harm reduction services accountable for their inaction. In May 2016, UNAIDS again did not put the burden on governments to act when it released figures estimating that just US$1.5 billion was needed to deliver harm reduction globally.[7] This figure excluded high-income countries altogether and assumed that upper middle-income countries would cover their own resource needs. By approaching resource needs in this way, HRI calculates that UNAIDS has excluded some three-quarters of people who inject drugs globally, with those left out living in countries like the USA, Russia, Greece, Hungary, Bulgaria, Thailand, China, Mauritius and Belarus, where harm reduction programmes are often severely limited. With 22 other civil society organisations, HRI wrote to UNAIDS Executive Director Michel Sidibe to raise concerns about these estimates and to urge UNAIDS to recruit a new focal point on people who inject drugs following the previous post holder's departure.[75] However, the figures have not been revised and the focal point role has been merged into a wider key populations role, significantly reducing the time and commitment that UNAIDS can dedicate to harm reduction.

Over the period 2015-2017, UNAIDS will cut its UBRAF funding for the UNODC HIV team by 75%, further reducing UN capacity and leadership on the health and rights of people who use drugs. UNODC is already warning that a number of its national and regional programmes are at risk of closure, an outcome that would squander advances made with law enforcement agencies, prison authorities and other traditional opponents of harm reduction. UNODC also warns that it will now be impossible to deliver the targets set out in the UNAIDS fast track strategy.

The global state of harm reduction funding

Funding for harm reduction remains critically low in many parts of the world. Overall, the international donor funding for the HIV response that has supported harm reduction in low- and middle-income countries is in decline. Donor contributions totalled US$8.2 billion in 2015, dropping 7% from the previous year,[76] whilst increasing donor focus on least developed countries means that middle-income states can no longer rely on donors to support their national HIV programmes.[76][a] The Global Fund, which remains the largest funder

[a] There are exceptions to this, including for example the Dutch Ministry of International Affairs (BUZA), the Elton John AIDS Foundation, Open Society Foundations, and PEPFAR.

of harm reduction, has stated that "all upper-middle income countries regardless of disease burden and all lower-middle income country components with low or moderate disease burden, should begin or build upon transition preparations during the 2017-2019 period",[f] and has produced a list of 24 countries that are projected to become ineligible in the coming years.(6) Echoing international donor trends, UNAIDS has emphasised within its Fast-Track strategy that governments of upper middle-income countries must fund their own HIV responses.(73) They also state that "special provisions may be needed where the draw-down of donor funding might result in de-funding of essential programmes for key populations in upper-middle-income countries"'(73)

More positively, in June 2016, the United States President's Emergency Plan for AIDS Relief (PEPFAR) launched a new US$100 million Key Populations Investment Fund to expand access to proven HIV prevention and treatment services for key populations in PEPFAR's priority countries,(77) which include a number of states and regions in major need of harm reduction investment.

While domestic investment in HIV programmes is increasing in some countries, few are prioritising HIV prevention for key populations.[g] Among those governments reporting to UNAIDS on HIV prevention expenditure, only 3.3% of total HIV prevention funds were directed towards programmes for people who inject drugs. Within this, international donor funding represented three-quarters of the investment, compared with one-quarter from governments.(76) There are significant challenges and risks for countries being required to transition from international to domestically supported harm reduction programmes. The Eurasian Harm Reduction Network, with support from APMG, have developed the Transition Readiness Assessment Tool(78)[h] to analyse a country's readiness for, and the risks of, transition from donor funding to sustainable domestic financing of harm reduction programmes. The tool has been piloted so far in Albania, Bosnia and Herzegovina, Macedonia, Montenegro and Romania.(79)

To fully understand the gaps and upcoming shortages in harm reduction funding, and to allocate limited resources most effectively, it is becoming increasingly important to map existing investment at national level. Civil society organisations are leading on these efforts in Europe, Asia and the Middle East and North Africa (see regional chapters for more details). Key harm reduction donors, including the Global Fund and PEPFAR, are also making efforts to increase transparency of their investments in programmes for key populations. PEPFAR recently announced that they will be making quarterly data publicly available via the PEPFAR dashboards, including information relating to their investment in programmes for people who inject drugs.(80)

The Global Fund

In the previous iteration of the *Global State*, concerns that the New Funding Model (NFM) would decrease the Global Fund's support for harm reduction were raised. The Global Fund analysis of approved NFM funding is partially complete, showing that by May 2016, US$142 million of approved NFM funding was allocated to programmes for people who inject drugs (see table 1).[i] As expected, the highest proportion of the US$142 million was allocated to NSP and OST (22.1% and 13.8% respectively) with another substantial proportion for management costs (17.2%).(112)

[f] GFATM Eligibility criteria http://www.theglobalfund.org/en/fundingmodel/process/eligibility.
[g] Key populations are those both vulnerable and most-at-risk of HIV infection, including people who inject drugs.
[h] The tool and user manual can be downloaded from the EHRN website http://www.harm-reduction.org/library/transition-readiness-assessment-tool-trat.
[i] This amount covers 58.32% of the total NFM allocation for HIV & TB/HIV which amounts to US$7,756,993,172. A total of 98 out of 150 Grants had been analysed at the time of writing from 62 of 110 Countries that the Global Fund funds, as well as 2 out of 7 Multi-Country Grants.

Table 1: Global Fund funding for programmes for people who inject drugs from 58% of approved NFM grants[112]

Band[j]	Total funding for PWID (US$)	Median % of country HIV allocation
Band 1 Bangladesh, Benin, Burkina Faso, Burundi, Cambodia, Chad, Congo (DR), Kenya, Myanmar, Nigeria, Senegal, Sierra Leone, South Sudan, Tanzania, Vietnam, Zanzibar	61,326,494	4.2%
Band 2 Djibouti, Laos	63,947	0.3%
Band 3 Indonesia, Philippines, Russian Federation, Thailand, Ukraine	56,125,659	21.2%
Band 4 Armenia, Azerbaijan, Belarus, Bhutan, Iran, Mauritius, Moldova, Mongolia, Paraguay	20,528,373	15.4%
Multi-country Eastern Europe (Belarus, Georgia, Kazakhstan, Moldova and Tajikistan)	4,500,000	N/A

Further analysis on certain country allocations is necessary to ascertain the extent to they have resulted in harm reduction service provision. In Nigeria, for example, US$8 million disbursed for harm reduction in 2015 may have been redirected to more politically supported HIV programming.[81] Once the analysis is complete, it may show that the overall allocation of Global Fund funding for harm reduction under the NFM will be comparable to that of the previous Round Based Model. These totals will mask many differences in national allocations, however, especially the inclusion of harm reduction components in Band 1 countries, such as Myanmar. The extent to which funding has declined in Band 4 countries is not yet clear, but extreme concerns remain for those that have been reliant on Global Fund monies for harm reduction and wider HIV prevention – especially in Eastern Europe, Central Asia and the Middle East.[82] The Global Fund allocation methodology continues to disadvantage these countries and several are now experiencing the reduction or complete loss of harm reduction support without any planned transition to national funding.

The recent replenishment saw donors pledge US$12.9 million to the Global Fund. It is essential that efforts are made to ensure that this success benefits all aspects of the response to HIV, TB and malaria, leaving no-one behind. The Global Fund should remain global and restrictions from its donors, such as the funding condition from the UK Government that 85% of money be spent on low and lower-middle income countries,[83] should be rejected or rebalanced elsewhere. It is paramount that checks are in place to ensure grants are awarded on the basis of technically sound proposals which include adequate funds for harm reduction where there is a need. In addition, the US$800 million set aside by the Global Fund Board for 'catalytic investments' must be made available to protect harm reduction services in countries where these will not be supported by governments.

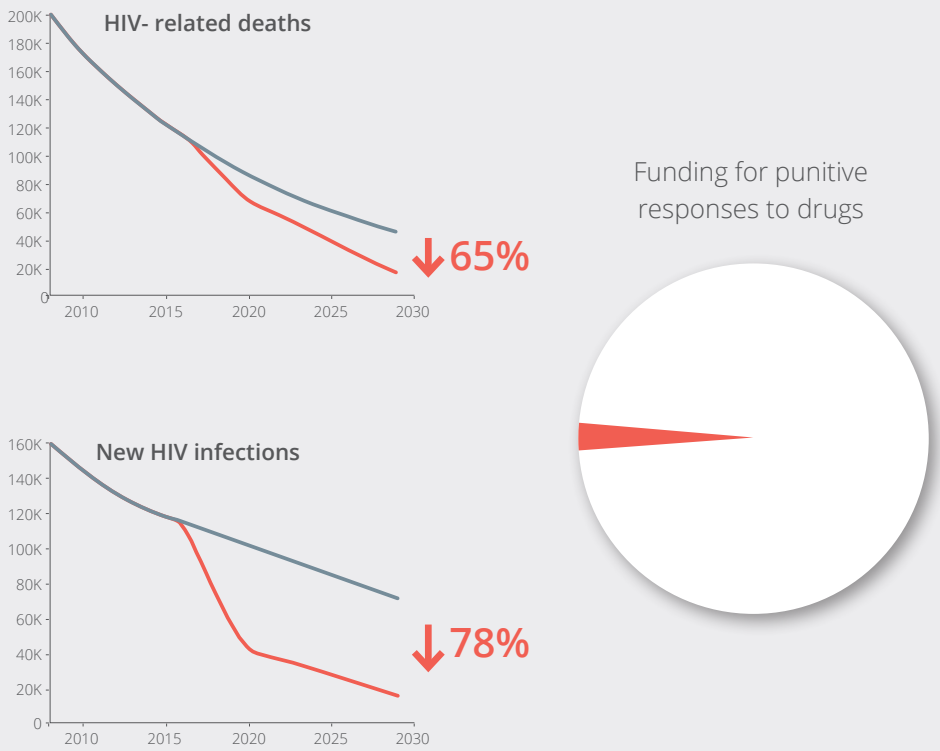
The '10 by 20' campaign

What is clear from the sections above is that harm reduction cannot rely on HIV-related funding from donors and governments – both because the available funding is shrinking but also because harm reduction is much broader than HIV prevention and treatment, including responses to TB and viral hepatitis, prevention of overdose, efforts to strengthen the capacity of people who use drugs, advocacy for human rights, and much more. In recognition of this, HRI launched the international '10 by 20' campaign in 2015, calling on governments around the world to redirect 10% of the estimated US$100 billion that they currently spend each year on drug enforcement to harm reduction.

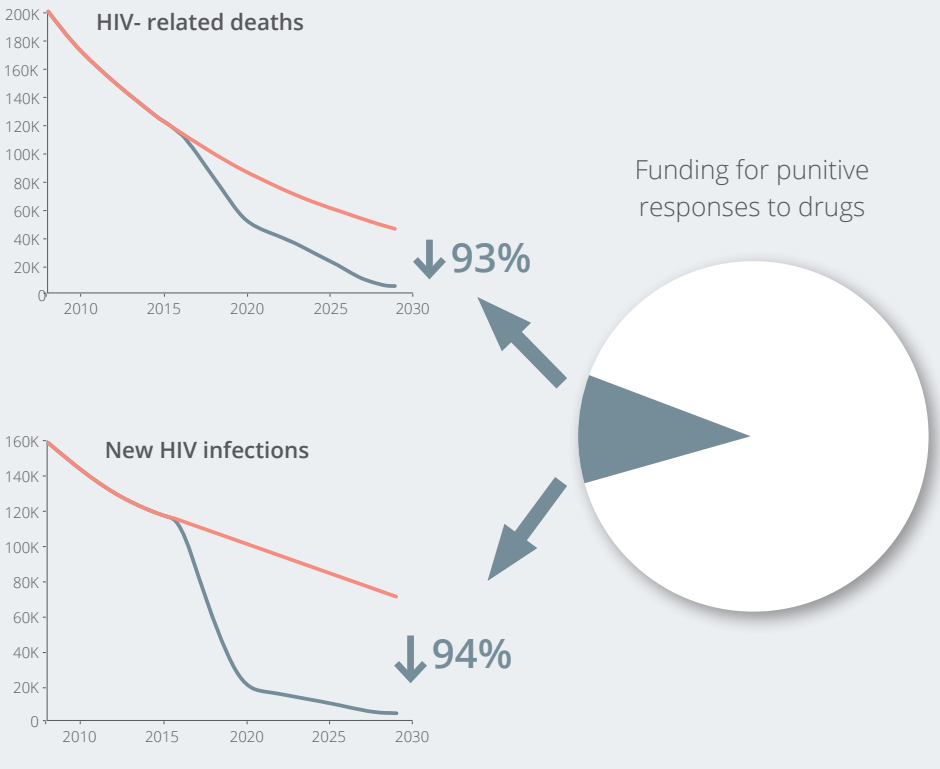
Recent research by HRI and the Burnet Institute used mathematical modelling to show some of the potential impacts of redirecting just 2.5% (US$2.5 billion). It found that these funds would support medium coverage of NSP, OST and ART for people who inject drugs and that by 2030, this would result in a 65% reduction in HIV-related deaths and a 78% reduction in new HIV infections among this key population. Increased to 7.5% (US$7.5 billion), this investment would deliver high coverage of harm reduction services worldwide and would come close to ending AIDS among people who inject drugs by 2030.

[j] The Global Fund NFM classifies countries into bands using the following criteria and allocations: Band 1 – below US$2,000 GNI, above disease burden threshold with US$11.2 billion between 2014-2016; Band 2 – below US$2,000 GNI, below disease burden threshold with US$915 million between 2014-2016; Band 3 – above US$2,000 GNI, above disease burden threshold with US$1.5 billion between 2014-2016; Band 4 – above US$2,000 GNI, below disease burden threshold with US$1.1 billion between 2014-2016.

Impact of resource shift to fund MEDIUM harm reduction coverage levels



Impact of resource shift to fund HIGH harm reduction coverage levels



Human rights and harm reduction

In 2008, the then Special Rapporteur on the right to health noted that that the UN human rights and drug policy regimes operated as though they existed in 'parallel universes'.[84] Eight years later, human rights concerns are now slowly but steadily being mainstreamed into the global response to drugs, with several important developments occurring in the last two years.

In September 2015, the UN Human Rights Council convened its first ever high-level thematic panel on drug control[85] during which the Office of the High Commissioner for Human Rights presented its authoritative 'Study on the impact of the world drug problem on the enjoyment of human rights'.[64] The report concludes that "the right to health should be protected by ensuring people who use drugs have access to health-related information and treatment on a non-discriminatory basis", and recommends that harm reduction programmes be available for people who use drugs, "especially those in prisons and other custodial settings."[64] This report shows a growing attention to drug control by the High Commissioner's office over the past several years, and lays the groundwork for continued engagement on these issues.

The UNGASS on drugs was another important step in bridging the historic divide between human rights and drug policy. During the session, 'human rights' was agreed as one of the cross-cutting themes, with a roundtable held on the issue.[k] Over the course of the UNGASS, over 60 Member States voiced their opposition to the practice of the death penalty for drugs.[86] Several of the UN Special Procedures, including the Special Rapporteurs on health and torture, also made powerful interventions into the process.[87] Their open letter reaffirmed that harm reduction is not merely a policy option for States, but rather "a legal obligation as part of State obligations to progressively realize the right to health and to guard against inhuman and degrading treatment."[87] As noted above, the UNGASS outcome document includes an important provision calling on states to adopt measures to bring drug enforcement activities in line with human rights obligations.[70]

The following month, ahead of a High-Level Meeting on Ending AIDS, the Special Rapporteur on the right to health and his two predecessors published a joint article in which they declared that ending AIDS by 2030 would not be possible without harm reduction. Recognising that people who inject drugs have been among those left furthest behind in the global response to HIV, they urged Member States to take action by committing to "fully funding harm reduction programmes" and "removing punitive frameworks that fuel mass incarceration, HIV epidemics and overdose."[88]

Many UN treaty bodies have also continued to strengthen their positions on harm reduction in the last two years. The UN Human Rights Committee, for example, raised concerns with Russia in 2015 about its legal ban on OST, as well as its approach to the treatment of prisoners who use drugs, which it felt did not adequately protect them from torture and ill treatment.[89] In July 2016, the UN Committee on Economic, Social and Cultural Rights commended the introduction of harm reduction strategies in Sweden, but expressed concerns about prisoners' restricted access to OST, the prevalence of HCV among PWID, and the increasing rate of fatal overdoses in the country.[90]

Despite this attention, the fact remains that human rights violations linked to drug control and enforcement remain endemic in many parts of the world. One of the most glaring examples of this is the Philippines, where President Duterte's campaign to eliminate drug use has led to the State-sanctioned extra-judicial killing of more than 2,500 people accused of being drug vendors or drug users by police and armed vigilante groups since July 2016.[91] This brutal approach has been widely condemned by the international community, including the UN Secretary-General,[92] the International Narcotics Control Board,[93] and civil society.[94] Most recently, the Committee on Economic, Social and Cultural Rights urged the state to "stop and prevent extrajudicial killings and any form of violence against drug users", "adopt a right-to-health approach to drug use with harm reduction strategies, such as syringe exchange programs" and "increase the availability of treatment services that are evidence-based and respectful of the rights of drug users."[95]

Research and data collection

In the context of shrinking funding for HIV-related harm reduction in many parts of the globe, it is increasingly important that national governments allocate available resources to achieve optimal impact and the requirement to 'know your epidemic' remains crucial. Governments must have recent reliable national and local epidemiological data as well as a clear understanding of any limiting factors that may affect their investments. Civil society also must be equipped with this information in order to make informed advocacy calls for strategic investment in harm reduction.

[k] Video available here: http://webtv.un.org/search/round-table-3-30th-special-session-on-world-drug-problem-general-assembly/4855659142001?term=round%20table%203.

Since the last *Global State* report was published in 2014, harm reduction advocates have continued to make strong calls for UN agencies to reinstate an independent academic research group to carry out systematic reviews relating to injecting drug use, HIV and viral hepatitis, as well as the coverage of existing harm reduction programmes. The last systematic reviews were published in 2008 and 2010 by the Independent Reference Group to the UN on HIV and Injecting Drug Use,[96, 97] but with no updates since then there has been a dangerous overreliance on government reported data submitted to UN data-gathering mechanisms such as the Global AIDS Response Progress Reporting (UNAIDS) and the Annual Reports Questionnaire (UNODC). The extent to which these data have been subject to peer review, critique or are made public with transparent data sources varies considerably. Since 2014, systems have been established to improve collaboration between UN agencies and civil society on these datasets, but these do not substitute the need for an independent academic process. The implementation of programmes reaching people who use drugs remains highly political in many parts of the world and as such, these data are often also political, so independent academic processes to collate the most accurate reflections are essential.

In 2016, a consortium of academic researchers led by the University of New South Wales, in collaboration with WHO, UNAIDS, the Global Fund, Open Society Foundations and UNODC began systematic reviews of injecting drug use prevalence, HIV, HBV and HCV prevalence among people who inject drugs, as well as HIV prevention and treatment coverage, which are due to be published in 2017. This crucial work will inform programme planning, monitoring and evaluation, help to calculate the most accurate resource needs estimates and ensure strategic funding allocations, and be widely used by harm reduction advocates around the world.

Technical guidance

In 2015 and 2016, new guidance has emerged with regard to key populations and specific groups of people who inject drugs, both from UN agencies and civil society

- In June 2016, the World Health Organisation launched an update of the 2013 Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach. These guidelines incorporated an exhaustive review of new evidence and consultations to develop new recommendations. Recommendations include initiating all adults with a CD4 count of less than 350 cells/mm in ART, and a recommendation to roll out pre-exposure prophylaxis or PrEP.[98]
- The World Health Organisation launched an update of its 2014 consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations in July 2016. This update expands upon the previous version to include new international guidelines on treatment as well as recommendations related to PrEP, clearer guidance on the peer distribution of naloxone and the "decriminalisation of behaviours such as drug use/injecting".[99]
- In 2015, the World Health Organisation launched a tool to supplement the consolidated guidelines for HIV prevention, diagnosis, treatment and care for key populations. The tool "to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations" aims to provide guidance on monitoring and evaluating the implementation of the comprehensive package of interventions to address HIV among key populations, it recommends engaging NGOs, communities and service providers in the planning and assessment process of such programmes.[100]
- In July 2016, UNODC launched a guide to address the needs of women who inject drugs. This guide aimed to support service providers to develop gender sensitive programmes and to set targets to expand coverage and access for women who inject drug.[101]
- The needs of young people who inject drugs were prioritised through the development of a technical brief by WHO, UNFPA, UNHCR, NSWP, The World Bank, INPUD, UNDP, UNESCO, UNODC, MSMGF, UNAIDS, HIV Young Leaders Fund, ILO and UNICEF in September 2015.[102] In October 2015, HRI along with the International HIV/AIDS Alliance, Save the Children and YouthRise also launched Step by Step, a toolkit to help harm reduction service providers prepare for work with children and young people who inject drugs.[103]
- In January 2016, UNODC, in collaboration with INPUD and LEAHN, developed a set of guidelines to improve cooperation between law

enforcement officers and HIV service providers.[104] These guidelines build upon the training manual launched by UNODC in 2014 for law enforcement officials on HIV service provision for people who inject drugs.[105]

- In February 2016, HRI launched 'Monitoring HIV, HCV, TB and Harm Reduction in Prisons: A Human Rights-Based Tool to Prevent Ill Treatment'.[57] This Tool provides support to national, regional and international prison monitoring bodies to help ensure that violations of prisoners' rights in the context of HIV, HCV, TB and harm reduction are prevented and awareness is raised around the need to urgently address this gap in health provision.

Civil society action

The period before the UNGASS on drugs and the HLM on HIV in 2016 saw a major surge in international activism by harm reduction organisations, as well as greater coordination between the harm reduction, drug user and drug policy reform communities.

HRI convened and resourced an international Harm Reduction Working Group which, in 2014, agreed to use the UNGASS and the HLM to call for a new approach to drug use rooted in science, public health, human rights and dignity – for a harm reduction decade. This call was officially launched at the International Harm Reduction Conference in Kuala Lumpur in October, 2015, and since then it has been endorsed by over 1,100 individuals and organisations. During thematic roundtables at the 2015 Commission on Narcotic Drugs meeting and as part of the Informal Interactive Stakeholder Consultation in 2016, a number of civil society representatives used their speaking slots and interventions to call for a harm reduction decade and for specific commitments to scaling up harm reduction and protecting human rights.[65, 106]

These calls were also reflected in a significant increase in online activity around the UNGASS and the HLM, with civil society organisations using Twitter, Facebook, blogs and other online tools to ensure that their messages were clearly heard. In addition, over 200 organisations came together to form www.stoptheharm.org, an online platform campaigning for a new global drug policy system.

Harm Reduction networks continue to operate in every region of the world. Global networks which have a focus on harm reduction include YouthRISE, International Network of People who Use Drugs (INPUD),[107], International Doctors for Healthy Drug Policies (IDHDP), Law Enforcement and Public Health Network (LEPH), Women's International Harm Reduction Network (WIHRN) and the International Drug Policy Consortium (IDPC).

Regional harm reduction networks include the Eurasian Harm Reduction Network,[108] Correlation,[109] Middle East and North African Harm Reduction Network (MENAHRA), the Harm Reduction Coalition (USA) and Intercambios (Latin America).

Since the *Global State* reported in 2014, there have been significant developments in the visibility and resourcing of networks of people who use drugs. The European Network of People who Use Drugs relaunched in 2013 with a new governance structure and set of priorities.[110] Regional networks of people who use drugs also continue to operate in other parts of the world, with the continued growth of the Asian,[111] Eurasian (ENPUD), Middle East and North African (MENAPUD) and Latin America Networks of People who Use Drugs.[111]

The International Network of People who Use Drugs has also continued to grow since 2014, and in 2015, launched its consensus statement on drug use under prohibition.[107] Based on a set of regional consultations the consensus statement outlines the harms faced by people who use drugs and a set of advocacy priorities to mitigate such harms.

Civil society action continues to be central to the harm reduction response around the world. Harm reduction workers comprise a diversity of individuals, groups and organisations, including peer workers, outreach workers, service providers and advocates, who work tirelessly, often in hostile environments, to reduce the harms associated with drug use and drug laws and policies and to promote the rights to life, health, humane treatment and non-discrimination for people who use drugs. It is due to the commitment and tenacity of these individuals and organisations that harm reduction services are available in some parts of the world at all. Their value as human rights defenders and as the designers of the harm reduction response must be recognised. Protections must be put in place so that no harm reduction worker experiences human rights abuses in the course of their work, as is routine in countries such as Thailand and Russia, and so that harm reduction services can be effectively delivered to those who require them.

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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 organisation and advocates, mapping harm reduction policy adoption and programme implementation globally.

The Global State of Harm Reduction 2016 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 a wide range of audiences, such as international donor organisations, multilateral and bilateral agencies, civil society and non-government organisations, 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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