



The Global State of Harm Reduction 2016



20
YEARS



**HARM REDUCTION
INTERNATIONAL**

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The Global State of Harm Reduction 2016

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Abbreviations and acronyms

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



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

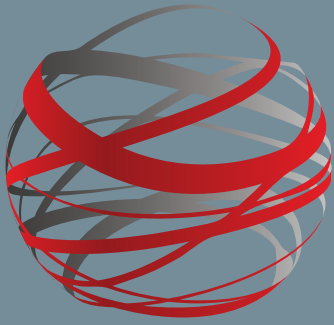
Section 1 provides a global overview of harm reduction policy and programming.

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.

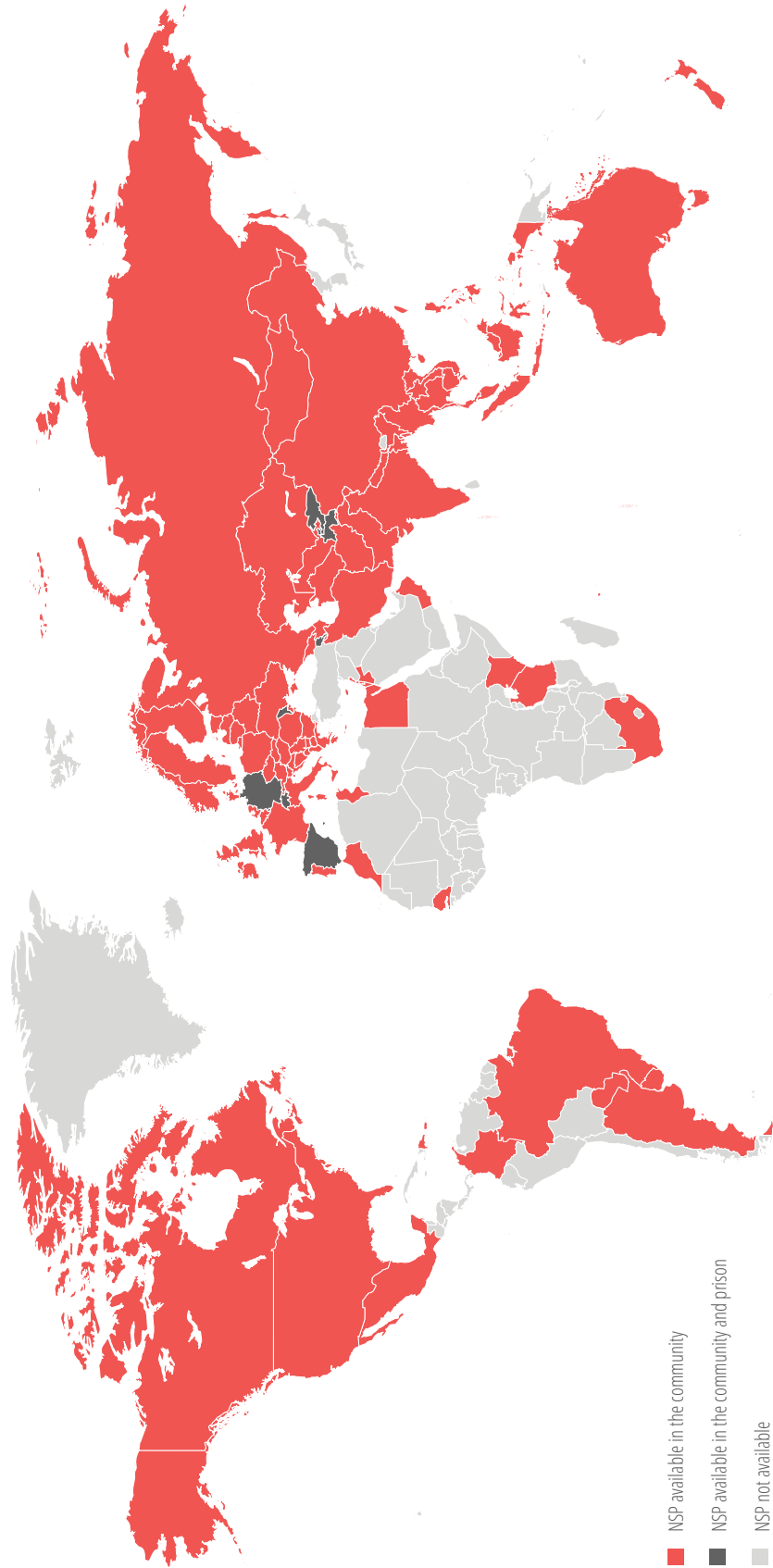


Country or territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid substitution programme operational	At least one drug consumption room	OST in at least one prison	NSP in at least one prison
EURASIA 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	✓	✓	✓	✗	✓	✗

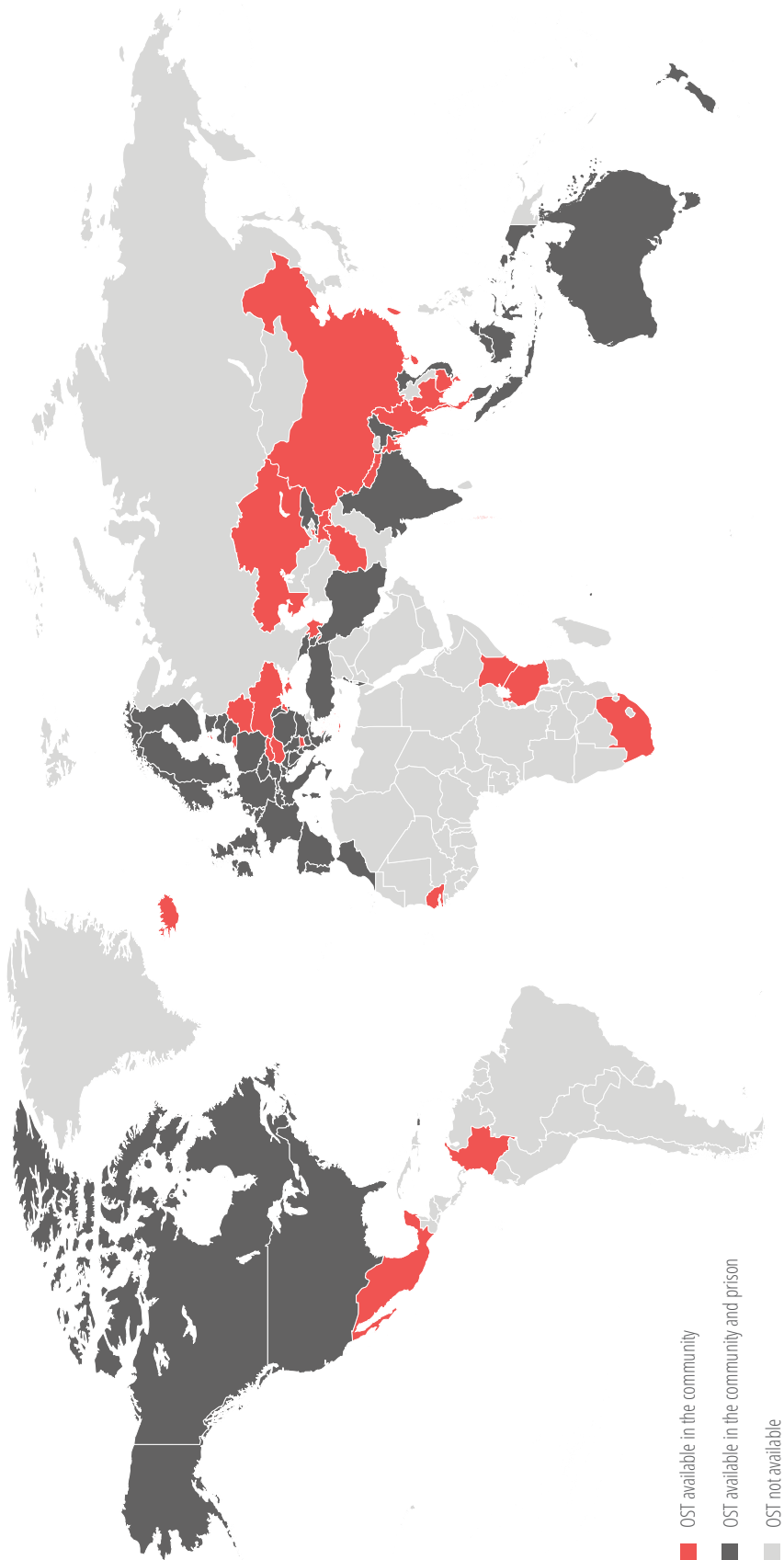
Country or territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid substitution programme operational	At least one drug consumption room	OST in at least one prison	NSP in at least one prison
CARIBBEAN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

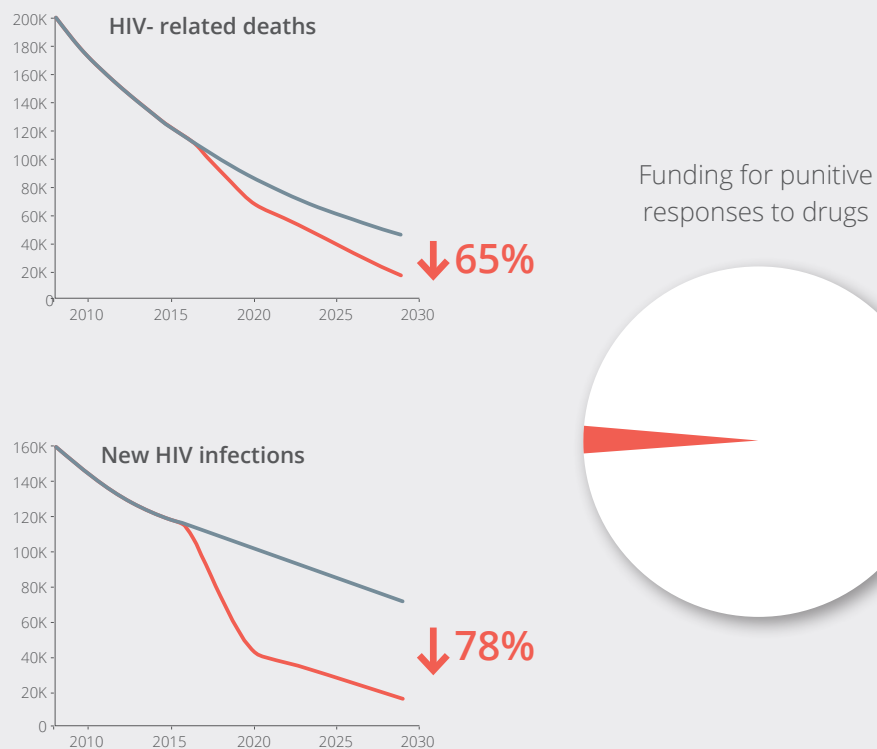
What is clear from the sections above is that harm reduction cannot rely on HIV-related funding from donors and governments – both because the available funding is shrinking but also because harm reduction is much broader than HIV prevention and treatment, including responses to TB and viral hepatitis, 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.

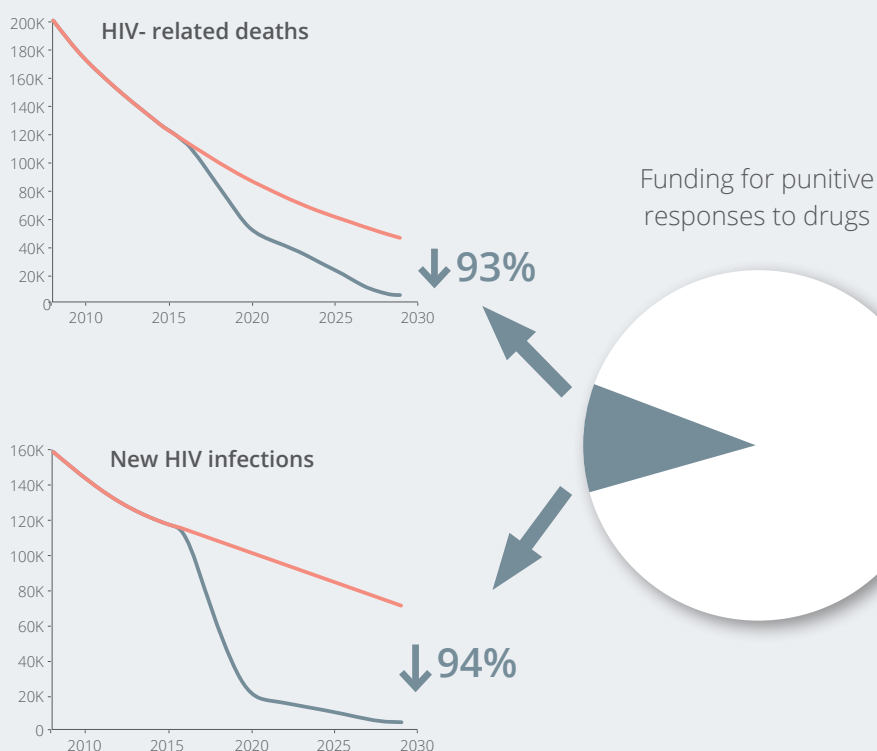
^j The Global Fund NFM classifies countries into bands using the following criteria and allocations: Band 1 – below US\$2,000 GNI, above disease burden threshold with US\$11.2 billion between 2014-2016; Band 2 – below US\$2,000 GNI, below disease burden threshold with US\$915 million between 2014-2016;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

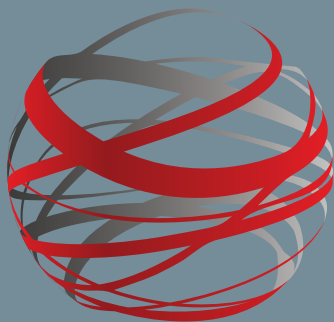


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Regional Overview

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 ^a □	OST ^b ■
Afghanistan	40,900 ⁽¹⁾ (13,500–80,000)	4.4 ⁽²⁾	31.2 ⁽²⁾	6.6 ⁽²⁾	✓18 ⁽³⁾	✓1 ⁽³⁾
Bangladesh	21,800–23,800 ^{(4)c}	1.1 (5.3 in Dhaka ⁽⁵⁾)	39.6 ⁽⁶⁾	9.4 ⁽⁷⁾	✓88 ⁽⁶⁾	✓3 ⁽⁶⁾ (M)
Bhutan	nk	nk	nk	nk	✗	✗
Brunei Darussalam	nk	nk	nk	nk	✗	✗
Cambodia	1,300 (1,200–2,800) ⁽⁸⁾	24.8 ⁽⁸⁾	nk	nk	✓5 ⁽⁹⁾	✓1 ⁽⁹⁾
China	2,580,000 ^{(10)d}	6 ⁽¹¹⁾	67 (60.9–73.1) ⁽⁷⁾	9.6 (3.8–15.4) ⁽⁷⁾	✓814 ⁽¹¹⁾	✓767 ⁽¹¹⁾ (B, M)
Hong Kong	nk	nk	nk	nk	✗	✓20 ⁽¹²⁾
India	1,700,000 ⁽¹³⁾	9.9 ⁽¹³⁾	41 ^{(7)e}	10.2 (2.7–17.8) ⁽⁷⁾	✓277 ⁽¹⁴⁾	✓145 ⁽¹⁵⁾ (M, B, O)
Indonesia	74,326 (61,901–88,320) ^{(16)f}	36.4 ⁽¹⁷⁾	63.5 ^{(18)g}	2.9 ⁽⁷⁾	✓194 ⁽¹⁷⁾	✓87 ⁽¹⁹⁾ (B, M)
Japan	nk	nk	64.8 (55–74.5) ⁽⁷⁾	3.2 (2–4.3) ⁽⁷⁾	✗	✗
Korea (Republic of)	nk	nk	54 ⁽⁷⁾	4 ⁽⁷⁾	✗	✗
Lao PDR	1,317 ⁽²⁰⁾	0.1 ⁽²¹⁾	nk	nk	✓4 ⁽²²⁾	✗
Macau	238 ⁽²³⁾	1.3 ⁽²⁴⁾	80.4 ⁽²⁵⁾	10.7 ⁽²⁵⁾	✓4 ⁽²⁵⁾ (P)	✓4 ⁽²⁵⁾ (B, M)
Malaysia	170,000 ⁽²⁶⁾	16.3 ⁽²⁶⁾	67.1 ⁽⁷⁾	nk	✓662 ⁽²⁶⁾	✓838 ⁽²⁶⁾ (B, M)
Maldives	793 (690–896) ⁽²⁷⁾	0 ⁽²⁸⁾	0.7 ⁽²⁹⁾	0.8 ⁽²⁹⁾	✗	✓1 ⁽³⁰⁾ (M)
Mongolia	570	nk	nk	nk	✓1 ⁽³¹⁾	
Myanmar	83,000 ⁽³²⁾	23.1 ⁽³²⁾	79.2 ⁽⁷⁾	9.1 ⁽⁷⁾	✓40 ⁽³³⁾ (P)	✓35 ⁽³²⁾ (B, M)
Nepal	52,174 ⁽³⁴⁾	6.3 ⁽³⁵⁾	87.3 (80.5–94) ⁽⁷⁾	5.8 (5.5–6) ⁽⁷⁾	✓60 ⁽³⁶⁾	✓15 ⁽³⁶⁾ (B, M)
Pakistan	104,804 ⁽³⁷⁾	37.8 ⁽³⁸⁾	93 ⁽³⁸⁾	6.8 (6–7.5) ⁽⁷⁾	✓34 ⁽³⁹⁾	✗(B) ⁽³⁸⁾
Philippines	20,000 (17,000–23,000) ⁽⁴⁰⁾	41.6 ⁽⁴¹⁾	70 ⁽⁷⁾	nk	✓ ^h	✗
Singapore	nk	2 ⁽⁴²⁾	42.5 ⁽⁷⁾	8.5 ⁽⁷⁾	✗	✗
Sri Lanka	nk	nk	nk	nk	✗	✗
Taiwan	60,000 ⁽⁴³⁾	17.7 ⁽⁴³⁾	41 ⁽⁷⁾	16.7 ⁽⁷⁾	✓1,254 ⁽⁴⁴⁾	✓162 ⁽⁴⁴⁾ (B, M)
Thailand	71,000 ^(40, 45)	21 ⁽⁴⁰⁾	89.8 ⁽⁷⁾	nk	✓14 ⁽⁴⁶⁾	✓147 ⁱ (M)
Vietnam	271,000 (100,000–335,000) ⁽⁴⁷⁾	40 ⁽⁴⁷⁾	74.1 ^{(7)k}	19.5 ⁽⁷⁾	✓297(P)	✓145 ⁽⁴⁸⁾ (M)

nk = not known

^a All operational needle and syringe programme (NSP) sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = pharmacy availability.

^b Opioid substitution therapy (OST), including methadone (M), buprenorphine (B) and any other form (O) such as morphine and codeine.

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

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

^e HCV prevalence rates vary greatly, from 90% in Manipur to 1% in Bihar; no national figure is available.

^f The Indonesian Ministry of Health is working on new population size estimates which have yet to be released at the time of writing.

^g Based on sub-national data from three cities: Tangerang, Denpasar, Makassar.

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

ⁱ Based on longitudinal data from two prison cohorts.

^j Civil society and experts in the region suggest that this estimate is too high and may not represent the actual level of OST provision in Thailand. It may include clinics that require periodic detoxification and re-enrolment.

^k Figure from 2003.

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





Harm reduction in Asia

Overview

Asia is the region with the second highest number of people living with HIV in the world (approximately 5.1 million). living with HIV in the world.⁽⁴⁹⁾ Of the estimated 300,000 new HIV infections in the region in 2015, 96% were in just nine countries: China, India, Indonesia, Malaysia, Myanmar, Pakistan, Philippines, Thailand and Vietnam; and were concentrated within three key population groups: people who inject drugs, men who have sex with men (MSM) and (male, female and transgender) sex workers.⁽⁴⁹⁾ According to a 2011 report, between 12 and 21 million people use opiates across Asia, representing half of the total global population of opiate users.⁽⁵⁰⁾ An estimated four million people inject drugs, the highest concentration in any region.⁽⁴⁰⁾ A disproportionate number of new HIV infections in Asia are found among the population of people who inject drugs.⁽⁴⁹⁾ Table 2.1.1 also illustrates very high levels of hepatitis C prevalence among this population. These figures clearly demonstrate the vital need for increased harm reduction service provision in Asia.

Since *The Global State of Harm Reduction 2014*, revised population estimates for people who inject drugs have been proposed and approved in India (ten times the size of previous estimates), Afghanistan (double previous estimates), Myanmar (approximately 10% more) and Thailand (approximately 65% more). A situational analysis of drug use in Mongolia, which was conducted in 2015 as a precursor to the implementation of a rapid assessment and response programme, revealed up to 2,300 people who use drugs, and 570 people who inject drugs, mostly concentrated in the capital city of Ulaanbaatar.⁽⁵¹⁾ While such revised estimates may lend support to the perception that the number of people who use and inject drugs is increasing, sometimes new figures can be the result of differences in the research methodologies used.

In 2015, based on *Global State 2014*, it was reported that the average HIV prevalence among people who inject drugs in Asia was 15.4%.⁽⁵²⁾ New data (see Table 2.1.1) suggest that this figure has risen to 17%, with increases in prevalence reported in Myanmar, Pakistan and Vietnam. Overlaps between people who inject drugs and other key population groups, including sex workers and MSM, have also been reported in several countries in the region, and require increased attention in the form of data gathering and integrated service

delivery.^(40, 53) Four Asian countries have been prioritised by UN agencies and other development partners due to the continued rapid expansion of their national HIV epidemics: Bangladesh, Indonesia, Philippines and Sri Lanka.⁽⁵⁴⁾ Meanwhile, several countries in the region continue to produce evidence that supports the effectiveness and cost-effectiveness of harm reduction interventions in the context of HIV and HCV transmission.^(55–57)

Although the need for harm reduction is increasingly accepted across the region, a largely punitive policy and legal environment continues to undermine access to life-saving harm reduction programmes. Eleven countries in the region still operate compulsory detention centres,⁽⁵⁴⁾ incarcerating over 455,000 people who use drugs in 2014.⁽⁴⁰⁾ Although UN agencies and member states increasingly advocate an end to the death penalty for drug offences,⁽⁵⁸⁾ some Asian states continue to execute people in high numbers, in violation of international law and contrary to the global trend towards death penalty abolition. China, Singapore, Malaysia, Indonesia and Vietnam are all considered 'high application states', prescribing the death penalty for drugs as common practice.⁽⁵⁹⁾ While the Philippines abolished the death penalty for all crimes in 2006, President Rodrigo Duterte promised to restore capital punishment following his election in 2016 and has instigated thousands of extrajudicial killings of alleged drug suspects by police and armed vigilante groups.^(60, 61)

Amphetamine-type stimulants remain the dominant drugs of choice in Asia, with between 3.5 and 20.9 million people using amphetamines.⁽⁵⁰⁾ HIV incidence rates are notably high among this group,⁽⁶⁾ yet tailored harm reduction and HIV prevention services for people who use amphetamines are lacking within the region.

Compulsory drug detention and rehabilitation centres in Southeast Asia

Detention and coercive treatment of people who use drugs remain the dominant approaches in 11 countries in the region,⁽⁵⁴⁾ including Cambodia, China, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Thailand and Vietnam.^(62, 63) UN agencies released a statement in 2012 calling for the closure of compulsory drug detention and

rehabilitation centres.⁽⁶⁴⁾ They also hosted formal regional inter-governmental consultations involving policy-makers from Asia, international experts and multilateral agencies in 2010, 2012 and 2015 to encourage governments to accelerate the transition towards voluntary community-based treatment and support services.

The Third Regional Consultation on compulsory centres for drug users (CCDUs) was held in September 2015 in Manila, the Philippines. It generated a commitment to transition away from compulsory models and towards evidence-informed and community-based approaches to address drug dependence. An expert paper produced by leaders from the region outlines key elements and principles that are important for a successful transition to voluntary community-based treatment and support services. It also proposes a model for initiating an effective transition at national level, and highlights recent examples of good practice from Cambodia, China, Indonesia, Malaysia and Thailand.⁽⁶²⁾

Harm Reduction International also documented six models in developing community-based alternatives to CCDUs from Cambodia, China, India, Indonesia, Malaysia and Vietnam. While these programmes naturally differ within and across countries, several common elements have been identified as critical to effective community-based services that meet the needs of people who use drugs.⁽⁶⁵⁾

The Malaysian government initiated the conversion of compulsory detention centres into Cure and Care (CNC) centres in 2010. These centres offer voluntary access to a comprehensive package of health and support services for people who use drugs, which has been identified as a good practice model.⁽⁶²⁾ In recent evaluations of CNC centres, clients expressed satisfaction with treatment outcomes and identified diminished withdrawal symptoms and fewer cravings for drugs as important personal successes.⁽⁶⁶⁾ Analyses of participant interviews identified four CNC services that contributed the most to these positive results: methadone treatment, psychological counselling, religious instruction and recreation. The open environment, with strong and trusting relationships among peers and staff, contributed to improved programme adherence. Participants felt that their access to healthcare greatly benefited their overall health. Another study, comparing CNC centres and CCDUs in Malaysia, found that 50% of clients coming out of CCDUs relapsed within 32 days of release compared with 429 days for those attending CNC centres.⁽⁶⁶⁾

Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

A total of 17 countries implement NSPs across Asia, a figure that has remained stable since the publication of the *Global State 2012*. Service-delivery modalities remain varied across the region, but implementation is concentrated largely in the civil society sector. As reported in 2012⁽²⁹⁾ and 2014,⁽⁶⁷⁾ no NSP sites are operating in Bhutan, Brunei-Darussalam, Hong Kong, Japan, Republic of Korea, Maldives, Singapore or Sri Lanka.

Few countries have reported changes in the scale of NSP service delivery. However, important reductions have occurred since the *Global State 2014* in Afghanistan (from 31 to 18 sites), in India (from 295 to 277 sites) and in Thailand (from 38 to 14 sites). In Thailand, the dramatic decrease was precipitated by the sudden termination of the partnership with local pharmacists due to reduced funding.⁽⁶⁸⁾ Only Taiwan has recorded an increased number of NSP service-delivery sites, from 1,103 to 1,254.

Reports show that Bhutan may implement NSPs in the coming years through Global Fund support.⁽⁶⁹⁾ However, many countries in the region report dwindling support for harm reduction – both financially and politically – in the wake of the Global Fund's new funding model allocation. The decrease in NSP sites in the countries highlighted above is a direct consequence.

The temporary closure of an NSP has been reported at a methadone maintenance clinic in Cambodia, due to stigma and discrimination aimed at personnel running the service.⁽⁷⁰⁾ NSPs in Bangladesh, Indonesia and Lao PDR have also been impacted by reduced donor support, though the scale of the reduction of these services has yet to be officially reported.

Table 2.1.2: Overview of needle distribution per person who injects drugs per year⁽⁴⁰⁾

Country	Needles distributed per person who injects drugs per year
Afghanistan	159
China	204
India	240
Indonesia	44
Malaysia	61
Myanmar	168
Pakistan	178
Philippines	0*
Thailand	14
Vietnam	62**

* Data from the Philippines show that among the 11,042 clients reached, an average coverage of 16 needles and syringes per client per month was achieved over a five-month period before the service was closed.

** NSP coverage in Vietnam has fallen from 180 in 2012,⁽²⁹⁾ to 98 in 2014,⁽⁶⁷⁾ to 62 in 2016.

A pilot peer-operated NSP was initiated in 2014 in Cebu, the Philippines, despite legal provisions making possession of needles and syringes a criminal offence. A temporary exemption negotiated with the Dangerous Drugs Board allowed the NSP to operate as a scientific study to assess effectiveness of such interventions among people who inject drugs.⁽⁷¹⁾ Although the project ended in December 2015, arrangements are in place to sustain this programme with Global Fund support. However, needle and syringe distribution remains on hold as local stakeholders evaluate the unfolding political turmoil around the extrajudicial killings of people alleged to be in the drug trade, as encouraged by President Duterte.

In Vietnam, the introduction of low-dead-space syringes was piloted with success in three provinces. An assessment of the pilot determined that exposure to social marketing approaches led to increased sales of commodities as well as increases in reported use and consistent use of such commodities.⁽⁷²⁾ Securing sustainable funding for this intervention has been an important challenge; at the time of writing, the project will run until the end of 2016 with support from the private sector.

Opioid substitution therapy (OST)

Fifteen countries in the region provide OST to people who use opioids. The number of sites has remained relatively stable since the *Global State 2014*, with increases documented in Malaysia (from 811 to 838 sites), Taiwan (from 90 to 162 sites) and Vietnam (from 80 to 145 sites). In Vietnam, government representatives stated in June 2015 that methadone was being dispensed to over 27,278 people in 43 provinces and cities.⁽⁷³⁾ While this increase is welcome, OST service coverage in the country is still considered extremely low, meeting only 15% of need.⁽⁷⁴⁾ In Indonesia, OST sites providing methadone have increased marginally, from 85 sites in 2014⁽⁶⁷⁾ to 87 in 2015.⁽¹⁹⁾ Although there has been an increase in provision, levels remain low according to UN guidelines.⁽⁷⁵⁾

Official documents indicate that plans are being developed to initiate OST for people who inject drugs in Pakistan, with buprenorphine availability before 2020.⁽⁷⁶⁾ In Bhutan, a pilot OST programme was planned for 2015 with financial support from the Global Fund, but it has not yet begun.⁽⁶⁹⁾ According to the UNODC Country Office in Afghanistan, plans are in place to scale up OST provision to 320 sites within the community (in Kabul, Herat, Balkh, Nangarhar, Badakhshan, Kunuz,

Ghazni and Kandahar) and 180 sites in prisons over the course of 2016.⁽⁷⁷⁾ As of 2016, OST continues to remain unavailable in nine countries across the region.

Since the Chinese government first supported the piloting of eight OST clinics in five provinces in 2004,⁽⁷⁾ the harm reduction programme in the country has expanded dramatically. There are currently 767 OST sites operating in 28 provinces, with 184,000 people receiving methadone maintenance therapy when UNAIDS last reported in 2015.⁽⁷⁸⁾ Between 2009 and 2013 in Yunnan, 63 new OST sites were established, with coverage reported to be 22.6%, equating to mid-level coverage according to UN targets.⁽⁷⁵⁾ Although harm reduction service providers illustrate promising results, it is important to note that NGOs delivering services operate in a difficult policy environment. China continues to support severe, punitive policies on drugs, with estimates of at least 600 people being executed for drug-related offences in 2014.⁽⁵⁹⁾

In Thailand, detoxification and long-term maintenance with methadone has been provided for free since 2014, as it is included in the universal health insurance scheme as well as in the social security scheme.⁽⁷⁹⁾ Methadone treatment is currently available only in district-/province-level hospitals and at a few remote drug treatment centres, reaching no more than 10% of all people who require methadone in the country.⁽⁷⁹⁾ In order to increase access, O-zone, a Thai NGO aiming to improve the quality of life for people who use and inject drugs in Thailand, has been implementing a peer-led, community-based methadone delivery service in the mountain village of Santikhiri in Chiang Rai province, where peer outreach workers operate methadone delivery at a drop-in centre with supervision from Mae Chan Hospital.⁽⁷⁹⁾ Initiated in 2013, the initiative attracted media attention and support from government agencies and has been replicated in Huay Pung in Chiang Rai province.

Provision of vital harm reduction services is often hindered by legal and policy barriers that restrict or prohibit implementation and scale-up, and the limited financial commitment of governments and donors means there is still much work to be done to ensure an enabling environment.

Amphetamine-type stimulants (ATS)

It has been estimated that between 13.9 million and 54.8 million people use amphetamines worldwide,⁽⁸⁰⁾ with more than 60% of global ATS use thought to be concentrated in Southeast Asia.⁽⁸¹⁾ The ATS market

continues to expand, particularly in Southeast Asia, China and Australia.⁽⁸²⁾ For example, 74% of people who use drugs in one treatment centre in Cambodia were receiving treatment for crystal methamphetamine use,⁽⁸³⁾ and 58% of people in a treatment centre in Lao PDR were receiving treatment for methamphetamine use.⁽⁸⁴⁾

A 2011 study conducted in three major urban areas in Malaysia found a rapid increase of ATS use in not-in-treatment opiate injectors after 1997, which was associated with an increased risk of HIV infection.⁽⁸⁵⁾ However, project data from Thailand indicate that patterns of drug use in Bangkok are changing, with approximately 50% of clients in the central region injecting ATS and pharmaceuticals in 2014, compared with 70% who were injecting heroin in 2009 in the same region.⁽⁸⁶⁾ Anecdotal evidence from Japan also suggests that up to 50% of ATS users may be injecting.⁽⁸⁷⁾ In a 2016 study among 103 women who use drugs in Malaysia, ATS were the most commonly used drugs (45.6%).⁽⁸⁸⁾

Very few interventions address ATS use in the region. The civil society organisation Health and Harm Reduction Tokyo has a 24/7 hotline in place to provide information to people who use and inject ATS drugs.⁽⁸⁷⁾ The Asia Pacific Coalition on Male Sexual Health (APCOM) is developing information, education and communication materials on chemsex for MSM in Thailand. It is worth noting that in the past two years an increasing number of harm reduction civil society organisations across the region have been calling for expanded HIV prevention interventions along with other harm reduction measures tailored to meet the needs of people who use but do not yet inject drugs. In light of the increasing trend of ATS use, Harm Reduction International produced an updated report in 2015 noting the ways in which harm reduction programmes can respond effectively to the harms associated with amphetamine use.⁽⁸⁹⁾

Viral hepatitis

Asia is disproportionately affected by viral hepatitis: 67% of the world's people living with hepatitis C (HCV) are found in this region.⁽⁹⁰⁾ Viral hepatitis has caused more than one million deaths in Asia, approximately 20% of which are related to chronic HCV.⁽⁹¹⁾ HCV prevalence rates among people who inject drugs are over 80% in Nepal, Thailand and Pakistan; above 70% in Myanmar and Vietnam; and over 60% in Indonesia, China, Japan and Malaysia.⁽⁷⁾ Where treatment is said to be available, it is often inaccessible for people who inject drugs.

ⁱ According to the 2012 revised WHO, UNODC and UNAIDS target-setting guide, less than 100 syringes distributed per person who injects drugs per year is considered low coverage (100 to 200 is medium coverage and more than 200 is high coverage).



Significant advances have been made in improving the efficacy of HCV treatment over the last few years. The introduction of direct-acting antiviral (DAA) based treatment regimens has shortened treatment times, reduced side effects and greatly increased the likelihood of virus elimination. The extremely high prices set by pharmaceutical company Gilead meant that such treatments remained out of reach of the majority of people who use drugs. However, a combination of factors have favoured generic production and a consequent drop in prices for DAAs in many countries in Asia. Specifically, Gilead issued voluntary licences to 11 Indian generic producers, allowing them to produce and market generic sofosbuvir with a 7% royalty payment to Gilead.⁽⁹²⁾ These licences allow the export of generic sofosbuvir to 101 predefined countries, including Afghanistan, Bangladesh, Bhutan, Cambodia, Indonesia, India, Malaysia, Mongolia, Myanmar, Nepal, Pakistan, Sri Lanka, and Vietnam.⁽⁹³⁾ Generic sofosbuvir can be made available in the countries listed at a cost of approximately US\$300 per month.⁽⁹⁴⁾ The licences exclude many large middle-income countries that are home to a significant proportion of people living with HCV in the region, including China and Thailand.⁽⁹²⁾

While the availability of DAAs remains limited to some countries, generic companies are working to complete regulatory requirements for registration of the medicines prior to future marketing distribution.⁽⁹⁵⁾ The Thai government approved Gilead's application to register sofosbuvir in Thailand in August 2015, but the Chinese government rejected one of Gilead's patent requests for sofosbuvir in June 2015.⁽⁹⁶⁾ Malaysia plans to make treatment available to more than 1,000 people who inject drugs living with HCV in 2016, and more than 15,000 people by 2025.⁽⁹⁷⁾ In Manipur, India, the Community Network for Empowerment (CoNE), a local civil society network led by and delivering services to people who use drugs, established hepatitis B and C testing camps across nine districts over one month. The testing camps targeted people who use drugs and people living with HIV. This initiative won the innovative hepatitis testing contest initiated by the WHO at an award ceremony and symposium about hepatitis testing on 17 April 2015 during the International Liver Congress in Barcelona, Spain.⁽⁹⁸⁾ In Indonesia, PKNI (Persaudaraan Korban Napza Indonesia) is conducting a peer-driven study among 500 people who inject drugs to educate the community on HCV treatment access and literacy while assessing barriers to treatment uptake.⁽⁹⁹⁾

Tuberculosis (TB)

Southeast Asia accounts for 38% of the global TB burden, with Bangladesh, India, Indonesia, Myanmar and Thailand among the highest TB-burden countries in the world.⁽¹⁰⁰⁾ Data on TB for people who inject drugs are sparse; however, individual studies indicate that there is a higher prevalence of TB among this population.^(101, 102)

Although all eleven Member States of the United Nations within Southeast Asia have national TB control programmes, and TB mortality has decreased in the region by more than 50% since 1990,⁽¹⁰⁰⁾ the continuing high rates in some countries must be more robustly addressed. TB and HIV control programmes are improving,⁽¹⁰⁰⁾ but joined-up programmes need to be strengthened in countries with a high TB burden. In Bangladesh, for example, national TB/HIV operational guidelines were developed in 2009, and a national TB/HIV committee has been put in place, yet, despite these policy improvements, limited numbers of NGOs provide HIV counselling, prevention and care for TB/HIV co-infected individuals.⁽¹⁰⁰⁾

The primary barriers to TB testing and treatment for people who inject drugs in Asia are a lack of integration into harm reduction programmes, stigma and discrimination against people who use drugs by service providers, a lack of awareness among criminal justice and healthcare providers, and limited testing and treatment opportunities at NSP and OST sites.^(46, 97) Given the dearth of data on people who inject/use drugs and TB prevalence, it is clear that further research should be undertaken, and that greater integration of TB services into existing harm reduction initiatives is required.

Antiretroviral therapy (ART)

The Asia and Pacific region has the second highest number of people living with HIV in the world, estimated to be 5.1 million in 2015.⁽⁴⁹⁾ China, India, Indonesia, Malaysia, Myanmar, Pakistan, Philippines, Thailand and Vietnam account for around 96% of the 300,000 new infections each year.⁽⁴⁹⁾ Although reports indicate a 5% decline in new HIV infection rates between 2010 and 2015, testing rates remain suboptimal in many countries, with evidence suggesting that 1.9 million people living with HIV in Asia and the Pacific in 2015 did not know their status.⁽⁴⁹⁾

While it is a fact that HIV in the region is concentrated among key populations, rates of HIV testing are extremely low among people who inject drugs. For example, fewer than one in three people who inject drugs in the region had tested for HIV in a 12-month period and knew their results.⁽⁴⁹⁾

UNAIDS reported in 2013 that of the total number of people living with HIV in Asia who are eligible for ART, only 18% accessed treatment.⁽¹⁰³⁾ ART coverage among people who inject drugs continues to remain low: just 5% in Malaysia,⁽¹⁰⁴⁾ only 2% in Thailand,⁽¹⁰⁵⁾ 6% in Indonesia^{(106)m} and 4% in Vietnam.⁽¹⁰⁶⁾ There are very few ART sites in Afghanistan, and where they do exist, a lack of follow-up and a weak referral system hinder their success.⁽⁷⁷⁾ Similar to TB testing and treatment uptake, many barriers – including a lack of integration into harm reduction programmes such as NSPs and OST sites, fear of arrest and stigma and discrimination against people who use drugs by service providers – serve to further deter people who inject drugs into seeking either testing or treatment for HIV.^(46, 77, 97)

Harm reduction in prisons

Over 3.89 million people are incarcerated in Asia,⁽¹⁰⁷⁾ and an additional 635,000 are being held in compulsory drug detention centres.⁽⁶³⁾ A large proportion of those in prison – for example, 20% in Japan,⁽¹⁰⁸⁾ 31% in Indonesia,⁽¹⁰⁹⁾ 50% in the Philippines⁽¹¹⁰⁾ and 72% in Thailand⁽¹¹¹⁾ – are being held on drug-related charges. Across much of the region, incarceration rates have been on the rise since 2000, leading to overcrowding in many facilities. The increase has in large part been the result of repressive drug laws and policies implemented in pursuit of a ‘drug free’ Association of Southeast Asian Nations (ASEAN) by 2020.⁽¹¹²⁾

Injecting drug use continues to be common in the region's prisons. A recent study in Indonesia, for example, found that more than half of a sample of 100 prisoners had injected drugs while incarcerated.⁽¹¹³⁾ Pakistan's national anti-narcotics policy acknowledges that up to 40% of the prison population may be using drugs.⁽⁷⁶⁾ In the Maldives, more than two-thirds of incarcerated people who inject drugs have used drugs in prison, and almost one-third have injected while in prison.⁽¹¹⁴⁾

Data on HIV, HCV and TB prevalence in prison settings in Asia continue to be very scarce. In Malaysia, it has been reported that approximately 4.8% of sentenced prisoners are living with HIV.⁽¹¹²⁾ Despite the known risks of HIV, HCV and TB transmission associated with injecting drug use and overcrowding in prison, few prisons offer comprehensive harm reduction services.

NSPs continue to remain unavailable to prisoners across the region. In 2015, however, government authorities in Nepal, in cooperation with national and international partners, developed standard operating procedures to

scale up HIV prevention, treatment and care services in prison settings, which involved officially adopting the 15 key interventions of the comprehensive package, including NSPs, OST and condoms.⁽¹¹⁵⁾ In practice, at the time of reporting, prevention messages continue to be the only intervention available in prisons in Nepal.⁽¹¹⁶⁾

OST is available in only some prisons in India (Tihar prisons, the largest prison complex in South Asia),⁽¹¹⁷⁾ Indonesia (11 prisons),⁽¹¹⁸⁾ Macau,⁽¹¹⁹⁾ Malaysia (18 prisons)⁽²⁶⁾ and Vietnam (1 prison).⁽¹²⁰⁾ UNODC reports that a second prison-based OST programme will soon be launched in Vietnam (Ha Noi), and plans are reportedly in place to continue expanding the programme into other prisons.⁽¹²⁰⁾

In Indonesia, prison-based OST and ART programmes are run by the Ministry of Health. Kerobokan prison in Bali, which has been used as a model, provides prisoners with condoms, OST, ART and bleach to sterilise injecting equipment (in the absence of sterile needles and syringes). It is important to note, however, that bleaching has proven ineffective at preventing HIV transmission.⁽¹²¹⁾ Currently, up to 11 prisons in the country are providing OST to 248 prisoners, and an estimated 40 prisons are delivering ART to people living with HIV.⁽¹¹⁸⁾

Since *Global State 2014*, Cambodia's Ministry of the Interior has publicly acknowledged the issue of drug use in prisons and reports indicate that there is some interest in piloting harm reduction interventions in these settings;⁽⁷⁰⁾ while in Myanmar, UNODC has reportedly voiced its support for initiating OST in prisons.

Where harm reduction and HIV treatment and care services are available in the region's prisons, they can be difficult to access for various reasons (including stigma and discrimination) or not provided in accordance with international prison and human rights standards. A recent study on the factors affecting opioid dependence during incarceration in India, for example, found that 74% of those surveyed chose to access OST while incarcerated. The majority of the remaining 26% did not access the service for fear of physical violence at the hands of other prisoners.⁽¹²²⁾ Similar barriers to access have been documented in Indonesia and Malaysia.⁽¹¹²⁾

In Malaysia, HIV testing continues to be mandatory upon entry to prison and those found to be living with the virus are segregated into special housing units. Not only is this a clear violation of international human rights law and minimum standards on the treatment of prisoners, but also it increases the risk of TB outbreaks and reinforces the stigmatisation of HIV in prison settings.⁽¹¹²⁾

^m 2010 data.



Due to the punitive environment that prevails in Asia, prisons remain one of the main sources of primary care for people who use drugs.⁽¹¹²⁾ Given all of the above, harm reduction must urgently be prioritised in these settings and adequate resources allocated. That way, the region's criminal justice systems can play a role in reaching global targets on HIV, HCV and TB.

Overdose

As in many other regions, data on the extent of drug-related overdose prevention and management remain extremely limited across Asia. No country in the region collects and routinely monitors drug-related overdose deaths.

However, an opioid overdose prevention and management project – Servicing Communities with Opioid Overdose Prevention (SCOOP) – was integrated into the civil society response to HIV among people who inject drugs in Thailand in 2013 to address the growing needs of this community.⁽¹²³⁾ Civil society organisations facilitated access to naloxone across 19 provinces over a two-year period. Important legal, policy and procurement barriers were addressed and, within 18 months of the project beginning, 1,575 vials of naloxone were distributed across implementation sites. At least 148 field workers and clients were trained to recognise an opioid overdose and to respond with emergency care and the injection of naloxone, with field workers successfully reversing 21 opioid overdoses using naloxone. Between January 2013 and June 2014, overdose prevention was discussed with each of the 74,852 people entering the service, and the SCOOP project empowered and motivated both field workers and people who use drugs.⁽¹²³⁾ Overdose management is also part of the harm reduction package in Afghanistan, with naloxone distributed by outreach workers.⁽⁷⁷⁾

Although China has no national programme for overdose prevention, AIDS Care China, with support from the European Commission-funded Asia Action project, started to operate naloxone peer-distribution programmes in Yunnan and Sichuan provinces. 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.⁽¹⁰⁾

Policy developments for harm reduction

In late 2014 Thailand announced the establishment of an ASEAN Narcotics Cooperation Centre.⁽⁸⁶⁾ In 2015 the ASEAN Economic Community was officially established. That same year, ASEAN ratified the new ASEAN Post-2015 Health Development Agenda, which maintains commitments to HIV through prioritisation of health-related Millennium Development Goals (MDGs) as well as of prevention and control of communicable diseases. The ASEAN Task Force on AIDS is finalising a working paper on HIV prevention among people who inject drugs in order to generate better system-wide coherence within ASEAN's various departments. A coalition of 12 civil society organisations from Southeast Asia was formed in 2015 to advocate for improved support for harm reduction interventions in ASEAN countries.

In Afghanistan, new national harm reduction guidelines were approved by the Counter Narcotics High Commission in December 2014.⁽¹²⁴⁾ In parallel, a new national strategic plan on HIV was designed to improve results from investments in the response to HIV for the period 2016 to 2020.⁽¹²⁴⁾

In Cambodia, a national strategic plan on harm reduction related to drug use was launched in March 2016. However, following a request from the Cambodian police to amend drug laws, high-level government officials reported that current policies were too lenient, but any formal amendments would need careful consideration.⁽¹²⁵⁾

In Malaysia, the Ministry of Health developed a new national strategic plan on ending AIDS for the period 2016 to 2030. However, leadership changes in Malaysia's national anti-drugs agency have weakened support for harm reduction and other effective approaches to address drug-related issues.⁽⁹⁷⁾

In Myanmar, a workshop involving a broad range of stakeholders, including senior representatives of the government, parliamentarians, international health and legal experts, international and national NGOs, drug user networks, and development agencies, recommended an amendment to the drug law to include harm reduction.⁽¹²⁶⁾

Thailand's national harm reduction policy, formally approved in 2014, expired in October 2015. Despite this important setback, a national drug law reform process was initiated in 2015, which should conclude by the end of 2016 with formal recommendations for adjustments

for several drug-related statutes that could facilitate harm reduction service delivery in the future.

Several Asian nations were represented at the 2016 UNGASS on the drugs. Unfortunately, few lent their support to harm reduction. Singapore's intervention was notable as the nation's representatives firmly opposed harm reduction.⁽¹²⁷⁾ China echoed Singapore's statement, underlining that harm reduction is acceptable only if it is aimed at reducing drug use. Malaysia spoke on behalf of ASEAN countries, outlining positions similar to that taken by Singapore and reiterating the vision of a drug-free region. Just Vietnam stated that harm reduction programmes are being implemented.⁽¹²⁸⁾

Civil society and advocacy developments for harm reduction

Civil society organisations in Asia continue to play an important role in harm reduction, at both regional and national levels. The Asian Network of People who Use Drugs (ANPUD) is now well established. However, after several years of inactivity, the Asian Harm Reduction Network (AHRN) is no longer functioning. Similarly, the Regional Task Force on Injecting Drug Use and HIV/AIDS in Asia and the Pacific, co-chaired by UNODC and UNAIDS, completed its operations in 2012.

National drug user networks are in place in Cambodia (Cambodian Network of People who Use Drugs – CNPUD), India (Indian Drug User Forum – IDUF), Indonesia (Persaudaraan Korban Napza Indonesia – PKNI), Myanmar (National Drug User Network Myanmar – NDNM), Thailand (Thai Drug User Network – TDN)⁽⁴⁶⁾ and Vietnam (Vietnam Network of People who Use Drugs – VNPU). The Malaysian Network of People who Use Drugs (MANPUD) has been established⁽⁹⁷⁾ and the Malaysian Welfare Association of Recovering Drug Users (WARDU) is in the process of registering as an official network. Nepal also has several drug user networks, including one specifically for women; and a small group of people who use drugs established a network under the national People Living with HIV (PLHIV) network but this is yet to be officially recognised.

Although ANPUD has grown significantly since its inception, and the number of drug user networks continues to grow, albeit slowly, there remain important barriers – such as declining funding, repressive government regimes and stigma and discrimination – that hinder meaningful civil society engagement and overall coordination across the region. Regional sources of technical support on harm reduction include the

Alliance Technical Hubs in Cambodia and India as well as the UNAIDS Technical Support Facility (TSF).

Across Asia, the 'Support Don't Punish' campaignⁿ has provided an opportunity for people who use drugs to have their voices heard and call for the end of their criminalisation and stigmatisation. The campaign's 'global day of action', which occurs on 26 June every year, has been an important tool to change the messaging around drugs and people who use drugs, with media outreach sometimes involving local/national celebrities (for example, the punk band Jeruji in June 2015 and rock band The Changcuters in June 2014 in Indonesia). The global day of action in Asia has also been an opportunity to bring NGOs together to discuss critical drug policy reform issues, and to open and build dialogue with government agencies, UN agencies, law enforcement officers, networks of people who use drugs, local civil society groups and harm reduction service providers.

On the first 'Support Don't Punish' global day of action in Asia in 2013, 22 cities in five countries became involved in the campaign. In 2014, 33 cities in ten countries gathered under the 'Support Don't Punish' banner – including representatives from Cambodia, India, Indonesia, Malaysia, Nepal, Philippines, Thailand and Vietnam. This number rose to 38 participating cities in the region in 2015, making Asia the region with the highest level of engagement in the campaign.

The NGO Bridge Hope and Health, together with Coact (an international peer-led support agency), with a small grant of US\$15,000 from the Czech government and technical support funding from Open Society Foundations, delivered a two-day capacity-building event and trained an Afghan community team in overdose management and peer interventions for people who use drugs. The peer outreach team is in the process of documenting 16 active drug scenes identified around the Kabul area, and Coact is assisting in translating a community needs assessment into a formal needs assessment and outreach plan. The Bridge Hope and Health team received language training in Dari and English and support with social media to support their engagement with the international community. Due to the limited funding, only four months of operations for the staff team are covered and no harm reduction commodities such as NSP, OST or naloxone distribution are included. However, Bridge Hope and Health is mobilising resources and has launched a crowd-sourced fundraising campaign through social media to increase the harm reduction response in Afghanistan.

ⁿ See <http://supportdontpunish.org/>.



The 24th International Harm Reduction Conference was held in Kuala Lumpur, Malaysia in October 2015. Malaysia's leadership in introducing harm reduction measures ten years ago and the need to continue to scale up similar interventions globally featured prominently during the three-day conference. Over 900 health workers, UN representatives, politicians, bureaucrats, researchers, medical professionals and community workers, representing over 70 countries, were in attendance at this biennial event. A civil society organisation coalition on the ASEAN drugs strategy was launched in the margins of the conference. This coalition, consisting of 12 civil society organisations from Southeast Asia, will seek to be a unifying voice and a platform for the engagement of harm reduction at the regional level.⁽⁹⁷⁾

Funding developments for harm reduction

The funding landscape for harm reduction in Asia since *Global State 2014* has been scarred by political constraints in terms of support for the approach, international donor withdrawal and transitions from donor funding to government funding for services.

Community Action on Harm Reduction (CAHR) – a project that aimed to expand harm reduction services to more than 180,000 people who inject drugs, their partners and children in China, India, Indonesia, Kenya and Malaysia – ended in 2014. The Asia Action on Harm Reduction project – funded by the European Union to empower civil society organisations and to increase the evidence and build political support for harm reduction among key policy-makers in Cambodia, China, India, Indonesia, Malaysia and Vietnam – ended in 2016.

The Australian government's international assistance programme was revamped following cuts to foreign aid, with the result being that previous beneficiaries lost its support for harm reduction interventions across the region. For example, the HIV Cooperation Programme in Indonesia (HCPI) ended in December 2015, with no provisions to mend the funding gap.⁽¹²⁹⁾ Meanwhile, financial support for harm reduction from the World Bank, Open Society Foundations, UNODC and USAID has also decreased across the region.

Decisions on how to prioritise allocations under its new funding model have negatively impacted several Global Fund-supported programmes targeting people who inject drugs in Asia. However, the Global Fund approved a regional harm reduction advocacy grant

covering seven countries in the region: Cambodia, India, Indonesia, Nepal, Philippines, Thailand and Vietnam. With a total budget of US\$5 million over a three-year period, implementation is expected to begin in early 2017.

Other sources of funding have been approved. A multi-country grant awarded by the Dutch government to support HIV prevention among people who inject drugs also covers three countries in the region: Indonesia, Myanmar and Vietnam. PEPFAR has mobilised over US\$20 million to support HIV prevention among key populations, including people who inject drugs. The United Nations Development Programme (UNDP) and the Global Fund have agreed a grant of US\$8.7 million to scale up HIV prevention measures and treatment for people most at risk of contracting the virus in Afghanistan, including people who inject drugs and prisoners.⁽¹³⁰⁾

By the end of 2011 the Malaysian government had invested approximately US\$17.3 million of the national budget to support the implementation of harm reduction programmes through partnerships with civil society organisations.⁽⁶⁵⁾ For example, financial contributions for NSPs between 2006 and 2015 show that 69% of funds came from national donors (and 31% from external sources).⁽¹³¹⁾ A recent assessment of returns on investments and cost-effectiveness of harm reduction programming in Malaysia shows conclusively that priority harm reduction services such as the distribution of sterile injecting equipment and OST, even with the present moderately low coverage, are effective and cost-effective interventions for averting HIV infections.⁽¹³²⁾

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Regional Overview

2.2 Eurasia





EURASIA

Table 2.2.1: Epidemiology of HIV and viral hepatitis, and harm reduction response in Eurasia

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 (%) ⁽⁴⁾	Harm reduction response	
					NSP ^{(5, 6)a} ■	OST ^{(7) b} ■
Albania	4,000–6,000	0.5	28.8	11.5	✓2	✓6 (M)
Armenia	12,700 ⁽⁸⁾	6.3	nk	nk	✓12	✓4 (M)
Azerbaijan	71,283 ⁽⁹⁾	9.5 ⁽⁹⁾	57.9 ⁽⁹⁾	7.4 ⁽⁹⁾	✓17	✓2 (M)
Belarus	75,000	25.1 ⁽¹⁰⁾	65.4 ⁽¹¹⁾	6.9 ⁽¹¹⁾	✓34 ⁽¹¹⁾	✓19 ⁽¹¹⁾ (M)
Bosnia and Herzegovina	12,500 (9,500–15,500)	0.3	12–43.4 ^c	2–3	✓28	✓8 (B, M)
Bulgaria	19,000	10.6 ⁽¹²⁾	67.8	5.7	✓100 ⁽¹³⁾	✓31 (B, M)
Croatia	10,000 ⁽¹⁴⁾	0.48	39.30	6.5	✓102 (P)	✓ (B, M)
Czech Republic	45,600 ⁽¹⁵⁾	0.2–0.3 ⁽¹⁵⁾	18.6	15.1	✓105 (P)	✓372 ⁽¹⁶⁾ (B, M)
Estonia	13,801 (8,178–34,732)	50–60 ^{(17)d}	75	21.3	✓36	✓8 (B, M)
Georgia	49,000 ⁽¹⁸⁾	2.2 ⁽¹⁹⁾	66 ⁽¹⁹⁾	7.2	✓18	✓18 (B, M)
Hungary	2,910–3,577 ⁽²⁰⁾	0.0	24.1	0.5	✓46 ⁽¹¹⁾	✓15 ⁽²⁰⁾ (B, M)
Kazakhstan	116,840 ⁽²¹⁾	7.9 ⁽²²⁾	60.3 ⁽²³⁾	7.9	✓155 – 168	✓10 ⁽¹¹⁾ (M)
Kosovo	10,000–15,000 ⁽²⁴⁾	0	26.6 ⁽²⁵⁾	4.1 ⁽²⁵⁾	✓	✓3 (M)
Kyrgyzstan	25,500 ⁽²⁶⁾	12.4–14.6	50	nk	✓40 ⁽²⁷⁾	✓30 ^{(27)e} (M)
Latvia	12,573	9.4 ⁽²⁸⁾	74.2	1.6	✓19 ⁽²⁹⁾	✓10 ⁽²⁸⁾ (B, M)
Lithuania	6,056 ⁽³⁰⁾	3.2 ⁽³¹⁾ –12.5 ⁽³²⁾	57.1 ⁽³²⁾	13.4 ⁽³²⁾	✓14	✓19 (B, M)
Macedonia	15,000–20,000 ^f	0.12 ⁽³³⁾	64.5 ⁽³³⁾	nk	✓16 ⁽³³⁾	✓16 ⁽³³⁾ (M, B)
Moldova	30,200 ⁽³⁴⁾	7.9 ⁽¹⁶⁾	70.2–72.8 ⁽¹⁶⁾	3.4–14.2	✓28 ^{(11)g}	✓19 ^{(11)h} (M)
Montenegro	nk	1.1 ⁽³⁵⁾	53.6	nk	✓13	✓5 ⁽¹¹⁾ (M)
Poland	15,119 (10,444–19,794)	3 ⁽³⁶⁾	44.3–72.4 ⁽³⁶⁾	26.3–46.7 ⁽³⁶⁾	✓34 ⁽³⁶⁾	✓25 (B, M)
Romania	19,265	24.90 ⁱ	79 ⁽³⁷⁾	5	✓2 ⁽³⁸⁾	✓8 ⁽³⁹⁾ (B, M)
Russia	1,815,000 ^j	18–31 ⁽⁴⁰⁾	72.5% (51.9– 94.7) ⁽⁴¹⁾	2.6–7.1 ⁽⁴²⁾	✓4 ⁽⁴³⁾	✗
Serbia	30,383 (12,682–48,083) ⁽⁴⁴⁾	<5 ⁽⁴⁵⁾	61 ⁽⁴⁵⁾	68.95 (60.5 –77.4) ^{(46)k}	✓13 ⁽⁴⁵⁾	✓25 ⁽⁴⁷⁾ (B, M)
Slovakia	18,841 (13,732–34,343) ^l	0.3 ⁽⁴⁸⁾	37.8	28.1	✓5 ⁽¹¹⁾	✓7 (B, M)
Slovenia	6,100 (5,580–6,750)	1.9	28.5	2	✓10 ⁽¹¹⁾ (P)	✓10 ⁽¹¹⁾ (B, M)
Tajikistan	25,000 (20,000–30,000)	13.5 ⁽⁴⁹⁾	36.2	nk	✓51 ⁽¹¹⁾	✓6 ⁽¹¹⁾ (M)
Turkmenistan	nk	nk	nk	nk	2 ⁽⁵⁰⁾	✗
Ukraine	310,000	21.9 ⁽⁵¹⁾	27.1 ^m	4.5	✓1667	✓169 (B, M)
Uzbekistan	80,000 ⁿ	7.3 ⁽⁵²⁾	21.8 ⁽⁵²⁾	nk	✓235	✗

nk = not known

^a 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.

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

^c Based on a study conducted in five cities.

^d Based on a study conducted in two cities.

^e This figure is inclusive of 7 operating in prisons.

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

^g There are an additional 16 sites operating in prisons.

^h There are an additional 13 sites operating in prisons.

ⁱ Civil society believes this figure to be higher.

^j Figure from 2007.

^k Based on findings from two cities.

^l Figure includes high-risk drug users. High-risk is considered to be recurrent drug use that causes negative consequences which may include health, psychological or social problems, or is placing the person at a high-risk of suffering such harms.

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

ⁿ 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 programmes (NSP) and opioid substitution therapy (OST)





Harm reduction in Eurasia

Overview

Eurasia is one of the only regions of the world where HIV infection rates continue to rise at an alarming rate. This rise is most pronounced in the countries of Eastern Europe and Central Asia, where between 2010 and 2015, UNAIDS reported a 57% increase in new HIV infections.⁽⁵³⁾ In 2015, over half of these new HIV cases were among people who inject drugs.⁽⁵³⁾ Over 20% of new HIV diagnoses in Romania and the Baltic states of Estonia, Latvia and Lithuania are among people who inject drugs and similar levels are almost reached in Bulgaria.⁽⁵⁴⁾ It is estimated that 3.1 million people who inject drugs live in countries in this region,⁽⁵⁵⁾ 1.8 million of whom reside in Russia.⁽⁵⁶⁾ In 2015, it was in Russia that over 80% of the region's new HIV infections occurred,⁽⁵⁷⁾ a situation attributed in large part to the absence of HIV prevention measures in place such as needle and syringe programmes (NSPs) and opioid substitution therapy (OST). Since the *Global State* last reported in 2014, HIV prevalence rates among people who inject drugs have increased in Belarus, Kazakhstan, Montenegro, and Ukraine. However, according to reports from Ukraine there has been a decrease in HIV prevalence among people who inject drugs observed in the last 7 years.⁽⁵⁸⁾ Although people who inject drugs account for up to 80% of people living with HIV infections in the region, it is reported that only a small minority (20%) are accessing anti-retroviral therapy (ART).⁽⁵⁵⁾

Harm reduction service provision is available to some extent in the vast majority of countries in the region. Needle and syringe programmes are available in all 29 countries, but implementation levels vary widely. For example, only two NSP sites operate in Romania and four in Russia, none with the support of government, whereas 1,667 sites provide NSP in Ukraine (see Table 2.2.1). OST provision also varies considerably, but is notably low in much of the region, with less than 10 operational OST sites in many countries (see Table 2.2.1). In the majority of countries, even those which have received support from the Global Fund to support service implementation and scale-up, harm reduction service provision falls far short of epidemiological need, and remains below the UN recommended levels.⁽⁵⁹⁾

According to the most recent data from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), some countries in this region have witnessed

a decline in opioid use, and an increase in amphetamine use. For example, in Hungary in 2014, only 2% of people who use drugs entering services used heroin as their primary drug, compared to 19% for stimulants other than cocaine.⁽²⁰⁾ Similar trends have also been observed in Poland, where 36% of people entering services reported stimulants as their primary drug, compared to 5% reporting opioids during the same time period.⁽³⁶⁾ The Czech Republic has seen a marked 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.⁽¹⁵⁾ From a sample of 10,108 people who use drugs in the Czech Republic in 2014, 7,038 reported methamphetamine as their primary substance, known locally as 'pervitin'.⁽¹⁵⁾ These changing patterns of drug use highlight that harm reduction services must adapt and respond to need accordingly. In general, people injecting amphetamines will do so more frequently than those using opioids for example, so NSPs operating in areas where amphetamine use is increasing must ensure a greater volume of injecting equipment is made available to clients.

Opioid use is not in decline across the whole region, however, with some countries witnessing an increase in opioid use (including synthetic opioids) among those entering drug services. For example, the majority of people entering drug dependence treatment in Estonia report using fentanyl,⁽⁵⁶⁾ the vast majority of people on the Register of Persons Treated for Psychoactive Drug Abuse in Croatia are treated for opioid use,⁽¹⁴⁾ and 42% of people entering services in Romania report opioids as their primary drug.⁽⁶⁰⁾

Overdose continues to be a major cause of death among people who inject drugs in countries within this region, as it was when the *Global State* last reported in 2014. Where evidence is available, rates of overdose are high, with 21-24% of people who inject drugs in Central Asia reporting having experienced a non-fatal overdose in the past year.⁽⁶¹⁾ The implementation of opioid overdose prevention strategies, such as naloxone distribution among people who use drugs, remains limited to pilot projects in a small number of countries in the region. Drug consumption rooms (DCRs) where people who use drugs are able to consume them with medical support or supervision, are another strategy to reduce drug-related deaths.⁽⁶²⁾ No country in this region has a DCR yet, but in 2015, in Ljubljana, Slovenia an NGO

obtained funding to prepare and operate a pilot drug consumption room to begin in 2016.⁽⁶³⁾

One of the most significant developments in the region in recent years is the departure of the Global Fund support for HIV work from countries such as Romania, Estonia, Serbia, Bosnia and Herzegovina, and Macedonia. This transition has resulted in a dramatic reduction in the number of NGOs delivering services, and in some countries has affected the spectrum and quality of harm reduction. For example, in Serbia following the end of the Global Fund, only one out of four NGOs providing NSPs continue to operate on a limited scale through trained outreach workers, with other NGOs providing needles via outreach on a volunteer basis until they could no longer provide the service.⁽⁶⁴⁾ Civil society state that there is a need for regulatory reform to ensure that NGOs are able to provide services through national funding mechanisms. This includes development of social contracting mechanisms, as well as licensing and accreditation of NGOs to make them eligible to apply for and receive government funding.⁽¹¹⁾ The role of NGOs and community-led service providers in HIV prevention is still not by many governments. At present, in much of Eurasia, national governments continue to be more inclined to direct funds towards antiretroviral therapy or rehabilitation services rather than harm reduction measures, despite the proven effectiveness of NSP and OST in reducing viral transmission among people who inject drugs.^(65, 66)

Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

The number of sites providing NSP has increased in eight countries in the region since the Global State last reported in 2014. These are Belarus (33 to 34 sites), Georgia (14 to 18 sites), Hungary (29 to 46 sites), Latvia (18 to 19 sites), Lithuania (11 to 14 sites), Moldova (23 to 28 sites), Poland (12 to 24 sites) and Tajikistan (43 to 53 sites). Bulgaria, Kyrgyzstan, Romania, Slovakia and Slovenia have witnessed a decrease in NSPs, but the majority of countries (16) have seen no change in the number of NSP sites operating. The coverage of these programmes remains low across the region. In Macedonia in 2015, for example, the 16 NSP sites available in the country reached just 3,900 of the estimated 17,500 people who inject drugs.⁽³³⁾ Among Eastern European and Central Asian countries reporting to UNAIDS, only Kyrgyzstan claimed to implement NSP at

coverage levels considered high by UN standards (over 200 needles/syringes distributed per person who injects drugs per year).⁽⁵⁷⁾ It is important to note, however, that these data represent the most robust estimates, which are not necessarily recent. Despite the scaling-up of NSP services in some countries in the region, NSP coverage continues to remain insufficient to meet need and an urgent need for further investment in this service is essential, particularly in light of increasing trends towards methamphetamine injecting.⁽¹¹⁾

Inadequate financial support from national government remains the primary constraint to sustainable NSP services. Many governments do not financially support the provision of this service, including Albania, Armenia, Azerbaijan, Belarus, Georgia, Kosovo, Kyrgyzstan, Macedonia, Tajikistan, Ukraine, and Uzbekistan.⁽¹¹⁾ In Armenia, the National AIDS Program 2011-2016, which was approved by the government, explicitly references NSP as a component of HIV prevention. However, the Ministry of Health has no explicit legal act on supplying NSPs and there are no government departments involved in supporting the service. It is, however, legal to provide NSP in Armenia.⁽¹¹⁾

Where government funding is not made available, countries often depend on international donor funding, which has been consistently decreasing in this region.⁽⁶⁷⁾ In light of the changing funding landscape, some governments provide partial funding for NSP provision, such as Bosnia and Herzegovina, Kazakhstan, Lithuania, Montenegro and Romania.⁽¹¹⁾ In others, such as Croatia, the Czech Republic, Estonia, Hungary, Poland, Slovenia and Slovakia, NSP is solely supported by government funds.⁽¹¹⁾ In countries such as the Czech Republic and Estonia, this financial support is coupled with political support for harm reduction and as such, funding to sustain these services is considered to be relatively stable. In others such as Hungary, government investment in NSP falls far short of what is required to support services to meet the needs of people who inject drugs.⁽⁶⁸⁾

In some countries where the Global Fund grants have reduced or come to an end, civil society report that NSP service provision has reduced in scope and/or scale as a result, for example in Albania, Macedonia, Romania, Serbia, Montenegro and Russia.^o Inadequate funding remains a consistent constraint to accessible and high-quality NSP provision in the region. Other barriers cited by civil society include repressive policy and legal environments, unequal coverage between urban and rural settings, a lack of legislative regulation of services, restrictive opening hours and poor quality injecting equipment.⁽¹¹⁾

^o Data relating to this reduction in service provision has only been updated in Romania. At the time of reporting no up-to-date site numbers were available for Albania, Macedonia, Serbia or Russia, and the statement is based on civil society reports from the region.



Opioid substitution therapy (OST)

OST continues to be prohibited in Russia and Turkmenistan, despite its proven effectiveness as a first line of treatment for people who inject drugs⁽⁶⁹⁾ and the recommendation within UN guidelines to provide this as a key HIV prevention measure.⁽⁵⁹⁾ While 26 countries have some OST provision, coverage varies considerably and remains extremely low in some states.⁽¹¹⁾ OST is provided to less than 1% of people who inject drugs in Azerbaijan and Kazakhstan (0.2%),⁽⁵⁷⁾ 3% in Armenia, Moldova, Ukraine and Tajikistan,⁽¹¹⁾ approximately 4.9% in Kyrgyzstan and 5.3% in Belarus.⁽⁵⁷⁾ One of the greatest barriers to effective service delivery of OST is the fact that many NGOs are simply prohibited to deliver it and that services are based within government premises.⁽¹¹⁾ Increases in OST provision have been seen in seven countries in the region since the Global State last reported in 2014. An increase has been observed in Belarus (14 to 19 sites), Hungary (12 to 15 sites), Kyrgyzstan (20 to 30 sites), Latvia (4 to 10 sites), Macedonia (12 to 16 sites), and Montenegro (3 to 5 sites), with the greatest increase in Poland, which has seen site provision increase from 3 to 25 sites. Moldova, Romania, Serbia, Slovenia, and Tajikistan have all witnessed a decrease in OST sites, but the vast majority of countries (14) where OST is available have seen no change in service provision.

Unlike NSP, many governments fully fund OST provision, including Azerbaijan (although this service is only available in the city of Baku), Bulgaria, Croatia, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Montenegro, Serbia, Slovakia and Slovenia.⁽¹¹⁾ In Hungary, Latvia and Lithuania, methadone prescription is financed by the government, and although buprenorphine can be prescribed, this must be financed by the individual.^(20, 28, 70) In Montenegro, buprenorphine was introduced in mid-2015, but it is still not used at national level, as doctors are afraid to prescribe it due to the absence of medical protocols.⁽¹¹⁾ In some countries OST is partially government funded, such as Georgia and Albania. In Albania, OST is financed partially through a Global Fund grant and partially from the Ministry of Finance. The NGO Aksion Plus initiated a small-scale buprenorphine project in Tirana, Albania, through financing from a special fund of laundered money seized from assets and illegal drug trafficking.⁽¹¹⁾

In Kazakhstan, methadone continues to be procured through a grant by the Global Fund whilst staff costs at sites are covered by the government.⁽²³⁾

Viral hepatitis

Hepatitis C prevalence rates among people who inject drugs are extremely high in many countries in Eurasia, reaching 50% or higher in 16 countries (Azerbaijan, Belarus, Bulgaria, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Macedonia, Moldova, Montenegro, Poland, Romania, Russia, and Serbia) from a total of 27 which provide data. Prevalence rates for hepatitis C are generally far higher than HIV rates for people who inject drugs across the region, although data limitations make it difficult to assess changes in the epidemic accurately. Hungary's reported hepatitis C prevalence rate among people who inject drugs is 24.1%, yet hepatitis C prevalence among people injecting stimulants during the same reporting year (2014) was far higher, at 74%.⁽²⁰⁾

In a number of countries, rapid screening for the hepatitis C virus cannot be carried out at community-based harm reduction sites. Where such screening is available for people who inject drugs the test often depends on whether the person has state insurance or is able to cover the cost of testing themselves.⁽¹¹⁾ Exceptions to this can be seen in the Czech Republic, where hepatitis C testing and treatment is available to people who inject drugs in 39 clinics, including those in prisons.⁽¹⁵⁾ Slovenia also provides hepatitis C treatment free of charge for all, although it is unclear how accessible this is for people who inject drugs.⁽⁶³⁾ In 2015, Georgia launched a new hepatitis C elimination programme, with a donation of hepatitis C treatment from one of the largest healthcare providers. The new universal treatment plan should extend coverage from 5,000 to 20,000 in the coming years and will include people who use/inject drugs.⁽⁷¹⁾ In Lithuania, Moldova, and Romania, hepatitis C treatment is limited to holders of health insurance. In Russia, Tajikistan, Ukraine and Armenia, hepatitis C treatment is expected to be covered in full by the individual.⁽¹¹⁾ However, Ukraine has access for some treatment provision under a Global Fund grant.⁽⁵⁸⁾ The high cost of treatment, therefore, remains a key obstacle to access in most countries. 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. In Latvia, Montenegro, Serbia, and Albania, people who inject drugs are required to stop using drugs prior to receiving treatment.⁽¹¹⁾

Overdose

Overdose continues to be a major cause of death among people who inject drugs in the region, with an estimated 100,000 people dying from an overdose-related death in Russia alone each year.⁽⁷²⁾ In 2014, rates of overdose-related death reached 113 per million in Estonia.⁽⁵⁶⁾ In the Czech Republic, which has one of the strongest harm reduction responses in the region, overall mortality rates for people using OST were relatively low, ranging from 3.5 to 7.2 deaths per 1,000 person years. In Bratislava, Slovakia, this rate was marginally higher at 7.3 deaths per 1,000 person years.⁽⁷³⁾ However, it is difficult to assess the true scale of overdose morbidity and mortality due to inconsistent reporting and differences in surveillance systems, which have led to systematic under-reporting of overdose-related death.

Naloxone, a highly effective opioid antagonist used to reverse the effects of opioid overdose, remains extremely limited in the region. In at least Kazakhstan, Latvia, Montenegro, Romania, Serbia, Slovenia and Uzbekistan, there are neither overdose prevention programmes in the form of education nor naloxone peer-distribution.⁽¹¹⁾ In Belarus, Bulgaria, and Russia, peer education programmes regarding overdose are provided, but naloxone is unavailable.⁽¹¹⁾ Naloxone became available via the three mobile NSP units in Lithuania in 2015, but the number of kits provided is not known.⁽⁷⁰⁾ In Estonia in 2013, the National Institute for Health Development launched a pilot take-home naloxone programme due to the high-rate of overdose-related deaths in the country. People who use opioids and their families were taught to recognise the signs of an overdose and administer naloxone.⁽⁷⁴⁾ Between 2013 and 2015, 1,630 naloxone kits were distributed. It is reported that overdose-related deaths reduced by over half, from 170 in 2012, to 84 in 2015.⁽⁶⁸⁾ In a recent Global AIDS Progress Report to UNAIDS, the Estonian government also report that naloxone became available within prisons in 2015.⁽⁷⁵⁾

The vast majority of people who use opioids in the region have no access to life-saving naloxone.⁽¹¹⁾ Barriers to increasing access to naloxone include overregulation of both the management of naloxone by non-medical staff, including prohibitions against injection by non-medical staff, and of the provision of naloxone by medical staff.⁽¹¹⁾

Tuberculosis (TB)

Multi-drug resistant TB rates are among the highest in the world in Eurasia.⁽⁷⁶⁾ Data on TB prevalence among people who inject drugs are sparse, and without these, it is difficult to assess the true scale of TB among people who inject drugs in the region.

In all countries in the region, TB screening and treatment is available for the general population, which theoretically includes people who inject drugs. In Estonia, for example, it is reported that free TB screening is provided for people who inject drugs, people living with HIV, those living in shelters, prisoners and other groups considered to be at heightened risk of TB infection that may not be covered by health insurance.⁽⁷⁴⁾ However, throughout the region, TB testing and treatment services are not generally tailored to the needs of people who inject drugs, and are rarely linked to HIV or harm reduction services meaning many people are lost via the referral process to specialised TB facilities.⁽¹¹⁾ A study undertaken in Ukraine illustrated the improvement in healthcare quality indicators for people who inject drugs that can be achieved using an integrated service delivery model.⁽⁷⁷⁾ However, funding for such linked services is not only limited, but is rapidly depleting in the region due to the retreat of international donors such as the Global Fund.

In recent years, due to a change in the eligibility criteria for a number of countries, Global Fund grants supporting TB programmes have ended, and many governments are yet to allocate sufficient funding to address the significant gap in provision which has been left behind.⁽¹¹⁾

Antiretroviral therapy (ART)

In the majority of countries in the region there is a distinct lack of integration of HIV testing and treatment services within harm reduction programmes.⁽¹¹⁾ Where integration of these services does exist, it often depends on ad-hoc collaboration between harm reduction services and specialised medical facilities. This integration is driven by personal contacts and does not offer full or even coverage. In many countries this leads to late HIV diagnosis, low coverage of ART among people who inject drugs, and suboptimal adherence to treatment.⁽¹¹⁾ ART coverage remains extremely low in much of the region, with only 21% of people living with HIV accessing treatment in Eastern Europe and Central Asia.⁽⁵³⁾ This poor coverage is particularly pronounced among people who inject drugs. In Russia, for example, people who inject drugs make up 67% of the cumulative



HIV cases, and yet represent only 25% of those receiving ART.⁽⁷⁸⁾ In contrast, notable progress has been achieved in Ukraine, where increased government investment has resulted in a dramatic rise in people receiving ART from 12,751 in 2010, to 43,790 people in 2013.⁽⁷⁹⁾

Disproportionately poor access to ART among people who inject drugs is further compounded by additional barriers in Armenia, Estonia, Lithuania and Tajikistan, where NGOs are prohibited from performing rapid testing for HIV and hepatitis C due to regulations that require them to hold a special medical license. To bypass this barrier, some NGOs collaborate with medical institutions to provide testing.⁽¹¹⁾

Harm reduction in prisons

Extremely punitive drug laws and policies across the region have given rise to some of the world's highest incarceration rates. Of the 29 countries in Eurasia, 19 still have incarceration rates that exceed the world average of 146 prisoners per 100,000 population, with 10 exceeding 200: Turkmenistan (583), Russia (445), Belarus (306), Georgia (274), Lithuania (268), Latvia (239), Azerbaijan (236), Kazakhstan (234), Estonia (216), and Moldova (215).⁽⁸⁰⁾ People who inject drugs reportedly represent about one third of prisoners in the region, although they could make up between 50-80% of the prison population in some countries.⁽⁸¹⁾ Similar to all other regions of the world, injecting drug use in prisons in Eurasia is common, with prevalence estimates ranging from 3% to 55%.⁽⁸¹⁾ When all of these factors converge, the result is a much higher prevalence of HIV, HCV and TB in prisons than outside of prisons. For example, HIV prevalence in prisons exceeds 10% in Latvia (20.4%), Ukraine (19.4%), Estonia (14.1%), and Kyrgyzstan (10.3%), and remains significantly higher than in the broader community in Uzbekistan (4.7%), Lithuania (3.4%), Kazakhstan (3.9%), Azerbaijan (3.7%), Armenia (2.4%), Tajikistan (2.4%), Moldova (2.6%), and Georgia (0.9%).⁽⁸¹⁾

Despite this reality, harm reduction services remain scarce in the region's prisons. Needle and syringe programmes are currently only provided in prisons in Armenia (all 11 prisons)⁽⁸²⁾, Kyrgyzstan (7 prisons),⁽²⁷⁾ Moldova (13 prisons on the 'right bank' and 3 prisons in the autonomous region of Transnistria)⁽³⁴⁾ and Tajikistan (1 prison).⁽⁸³⁾ In theory, NSPs are also available in 8 prisons in Romania, but prisoners reportedly do not access them for fear of negative consequences⁽⁸⁴⁾. Despite their proven success, the few prison-based NSPs operating in the region face an uncertain future due to loss of funding from international donors.⁽⁸¹⁾

Provision of OST in prisons is slightly more widespread, with the service currently available in at least one prison in 18 countries in the region. Quality and accessibility, however, vary considerably, both between and within countries. For example, in Bosnia and Herzegovina, prisoners can initiate OST at Orasje prison, but in Tuzla and Zenica prisons in Sarajevo, the service is only available to prisoners who were receiving it prior to incarceration.⁽⁸⁵⁾ In Albania,⁽⁸⁶⁾ Bulgaria,⁽¹¹⁾ Latvia,⁽⁸⁷⁾ Lithuania⁽⁷⁰⁾ Montenegro,⁽¹¹⁾ and Serbia,⁽¹¹⁾ OST cannot be initiated in prisons at all. Meanwhile, OST is only available for detoxification in some pre-trial detention facilities in Georgia.⁽⁸¹⁾ A blanket prohibition on OST continues to be upheld in Russia, Turkmenistan and Uzbekistan, and the service is still unavailable in prisons in Azerbaijan, Hungary, Kazakhstan, Kosovo, Slovakia, Ukraine (although legislation from 2011 permits OST in prisons)⁽⁸⁸⁾ and Tajikistan. While guidelines on OST in prisons have been developed in Tajikistan, actual implementation of the service was last reported to be under consideration.⁽⁸³⁾ Positively, however, since the Global State last reported in 2014, OST was expanded to two more prisons in Moldova.⁽³⁴⁾

More countries must follow Moldova's example and introduce, expand and/or remove any barriers to accessing NSPs and OST in their prisons as a matter of urgency. Not only is this a legally binding obligation under international human rights law, but it could also considerably reduce HIV transmission. Recent scientific modeling of the impact of incarceration and scale-up of OST in prisons on HIV transmission among people who inject drugs in Ukraine suggests that if prison-based OST were initiated in the country, 19.8% of HIV infections would be averted between 2015-2030, and community coverage of OST would increase by 8.3%.⁽⁸¹⁾

Civil society reports that HIV treatment is available in prisons in all countries across the region, although the regulation, quality and coverage of this service varies considerably.⁽¹¹⁾ Azerbaijan and Kyrgyzstan are considered to provide high coverage of ART for people living with HIV who are diagnosed within prison,^(89, 90) and Poland has reportedly increased ART coverage in the last 5 years, with all prisoners living with HIV now able to access the service.⁽⁹¹⁾ In some countries, such as Tajikistan, ART coverage in prisons (43% in 2014) is substantially higher than it is outside of prisons.⁽⁸³⁾ Meanwhile, less than 4% of people living with HIV in Ukrainian prisons currently have access to ART,⁽⁹²⁾ while frequent lack of medication in Russian prisons that ART availability is sporadic.⁽¹¹⁾ In some prisons in Bosnia and Herzegovina, HIV treatment is not available.⁽⁸⁵⁾

Importantly, where ART and other essential health services are available in prisons, barriers of all kinds continue to impede their access. For instance, in the Czech Republic, prisoners are required to pay a “regulatory fee” of CZK30 for every medical appointment and every prescription, which - as a rule - is not reimbursed by health insurance.⁽⁹³⁾

Information on hepatitis C testing, treatment and care in the region's prisons is scarce, but civil society reports that it typically reflects the situation outside of prisons.⁽¹¹⁾ In Georgia, a recently launched internationally funded HCV elimination strategy has included prisoners, enabling them to access costly new direct-acting antiviral treatments.⁽⁹⁴⁾ At the same time, the European Committee for the Prevention of Torture recently reported that funding for peg-interferon treatment for HCV in relation to newly detected cases was being discontinued in Serbian prisons.⁽⁹⁵⁾ Across the border in Bosnia and Herzegovina, prisoners are reportedly being prescribed non-evidence-based treatments, such as artichoke tablets, which are believed by some health professionals to cure HCV.⁽⁸⁵⁾

Civil society reports that testing and treatment for TB is likely available in all prisons in the region.⁽¹¹⁾ In Georgia, all prisons are now covered by the national programme for the Prevention of Tuberculosis which has resulted in a 52% reduction in TB prevalence in the prison system since 2012.⁽⁹⁶⁾ Information on naloxone in prisons is limited, but news that Estonia introduced a take home naloxone programme from prisons in 2015, with prisoners who inject drugs now being trained in its use prior to release, is promising.⁽⁷⁵⁾ In terms of condom provision, civil society reports that in most countries' prisons, condoms are either available to a limited extent in prisons where there are relevant NGO projects distributing them, or not available at all.⁽¹¹⁾

Policy developments for harm reduction

The majority of countries (26 of 29) have national HIV or drug policies that include explicit support for harm reduction.⁽⁵⁰⁾ However, most countries also have strongly punitive drug policies which emphasise criminalisation of drug use and possession. Within this policy environment, hostility towards harm reduction is common. National legislation on drugs in the former Soviet states includes tables that set thresholds for considering illicit drug seizures as ‘small’, ‘large’, and ‘extremely large’, with associated criminal laws and prison terms. Thresholds for possession which lead to

imprisonment are low, especially in comparison to the commonly disproportionate length of prison sentences for offenders.⁽¹¹⁾ At the time of reporting the only two countries which had decriminalised the possession and use of small quantities of drugs in the region were the Czech Republic and Armenia. In Armenia, use and possession of small amount of drugs for personal use is not a criminal offence. However, the administrative fine for possession is so high that many cannot afford to pay and instead are arrested for non-payment.⁽¹¹⁾ The low prevalence of HIV among people who inject drugs in the Czech Republic has been attributed to decriminalisation combined with sustained and scaled-up NSP and OST provision.⁽⁹⁷⁾

Legislation in the vast majority of countries does not include options for providing non-criminal measures as an alternative to prison for drug use or possession. Moreover, in countries where such non-criminal options are available, these are often not utilised. For example, in Estonia, a lack of motivation by law enforcement and criminal justice institutions to use non-criminal options, along with an absence of implementation mechanisms, results in criminal sanctions remaining the norm.⁽¹¹⁾ Civil society report that fear of potential arrest and criminal penalties among people who use drugs significantly interferes with the utilisation and provision of NSP and OST services in the region, where data is often shared with the police.⁽¹¹⁾

In April 2016, during the United Nations General Assembly Special Session (UNGASS) on the drugs in New York, the Czech Republic, Estonia, Latvia, Lithuania, Poland, Romania and Slovenia all made statements in explicit support of harm reduction.⁽⁹⁸⁾ The European Union (EU)'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.⁽⁹⁸⁾ It is important to note, however, that the expressions of international support among these countries have not yet been matched by financial or political commitments.

Civil society and advocacy developments for harm reduction

Civil society continue to play a crucial role in advocating for harm reduction in the region and internationally. In recent years, the changing funding landscape has increasingly required civil society to focus their advocacy



on the sustainability of harm reduction funding in the region. In 2014, the Eurasian Harm Reduction Network (EHRN) became the principal recipient for the first Global Fund regional HIV/AIDS grant in Eastern Europe and Central Asia (EECA) and created a regional research and advocacy programme, 'Harm Reduction Works! – Fund it'. The goal of this programme is to strengthen advocacy by civil society, including people who use drugs, for sufficient, strategic and sustainable investments in harm reduction as HIV prevention in the region.⁽⁹⁹⁾ The project, which covers Belarus, Georgia, Kazakhstan, Moldova, Tajikistan and Lithuania, is due to end in March 2017, when the results of the programme will be published.

In 2015, EHRN and the Global Fund co-organised a technical consultation in Istanbul, Turkey, bringing together key stakeholders^p to shape an appropriate technical framework for the transition from Global Fund funding to national funding, and the sustainability of HIV and TB programmes in the region. Also in 2015, in Tbilisi, Georgia, the Regional High Level Dialogue on Successful Transition to Domestic Funding of HIV and TB Response in Eastern Europe and Central Asia 'Road to Success' meeting was held. 318 delegates from 31 countries gathered, representing governments from Eastern Europe and Central Asia (EECA), civil society organisations, key populations and communities, international organisations and technical agencies with the goal of discussing commitments and principles of the successful transition process from donor to national funding.

In early 2016, the Georgia Network of People Who Use Drugs (GeNPUD) established the Georgian National Drug Policy Platform (GNDDP), creating a broad national drug policy platform.⁽¹¹⁾ The GNDDP unites a broad range of over 30 organisations, which include community organisations and drug user activists, service delivery organisations, drug clinics and medical personnel, researchers and academics, human rights organisations and activists. Members agreed on three priority areas: 1) drug policy reform 2) improving the availability and quality of services, and 3) reducing stigma and raising public awareness. It is the first time that representatives of different sectors were able to come together, agree on common goals and pool their efforts in petitioning governments to take action in the field of drug use and harm reduction initiatives.⁽¹¹⁾

There are some well-established networks of people who use drugs in the region, with the Eurasian Network of People Who use Drugs (ENPUD) at regional level, and country-based active drug user networks in Macedonia, Georgia, Azerbaijan, Kyrgyzstan, Montenegro and Romania.⁽¹¹⁾

Funding developments for harm reduction

Since the *Global State* last reported in 2014, there have been a number of civil society initiatives with a focus on advocacy for harm reduction funding in this region. EHRN's 'Harm Reduction Works! – Fund It' project has examined funding levels and challenges for NSP and OST in Belarus, Georgia, Kazakhstan, Moldova, Tajikistan and Lithuania. A project report released in 2015 stated that harm reduction in the region remained heavily dependent on international donor support. It raised serious concerns regarding the lack of commitment of the Government of Georgia to fund NSPs, the minimal domestic contributions in Moldova and Tajikistan (15% and 2% respectively), the lack of domestic support for OST in Kazakhstan and at the limitations of domestic support in Lithuania which do not allow harm reduction services to meet the national need.⁽¹⁰⁰⁾ In Ukraine, the government recently committed to coverage of some methadone after the threat of a reduction in Global Fund support, and in the municipality of St Petersburg in Russia, the government are also expected to begin supporting needle and syringe programming. Both of these contributions, however, will be insufficient to match the reduction in Global Fund support, or to reach the desired coverage levels.⁽¹⁰¹⁾

Research carried out by HRI within an EC-funded project 'Harm Reduction Works!'^q also examined the sustainability of harm reduction funding in European Union states within the Eurasia region. These are generally the countries with the more established harm reduction programmes in the Eurasia region with, for example, civil society reporting that funding for harm reduction in the Czech Republic and Estonia was considered to be relatively stable and secure. However, there were grave concerns raised about the potential for rapid increases in HIV infection among people who inject drugs in some countries due to poor funding or an imminent end to funding for harm reduction. For example, currently in Bulgaria, a Global Fund grant is ending without any indication that government will fund existing harm reduction services to continue operating. In Romania, there has been a decrease in the already limited harm reduction service provision in recent years as a result of funding cuts, with some, though insufficient, investment by the municipality of Bucharest.⁽¹⁰¹⁾ Similarly, minimal domestic support for harm reduction in Hungary continues to limit the extent to which services can prevent epidemics from rapidly increasing among people injecting drugs. There remain

^p Including national government agencies, donor organisations, technical support providers, UN agencies, civil society organisations and communities.

^q Jointly coordinated by EHRN and HRI running from 2014-2016.

many challenges in establishing existing spending on harm reduction, highlighting the need for greater transparency among governments and donors on their harm reduction investments and for this spending to be systematically tracked. This information is urgently needed if the limited available funds are to be invested optimally and according to epidemiological need.^r By far the biggest challenge to the sustainability of harm reduction in this region, however, remains the lack of political acceptance of harm reduction and the unwillingness of governments to invest what is required.

Transition from Global Fund support to national funding for harm reduction

In most countries in Eurasia, harm reduction programmes have been introduced and financially supported by international donors, with national funding supporting all OST and NSP delivery in only a few EU Member States. In all other cases the Global Fund has been the single major funding source for these programmes. However, the Global Fund has been revisiting its priorities and funding policies and has been gradually withdrawing from many countries within Eurasia. Due to this, these countries have engaged in the process of transition from Global Fund funding to national funding for HIV and TB programmes. Experience accumulated in relation to sustainability of donor funded programmes, and the results of Global Fund withdrawal from Albania, Romania, Bulgaria, Estonia, Montenegro, Russia and Serbia, suggest that this will be a challenging process and that there are considerable risks to the sustainability of HIV programmes in the region. Since the *Global State* last reported, there has been a rise in HIV prevalence among people who inject drugs in Montenegro and a decrease in harm reduction services in Romania going from 7 NSPs in 2014, to 3 in 2016, and from 13 OST sites in 2014, to 8 in 2016.

In the environment of ever-limited funding and an abundance of competing priorities for scarce public health resources, harm reduction interventions, still subjects of political and ideological controversy, seem to be most vulnerable. Furthermore, countries lack mechanisms to finance NGOs through government budgets. In Georgia, NSPs are projected to receive no domestic funding, however a transition plan is being finalised for government approval for the beginning of 2017, which should include funding for NSPs.⁽¹⁰²⁾

In Tajikistan, just 1.6% of NSP costs will be received from government funding, with the government covering 15% of costs in Moldova.⁽¹¹⁾ Starting from 2015, the Global Fund has reduced its financial support to Russia by approximately 30%, which immediately resulted in a dramatic decrease in the coverage of already limited harm reduction services. Support is set to end entirely by 2018. The total number of HIV prevention projects among key populations has decreased from 62 to only 19, and annual coverage of harm reduction services decreased by over 60% from 66,351 in 2014, to 25,390 in 2015.⁽¹⁰³⁾ It is likely that many other transition countries will not be able to sustain the existing harm reduction programmes at even a low level of coverage, let alone scale up to UN recommended standards.

^r The report will be published in the coming months by HRI.



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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 (%) ⁽⁴⁾	Harm reduction response		
					NSP ^{(6, 7)a} 	OST ^{(8) b} 	DCR ⁽⁵⁾ 
Andorra	nk	nk	nk	nk	nk	✗	✗
Austria	11,000-15,000 ⁽⁹⁾	10.5	51.3 (33.9-74.1)	1-44.1 ⁽⁹⁾	✓37	✓(B, M, O)	✗
Belgium	25,295 (17,638–35,699)	0.0–5.7	17.1–75.1 ^c	0.1.9	✓96	✓140 (B, H, M)	✗
Cyprus	291 (216–427)	0–1.6	43.1	0.9	✓1	✓2 (B, O)	✗
Denmark	12,754 (10,066–16,821) ^d	2.1	52.5	1.3 ^e	✓	✓(B, H, M)	5
Finland	15,611 (13,770–22,665) ^f	1.19 ^g	74 ^h	nk	✓40	✓(B, M, O)	✗
France	122,000 ⁱ	6.2 ^j	63.8 ^k	0.8 ^l	✓583	✓(B, M, O)	1 ⁽¹⁰⁾
Germany	94,250 (56,000–169,500) ⁽¹¹⁾	1.6-9. ^m	62.6-73 ⁿ	0.1-6.3 ^o	✓156	✓(B, H, M)	24
Greece	5,120 (4,209-6,303)	6.4-8.5	66.7-73.5	1.9-2.8	✓16	✓56(B, M, O)	✗
Iceland	nk	nk	63 ^p	nk	nk	✓(B, M)	✗
Ireland	6,289 (4,694–7,884) ^{(12)q}	6 ^r	41.5 ^s	0.5 ^t	✓143	✓721(B, M, O)	✗
Italy	326,000 ^u	30.1	54	12.1 ⁽¹³⁾	✓620	✓(B, M, O)	✗
Luxembourg	1907 (1,524–2,301) ^v	4.5	80.7-90.7 ^w	nk	✓8	✓(B, M, O)	1
Malta	1,524-2,301	0	14.7	1.8 ⁽¹⁴⁾	✓7	✓(B, M)	✗
Monaco	nk	nk	nk	nk	✓nk	✓1 ⁽²⁵⁾	✗
Netherlands	2,390 (2,336–2,444) ^x	0	66.7 ^y	0	✓175	✓(B, H, M)	31
Norway	8,145 (6,948-9,842) ^z	2.4	62.1	0.9 ^{aa}	✓33	✓(B, M)	1
Portugal	14,426 (12,732-16,101) ^{bb}	14.7	84.4	5.2	✓	✓(B, M)	✗
Spain	9,879 (7,971-11,786) ^{cc}	30.6 ^{dd}	nk	nk	✓1578	✓(B, H, M)	12
Sweden	8,021 ^{ee}	7.4 ^{ff}	96.8 ^{gg}	nk	✓6	✓110(B, M)	✗
Switzerland	31,653 (24,907–38,399) ^{(12)hh}	nk	nk	nk	✓	✓(B, H, M, O)	12
Turkey	nk	0.2	42.8	4.2	✗	✓(B)	✗
UK	122,894 (117,370-131,869) ⁽¹⁶⁾	1 ⁽¹⁶⁾	50 ⁽¹⁶⁾ⁱⁱ	0.2 ^{jj}	✓1,523	✓(B, H, M, O)	✗

nk = not known

^a 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 2014 unless otherwise stated.

^b (M) = methadone, (B) = buprenorphine, (O) = any other form (including morphine and codeine). Figures for the number of sites are often not available in Western Europe due to a variety of service providers which include general practitioners.

^c Estimate is based on sub-national data from 2014.

^d Estimate based on Global State of Harm Reduction 2014 report. No new data available.

^e Year of estimate: 2007. See: reference 9.

^f Year of estimate 2012.

^g Estimate is based on sub-national data from 2014.

^h Estimate is based on sub-national data from 2014.

ⁱ Year of estimate: 1999.

^j Estimate is based on sub-national data from 2011/12.

^k Estimate is based on sub-national data from 2011.

^l Estimate is based on sub-national data from 2011.

^m Figure is based on sub-national data from 2013/14.

ⁿ Estimate is based on sub-national data from 2013/14.

^o Estimate is based on sub-national data from 2013/14.

^p Year of estimate: 1990–1993.

^q Year of estimate: 1996.

^r Year of estimate: 2010.

^s Year of estimate: 2010.

^t Year of estimate: 2010.

^u Year of estimate: 1996.

^v Year of estimate: 2009.

^w Year of estimate: 2005.

^x Year of estimate: 2008.

^y Year of estimate: 2014.

^z Year of estimate: 2013.

^{aa} Estimate is based on sub-national data from 2012.

^{bb} Year of estimate: 2012.

^{cc} Year of estimate: 2013.

^{dd} Year of estimate: 2013.

^{ee} Year of estimate: 2008–2011.

^{ff} Estimate is based on sub-national data from 2012.

^{gg} Year of estimate: 2007.

^{hh} Year of estimate: 1997.

ⁱⁱ Estimate is based on sub-national data from 2014.

^{jj} Estimate is based on sub-national data from 2014.

Map 2.3.1: Availability of needle and syringe 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

Overview

In much of Europe, HIV rates among people who inject drugs are reported to be stable or declining, with 1,236 newly reported drug-injection related HIV diagnoses in the European Union in 2014, the lowest number reported in more than a decade.⁽¹⁷⁾ A recent UNAIDS report estimates there to be between 719,000 to 914,000 people who inject drugs in Western Europe, with HIV incidence among this population estimated to be 0.8%.⁽¹⁸⁾ The low rates of HIV infection can be attributed to early scale-up of harm reduction measures in many countries.⁽¹⁹⁾ Localised outbreaks of new HIV infections among people who inject drugs have been documented, however, in Ireland, Scotland, and Luxembourg in 2015.⁽¹⁷⁾ In Ireland, data from 2014 indicated that among the 359 people newly diagnosed with HIV, 25 were linked to unsafe injecting, a rise from previous years.⁽¹⁷⁾ An epidemiological investigation has been launched to determine the reasons behind this increase.⁽¹⁷⁾

Changes in drug use patterns, particularly increased amphetamine-type stimulant (ATS) injecting, and high levels of marginalisation have been common factors in a number of the recent HIV outbreaks in Western Europe.⁽¹⁷⁾ Crystalline methamphetamine is reported to be increasing in availability, including in countries where methamphetamine use has not been commonly reported in the past. For example, according to the Federal Criminal Police Office in Germany, the number of first-time crystalline methamphetamine users increased by almost 7% in 2013.⁽²⁰⁾ The region has also seen a rise in the use of synthetic ATS substances such as mephedrone. Although first synthesised in 1929, mephedrone did not become widely available until 2007, and has now been placed under national legislative controls in a total of 31 countries.⁽²¹⁾ Since mephedrone was scheduled under Article 2 of the Convention on Psychotropic Substances and made an illicit drug, the United Kingdom has been the only country in Europe to conduct repeat surveys on mephedrone use. According to the Crime Survey for England and Wales (CSEW) 2011/12, mephedrone had the highest annual prevalence rate of any ATS, ranking fourth among the general population, and third among those aged between 16-24.⁽²⁰⁾ There are currently relatively few harm reduction programmes for people who use ATS. In light of this, in 2015, Harm Reduction International produced a report synthesising available data and programme

experience in this area, noting the ways in which harm reduction programmes can respond effectively to reduce the harms that can be associated with ATS use.⁽²²⁾

Although Western Europe is home to many of the strongest national harm reduction programmes in the world, with the vast majority of countries offering needle and syringe programme (NSP) provision and half of all opioid users accessing opioid substitution therapies (OST),⁽²³⁾ there are still important gaps in service provision. For example, access to hepatitis C treatment for people who inject drugs remains consistently low and new direct-acting antivirals (DAAs) continue to be priced out of reach. 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, and overdose continues to be a major cause of death.

Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

In Western Europe, NSPs operate in 19 of the 23 countries (please refer to Table 2.3.1), to greater or lesser degrees. In a few of the countries in the region, the annual number of syringes distributed per person who injects drugs per year approaches the UN recommended high coverage level of 200.^(25, 26) Since the *Global State* last reported, the number of NSPs has declined in Austria, Belgium, Finland, Germany, Luxembourg, and Norway, with a large decrease in service provision seen in Portugal (from 1,270 to 590) and Spain (from 2,386 NSPs to 1,578).⁽²⁷⁾

In Austria, syringes are available at 15 fixed sites, there are also 20 syringe vending machines located in five provinces, and five sites serviced by outreach workers. Syringe vending machines are also available in Luxembourg⁽²⁸⁾ and Germany, the latter having the highest number of syringe vending machines in the world (approximately 160 across nine of its 16 federal states).⁽²⁹⁾ Although Germany's NSP service currently spans 180 cities, there is still a need for increased investment, particularly in light of the declining numbers of NSP sites.⁽³⁰⁾ In the majority of countries in the region, needles and syringes can be also be purchased without a medical prescription at most pharmacies, which play

a vital role in providing NSP services.⁽³¹⁾ In the Flemish region of Belgium, annual evaluations of the needle and syringe programmes indicated that pharmacies play an important role, with almost two-thirds of people who inject drugs reporting purchasing needles through this medium as opposed to NSP sites.⁽³²⁾ Pharmacy provision often ensures that even where NSP sites do not cover a wide geographical area, sterile injecting equipment is still available to people. However, pharmacy staff are often not equipped with the expertise to provide harm reduction advice and will be unlikely to have had training in this area.

NSP service delivery varies widely across Western Europe. In Belgium in 2014, approximately 926,000 syringes were distributed through 51 specialised agencies and 14 sites serviced by outreach workers, coordinated by the Free Clinic in the Flemish community and by Modus Vivendi in the French community.⁽³²⁾ In Portugal, the National Commission for the Fight Against AIDS (Comissão Nacional de Luta Contra a SIDA), in cooperation with the National Association of Pharmacies (Associação Nacional de Farmácias), implements the national needle and syringe programme “Say No to a Second-Hand Syringe”, which was established over twenty years ago to prevent HIV transmission among people who inject drugs. The programme involves pharmacies, primary care health centres and NGOs, and includes several mobile units.⁽³³⁾ In 2012, a mobile medical care unit was launched in Luxembourg as an additional service to the five fixed sites and three vending machines, and facilitated the provision of primary medical care at low-threshold harm reduction centres.⁽²⁸⁾ It is reported that most of those registered as people who inject drugs in the country^{kk} were then able to obtain syringes from specialised agencies as well as pharmacies. Drug services in Luxembourg are decentralised and most commonly provided by state-accredited NGOs financed by the government. Many of the specialised agencies providing NSP have signed agreements with the Ministry of Health which guarantee their annual funding.⁽²⁸⁾ However, civil society organisations report that there have been problems with harm reduction funding for measures such as NSPs.⁽³⁴⁾

Even in countries with relatively good levels of NSP coverage, important gaps 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.⁽³⁵⁾ In Greece, an urgent priority to respond

to the needs of the refugee population is reported to have affected mobile NSP provision. In 2015, 368,000 syringes were distributed, a decrease from 2014 figures, even though a further two sites had been initiated. This decrease was attributed to a re-focusing of three out of four mobile sites to the needs of refugee.⁽³⁶⁾

Opioid substitution therapy (OST)

There were an estimated 644,000 people who use opioids receiving OST in Western Europe in 2014, equating to about half of all people using opioids in the region.⁽²³⁾ Coverage rates vary widely across the region, however, from low coverage in Cyprus, for example, to high coverage in countries such as France and Portugal. Methadone remains the most commonly prescribed form of opioid substitute, received by 61% of those receiving OST.⁽²³⁾ OST in the region is prescribed from various sites, including healthcare centres, specialist treatment facilities, via general practitioners, and outreach services. Due to this dispersal of prescription sites, the actual numbers of OST sites in countries within the region are often difficult to determine.

In some countries, national OST coverage may reach UN-recommended levels, while at the local level there may be some regions or some populations in those countries for whom coverage remains inadequate. In Germany for example, although OST is estimated to be received by 30-50% of people who inject drugs,⁽³⁷⁾ regulations for prescribing are reported to be overly bureaucratic, serving as a deterrent in attempting to access OST. In 2016, with pressure from prescribing doctors and NGOs, the barriers regarding access were considered by the Federal Ministry of Health in Berlin, and amendments have been made in order to attract a greater number of doctors as OST prescribers.⁽³⁰⁾

In Greece, the Greek Organisation Against Drugs (OKANA) is the only organisation which has legal permission to establish, operate and monitor OST. According to latest available estimates from 2014, a total of 10,266 people who use drugs received OST, with buprenorphine-based treatment being the most predominant substitute. In the Attica region of Athens, where the majority of opioid users are situated, waiting lists to initiate OST still average three years,⁽³⁶⁾ highlighting the inadequacy of harm reduction provision in this area, despite a large scaling-up process which started after the HIV outbreak in 2011.

In Cyprus, OST was introduced in 2007 and is currently only available from two specialised drug treatment service units (one hospital and one private clinic). OST is

^{kk} Réseau Luxembourgeois d'Information sur les Stupéfiants (RELIS) is a multi-sectoral drug monitoring system.



prescribed in the form of oxycodone, dihydrocodeine, buprenorphine, and methadone, but the latter is only used for detoxification purposes. In 2014, 178 people were receiving OST in Cyprus.⁽³⁸⁾ Similarly, Turkey introduced OST in 2009, with buprenorphine and naloxone licensed for use for both detoxification and substitution since 2010. Prior to 2014, OST was only prescribed by psychiatrists, but since 2014 all drug treatment centres licensed by the Ministry of Health have been able to implement OST provision.⁽³⁹⁾

Drug Consumption Room (DCRs)

Alongside other effective harm reduction approaches such as OST⁽⁴⁰⁾ and NSP⁽⁴¹⁾ provision, several countries in the region operate drug consumption rooms (DCRs).⁽⁴²⁾ These are professionally supervised healthcare facilities where people can consume drugs in safe conditions.

The first supervised drug consumption room was opened in Berne, Switzerland in June 1986.⁽⁵⁾ In subsequent years further facilities were established in Germany, the Netherlands, Spain, Norway, Luxembourg, Denmark, Greece, and France.⁽⁵⁾ Currently, there are 87 DCRs operating across eight countries in Western Europe: Denmark, Germany, Luxembourg, Netherlands, Norway, Spain, Switzerland and France.⁽⁵⁾ In 2014, the only DCR available in Greece was closed due to policy makers' failure to adopt the necessary legislative amendments. Both Norway and Luxembourg are preparing to open a second DCR but these may not be in operation until 2018. In January 2016, France approved a six-year trial of drug consumption rooms, with facilities opened in Paris in October 2016.⁽⁵⁾ Switzerland is also planning to open a further DCR in the near future,⁽⁴³⁾ and Ireland is planning to introduce supervised injecting facilities during 2016.⁽⁴⁴⁾

There is often political resistance to DCRs. For example in Bavaria, Germany, despite the high rates of drug-related deaths, the regional government did not issue the required regulation for operating DCRs.⁽³⁰⁾

Viral hepatitis

Although Western Europe has good harm reduction practices and programme provision when compared to the rest of the world, access to hepatitis C treatment for people who inject drugs is still low.^(45, 46) With hepatitis C (HCV) antibody levels among national samples of people who inject drugs between 14-84% in 2012/13, five of the ten countries with national data reported HCV prevalence rates in excess of 50%.⁽¹⁷⁾ In Western Europe, as in the rest of the world, there is a significant gap in data relating to HCV prevalence and access to testing

and treatment for people who inject drugs. However, the limited available data suggest an increasing epidemic among people who inject drugs in the region. Among countries with national trend data for the period 2006-2013 declining HCV prevalence among people who inject drugs was only reported in Norway, whilst six others countries observed an increase.⁽¹⁷⁾

Deaths from HCV related to end stage liver disease and liver cancer doubled during the last decade in the UK, with the majority of people who died being from marginalised and under-served groups in society such as people who inject drugs.⁽⁴⁷⁾ In England and Wales, 50% of people who inject drugs are believed to have contracted HCV, with lower levels in Northern Ireland (23%) and higher levels in Scotland (57%).⁽⁴⁷⁾ In response to this, Scotland has in place a well-funded hepatitis C programme, which makes testing available in low-threshold settings and provides treatment to people who inject drugs.⁽⁴⁸⁾ In France, 344 anonymous screening centres operate and screen for infectious diseases such as HIV and HCV, but as far as the *Global State* is aware, they do not offer treatment options for HCV.⁽⁴⁹⁾

One of the primary barriers in achieving HCV viral suppression is the cost of treatment. A revolution in treatment came about via the approval by the European Commission in January 2014 of direct-acting antivirals (DAAs). However, these new DAAs are expensive when compared to older medicines. In a survey of 21 European Union countries, the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) found that the average cost of three months treatment was around €60,000, whereas treatment with HCV medicines from the previous generation of drugs cost between €17,000 - €26,000.⁽²³⁾ It is clear from Table 2.3.1 that the need for HCV treatment for people who inject drugs is considerable, and that addressing this gap is imperative.

Tuberculosis (TB)

Findings of a report undertaken by the EMCDDA in 2011 suggested that TB in Europe is predominantly concentrated among high-risk groups, such as migrant populations, homeless people, people who use drugs and people in prison.⁽⁵⁰⁾ 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 and HCV infection. Despite these facts, data on TB prevalence and treatment access among people who inject drugs in Western Europe continues to be limited. Globally, TB-related deaths among people living with HIV have fallen by 32% since 2004,⁽⁵¹⁾ and in 2014, the percentage of identified HIV-

positive tuberculosis patients who started or continued on antiretroviral therapy (ART) reached 77%.⁽⁵¹⁾

Antiretroviral therapy (ART)

As noted in the overview of this chapter, HIV prevalence rates among people who inject drugs are reported to be stable or declining.⁽¹⁷⁾ In Belgium, for example, only 11 people newly diagnosed with HIV reported injecting drug use as the probable mode of transmission in 2014.⁽⁵²⁾ In the UK, there were an estimated 2,160 people who inject drugs living with HIV in 2014, with approximately 150 new HIV diagnoses believed to be as a result of sharing injecting equipment.⁽¹⁵⁾ The Netherlands has also witnessed a decreasing trend in the annual number of new HIV diagnoses among people who inject drugs.⁽⁵³⁾ Similarly, Greece reported a 12.9% decrease in new HIV diagnoses among people who inject drugs in 2014,⁽⁵⁴⁾ although recent reductions in funding for harm reduction have begun limiting the provision of HIV prevention interventions among this group.

ART is available in principle in all countries in Western Europe, however, in a recent report by the European Centre for Disease Prevention and Control (ECDC) and the EMCDDA, Spain, Greece, Portugal and Sweden all reported people who inject drugs experiencing difficulties in accessing treatment, care and support. Spain also noted a reluctance by service providers to prescribe ART for people who inject drugs due to a lack of services to support adherence to treatment.⁽⁵⁵⁾ Late presentation (where people learn their HIV status at the point when their immune system is already significantly compromised) is often much more common among people who inject drugs,⁽⁵⁵⁾ and late diagnosis was reported in more than half of HIV cases acquired through injecting drug use in Austria (61%), Belgium (57%), Greece (75%), Ireland (56%), Italy (61%), Portugal (59%) and Spain (55%).⁽⁵⁵⁾

Although the information available on the level of access to ART among people who inject drugs is only partial in Western Europe, data continues to suggest that improvements may be needed in social and adherence support for people who inject drugs to ensure ART is made more easily available.

Harm reduction in prisons

Since Portugal decriminalised drugs for personal possession in 2001, there has been a trend towards reducing the likelihood of imprisonment for minor offences related to use and personal possession of drugs in Western Europe.⁽²³⁾ Some countries such as Spain and Italy only apply non-criminal sanctions (e.g. a

fine) for offences relating to drug use and possession,⁽²³⁾ while Ireland recently announced its intention to decriminalise substances including heroin, cocaine and cannabis in the near future.⁽⁵⁶⁾ Despite these positive developments, most western European countries still treat drug use and possession as a criminal offence. In fact, the majority of drug law violations in the region currently relate to use or possession for use, which has resulted in a very large proportion of the prison population comprising of people who use and inject drugs.⁽²³⁾

Injecting drug use in prisons in the region is common. At last count, between 5% and 38% of prisoners in Europe had ever injected drugs,⁽⁵⁷⁾ and between 2% and 31% of prisoners in the European Union, depending on the country, reported having ever injected drugs while in prison.⁽⁵⁸⁾ At the same time, prevalence estimates for HIV (4.6%) and HCV (15.5%) in Western Europe remain considerably higher among the prison population than the broader community.⁽⁵⁹⁾ These figures highlight the need for quality harm reduction services in the region's prisons.

Availability of OST is improving, with all countries apart from Andorra, Cyprus, Iceland and Monaco now providing the service in some or all prisons. Since the *Global State* last reported in 2014, pilot OST programmes have been introduced in two prisons in Greece,⁽⁵⁴⁾ with indications that this service could be scaled up in the future.⁽⁶⁰⁾ OST coverage in prisons is considered high in Austria, France, Ireland, Spain, the UK and Luxembourg,^(61, 62) however there remains considerable room for improvement in terms of accessibility and the quality of the service in many countries in the region. In Finland and Malta, for example, OST is mostly available to prisoners who were receiving it prior to incarceration,^(63, 64) while in the UK, OST is available in all prisons and can be newly initiated, but accessibility is restricted due to time-limited prescribing.⁽⁶⁵⁾ In Portugal and Greece, long waiting times act as a serious barrier to access for many prisoners,^(60, 66) while in Ireland, quality is said to vary by institution.⁽⁶⁷⁾ In Germany, access to, and quality of, OST in prisons varies by region.⁽³⁰⁾ In the German region of Bavaria, for example, OST is not available to prisoners at all. This was very recently the subject of a European Court of Human Rights case, where Germany was ultimately found to be in violation of the prohibition of cruel, inhuman and degrading treatment for denying the applicant access to OST while in detention.⁽⁶⁸⁾

Provision of prison-based NSPs continues to be inadequate in Western Europe, with the service only



available in Spain (22 prisons),⁽⁶⁹⁾ⁱⁱ Luxembourg (both prisons),⁽⁶²⁾ Germany (one female prison in Berlin)⁽³⁰⁾ and Switzerland (three prisons).⁽⁴³⁾ An important legal development in France, however, is reason to remain optimistic that this service will soon become more widely available in prison settings in the region. In December 2015, the country enacted a new law (*Loi Santé*), which includes a specific section on compulsory compliance with the principle of equivalence specifically in relation to the provision of harm reduction in prison settings. The law provides that harm reduction services that are available in the broader community, including NSPs, must also be available in prison settings.⁽⁷⁰⁾

Condom provision in Western European prisons varies by country and/or prison. In Spain, for example, condoms are available and easily accessible in all 72 prisons, while in all Belgian and approximately 85% of Swiss prisons, condoms can be accessed discreetly through machines.^(43, 61) Condoms are only available on request at medical services or the prison health service in Finland, Portugal, the Netherlands and France, while in Austria and Denmark, female condoms are only available in approximately half of the prisons detaining female prisoners.⁽⁶¹⁾ In the UK and Germany, condoms are reportedly not available in all prisons,^(30, 65) whereas in Italy and Cyprus, condoms are not available in prisons at all.^(71, 72)

Availability, accessibility and quality of diagnostics, treatment and care for HIV, HCV and TB in the region's prisons also vary. For instance, HIV-related services are reportedly not available to female prisoners in Cyprus,⁽⁷²⁾ while ART is only available in 89% of Italy prisons.⁽⁷¹⁾ In Switzerland, HCV testing and treatment are only available in 85% of prisons,⁽⁴³⁾ while in Finland and Ireland, HCV treatment is only provided to prisoners who use drugs if they are either stable on methadone or have achieved abstinence for a period of time.⁽⁶¹⁾

This type of variable standard of care contravenes international human rights law and standards relating to the treatment of prisoners. Measures must urgently be taken to ensure that all prisoners have equal access the same quality of services available to the broader community.

Since the *Global State* last reported in 2014, the UK has been implementing a programme across the country that aims to achieve a higher and more uniform standard of care in prisons. The universal 'opt-out' blood born virus (BBV) testing programme, which is expected to be fully implemented in all prisons in England by the end of 2016-17, offers prisoners the chance to be tested for infections near reception and at several time points

thereafter by appropriately trained health care staff. A preliminary evaluation of the programme undertaken in 2015 revealed a near doubling of BBV testing only 6 months after it was introduced.⁽⁷³⁾

Despite people who inject drugs being at particular risk of overdose following release from prison, take-home naloxone kits are still not widely available to prisoners either during their incarceration or following release in Western Europe. In Spain, for example, naloxone is reportedly only available to prisoners in Madrid.⁽⁶¹⁾ As far as we are aware, naloxone is only available in some prisons in Norway, and all prisons in England, Wales and Scotland.⁽⁶¹⁾ Scotland's National Naloxone Programme, which began in 2011 and supplies naloxone kits for home leave and/or on release to those identified as being 'at risk' while in prison, has been recognised as a model of good practice. A recent evaluation of the programme found that it was associated with a 36% reduction in the proportion of opioid-related deaths that occurred in the 4 weeks following release from prison.⁽⁷⁴⁾

"Improving Prison Conditions by Strengthening Infectious Disease Monitoring", an HRI led project

HRI's two year, EU co-funded project, "Improving Prison Conditions by Strengthening Infectious Disease Monitoring" came to an end in September 2016. Led by HRI and implemented with partners in 7 European countries, this project aimed to improve prison conditions and reduce ill treatment of prisoners by strengthening HIV, HCV, TB and harm reduction monitoring in prisons.

The project mapped HIV, HCV, TB and harm reduction in prisons and current monitoring practices on these issues in Catalonia (Spain), Greece, Ireland, Italy, Latvia, Poland, and Portugal. In each of these countries, rates of HIV, HCV and TB inside prisons were higher than rates in the general population, particularly in Latvia. While each country was found to provide a wide range of harm reduction services in the broader community, the majority failed to provide these same services, or the same quality of these services, in prison settings. Where harm reduction services had been available and easily accessible in prison settings for some time, such as in Catalonia, better health outcomes were observed, including significantly reduced rates of HIV and HCV incidence. A scarcity of systematic and

ⁱⁱ Correct numbers are always difficult to pin down. In 2014, the *Global State* reported that NSPs were available in 38 prisons in Spain based on a UNODC document. This year, we relied on the most recent *Secretaría General de Instituciones Penitenciarias* annual report (2014, published in 2015), which indicated that only 22 prisons provided the service.

comprehensive monitoring of HIV, HCV, TB and harm reduction in prisons was observed at the national level in all countries surveyed. Overall, the provision of harm reduction in each of these countries' prisons varied considerably, but certain key themes and lessons were distilled, including around features of an enabling environment for harm reduction, resource allocation, collection of data, and accessibility of services.

The project also charted existing European and international public health and human rights standards relating to HIV, HCV, TB and harm reduction, as well as monitoring practice in relation to these issues. This research found that United Nations human rights bodies and the European Court of Human Rights are increasingly finding that issues relating to disease transmission in detention – including the denial of harm reduction services and the inadequate prevention, care or treatment – can contribute to, or even constitute conditions that meet the threshold of ill treatment. In spite of this, however, HIV, HCV, TB and harm reduction are not adequately monitored in the current European and International approach to the prevention of ill treatment in prison settings.

Finally, based on this research, a user-friendly, human rights-based tool was developed, in consultation with an Expert Committee, to generate better informed, more consistent, and sustained monitoring of HIV, HCV, TB and harm reduction in prisons by national, regional and international human rights-based monitoring mechanisms.

For more information on the project, or to access all reports and the monitoring tool, please visit: <https://www.hri.global/prison-project>.

Overdose

Overdose 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.⁽²⁴⁾ In 2012, the six highest national mortality rates associated with drug overdose in Europe were reported by countries located in the north (in descending order): Norway, Ireland, Sweden, Finland, Denmark and the UK.⁽²⁴⁾ The overdose mortality rate in Norway, for example, is comparable to or higher to the overdose mortality rates in the 1990s prior to the introduction of harm reduction measures.⁽²⁴⁾ In the UK, there has been a 64% increase in drug-related deaths

linked to heroin and morphine from 2014-2016, the highest ever recorded in the country.^(65, 75)

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 drug users, as well as changing consumption patterns, including the use of highly potent synthetic opioids and medicines.⁽²³⁾

Overdose is predominantly reported among older opioid users (35-50) but increases in overdose deaths are also seen among the under-25s in some countries (for example, Sweden) warranting closer scrutiny.⁽²³⁾

Whilst heroin remains the most commonly used opioid, synthetic opioids are increasingly used and there has been a rise in the number of countries reporting synthetic opioids as the primary drug used by those entering treatment. Synthetic opioids used in substitution treatment (e.g. methadone, buprenorphine) are also regularly found in toxicology reports and these substances are associated with a substantial share of drug-related deaths in some countries (e.g. Ireland, France, Finland and the UK).⁽²³⁾

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, often continues to be blocked by administrative barriers in the region, being available by prescription or medical personnel only, rather than for peer-distribution. However, Scotland is the first country in the region to have a nationwide take-home naloxone programme, initially piloted in 2007. The naloxone distribution system targets people who have been in contact with drugs services, including NSP and OST programmes.⁽⁷⁶⁾

Scotland now also distributes naloxone to people who inject drugs at the end of their prison sentence. The Scottish Government's 2014 assessment of the first three years of this programme estimated that over 500 overdose deaths had been averted, and 90% of people who participated said that the programme had helped them to better understand the causes of overdose.⁽⁷⁷⁾ In Italy, naloxone is available over the counter from pharmacies, and take-home naloxone is also distributed through drop-in centres and outreach programmes in the country.⁽⁷⁸⁾

In the spring of 2014, a trial project of nasal naloxone sponsored by the Norwegian Ministry of Health and



care Services was launched in Oslo and Bergen. Within this project, staff working in low-threshold services were trained and overdose response kits distributed to people who use drugs. The project is now being expanded to train police and security staff, staff at detoxification centres, emergency health centres and prisons.⁽⁷⁹⁾ In October 2015, legislative changes were introduced in the UK to increase the availability of naloxone, making this specific drug exempt from prescription-only medicine requirements when it is supplied by drug services commissioned by a local authority or the National Health Service.⁽¹⁶⁾ Overdose prevention remains a relatively neglected issue in much of Western Europe and there is a need for continued advocacy for political and financial support for cost-effective and proven overdose prevention measures such as take-home naloxone programmes⁽⁸⁰⁾ and drug consumption rooms. There is great potential for valuable lessons and experiences to be taken from Scotland and Italy in implementing take-home naloxone programmes to be shared with other countries in the region, and elsewhere.

Policy developments for harm reduction

In comparison to some other regions, Western European HIV policy frameworks have specifically addressed and acknowledged harm reduction as a central component of the HIV response. At the regional level, harm reduction is noted in the European Union Action Plan on HIV/AIDS in the EU and Neighbouring Countries: 2014-2016,⁽⁸¹⁾ which is harmonised with the WHO-led European Action Plan for HIV/AIDS 2012-2015,⁽⁸¹⁾ 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)⁽⁸²⁾ and EU Drugs Action Plan (2013-2016) addresses harm reduction, human rights, civil society engagement and transparency more than in previous European Union drug policy documents. Advocacy and policy work by civil society had a positive impact on support for harm reduction in these processes.

As harm reduction services have become widespread in the region, increasing focus has been placed on service quality, culminating in the adoption of 'Minimum quality standards in drug demand reduction in the European Union' by the EU Council of Ministers in September 2015. Sixteen standards for prevention, treatment, harm reduction and social reintegration set minimum quality benchmarks for interventions. These newly adopted standards represent a major development at the EU

level, and serve to facilitate the sharing of best practice at a European level.⁽²³⁾

During several important international policy processes, the European Union championed harm reduction both regionally and through individual member state support. In April 2016, during the United Nations General Assembly Special Session (UNGASS) on the drugs in New York, Italy, Finland, Norway, Sweden, Germany, the Netherlands, Lichtenstein, Portugal, Greece, Austria, Cyprus, Malta and Belgium all made statements in explicit support of harm reduction.⁽⁸³⁾ The European Union's common position 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.⁽⁸³⁾ During the UNGASS roundtable on health and drugs, a Scottish National Party (SNP) Member of Parliament (MP) also made the case for increased investment in harm reduction.

Following the UNGASS, in June 2016, a United Nations General Assembly High-Level Meeting (HLM) on Ending AIDS was held, and a new Political Declaration adopted by United Nations Member States, which charts a course to end AIDS as a public health threat by 2030. This meeting gave governments the opportunity to elaborate on how they intended to meet the target of ending AIDS by 2030. Greece, the UK, the Netherlands and Switzerland explicitly supported harm reduction in their national statements during the HLM. Several other countries including Denmark, Liechtenstein, Germany, Sweden, Norway, Finland, Luxembourg and the EU referred to the need to target interventions towards key populations, with several mentioning people who inject drugs specifically. (See the Global Overview section of this report for more analysis of the outcome for harm reduction within recent high level political processes).

Civil society and advocacy developments for harm reduction

Civil society organisations continue to play a significant role in mobilising and advocating for harm reduction in Western Europe, both at national and regional levels. 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 the prevention of drug use, drug-related treatment, social support services and harm reduction.

The meaningful involvement of people who use drugs in policy development and service delivery is often aided by civil society harm reduction networks, and/or networks of people who use drugs. The European Network of People who Use Drugs (EuroNPUD) was founded in 2011 within the framework of a European Commission-supported project to form the European Harm Reduction Network.⁽⁸⁴⁾ The network was relaunched in 2013 during a side meeting at a peer workshop on HCV and drug use. EuroNPUD is now comprised of an Executive Committee with representation from across the European Region and has identified a number of key thematic areas for focus including NPS, HCV and overdose prevention.⁽⁸⁵⁾

The European Harm Reduction Network lost funding at a regional level in 2014, leaving an important gap remaining for a strong and funded regional harm reduction network. However, a number of other networks continue to progress and have undertaken projects focusing on various aspects of harm reduction. The Correlation network⁽⁸⁶⁾ established the 'Hep C and drug use initiative' in 2013, the purpose of this platform is to reduce the burden of HCV among people who use drugs by promoting universal access to HCV prevention, treatment and care through collaborative activities including research, advocacy and civil society strengthening.⁽⁸⁷⁾ The 'NPS in Europe' is a multi-partner project aiming to increase knowledge and understanding of the risks associated with the use of new psychoactive substances and effective harm reduction responses. This project is undertaken by APDES (Portugal), CUNI (Czech Republic), Rainbow Group (Netherlands), Praxis (Greece), Carusel (Romania), Sananim (Czech Republic) and Monar (Poland).⁽⁸⁸⁾

At national level the existence of harm reduction networks varies across the region. There is no national harm reduction network in Switzerland, however, there are two regional networks on harm reduction in the German and the French parts of Switzerland.⁽⁴³⁾ In the UK there are a number of coalitions, including the National Needle Exchange Forum, UK Harm Reduction Alliance and the Harm Reduction Network. The Naloxone Action Group has also been recently formed to place pressure on local commissioners to pay for naloxone and for amendments to be made in prescribing regulations. This group includes civil society, activists and drug treatment providers.⁽⁶⁵⁾ Germany also has a national network on harm reduction, Akzept, with many smaller state level civil society organisations operating at the local level. Alongside this Germany also has JES, its national network of drug user rights groups, which is one of the oldest in

the world.⁽³⁰⁾ National harm reduction networks are also in existence to some extent in Italy, Portugal and France.

Funding: developments for harm reduction

This region contains some of the earliest adopters and long-term implementers of harm reduction and as such, Western European countries are among those globally that invest most heavily in harm reduction. However, there remains much variety in the levels and sustainability of harm reduction funding between and within countries. Limited political support for harm reduction still hinders investment in some countries and austerity measures brought in following the financial crisis continue to affect the sustainability of services in the region.

In 2015 and 2016, HRI and EHRN coordinated an EC funded project called 'Harm Reduction Works!' that aimed to fill a knowledge gap on harm reduction funding across EU member states and build the capacity of civil society to call for strategic investment into harm reduction.^{mm} In many countries surveyed, civil society identified the need for greater transparency of harm reduction investment. Spending on key harm reduction interventions such as NSP and OST was challenging in all countries surveyed and gaps in knowledge remain. However, the research did indicate that several countries have seen harm reduction funding cuts in recent years, for example, as a result of national austerity measures. The resultant impact on service provision in Greece, for example, has been marked and there are concerns that the potential for another sharp increase in HIV among people who inject drugs is now apparent. In some countries it was reported that challenges to sustainable, adequate financing for harm reduction were faced at the local level, despite endorsement of the approach in national policies. Six out of twenty Italian regions currently have no harm reduction services in place, for example, while others with supportive local governments have well-functioning harm reduction services.⁽⁷⁸⁾ In the UK, this was also highlighted as an issue, with the expectation that some parts of England will see dramatic cuts to services in the near future.

Most countries in the region cover the majority of the harm reduction investment without external support. While some countries have received international donor support, for example from the Elton John AIDS Foundationⁿⁿ and the European Commission,^{oo} much of this support has decreased or stopped in recent years.

^{mm} A report summarising the research findings is due to be published in the coming months.

ⁿⁿ Elton John AIDS Foundation (EJAF) for example, provided support to the roll-out of a nationwide pharmacy NSP programme since 2011.

^{oo} European Commission funds supported harm reduction scale up in Greece in 2011/2012, in response to the rapid increase in HIV infection among people who inject drugs, but this funding has now stopped.



There are concerns from civil society in many countries that the need for a well-funded harm reduction response is more pressing than ever, with drug use trends changing and NPS and stimulant use increasing. In order for harm reduction approaches in Western European countries to adapt to these new trends, adequate funds and political support is required.

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Regional Overview



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 ^a	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 ^b 	OST ^c 
Bahamas	nk	nk	nk	nk	✗	✗
Bermuda	nk	nk	nk	nk	✗	✗
Dominican Republic	200,000–350,000 ⁽¹⁾	11 ⁽²⁾	3.4 ⁽¹⁾	3.1 ⁽¹⁾	✓1	✗
Haiti	nk	nk	nk	nk	✗	✗
Jamaica	nk	nk	nk	nk	✗	✗
Puerto Rico	29,130 ^{(3)d}	22.9 ⁽⁴⁾	89 ^{(5)e}	nk	✓6 ^{(6)f}	✓8 (M, B, O)
Suriname	nk	nk	nk	nk	✗	✗

nk = not known

^a 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 consulted for this report noted that this information is no longer up to date.

^b All operational needle and syringe exchange programme (NSP) sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers.

^c Opioid substitution therapy (OST), including methadone (M), buprenorphine (B) and any other form (O) such as morphine and codeine.

^d Estimate from 2002. Civil society consulted for this report believed the number of people using opiates to have doubled to approximately 60,000.

^e Estimate based on sub-national data, relating to the area of San Juan only.

^f Each of the six NSPs has multiple sites; for example, one syringe programme has 15 sites.

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





Harm reduction in the Caribbean

Overview

The *Global State of Harm Reduction 2014* reported a UNAIDS finding that HIV prevalence in the Caribbean had decreased greatly since 2001.⁽⁷⁾ According to a 2016 UNAIDS report, however, the Caribbean witnessed a 9% rise in new HIV infections among adults between 2010 and 2015, with the annual number of new HIV infections ranging between 7,500 and 11,000.⁽⁸⁾ UNAIDS also reports that 75% of people living with HIV in Latin America and the Caribbean are aware of their HIV status, yet survey data among key populations in the Caribbean indicate that periodic HIV testing and knowledge of HIV status are particularly low.⁽⁸⁾

Epidemiological data on HIV, viral hepatitis and drug use in the Caribbean region continue to be sparse. UNAIDS reports that the number of people who inject drugs in Latin America and the Caribbean is 721,000, but the wide-ranging interval of 312,000–1,375,000 illustrates the lack of robust data for both regions.⁽⁹⁾ Most of the information comes from Puerto Rico and, to a lesser extent, the Dominican Republic. Due to the paucity of data, however, the *Global State* can only report population size estimates from these two countries/territories (see Table 2.4.1), both of which civil society believes to be vast underestimates.^(6, 10) A unique issue in terms of data collection for Puerto Rico specifically is that it is often omitted from reports on the Caribbean because it is a territory of the United States, but also it is excluded from some US reporting.⁽¹¹⁾

HIV prevalence rates among people who inject drugs are available only for Puerto Rico and the Dominican Republic, where poor access to sterile injecting equipment has been identified as a significant contributor to HIV epidemics. Between 1981 and 2013, 51% of people in Puerto Rico who died whilst living with HIV/AIDS acquired the infection via unsafe injecting practices.⁽⁶⁾ In the same time period, people who inject drugs represented the highest percentage of those living with HIV/AIDS who did not have access to medical care for their condition.⁽⁶⁾ The distinct lack of adequate harm reduction services in the country means that this key population faces a higher risk of both HIV and hepatitis C infection,⁽¹¹⁾ with over 20% of new HIV infections attributed to this demographic.⁽¹²⁾

Drug treatment services for people who use drugs in much of the Caribbean region primarily focus

on abstinence. St Lucia, for example, has only one drug treatment service, which exists in the form of a rehabilitation centre.⁽¹³⁾ Similarly, Trinidad has a government-supported drop-in centre offering assessment, referral and rehabilitation for homeless people who use drugs.⁽¹⁴⁾ Abstinence-oriented interventions have been found to be effective for only a minority of people who inject drugs; harm reduction services such as opioid substitution therapy (OST) are widely acknowledged as the first line of treatment.⁽¹⁵⁾ Yet Puerto Rico and the Dominican Republic remain the only countries in the region offering harm reduction services.

Although there are a number of harm reduction programmes providing needle and syringe programmes (NSPs) and OST in Puerto Rico, a reduction in state funding in recent years due to the financial crisis has seen many of these essential services decline or close down completely. As such, the various faith-based drug treatment services in the country now represent the sole treatment option for many people who inject or use drugs in Puerto Rico. The Mental Health Law of 2000, which labelled ‘addiction’ as a spiritual and social issue rather than as a health issue, served to cement faith-based services as central to the national drug treatment response.⁽¹⁶⁾ The implementation of this law exempted faith-based treatment from State regulation. In 2008, however, the Mental Health Law was amended to recognise the role of physicians alongside spiritual advisors, as opposed to just the latter. Many of the residential drug treatment programmes are run by one chain – Comunidad de Re-Educación de Adictos (CREA), which reportedly approaches people who use drugs and their families via the drug courts.⁽¹⁷⁾ CREA centres, which are faith-based, receive little government supervision and some of their practices have been criticised on human rights grounds.^(17, 18) It is also reported that many people who use drugs in Puerto Rico have been forcefully relocated to drug rehabilitation centres in the United States, where their identification documents are confiscated upon arrival and treatment is denied, culminating in people being left homeless and unable to return home.^(19, 20) Even these controversial and restricted services are insufficient for the number of people who use drugs in the country.⁽¹⁸⁾ With high rates of HIV, and hepatitis C prevalence rates of 89% among people who inject drugs, it is clear that Puerto Rico urgently needs to increase its harm reduction response.

In the Dominican Republic, unsafe injecting drug use is reported to account for 1% of HIV transmission,⁽²¹⁾ although civil society queries the accuracy of this figure. The country opened its first NSP in 2012, and in 2016 is reported to be planning the implementation of a small OST site providing buprenorphine-assisted treatment for people who use heroin.⁽⁶⁾

Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

Even though the effectiveness of NSPs in reducing viral transmission of both HIV and hepatitis has been documented numerous times,⁽²²⁾ the annual budget designated to NSPs in Puerto Rico (\$80,000) is five times less than that of NSP services in the Northwest region of the United States (\$400,000).⁽¹¹⁾ Intercambios Puerto Rico, the island's primary harm reduction organisation, has managed to expand its NSP provision to include two new municipalities in the eastern region of the island and, between 2014 and 2015, distributed 165,000 syringes to people who inject drugs.⁽⁶⁾ However, several state-funded NSPs were forced to reduce their syringe provision services, or temporarily close, due to a government delay in allocating funds.⁽⁶⁾ The impact of this on people who inject drugs has not yet been documented. Meanwhile, as the Puerto Rican bankruptcy and budget crisis worsens, it is almost certain that government funding to assist harm reduction and HIV responses in the country will diminish further.⁽⁶⁾

Although there has been an expansion of NSP services to the east in Puerto Rico, there is still a largely unmet need in semi-urban and rural areas, with the present facilities operating at full capacity. There is an urgent need to expand services to neighbouring municipalities and communities. This cannot be done without increased financial support from government.⁽⁶⁾

The Dominican Republic opened its first NSP in 2012, supported by Centro de Orientación e Investigación Integral (COIN).⁽²³⁾ Since its inception, more than 1,000 people have accessed its Open Doors programme. Between June and December 2012, 4,000 syringes were distributed, 20% of them to women who inject drugs.⁽²⁴⁾ In 2015 this service distributed a total of 14,398 needles/syringes to people who inject drugs in the Dominican Republic.⁽⁶⁾

In 2016 St Croix began implementing a new pilot NSP in the US Virgin Islands, run by Frederiksted Health

Care Incorporated with technical assistance from Intercambios Puerto Rico and the Migrant Health Centre.⁽⁶⁾ Although there is a much greater need for NSP service provision within the region, the introduction of such new services is an important step forward.

Opioid substitution therapy (OST)

Puerto Rico remains the only territory in the Caribbean to provide OST. Plans have been made for the implementation of buprenorphine-assisted therapy for people who use heroin in the Dominican Republic, with support from consultants from the School of Public Health of Puerto Rico, but the programme is yet to be established.⁽⁶⁾

OST in Puerto Rico in the form of methadone or buprenorphine is provided at six fixed sites, two mobile units and through one prison-based programme. Although there has been an increase in the availability of buprenorphine, the number of sites has not been scaled up since 2014. People who use drugs still face huge barriers to accessing quality OST services, with many reporting stigma, poor treatment, arbitrary decision making by medical providers, punitive measures and providers withholding care.⁽⁶⁾ The only providers of methadone are government-run clinics, which have scaled back provision since 2014.⁽⁶⁾ While the availability of buprenorphine has increased at community level, many people who inject drugs report a very high threshold requirement for new admissions, making access extremely restrictive.⁽⁶⁾ People who use drugs who are homeless or estranged from their family face additional barriers as the OST programme requires an accompanying adult who will vouch responsibility for the appropriate use of the prescribed medication.⁽⁶⁾ Anyone based in a rural setting is also at a disadvantage because services are only located in the large metropolitan areas of Ponce and San Juan.⁽⁶⁾ Women who use drugs are especially affected by the lack of access to OST as many treatment centres on the island refuse to accommodate them.⁽⁶⁾

Harm reduction for people who use crack cocaine

Crack and similar cocaine derivatives are the main stimulant used in the Caribbean, and in the Americas.^(25, 26) Despite the number of people who use crack in the region, and the health implications of sharing pipes (in terms of hepatitis infections via sores) being widely documented,^(27, 28) there are only a small number of drop-in centres in the Dominican Republic, Trinidad, Jamaica and St Lucia that provide any form of service for this group.⁽²⁹⁾



The Castries facility in St Lucia offers shelter and other services for people who use crack cocaine who are homeless and 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 dependence and the nausea that is often a side-effect of ART.⁽²⁹⁾ Small-scale studies on the experimentation of cannabis as a form of substitution therapy for crack have yielded positive results.^(30, 31) There is a need for further research and exploration into harm reduction responses to crack use in the region and worldwide.

In Jamaica, Tek it to Dem 2 provides outreach to homeless people who use crack and who are reluctant to access zero tolerance or total abstinence programmes. The initiative provides peer education on HIV and sexually transmitted infection prevention, alongside hot food, companionship and transportation.⁽³²⁾

In Puerto Rico, Intercambios is working to establish harm reduction services for people who use crack, which will begin in 2017.⁽⁶⁾

Viral hepatitis

Since *Global State 2014*, there has been very little new information on hepatitis C (HCV) among people who inject drugs in the Caribbean region. As illustrated in Table 2.4.1, HCV prevalence rates are markedly higher than HIV prevalence rates among people who inject drugs in Puerto Rico. A 2016 study attributed this high rate of HCV not to the sharing of needles and syringes, but to the sharing of injection 'works' (i.e. cookers, cotton and water), with this occurring more than twice as often as needle sharing.⁽³⁴⁾ Despite this, the Puerto Rico Department of Health does not routinely monitor HCV infection rates.⁽⁶⁾

Hepatitis C testing and treatment is rarely offered to people who use drugs in the Caribbean,⁽⁶⁾ with treatment available only from private healthcare providers, whose prohibitive costs restrict access for the vast majority of people who use drugs.

Tuberculosis (TB)

There has been a consistent dearth of information on the extent of tuberculosis infection rates among people who inject drugs in the Caribbean. The World Health Organization (WHO), however, asks countries to report on TB case notifications among the general population and from this we can see that the highest number of reported cases of TB in the Caribbean in 2014 were in Haiti (15,806) and the Dominican Republic (4,405).⁽³⁴⁾

A 1999 study in Puerto Rico found that TB incidence was highest among people living with HIV who inject drugs.⁽³⁵⁾ Between 1981 and 2013 a total of 1,302 people in Puerto Rico received diagnoses of HIV and TB co-infection, with 61.6% of cases occurring among people who inject drugs⁽³⁶⁾ – again highlighting a disproportionate vulnerability to TB. 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 TB treatment then available at health centres.⁽⁶⁾

Antiretroviral therapy (ART)

Approximately 75% of people living with HIV in the Caribbean know their HIV status.⁽³⁷⁾ Between 2010 and 2015 this region saw a 9% rise in new infections among the general population.⁽⁸⁾ Although ART coverage in the Caribbean rose from 20% in 2010 to 50% in 2015,⁽⁸⁾ key populations continue to struggle to gain adequate access to HIV testing and treatment. For example, considering the high prevalence of HIV among people who inject drugs in Puerto Rico, HIV care for this group is often grossly inadequate.⁽¹¹⁾ There is a distinct lack of funding to support rapid HIV testing for hard-to-reach populations such as people who use drugs.⁽⁶⁾ Within Puerto Rico, it is reported that over 43% of people living with HIV/AIDS acquired the infection via unsafe injecting drug use.^(6, 38)

Between 1981 and 2013 over half (51%) of the people in Puerto Rico who died while living with HIV/AIDS acquired the infection via injecting drug use.⁽³⁹⁾ Moreover, in 2013 people who inject drugs represented the highest percentage of the population living with HIV/AIDS who did not have access to medical care for their condition (between 41% and 53%) even though they had the highest retention rate once they initiated treatment.⁽³⁹⁾

People who use drugs are heavily criminalised in Puerto Rico. They rarely seek medical treatment due to fear of incarceration. When they do seek ART, many are denied this service until they can demonstrate abstinence from drug use, with drug treatment and detoxification centres denying services to people who have visible ulcers.⁽⁶⁾

HIV prevention is inadequately funded across the Caribbean.⁽⁸⁾ Only four islands have healthcare facilities providing integrated HIV and TB treatment services (Antigua and Barbuda, Dominican Republic, Haiti and St Lucia).⁽⁷⁾ Overall, there is very little information covering testing and ART for people who inject drugs in the region, 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.⁽⁴⁰⁾

Harm reduction in prisons

The Caribbean region's median prison population rate stands at 347 per 100,000.⁽⁴¹⁾ Thanks to the implementation of extremely punitive drug laws across the region, driven by the US 'war on drugs', people who use drugs make up a large proportion of this prison population. In 2012, for example, the Puerto Rican Department of Corrections and Rehabilitation reported that 87.71% of prisoners had been sentenced in cases relating to drug use, of which nearly 50% were first-time offenders and approximately 75% were people who use drugs.⁽¹⁸⁾

The prevalence estimate of HIV among incarcerated populations in most Caribbean countries and territories is double the national prevalence estimate.⁽⁴²⁾ Data relating to HIV and HCV prevention, treatment, care and support in the region's prisons, however, are scarce due to a continued lack of systematic monitoring. One study in 2014 unsurprisingly found that Puerto Rican prisons represented the main point of access to HIV screening and treatment for the people who circulate through the country's prison system.⁽⁴³⁾

In addition to unsafe injecting drug use, the risk of HIV and HCV transmission in Caribbean prisons is intensified by the criminalisation of sex between men, the lack of condom provision and the denial of key harm reduction services.⁽²³⁾ According to civil society, OST is available in only some prisons in Puerto Rico, and this service remains limited to small numbers. There are no prison NSPs operating in the Caribbean. Given the rise in new HIV infections and the large proportion of people who use drugs in detention, there is an urgent need to introduce or expand harm reduction services in prisons across the region.⁽⁶⁾

Overdose

The Caribbean continues to have an extremely limited overdose response, with no naloxone peer distribution and no overdose programmes operating in the region.

Fatal overdose is reported to be high in Puerto Rico among the population of people who inject drugs (37% in Puerto Rico compared with 13% in New York).⁽¹¹⁾ A cross-sectional survey in Puerto Rican prisons found that almost half of the incarcerated population had witnessed an overdose in prison, and one-third knew someone to have died of an overdose while incarcerated.⁽⁴⁴⁾ Of those

reporting injecting drug use prior to incarceration, over 60% had witnessed an overdose incident and just under half knew of an overdose death.⁽⁴⁴⁾ There is no overdose surveillance programme operating at the Department of Health, yet there is a clear and urgent need for monitoring and for an effective overdose response in the country.

In 2015 legislation was introduced in Puerto Rico to permit naloxone distribution programmes, however, it is yet to be voted in by the House of Representatives and there appears to be a lack of political will to pass this legislation.⁽⁶⁾

Policy developments for harm reduction

Since *Global State* 2014, there have been few developments in harm reduction policy at national or at regional level in the Caribbean.

As mentioned above, in Puerto Rico, a Good Samaritan Bill to allow overdose prevention education and naloxone distribution was passed by the Senate and is pending a vote by the House of Representatives (P.S. 1445).⁽⁶⁾ In relation to wider drug policy developments, the potential decriminalisation of cannabis represents an important change in Puerto Rican legislation. A bill to eliminate criminal penalties for possession of small amounts of marijuana for personal use (P.S. 517) has been passed by the Senate and is pending a vote by the House of Representatives; a bill to legalise marijuana for medical purposes is also pending a vote by the House of Representatives (P.C. 1362); and a house bill to call for a referendum on the issues of marijuana decriminalisation has been submitted to a judiciary committee, but has not yet been voted on (P.C. 2172).⁽⁶⁾

In Jamaica, the House of Representatives passed a law decriminalising possession of up to two ounces of marijuana, and allowing for the cultivation and distribution of cannabis for medical and religious purposes.⁽⁴⁵⁾

Harm reduction is mentioned as a key component of the national response to drugs in the 2014 version of the National Drug Policy of Trinidad and Tobago.⁽⁴⁶⁾ According to data gathered for this *Global State* report, this policy appears to be the region's sole national policy relating to HIV and/or drugs to include harm reduction.



Civil society and advocacy developments for harm reduction

Although policy changes are extremely slow, civil society action for harm reduction in the region continues to be at the forefront, advocating for change.

Intercambios Puerto Rico, in particular, has been a dedicated influential advocate of harm reduction in the region. In April 2013 it launched a campaign for the decriminalisation of people who use drugs, which was featured locally in over 30 radio shows, 16 television interviews, 8 newspapers and more than 56 online publications. In November 2014 the UNAIDS Programme Coordinating Board Thematic Statement for the meeting 'Halving HIV Transmission among People Who Inject Drugs' held this campaign up as a successful example of pairing harm reduction services and advocacy to decriminalise drug use, and one that should be replicated.⁽⁶⁾ This campaign has been central to the strengthening of drug policy discourse in the region, as well as serving to put public pressure on legislators to reduce or overturn the sentences of people imprisoned for possession of marijuana.⁽⁶⁾

In 2013 the Coalición Puertorriqueña de Reducción de Daños (CoPuReDa - Puerto Rican Coalition of Harm Reduction) began unifying four of the six NSPs providing services in Puerto Rico: Amore Que Sana, Casa Joven del Caribe, Intercambios Puerto Rico and Migrant Health.⁽⁶⁾ The coalition advocates for better harm reduction policies and increased state funding for essential harm reduction interventions.

In April 2015 Intercambios Puerto Rico partnered with the Transnational Institute (TNI) and the Washington Office on Latin America (WOLA) to organise and host the first 'Caribbean Drug Policy Dialogue' in San Juan, Puerto Rico. The meeting focused on drug decriminalisation in the Caribbean and on the upcoming United Nations Special Session (UNGASS) on the drugs. Intercambios Puerto Rico was invited to speak at UNGASS as a civil society representative for Puerto Rico and the Caribbean, enabling it to raise awareness of the need for drug policy reform and improved harm reduction in the region at an important international forum. Increased involvement of Caribbean civil society in global drug policy discussions is an important step forward for the region, which can often be neglected in drug policy forums.⁽⁶⁾

In September 2015 Caribbean representatives from Intercambios Puerto Rico and COIN (Dominican Republic) joined LANPUD (Latin American Network of People Who Use Drugs) in a meeting held in Taganga, Colombia to raise awareness of the needs of people who use drugs within the region.

In October 2016 the Fifth Latin American and First Caribbean Drug Policy Conference was held in Santo Domingo, Dominican Republic, with local partner COIN, helping to ensure a focus on drug policies and harm reduction within the Caribbean. It was the first time this biannual conference had been held in the region.⁽⁶⁾

Funding developments for harm reduction

Harm reduction within the Caribbean has been largely funded by international donors. Although the Global Fund Round 9 signified an important advance for harm reduction funding in the region, much of this support ceased in 2014.⁽⁴⁷⁾ Within Puerto Rico, AIDS United provided financial support to three NSPs. However, this funding has been diminishing and the future of this support is uncertain. The other NSPs, supported by the Government of Puerto Rico, have already seen their funding suspended due to the country's budgetary crisis.⁽⁶⁾ Open Society Foundations (OSF) provided funding for advocacy against rights violations in drug dependence treatment and for harm reduction services, which will continue until 2017.⁽⁴⁸⁾ Intercambios Puerto Rico and CoPuReDa have been, and continue to be, involved in advocacy efforts with the Department of Health to increase funding for harm reduction services. However, the funds allocated to these vital services remain the same, with below US\$750,000 being spent annually on HIV prevention, only US\$135,000 of which is directed towards the three NSP programmes and HIV testing for people accessing NSP services.⁽⁶⁾ It is interesting to note the vast difference between funds spent on reducing harms associated with drug use and those spent on punitive drug control measures. For example, the Puerto Rico Police received an annual budget of US\$749,373,000 in 2014, but just US\$2,500,000 of this was allocated to anti-drug operations and related costs.

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Regional Overview

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 (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction response ^a	
					NSP ■	OST ■
Argentina	65,829 (64,500 - 67,158) ^{(2)b}	3.5 ⁽³⁾	4.8 ⁽⁴⁾	1.6 ⁽⁴⁾	✓ ^{(5)c}	✗
Bolivia	nk	nk	nk	nk	✗	✗
Brazil	540,000 ⁽²⁾	5.92 ⁽⁶⁾	63.9 ^d	2.3	✓ ^e	✗
Chile	21,783 ^{(7)f}	nk	nk	nk	✗	✗
Colombia	nk	2.7 ⁽⁸⁾	nk	nk	✓ ⁽⁹⁾	7 ^{(5)g}
Costa Rica	nk	nk	nk	nk	✗	✗
Ecuador	nk	nk	nk	nk	✗	✗
El Salvador	nk	nk	nk	nk	✗	✗
Guatemala	nk	nk	nk	nk	✗	✗
Honduras	nk	nk	nk	nk	✗	✗
Mexico	164,000 ⁽¹⁰⁾	2.5 ⁽¹⁰⁾	96	nk	✓ ⁽⁵⁾	18 ^{(5)h} (M, B)
Nicaragua	nk	nk	nk	nk	✗	✗
Panama	nk	nk	nk	nk	✗	✗
Paraguay	nk	9.35 (3.7-15) ⁽¹¹⁾	9.8	nk	✓ ⁽⁷⁾	✗
Peru	nk	1 ⁽¹²⁾	nk	nk	✗	✗
Uruguay	nk	0.2 ⁽¹³⁾	21.5 ⁽¹⁴⁾	19.5 ⁽¹⁴⁾	✓ ⁽⁵⁾	✗
Venezuela	nk	nk	nk	nk	✗	✗

nk = not known

^a 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.

^b This estimate was taken from 1999 and injecting drug use is thought to have reduced significantly since this date. However, no new estimates of either drug use or injecting drug use have been undertaken in the country.

^c The number of NSP sites has declined since the Global State last reported (n=25) with civil society reporting a decline in the number of people who inject drugs in Argentina

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

^e The number of NSP sites are believed to have diminished from the 150-450 Global State estimate in 2012. No new estimate of NSP service provision is currently available

^f Civil society organisations believe this figure to be an overestimate.

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

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

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





Harm reduction in Latin America

Overview

There are an estimated 721,000 people who inject drugs in Latin America.⁽¹⁰⁾ Prevalence of injecting drug use remains low although unsafe injecting has been associated with HIV and viral hepatitis transmission, particularly in northern Mexico, and in Colombia.^(15, 16) Cocaine is more commonly injected than heroin in the region,⁽¹⁶⁾ and non-injecting drug use primarily centres on cocaine and its derivatives (particularly the smoking of crack cocaine and pasta base¹) which remain the most predominant drugs used in the region. In certain areas, such as Tijuana and Cd. Juarez in northern Mexico, injecting drug use has seen an increase, with an escalating HIV epidemic among people who inject drugs.⁽¹⁷⁾ In Argentina, however, the estimated proportion of new HIV infections among people who inject drugs has reduced, going from 7.6% to 0.4% in 2013, indicating a decrease in people who inject drugs in the country.⁽¹⁰⁾ It is important to note that due to the lack of data, the figures included in Table 2.5.1 may not reflect overall prevalence of injecting drug use across the region,^(5, 18) as they are based primarily on data from the Reference Group to the United Nations on HIV and Injecting Drugs Use collected in 2008.⁽²⁾ There is a clear need for updated research on the numbers of people who inject/use drugs in this region.

According to a recent report by UNAIDS, HIV among people who inject drugs averages 2%,⁽¹⁹⁾ with a 0.3% incidence of new HIV infections among this population each year.⁽¹⁰⁾ However, these rates can vary greatly between countries and reliable figures on incidences of HIV, viral hepatitis and tuberculosis (TB) among people who inject/use drugs are extremely limited. The latest figures from Brazil report HIV prevalence among people who inject drugs at 5.9%, yet this reflects data published in 2009.

The Brazilian Ministry of Health reports there has been a statistically significant decreasing trend of HIV among people who inject drugs between 2004-2013.⁽⁶⁾ The use of crack and other coca derivatives (e.g. coca paste), is growing. Brazil is reported to have one of the world's largest crack markets, which may comprise of up to 1 million people,⁽²⁰⁾ with research finding levels of HIV at approximately 23% among people who smoke crack cocaine.^(21, 22) In the previous edition of the *Global State*, it was reported that the non-governmental organisation É de Lei of São Paulo had been distributing new crack

pipes as a harm reduction response.⁽²³⁾ However, civil society organisations report crack pipe distribution as part of this project has now been halted.⁽¹⁸⁾ Other initiatives, such as the “Braços Abertos” (Open Arms) programme which aims to reduce the significant health, social and security problems in *Cracolândia*, a huge open crack scene in São Paulo, Brazil, which was launched by the São Paulo City Council in 2014. This project offered people living in the “favela” (slum) housing in one of the motels contracted by the government, without requiring abstinence from crack use as a precondition of housing. Program participants are given access to health care, receive three meals a day and the opportunity to work cleaning parks and other public places. Information is provided about existing treatment programs and other services, but there's no obligation to use them. Thus far the programme has made a significant impact on health outcomes,⁽²⁴⁾ and the Brazilian government announced plans to support reproduction of the program in other Brazilian cities in 2015. In São Paulo, however, a newly elected Mayor declared shortly after winning that he would close Bracos Abertos.⁽²⁵⁾

Injecting drug use does occur in Mexico, and has increased since the *Global State* last reported,⁽²⁶⁾ yet the harm reduction response in terms of needle and syringe programmes (NSP) or opioid substitution treatment (OST) has decreased following cessation of Global Fund support to the country.^(18, 27) An increase in polydrug use has been observed, particularly in the Northern border cities such as Tijuana,⁽²⁸⁾ with methamphetamine use continuing to expand.^(29, 30)

Harm reduction services at raves and festivals are being increasingly practiced via civil society organisations, with substance analysis taking place to ensure drugs are safe, general information regarding drug use is offered, and psychological support is given for people experiencing psychological difficulties.⁽³¹⁾ Since 2012, *Échele cabeza cuando se de en la cabeza* (or, Use your head before it goes to your head), a project of Acción Técnica Social (ATS) has been implementing harm reduction services and substance analysis in festivals and raves. They have analyzed more than 2,000 samples and have witnessed a decrease in the adulteration of MDMA/ecstasy pills by 25%. During this time, ATS has also emitted 17 health alerts to bring attention to the adulteration of cocaine, fake LSD and 2CB. These alerts were shared more than 45,000 times on social media and taken up by both print and television media.⁽³²⁾

¹ 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.

Harm reduction services such as these demonstrate Mexico and Colombia's policy shift away from punitive responses to drug use and further towards decriminalisation. However, reports suggest that these changes to laws have not translated into reduced arrests or incarceration in many instances, and services are primarily being undertaken without the support of the government.^(32, 33) There is still some way to go until harm reduction services are scaled-up to meet needs.

Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

NSP services for people who inject drugs in Latin America continue to be extremely limited, and since the previous edition of the *Global State*, coverage has reportedly diminished.⁽¹⁸⁾ It is important to note, however, that the majority of substance use in the region relates to the use of cocaine and its derivatives, which are often smoked. In some cases coverage of NSP services are believed to have declined due the reduction in the number of people who inject drugs, for example, in Argentina,⁽¹⁰⁾ Brazil and Uruguay.^(5, 34) However, up to date estimates on the number of people who inject drugs in much of Latin America is unavailable. Of the 12 countries in the region that report injecting drug use, only six operate NSPs (see Table 2.5.1).

Colombia began implementing a mobile health service through the Medical Care Centre for Drug Addicts (CAMAD), which targeted people who inject drugs. However, this service has since closed.⁽⁸⁾ Support from Open Society Foundations helped establish a syringe programme in Pereira and Dos Quebradas in 2014,⁽⁸⁾ with 818 people who inject drugs registered in the programme.⁽⁵⁾ Further NSPs have since been developed by NGOs with support from the Ministries of Justice and have begun operating in Bogotá and Cali.⁽⁵⁾ However, the services available for people who inject drugs remain limited, and are often unavailable outside of city centres. A study undertaken in Colombia in 2016 observed a high rate of new injector initiation and the sharing of products used to clean syringes, noting HIV prevalence rates among this population of 2.7% in Medellín and Pereira.⁽⁸⁾ Due to a lack of knowledge regarding safe injecting practices, and limited harm reduction service provision, these figures are expected to rapidly increase.⁽⁸⁾ In light of this, it is essential that NSP continue to be implemented in the country.

In Mexico, the sale of needles is legal and does not require a prescription. However pharmacists often resist sales to people who inject drugs.⁽¹⁶⁾ UNAIDS reports that the number of needles and syringes has increased in Mexico, going from 3.9 per person who injects drugs per year in 2014,⁽³⁵⁾ to 7.2,⁽¹⁰⁾ a figure which is still low in terms of provision.⁽³⁶⁾ However, NGOs in Tijuana and Cd. Juárez report that distribution of needles and syringes per person who injects drugs fell by between 60 to 90% following cessation of Global Fund support. Funding cuts also meant that outreach was reduced, requiring people who inject drugs to come to NGO offices, rather than receiving sterile injecting equipment where they are. Even the limited level of existing harm reduction services has relied partly on commodities donated by organisations ceasing operations after the withdrawal of the Global Fund.

Redumex, a network of organisations working to reduce HIV among people who inject drugs, report a reduction in the amount of needles distributed, with women experiencing more pronounced inaccessibility to NSPs due to greater stigma.⁽³⁴⁾

In the countries where NSP provision is available, many people who inject drugs are deterred from accessing services due to restricted opening hours, long waiting times, insufficient resources, criminalisation of drug use and inadequately trained service providers.^(18, 34) Further research, advocacy and service provision is necessary in the region to ensure people who inject drugs have appropriate access to safe injecting equipment.

Opioid substitution therapy (OST)

Of the 17 countries where injecting opioid use has been reported, civil society organisations note that only Mexico, Colombia, Argentina and Brazil provide OST to people who inject drugs and/or use opiates, primarily in the private sector.⁽⁵⁾ Of these, only Colombia and Mexico provide OST outside of the private sector, with Mexico having one government facility providing methadone for people who use opiates compared to 17 private OST sites. In Colombia, publicly available OST sites operate across seven cities: Bogotá, Medellín, Cali, Pereira, Armenia, Cúcuta and Bucaramanga.⁽³⁷⁾ However, the number of sites available is unknown. As a controlled medicine, several countries in Latin America, such as Mexico, Guatemala, Bolivia, El Salvador, Honduras and Colombia have requirements that impede access to opiates as a form of OST in hospital-based services, often requiring four doctors to sign an opiate prescription.⁽³⁸⁾



In Argentina, opiate use is reportedly rare, but OST can be made available at some public hospitals based on results from toxicology services,⁽³⁹⁾ and a methadone programme was initiated in 2015.⁽⁴⁰⁾ Given that opiate use, although not common, is apparent in the region, a scale-up of OST provision continues to be necessary.⁽³⁴⁾ In Brazil, there are no public methadone programmes integrated within the healthcare system, but methadone can be obtained through private clinics.⁽⁵⁾

In 2016, the Community of Latin American and Caribbean States (CELAC), adopted the Quito Declaration. Drug policy officials highlighted the need to incorporate the principles of the Universal Declaration of Human Rights into drug conventions in a comprehensive way, concentrating on policies which centre on citizens well-being.⁽⁴⁷⁾ The implications of the Declaration could significantly improve drug treatment centres if actioned.

Human rights, 'treatment' and harm reduction in Latin America

Abstinence-oriented drug treatment services for people who use opiates continue to remain the norm in the region. Such interventions have been found to be effective for only a small minority of people who inject opiates, with harm reduction services, such as OST, widely acknowledged as the preferred first line of treatment.^(36, 41)

Mexico has approximately 2,000 registered residential abstinence-focused treatment centres and a reported 35,000 people who use drugs placed in centres that operate outside the law.⁽⁴²⁾ Many of the unregistered centres have no medical personnel, and no medications for withdrawal like opioid substitution therapy.⁽⁴³⁾ It has recently been reported that treatment can consist of inhumane acts such as forcing people to eat their own vomit, and to eat food from the container where they urinate or defecate.⁽⁴³⁾ Reports also suggest that a 'spiritual patrol' operate, in which people who use drugs are often forced into church-run treatment centres.⁽⁴⁴⁾

Centres such as these are not unique to Mexico. In Guatemala many people who use drugs end up in private Pentecostal rehabilitation centres rather than prisons.⁽⁴⁵⁾ And the US and Caribbean also contain organisations operating unorthodox and zero tolerance faith-based rehabilitation centres, using methods not based on the scientific evidence of harm reduction or substitution therapy, but instead preferring 'confrontational therapy' which sometimes involves sessions throughout the night over 12 hour periods with buckets of icy water thrown at the participant.⁽⁴⁵⁾ Both registered and unregistered centres in the region receive little government supervision, and often violate the rights of people who use drugs, such as the right to be free from cruel and inhuman or degrading treatment.

^(45, 46)

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 hepatitis C among people who inject drugs in the region, at 4.8%⁽⁷⁾ and Mexico the highest, at 96%.⁽¹⁾ In Brazil, prevalence rates for hepatitis C were recorded as 28.9% among people who inject drugs in 2011.⁽⁴⁸⁾ The figures cited are from data published in 2009 and 2005 respectively, and since the *Global State* last reported in 2014, there are no updated estimates available for Latin America.

A 2002 study in Buenos Aires and Montevideo, 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 in Latin America.⁽⁴⁹⁾ 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 hepatitis C testing and treatment said to be available across the country.⁽⁵⁰⁾ Mexico is currently drafting a national viral hepatitis programme with REDUMEX as one of the consultants, it is expected that the plan will be complete by the end of 2016.⁽³⁴⁾

Tuberculosis (TB)

Previous evidence has suggested that tuberculosis (TB) rates in countries such as Brazil are extremely high, with 44 cases per 100,000 people in the general population in 2014,⁽⁵¹⁾ a marginal decline since the *Global State* last reported.⁽²⁶⁾ Although research on TB prevalence among people who use drugs in Latin America is lacking, there is evidence to suggest that they are experiencing elevated TB infection rates,⁽⁵²⁾ perhaps as a result of disproportionate rates of incarceration or detention in treatment facilities lacking TB control.

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, whilst diagnosis services are available across the region, access to these is inconsistent for people who use drugs.⁽⁵⁾

Antiretroviral therapy (ART)

In a recent report, UNAIDS noted that coverage of antiretroviral therapy (ART) for people living with HIV in Latin America was 55%,⁽¹⁹⁾ a decrease of 8% in comparison to 2010.⁽¹⁵⁾ Latin America has the highest total spend on ART among low- and middle-income countries, at just under US\$800 million.⁽⁵³⁾ Argentina, Brazil, Chile, Cuba, Guyana, and Mexico all achieved universal access to treatment for HIV in 2012.⁽⁵⁴⁾ However, access for people who inject/use drugs remains unclear in many of the aforementioned countries.

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 a lack of access to HIV testing and stigma surrounding injecting drug use.⁽⁵⁵⁾ 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

Despite the gradual trend towards decriminalising drug use and possession for personal use in the region, the cultivation and distribution of drugs - including for very small quantities - continue to be heavily criminalised. As a result, people who use drugs continue to be treated as criminals, and frequently end up being prosecuted as traffickers. Currently, approximately one in five prisoners are detained in the region's grossly overcrowded criminal justice system for drug-related offences, many of them in pre-trial detention facilities where they can wait years before being sentenced.^(56, 57) Drug-related incarceration rates have grown in most countries in the region in recent years.⁽⁵⁶⁾ In Mexico, for example, the number of people held for drug-related offences increased by 1,200% between 2006 and 2014,⁽⁵⁶⁾ while in Brazil it has gone up by 211% since 2005.⁽⁵⁸⁾ This punitive approach to drugs has been shown to have

a particularly disproportionate impact on women in the region. Currently, more than 60% of the female prison population in Argentina, Brazil, and Costa Rica is incarcerated for drug-related offences, the majority of whom are single mothers.⁽⁵⁹⁾

Despite the lack of data on the issue, injecting drug use in prison has recently been reported in some countries in the region, including in Mexico⁽⁶⁰⁾ and Brazil.⁽⁶¹⁾ Similarly, despite the persistent scarcity of research on HIV, HCV and TB in Latin American prisons, prevalence rates are still reported to be much higher (up to 25% in some countries) in prisons than in the broader community.⁽⁶²⁾ A recent systematic review of the global burden of HIV, HCV and TB among prisoners found that prevalence rates among prison populations in Latin America are 2.3%, 4.7% and 1.9% respectively.⁽⁶³⁾ At the national level, a recent study in Mexico revealed that the prison population was six times more likely to be living with HCV, and that HIV prevalence was 0.7% higher among prisoners than the broader community.⁽⁶⁰⁾ In Argentina, HIV prevalence is reportedly more than seven times higher in prisons,⁽⁶⁴⁾ while in Brazil, HIV prevalence among prisoners is reported to be between three and 16%,⁽⁶⁵⁾ and a recent systematic review found the mean prevalence of HCV to be 13.6% among prisoners.⁽⁶⁶⁾

Despite the clear need for comprehensive harm reduction service provision in prisons in Latin America, the regional response remains the weakest in the world. Available data (or lack thereof) suggest that NSPs, OST and harm reduction approaches to cocaine use continue to be entirely absent in Latin American prison settings, in violation of public health and human rights standards. Research on prison-based testing, treatment and care of HIV, HCV and TB is still scarce, but existing data suggest the availability and accessibility of these services vary between and within countries. A recent cross-sectional study of prisoners in Mexico City, for example, revealed that there is no routine testing for communicable diseases on entry to prison,⁽⁶⁰⁾ and that prisoners are only tested for HIV, for example, when prison healthcare staff suspect infection.⁽⁶⁰⁾ According to Mexican civil society organisations, HIV, HCV and TB treatment and care are only sometimes available within prisons and condom provision tends to be unreliable due to a lack of resources.⁽¹⁸⁾ In Brazil, HIV testing and condom use are reported as being irregular, which may in part be due to the stigma associated with HIV status in prisons.⁽⁶¹⁾ Thanks to standardised treatment guidelines in that are used in both prison and community settings, access to HIV-related medical services in Argentinian prisons is considered widespread, and prisoners reportedly feel



confident they will continue to receive these services upon release.⁽⁶⁴⁾

Alongside the obvious and urgent need to scale up prison-based harm reduction in the region in accordance with international human rights and public health standards, more systematic research is desperately required to help ensure that prison-based harm reduction policies and programmes, when they are developed and implemented, are as effective as possible.

Overdose

As mentioned in *The Global State of Harm Reduction 2014*, there is no official support for overdose prevention programmes in the whole of Latin America. One of the central issues amongst people who use/inject drugs is the fear of arrest when seeking medical care or attention.⁽³⁴⁾

Naloxone, a highly effective opioid antagonist used to reverse the effect of overdose, is generally unavailable in Latin America except in hospitals. Naloxone is made available by the federal government in Mexico, but has been consistently undersupplied, with paramedics lacking it as part of their basic medical kit.⁽¹⁸⁾ In Colombia, a study undertaken in 2012 noted that in both Pereira and Medellin, six out of ten people who use drugs revealed they would not access healthcare services if they had another overdose for fear of referral to law enforcement authorities.⁽⁶⁷⁾ During 2014-2015, civil society organisations began building capacity and training to increase the use of Naloxone in Colombia. Since then, 84 doses of Naloxone have been distributed and have been effectively used 49 times by people experiencing an overdose.⁽³²⁾

Policy development for harm reduction

Several Latin American countries are slowly seeing a policy shift away from a punitive approach to drug use and towards a model that favours health and human rights. In August 2009, Mexico's federal government partially decriminalised the possession of small quantities of drugs such as cannabis, cocaine, amphetamines and heroin, with people being diverted to treatment services or OST, rather than criminalised.⁽³³⁾ As previously noted, however, this has yet to reduce incarceration or arrest rates. In 2011, Bolivia denounced the 1961 Single Convention on Narcotic Drugs, reassessing it with a reservation allowing the traditional use of the coca leaf domestically, enabling indigenous communities to legally

cultivate and use the leaves.⁽⁶⁸⁾ In 2013, the Government of Uruguay passed legislation to regulate state-controlled sales of cannabis becoming the first country in the world to do so,⁽⁶⁹⁾ and the National Strategy on Drugs 2016-2020 advanced the development of an alternative model using risk and harm reduction as the basis for a new approach to the use of drugs. Colombia has also begun defining guidelines for a new approach to drug policy which promotes human rights and social inclusion.⁽⁷⁰⁾ However, the recent referendum on the peace process in Colombia is believed to have had a significant impact on advocacy as well as policy reform in the future.⁽⁷¹⁾

In April 2016, during the United Nations General Assembly Special Session (UNGASS) on drugs in New York, Brazil, Costa Rica, Colombia and Uruguay all made statements in explicit support of harm reduction.⁽⁷²⁾ The Research Consortium on Drugs and the Law (Colectivo de Estudios Drogas y Derecho – CEDD), incorporating researchers from nine Latin American countries (Argentina, Bolivia, Brazil, Colombia, Costa Rica, Ecuador, Mexico, Peru and Uruguay) was established in 2010. CEDD seek to foster debate in the region regarding the effectiveness of current drug policies and recommend more feasible policy alternatives given the increasing and unmanageable rate of incarceration for drug offenses in Latin America.⁽⁷³⁾

An important development emerged during the 55th Directing Council 68th Session of the Regional Committee of WHO (World Health Organisation) for the Americas, held in September 2016, which included non-injecting drug users as a key population group within the new Plan of Action for the Prevention and Control of HIV and Sexually Transmitted Infections 2016-2021.⁽⁷⁴⁾

Civil society and advocacy developments for harm reduction

One of the challenges increasingly recognised by civil society groups in Latin America is the integration of harm reduction into drug services as a cost-effective and human rights based approach.⁽⁷⁵⁾ In light of this, the Civil Society Task Force – established as the official NGO (Non-Governmental Organisation) engagement mechanism in the run up to the United Nations General Assembly Special Session (UNGASS) on the drugs – surveyed a number of NGOs actively engaging with people who use drugs to urge governments to respond to the different forms of drug consumption in the region using a harm reduction approach.⁽⁷⁵⁾ This sentiment was echoed by the Latin American Network of People

Who Use Drugs in their contribution to the UNGASS, together with Caravan for Peace, Life and Justice, a large organisation of networks and activists highlighting the growing discontent with the effects of the drug war.⁽⁷⁶⁾

⁽⁷⁷⁾ In 2015, in Sao Paulo, a Regional Dialogue on HIV and Drug Policy, organised by the United Nations Office on Drugs and Crime (UNODC) and involving civil society took place, with the objective of offering technical assistance to participants contributing to the ongoing regional, national and international level discussions in the approach to the UNGASS.

In Argentina, to develop a harm reduction perspective and facilitate access to health services, training workshops on the accessibility of drug users to health services was undertaken with support from the UNODC, and co-organised by the National Direction of AIDS and STD and local government. Intercambios developed the workshops in seven Argentine provinces and the deferral penitentiary system in order to improve health providers' practices, aiming to build capacity among health and social teams and enabling better access for people who use drugs.⁽⁷⁸⁾ In August 2016, the Argentinian civil society organisation Asociación Pensamiento Penal (APP) introduced a Declaration endorsed by more than 550 Argentine magistrates, judges and lawyers calling on the government to redraw its policy on narcotics and end the 'War on Drugs'.⁽⁷⁹⁾ It is estimated that approximately 70% of cases pending before the Federal Courts relate to possession of drugs for personal use.⁽⁷⁹⁾ Mexico, too, is resuming its leadership between the federal government, civil society organisations, and local governments to carry out a more coordinated approach to harm reduction.⁽³⁴⁾

In October 2012, the Latin American Network of People who Use Drugs (LANPUD) was formed.⁽²⁶⁾ Since then, the regional Harm Reduction Network of the Americas (which include Colombia, Brazil, Canada, United States, Mexico) has been formed, and country level groups are in development such as the Mexican Harm Reduction Coalition.⁽¹⁸⁾ The 'Support Don't Punish' campaign, a global advocacy campaign which occurs every year on 26 June and calls for drug policies to be based on health and human rights, has been growing throughout Latin America. It is receiving greater support and raising awareness of harm reduction and the need to end repressive policies against people who use drugs, subsistence farmers and vulnerable groups.⁽¹⁸⁾

Harm reduction as a concept is expanding within Latin America, with organisations questioning the impact not only of drug use, but also the negative impacts of the

current policies. As a means of addressing these policies, including violence, corruption and widespread human rights violations, organisations are diversifying their partners to include victims and ensure that their voices are heard within the drug policy debate. In addition to seeking new ways of addressing the increasing levels of stimulant consumption, the increase in the use of substance analysis services in nightlife spaces provide an innovative opportunity to reach young people and people who use drugs. There is a clear recognition by civil society organisations that most people who use psychoactive substances do so without generating any problematic use and therefore must be provided with information, harm reduction services and improved quality of access. Responsible consumption as a concept is gaining force amongst a new generation that seeks direct information and political and social mechanisms through which they can contribute.^(32, 71)

Funding developments for harm reduction

As previously reported, much of Latin America has received limited international donor support for their harm reduction initiatives.⁽²⁶⁾ The Global Fund, one of the primary donors in the region, has allocated funding in Colombia and Paraguay.⁽⁵⁾ Open Society Foundations have also provided harm reduction funding in the region, and the Levi Strauss Foundation have supported similar initiatives in Argentina.⁽⁵⁾ However, the Global Fund is no longer providing funds for harm reduction, and other international organisations have continued to reduce resources.⁽¹⁸⁾

Civil society organisations report that one of the main issues regarding HIV funding is the focus on injecting drug use rather than stimulant-oriented non-injecting and poly-use consumption patterns which occur to a greater extent in the region.⁽²⁸⁾ This has left many innovative harm reduction approaches, for example cannabis as a substitute for crack use, overlooked and lacking financial support.⁽¹⁸⁾ Donors are increasingly restricting resources for middle-income countries, and the sustainability of many harm reduction projects in Latin America is therefore at risk.⁽⁵⁾ With an estimated 2% of HIV prevention investment directed towards key populations in the region,⁽⁸⁰⁾ it is imperative that government support increases, as it has been in Colombia and Uruguay, where the governments have increasingly begun to advocate for harm reduction, and now provide state funding to support operational and administrative aspects of various projects.⁽¹⁸⁾



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Regional Overview




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 ^a	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 ^b 	OST ^c 	DCR ^d 
Canada	90,000 (72,000 – 108,000) ⁽¹⁾	11% ⁽²⁾	68 ⁽³⁾	nk	✓	✓	✓ ²
United States	800,000 ^{(4)e}	3.6% ⁽⁴⁾	43.1 ⁽⁵⁾	11.8 (3.5–20) ^{(6)f}	✓ ²⁴⁴ ^{(11)g}	✓	✗

nk = not known

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

^b 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.

^c 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).

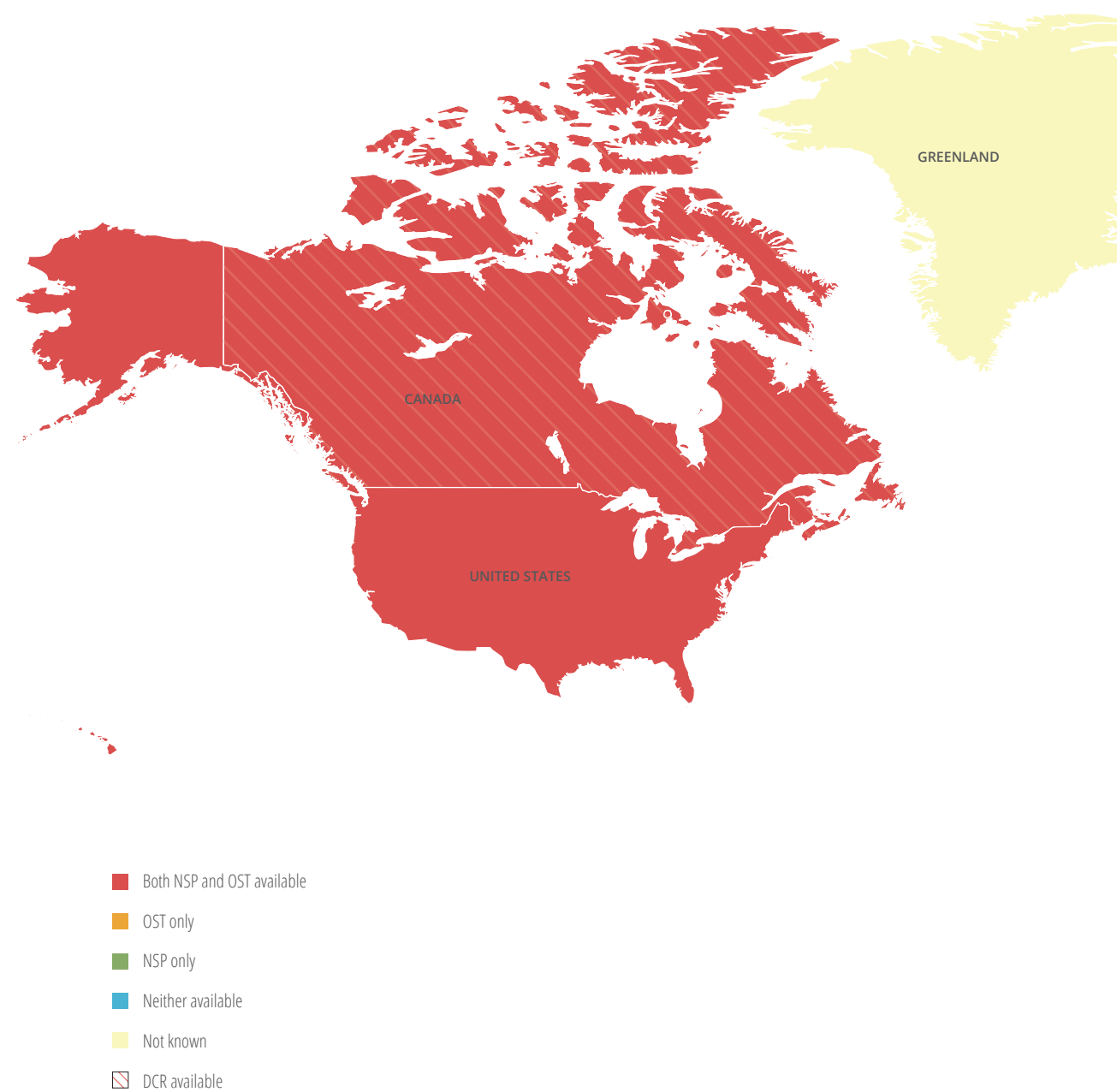
^d DCR = drug consumption room, also referred to as a safer injecting facility (SIF).

^e It has been reported that over 2 million people who inject drugs reside in North America, with both figures for Canada and the United States believed to be underestimates.

^f Year of estimate: 1992.

^g These services operate in 35 of the 50 states, which include Puerto Rico. Figure from 2016.

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





Harm reduction in North America

Overview

There are an estimated 2 million people who inject drugs in North America, of which 90% currently live in the United States.⁽⁴⁾ Approximately 3.6% of people who inject drugs in the US are living with HIV, 80% of whom are also co-infected with hepatitis C (HCV).⁽⁴⁾ In Canada, 11% of the estimated 90,000 people who inject drugs are living with HIV.^(3, 4) National estimates, however, suggest the number of people who inject drugs newly infected with HIV in Canada is declining.⁽²⁾ While the total number of new HIV infections is declining in the US thanks to HIV testing remaining stable or increasing in recent years, progress has been uneven and diagnoses have increased among some key populations.⁽⁸⁾ The most explosive HIV outbreak on record, for example, occurred in 2014/2015 and was associated with injecting drug use.

The election of a new federal government in Canada in October 2015 has ushered in the prospect of drug policy reform in the country, with harm reduction adopted as a pillar in its response to drugs. Although the US has not embraced harm reduction in quite the same way, it does appear to be adopting more of a public health approach than in previous years.

Key harm reduction services, such as needle and syringe programmes (NSPs) and opioid substitution therapy (OST), are available to people who inject drugs in both countries, but barriers to access persist and service provision remains uneven. The region's most marginalised and stigmatised populations, including prisoners, racialised and Indigenous communities, continue to be the most disproportionately affected by these disparities.

The prevalence of opioid use in North America remains high (3.8%) in relation to the global average,⁽⁹⁾ and the region continues to experience the world's highest drug-related mortality rate in the world.⁽¹⁰⁾ The magnitude of the epidemic has forced leaders in both countries to intensify their responses, resulting in a number of positive developments since 2014, including a dramatic increase in naloxone coverage on both sides of the border. Civil society continues to be very active and has played a key role in the numerous harm reduction victories achieved since the *Global State* last reported in 2014.

Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

NSPs are available in both Canada and the US. Although the exact number of NSPs operating in Canada is not known, it is estimated that 94.5% of people who inject drugs used sterile injecting equipment at last injection.⁽⁴⁾ In the US, 244 NSPs are now operating across the country,⁽¹¹⁾ representing a 25% increase since the *Global State* last reported in 2014. In reality, however, with several NSPs operating clandestinely in those states where punitive environments prevail, these figures are likely to be higher.

This increase in NSPs in the US has in large part been driven by a dramatic HIV outbreak in rural Indiana in 2014/2015 associated with injecting drug use. In less than 12 months, 181 cases of HIV infection were documented in a town with a population of 4,300 - one of the highest incidence rates ever recorded.⁽¹²⁾ In the wake of this public health emergency, the federal government changed its legal position on NSPs, resulting in a partial repeal of the 28-year ban on federal funding for NSPs. While the use of federal funds to purchase sterile needles or syringes to inject illegal drugs remains prohibited, the Consolidated Appropriations Act, 2016, passed by Congress in December 2015, enables federal funds to be allocated to other aspects of NSPs, including HIV and HCV testing, naloxone provision, human resources, rent, and other expenditures needed to keep them in operation.⁽¹³⁻¹⁵⁾

Despite these developments, NSP coverage in the US remains low. According to UNAIDS, 50 syringes are distributed per person who injects drugs per year, and only 35% of people who inject drugs are believed to have used sterile equipment in the past 12 months.⁽⁴⁾ According to civil society, people who inject drugs in both the US and Canada continue to come up against several barriers to accessing this service. Fear of stigma and discrimination, for example, impedes access, particularly in rural or remote communities where there is a heightened risk of being identified. In Canada, some municipal bylaws and other legal barriers reportedly continue to prevent NSPs from operating within particular communities which, again, tends to disproportionately affect people who inject drugs in rural and remote communities, as well as Indigenous (First Nations, Métis and Inuit) communities.⁽¹⁶⁾

^h Only in 35 states, the District of Columbia, Puerto Rico, and the Indian Nations. For more info, see North American Syringe Exchange Network. Directory of Syringe Exchange Programs. Available at: <https://nasen.org/directory>.

Meanwhile, in the US, drug law enforcement is often responsible for hindering access to NSPs, even where these are legally sanctioned. Five years ago, a national survey revealed that nearly 50% of NSPs reported that their clients experienced police harassment on at least a monthly basis.⁽¹⁷⁾ A recent study on police encounters among NSP clients in Baltimore confirms that this harmful practice continues today. The study found that even under a favourable policy and legal regime, police continue to unlawfully confiscate injecting equipment and interfere with the functioning of NSPs, with non-white clients more likely to report confiscation of injecting equipment or arrest.⁽¹⁸⁾ Adversely affecting both the behaviour and health of people who inject drugs, drug law enforcement is evidently an important determinant of health for this population, and particularly for marginalised groups within it. In order to ensure the full uptake and impact of NSPs, policing as a barrier to access should be urgently addressed in the country.

Opioid substitution therapy (OST)

Like NSPs, OST is available in both Canada and the US. In Canada, methadone and suboxone are available to people who use opioids.^(16, 19) In Ontario, Canada's most populous province, the number of people receiving methadone was just under 50,000 in 2014, up from 29,000 in 2010.⁽²⁰⁾ A comparable number of people are currently also receiving OST in the provinces of British Columbia, Saskatchewan and New Brunswick.⁽²¹⁾ In light of a staggering number of opioid overdoses across the country in recent years, however, there have been calls to scale-up OST provision across the country.⁽¹⁶⁾ Following a legal challenge, the federal government took an important step on 7 September 2016 by officially overturning the ban on heroin-assisted therapy (HAT).⁽²²⁾ Under the new regulations, physicians can prescribe pharmaceutical-grade heroin to individuals for whom it is clinically indicated, including those who have tried other approaches, such as methadone and buprenorphine, without success.⁽²³⁾

In the US, the 2015 National Drug Control Strategy affirms the government's commitment to ensuring access to evidence-based treatment models, including OST⁽²⁴⁾ and methadone or buprenorphine is currently available in 48 states, as well as in Washington DC. Regrettably, the service remains completely unavailable in North Dakota and Wyoming.⁽¹⁵⁾ According to the most recent data, 382,237 people are enrolled in OST in the country.⁽⁴⁾ Unsurprisingly, the number of private, for-profit facilities providing methadone has been

increasing, with 60% of people who received methadone in 2012 receiving it from this type of facility.⁽²⁵⁾

Despite these services being available, several barriers continue to limit their accessibility throughout the region. In the US, these are typically associated with unreasonable cost and lack of health care coverage.⁽²⁶⁾ In Canada, obstacles range from unaffordable user or clinic fees, long waiting lists, restrictive directly-observed therapy requirements, lack of access to take home doses, and municipal resistance to the operation of OST clinics materialising in zoning bylaws and other legal barriers.^(16, 19) One other serious obstacle to accessing OST in Canada is the limited number of physicians able to prescribe OST, coupled with their geographical inaccessibility, which disproportionately affects Indigenous and other rural or remote communities. Recent advances in telemedicine-delivered OST in Ontario, whereby physicians prescribe OST through telecommunications technology, are encouraging, however, and experts believe this trend could be adopted by other provinces in the near future.⁽²¹⁾

Drug Consumption Rooms (DCRs)

Drug consumption rooms, generally known as safe injection facilities or sites (SIFs/SISs) in North America, are professionally supervised healthcare facilities where people can consume drugs in a safe and non-judgmental environment. Since the *Global State* last reported, one additional DCR – the Dr. Peter Centre – received a two-year stamp of approval from the Canadian government to operate legally in Vancouver, bringing the total of authorised DCRs in the region to two. With so many people injecting drugs in North America and so few sanctioned DCRs, coverage is currently virtually non-existent, particularly since both facilities are located in Vancouver. Several cities across Canada, however, now have firm plans to establish DCRs. Toronto, for example, is in the process of applying for legal exemption to open three facilities.⁽¹⁹⁾ While Canada has become much more amenable to the idea of DCRs since 2015, having recently approved a 4-year extension for Insite to continue operating its DCR, the new federal government has defended the *Respect for Communities Act*, a law which requires a minimum of 26 conditions to be met before the federal Minister of Health may even consider allowing an exemption for a DCR to legally operate. Regrettably, the current government has not taken firm steps to repeal or amend the law.^(16, 19)

While there are still no DCRs in the US, some recent initiatives are worth mentioning. For example, in



September 2015, the Harm Reduction Coalition, with OSF and the American Foundation for AIDS Research, convened a consultation on alternatives to public injecting.⁽¹⁵⁾ Experts from several countries shared their various DCR models, planning and policy development processes, implementation challenges and evaluation results, with participation from a broad range of stakeholders, including government representatives, advocates for people who use drugs, service providers and law enforcement.⁽²⁷⁾ Also in 2015, a community-based NSP modified a bathroom to accommodate safer drug consumption and then shifted to opening a supervised injecting room.⁽¹⁵⁾ Although service delivery was limited in a number of ways due to the illegal nature of the DCR, both models were evaluated to determine and compare the benefits and challenges in how each operated. The study has now officially come to an end and the results will soon be published. In terms of legal and policy developments, DCR bills have now been introduced in the states of Maryland and California, and there have been discussions around introducing one in Seattle, too.⁽¹⁵⁾ Finally, New York City Council Preliminary Budget for 2017 includes a US\$100,000 for an impact study on instituting DCRs in New York City.⁽²⁸⁾

Viral hepatitis

Viral hepatitis among people who inject drugs continues to be a major public health concern in North America. In the United States, there are between 2.7 to 4.7 million people living with chronic hepatitis C virus (HCV),⁽²⁹⁾ and an estimated 30,000 new cases are acquired each year,⁽³⁰⁾ making HCV the largest on-going infectious disease epidemic in the country. Injecting drug use remains the most common risk factor for acquiring HCV in the US, accounting for more than 50% of all American cases.⁽³¹⁾ Nearly 75% of people living with HIV who inject drugs are also living with HCV, which more than triples their risk for liver disease, liver failure and liver-related death.⁽³²⁾ In recent years, an emerging HCV epidemic among young people who inject drugs has been reported in rural and suburban settings in the US^(30, 33-35) Those most likely to be affected have been identified as being 25 years of age or younger, primarily white, both male and female, residing in non-urban areas, having used oral prescription opioids (e.g. oxycodone) before transitioning to injecting heroin, and highly mobile, often making them more difficult to locate.^(30, 36) There is a growing concern that this emerging epidemic could begin to reverse the decline in overall HCV incidence and prevalence observed in the country over the past two decades.⁽³⁶⁾

According to the latest modelling, approximately 252,000 Canadians were chronically infected with HCV in 2013.⁽³⁷⁾ Similar to the US, sharing injecting equipment is considered the most significant mode of HCV transmission in the country,⁽³⁸⁾ accounting for over 60% of newly acquired HCV infections each year.⁽³⁹⁾ A considerable proportion of people living with HCV are also living with HIV. Canadian studies conducted among people who inject drugs have reported HCV and HIV co-seropositive infection at approximately 10%.⁽³⁾

Despite the lack of data on testing and treatment coverage in the region, the considerable barriers standing between people who use drugs and these services suggest that accessibility remains quite limited for this population. In the US, access to HCV testing is limited by the cost of testing kits,⁽¹⁵⁾ and treatment is so prohibitively expensive (US\$84,000 per HCV treatment course)⁽³⁹⁾ that Medicaid and private insurers have responded by restricting access. Despite the fact that treating people who inject drugs with curative HCV therapies could reduce HCV prevalence by 20-80%,⁽²⁹⁾ the overwhelming majority of states restrict access to HCV treatment for people who inject drugs and those receiving treatment for drug dependence, such as OST.⁽⁴⁰⁾ In 88% of state Medicaid committees, drug and alcohol use is included in the eligibility criteria, with half requiring a period of abstinence and two-thirds requiring drug screening.⁽⁴⁰⁾ With these discriminatory, unfounded and stigmatising restrictions in place, it is not surprising that lawsuits alleging discrimination are currently being prepared.⁽⁴¹⁾ Furthermore, two-thirds of states have restrictions that limit the prescription of newly approved HCV medicines to HCV specialists, rather than allowing prescription by HIV or harm reduction service providers, who are in better contact with people who inject drugs.⁽⁴²⁾ The recent *Action Plan for the Prevention, Care, and Treatment of Viral Hepatitis 2014-2016* is somewhat encouraging, however, in that it recognises the importance of focusing a variety of resources on improving access to HCV services for people who inject drugs, and recommends that “(w)here state, local, or private resources are available, these comprehensive services should include access to sterile injection equipment”.⁽³⁶⁾

Although Canada does not have a national policy on HCV, testing and treatment are theoretically available for people use drugs. Again, while coverage is difficult to assess due to a lack of data, civil society reports that access remains a challenge for many.⁽¹⁶⁾ In a national sample of people who inject drugs, for example, over 25% of those found to be living with HCV were unaware

of their positive status prior to being tested in the study.⁽⁴³⁾ In addition, only half of those who knew their status were consulting a physician for HCV care, while only 10% of these individuals reported ever receiving HCV treatment.⁽⁴³⁾ One of the primary deterrents to seeking testing and treatment in the country remains fear of stigma and discrimination in health care settings. This was made vividly clear in a 2011 study among 528 HCV specialist physicians from across Canada, which found that only 19% were willing to provide HCV treatment to patients who were actively injecting drugs.⁽⁴⁴⁾

Tuberculosis (TB)

Data on tuberculosis (TB) prevalence, prevention, treatment and care among people who inject drugs in the region continue to be scarce, limiting the effectiveness of policies and programmes designed to address this issue and making it difficult to provide a useful overview of the situation in both countries. Despite this shortage of systematic research, a few general comments and recommendations can still be made.

Like in all other regions of the world, people who use drugs in North America have increased rates of TB infection, particularly if they are living with HIV.⁽⁴⁵⁾ When TB treatment is integrated with HIV, HCV and OST, improved outcomes for each condition have been observed, as well as improved adherence and retention in TB treatment for those living with TB.⁽⁴⁵⁾ In accordance with international standards, services in both the US and Canada should ensure that they adopt a coordinated and integrated response to the needs of people who use drugs in order to provide universal access to prevention, treatment and care services at all entry points.⁽⁴⁶⁾ This requires collaborative planning between HIV and TB services, harm reduction services and the criminal justice system.⁽⁴⁶⁾

Antiretroviral therapy (ART)

People who inject drugs continue to be at high risk of transmitting or acquiring HIV in the region for several reasons, including laws criminalising the possession and use of drugs, the resulting high rates of incarceration, and a lack of sterile syringes. In 2010, 7% (3,096) of the estimated 47,352 diagnoses of HIV infection in the United States were attributed to injecting drug use, of which 46% were among Black people.⁽⁴⁷⁾ In 2013, 10% of all AIDS diagnoses and more than one in four (26%) deaths among people with AIDS were attributed to injecting drug use.⁽⁴⁷⁾ More recently, an HIV outbreak in

rural Indiana associated with injecting drug use resulted in 181 cases of HIV infection in a small village in less than 12 months, one of the highest incidence rates ever recorded.⁽¹²⁾

In Canada, incidence and prevalence rates are similarly high. According to national HIV estimates from 2014, people who inject drugs are 59 times more likely to get HIV than people who do not inject drugs, 19% of people living with HIV may have acquired their infection through injecting drug use, and HIV prevalence among people who inject drugs is approximately 11%.⁽¹⁾ The same study found disparities in HIV incidence among people who inject drugs, with 21% and 45% of the estimated new HIV infections in women and Aboriginal people attributable to injecting drug use, compared to an estimated 11% of new infections among all Canadians.⁽²⁾

Despite these figures, a large proportion of people who inject drugs often still have trouble accessing HIV testing, treatment and care. According to UNAIDS, between 50-75% of people who inject drugs in the US, and around 75% of people who inject drugs in Canada are accessing HIV testing.⁽⁴⁸⁾ Data collected as part of the Canadian HIV surveillance system showed that an estimated 20% of people who inject drugs and are living with HIV are not aware of their positive status.⁽⁴⁹⁾ Civil society reports that Indigenous people living with HIV are only half as likely to have access to ART as non-Aboriginal individuals.⁽¹⁹⁾ In the US, access to treatment is often restricted by socio-economic factors, with almost two-thirds of people who inject drugs living with HIV reporting being homeless, 61% reporting being incarcerated, and 44% reporting having no health insurance in the last 12 months.⁽⁴⁷⁾ Barriers to initiating ART in Canada are often linked to many of the same issues. They may also relate to health professionals' stigma and discrimination against people who inject drugs and/or a requirement to initiate drug treatment as a condition of access to ART.⁽⁵⁰⁾

Harm reduction in prisons

The United States has the world's second highest rate of incarceration at 698 per 100,000.⁽⁵¹⁾ A new Human Rights Watch report on the human toll of criminalising drug use in the US reveals that state law enforcement agencies made more than 1.25 million arrests for drug possession in 2015, which translates into an arrest for drug possession every 25 seconds of each day.⁽⁵²⁾ The majority of these arrests result in incarceration. Indeed, 50% of males and 59% of females in federal prison were serving time for drug offences in September 2014,⁽⁵³⁾ and every year, nearly 200,000 people who are dependent on opioids enter the American criminal justice system.⁽⁵⁴⁾



The US's so-called “war on drugs” has had vastly unequal outcomes across racial groups, with Black and Latinx communities experiencing much higher arrest and incarceration rates.⁽⁵²⁾ For example, Black adults accounted for only 14% of people who used drugs in the country in 2014, but made up 37% of those arrested for drug possession, effectively making them nearly six times more likely to be arrested for drug possession than white adults.^(52, 55)

Although the incarceration rate is much lower in Canada, systemic discrimination and inequality have similarly resulted in Aboriginal and Black people being overrepresented in the country's prisons. Although they only make up 3.8% of the Canadian population, Indigenous people currently represent approximately 23% of the federal prison population⁽⁵⁶⁾ and are among those most targeted in the country's drug enforcement measures.⁽⁵⁷⁾ Similarly, Black people represent approximately 9.5% of the federal prison population while representing just 2.9% of the Canadian population as a whole, and Black women are most likely to be incarcerated for a drug-related offence, often committed as an attempt to address situations of poverty.⁽⁵⁸⁾

Similar to all other regions of the world, injecting drug use occurs in North American prisons. A recent study undertaken in Baltimore on the links between incarceration and injecting drug use found that not only did incarceration *not* curtail injecting drug use, but also that longer periods of incarceration were associated with increases in injecting among former injectors.⁽⁵⁹⁾ In Canada, 80% of men entering the Canadian federal system are thought to use drugs.⁽⁵⁸⁾ In 2012, it was reported that 34% of drug offenders had ever injected drugs, while injecting during incarceration was reported by 11% of the prison population in Canada.⁽⁶⁰⁾

HIV prevalence among prisoners in the United States is reportedly three times greater than the broader population, and one in every seven people living with HIV will be incarcerated every year.⁽⁶¹⁾ At the same time, 4.2% and roughly 33% of prisoners are living with TB and HCV respectively.^(62, 63) In Canada, the estimated HIV and HCV (17.2%) prevalence rate is respectively 10 and 30-40 times greater in prisons than it is outside of prisons.^(58, 64) These infections, like incarceration, are marked by significant racial and socio-economic disparities. In Canada, for example, incarcerated Indigenous people experience significantly higher rates of HIV and HCV than other prisoner groups.⁽⁶⁵⁾

Despite the clear necessity for harm reduction in prisons in the region, provision continues to be woefully

inadequate, falling far short of meeting both the needs of prisoners and international human rights and public health standards. Most critically, needle and syringe programmes remain completely unavailable in the region's prisons. Canadian civil society continues to apply pressure on federal and provincial governments to make this essential service immediately available to prisoners,^j including through a lawsuit against the federal government to compel it to implement prison-based needle and syringe programs.

With OST only available in a small number of American prisons (Riker's Island in New York, and a selection of prisons in Baltimore, Philadelphia and Rhode Island),⁽¹⁵⁾ coverage remains abysmally low. It is estimated that nearly 90% of those currently receiving OST outside of prisons would have their treatment cut off if they were incarcerated,⁽⁶⁶⁾ while the only people typically allowed to initiate OST in prison settings are pregnant women.⁽¹⁵⁾ The situation in Canada, although far from perfect, is considerably better. In all 43 of the country's federal prisons, where people serve a sentence of 2 years or more, OST initiation and maintenance are both available.⁽¹⁶⁾ At the provincial and territorial level, however, there are major gaps in availability and accessibility. Civil society reports that only ten provinces (out of 13 provinces and territories) permit OST continuation, while even fewer allow OST initiation in prisons.⁽¹⁶⁾ Prioritisation of candidates for prison-based OST is also reportedly problematic, with sentence length and release eligibility dates often arbitrarily used to determine who gains access first.⁽⁶⁷⁾ Prisoners in British Columbia launched a constitutional challenge in 2016, alleging that correctional policy prevented them from accessing OST if they were not in custody for at least three months. The policy has since been amended to ensure the provincial prison system follows the same guidelines for administering OST as the College of Physicians and Surgeons of BC, which does not require a waiting period in order to be eligible for OST.⁽¹⁶⁾ Regrettably, and as is often the fate of prison-based harm reduction services, the annual budget for OST in Canadian prisons was cut by just over 10% in 2014/15,⁽⁶⁷⁾ a retrogressive measure that could amount to a violation of the prisoners' right to health under international law.^k Canada's new federal government may revisit this decision as part of its drug policy reform, however.

HIV treatment and care are generally available in American prisons.⁽¹⁵⁾ A recent study found that although most detention facilities provide some degree of HIV testing, only 19% of prisons and 35% of jails provide routine opt-out testing consistent with national and

^j Latinx, pronounced 'La-teen-ex', is the gender-neutral alternative to Latino, Latina and even Latin@.

^k See, for example, Canada Can't Wait: The time for Prison-Based Needle and Syringe Programs is Now. Statement by nearly 250 organisations Canada-wide. 1 June 2016.

^k Under international human rights law, there is a strong presumption that retrogressive measures taken in relation to the right to health contradict the principle of progressive realisation and constitute a violation unless they have been duly justified and weighed against the enjoyment of other rights. See, Committee on Economic, Social and Cultural Rights, General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4, 11 August 2000, paras. 32 and 48.

international guidelines.¹ Routine mandatory HIV testing for all prisoners was reported by only 37% of prisons, in clear violation of prisoners' human rights.⁽⁶⁸⁾ Despite the importance of retaining people living with HIV in treatment, the study also found that less than one-quarter of prisons and jails provide comprehensive treatment services for prisoners living with HIV after their release.⁽⁶⁸⁾ A recent Human Rights Watch report identifies funding as a major barrier to implementing HIV interventions in American jails and prisons. According to the report, "(t)he federal government is the primary funding source for managing the HIV epidemic in all 50 states. The unavailability of this federal funding for prisoners significantly impacts the response to HIV in local correctional settings."⁽⁶⁹⁾

In Canada, HIV testing and treatment are available to individuals in federal, provincial and territorial prisons.⁽¹⁶⁾ Although 93% of all individuals living with HIV in federal prisons were on antiretroviral treatment in 2014-2015,⁽⁷⁰⁾ some harmful practices have still been reported, including treatment disruptions⁽¹⁶⁾ and stigma and discrimination.⁽⁷¹⁾ Earlier this year, a landmark outcome from a legal challenge concerning stigma and discrimination based on a prisoner's HIV status secured a number of positive outcomes, including a requirement to train prison staff on issues relating to people living with HIV or AIDS in prison and display notices on the rights of people living with HIV in all Ontario provincial prisons.⁽⁷¹⁾

While American prisons offer some HCV treatment, routine testing and treatment protocols are available in less than one-third of US prisons and jails.⁽⁷²⁾ A recent study evaluating the effects of HCV screening and testing in prisons found that implementing risk-based and opt-out screening could diagnose up to 122,700 new HCV cases in the next 30 years. Compared with no screening, this could avert up to 12,700 new HCV infections and prevent up to 11,700 liver-related deaths.⁽⁷³⁾ In Canada, systematic screening for HCV is available to prisoners in federal facilities, but unfortunately not in most provincial and territorial facilities.⁽⁷⁴⁾ HCV treatment is available in federal prisons, but prisoners have reported difficulties in accessing treatment, with data recently released by Correctional Service Canada revealing a sharp decline in the number of prisoners receiving HCV treatment because of budget cuts, increasing prison populations and substantial HCV treatment costs.⁽⁷⁵⁾ In many provincial and territorial prisons, HCV treatment is only available to those who were already undergoing treatment in the community.⁽⁷⁴⁾

Condoms are only available in prisons and jails in three American states, Vermont (since 1992), Mississippi (since 1992 and limited to married prisoners receiving conjugal visits) California (since 2014), as well as several cities.⁽⁷⁶⁾ In Canada, condoms are available in all federal prisons, but barriers to access have been reported, including as a result of inconsistent stocking or condom dispensers being located in areas visible to security staff.⁽¹⁶⁾

Finally, some positive developments in overdose prevention among prisoners have taken place in the region since the *Global State* last reported. Most recently, the naloxone programme for public health units in the Canadian province of Ontario was expanded to include prisoners returning to the broader community,⁽⁷⁷⁾ and the Canadian province of British Columbia has begun to provide overdose response training and naloxone kits to prisoners in provincial institutions upon discharge.⁽¹⁰³⁾ In the United States, the Harm Reduction Coalition has been involved in providing naloxone and overdose prevention training to prisoners and their family members in prisons and jails in San Francisco⁽⁷⁸⁾ and in the state of New York, including Rikers Island.⁽¹⁵⁾ In early 2015, a pilot training programme began at the Queensboro Correctional Facility in New York City. To date, more than 1,000 prisoners have been trained in opioid overdose recognition and response, with these now part of the facility's prisoner orientation. A refresher training is offered shortly before prisoners are released, along with the option to receive a naloxone kit free of charge upon release.⁽¹⁵⁾

Overdose

Contributing an estimated 25% of the world's drug-related deaths, North America continues to have the highest drug-related mortality rate in the world.⁽¹⁰⁾ 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.^(10, 79) Across the border in Canada, drug overdose deaths have jumped 327% since 2008.⁽⁸⁰⁾ In British Columbia and Alberta, two of the hardest-hit provinces, fatal overdoses linked to fentanyl soared from 42 in 2012 to 418 in 2015.⁽⁸¹⁾ Following 200 opioid-related deaths in the first three months of 2016, the province of British Columbia declared its first ever public health emergency.⁽⁸²⁾

This rise in fatal overdoses in the region is thought to be in large part driven by an explosion in prescription opioid dependence. North Americans are thought to consume about 80% of the world's prescription opioids,⁽⁸³⁾ and nearly 80% of current opioid users report

¹ Prisons and jails are different institutions in the United States. Prisons are operated by a state or the federal government and typically hold people with sentences of more than one year. Jails detain people who are accused of crimes and awaiting trial, as well as those convicted of a crime, with the median length estimated to be 48 hours, and generally not exceeding one year. Solomon L, Montague BT, Beckwith CG et al. (2014) 'Survey Finds that Many Prisons and Jails Have Room to Improve HIV testing and Coordination of Post Release Treatment.' *Health Affairs* 33(3):434-42.



that their first opioid was a prescription pain reliever.⁽⁸⁴⁾ Accessibility, cost, and high potency of heroin are reported to be driving the transition from prescription opioids to use of heroin.⁽⁸⁵⁾ This is taking place alongside the rise of illicitly produced fentanyl, a synthetic opioid 50 times stronger than heroin and 100 times more powerful than morphine. The result is that people looking to buy drugs similar to what they were using before, are getting fentanyl (or fentanyl-laced drugs) instead, which are far stronger than what they are used to and leading to a huge increase in fentanyl-related overdoses.⁽⁸⁶⁾

Several important developments have taken place in the region 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.⁽⁸⁷⁾ This represents an increase of 13 states since 2014. In 2015, the United States Food and Drug Administration approved nasal spray naloxone, which is thought to be easier to administer,⁽⁸⁸⁾ and as of June 2016, all but three states (Kansas, Montana, Wyoming) had passed legislation designed to improve access to naloxone.⁽⁸⁹⁾ Largely as a result of these legal and regulatory changes, over 150,000 people had received training and naloxone kits by the end of 2014, which has reportedly resulted in the reversal of more than 26,000 overdoses.⁽⁹⁰⁾ Additionally, as of May 2016, naloxone programmes for law enforcement had begun in at least one municipality in 35 states and, while naloxone is still not available 'over the counter', civil society report that it is now available in the corporate pharmacy chains CVS and Walgreens without needing a prescription from a doctor in 23 states.⁽¹⁵⁾

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.^(16, 19) In a further move to make naloxone more accessible, the health Minister officially authorised naloxone nasal spray for non-prescription use in October 2016.⁽⁹¹⁾ Until then, only injectable naloxone had been approved in the country. Some provinces and territories (7 out of 13) have already implemented community-based take-home naloxone programmes, while others have undertaken regulatory changes to allow use by first responders.^(16, 19) Despite these developments, access to naloxone still varies from province to province, with cost (particularly for the nasal spray) reported as one of the barriers.⁽⁹²⁾

In Ontario, however, all pharmacies are eligible to dispense naloxone emergency kits free-of-charge, significantly increasing their accessibility.⁽¹⁹⁾ Additionally, earlier this year a Good Samaritan Act was introduced as a private members' bill in Parliament.⁽⁹³⁾ An essential step in dealing with Canada's overdose crisis, this bill has received widespread support across the country and, as of September 2016, had passed the first two readings and was in the 'Report' stage.

Finally, both countries have been taking steps to respond to the increase of prescription opiate dependence. In the US, the Centers for Disease Control and Prevention (CDC) released guidelines for prescribing opioids for chronic pain in 2016, representing an important step for improving prescriber education and pain prescribing practices in the country.⁽⁸⁵⁾ In Canada, the College of Physicians and Surgeons in at least four provinces (British Columbia, Nova Scotia, New Brunswick, and Newfoundland) are proceeding with initiatives to rein in opioid prescribing, including incorporating some of the CDC's 2016 guidelines.⁽⁹⁴⁾

Policy development for harm reduction

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.⁽¹⁵⁾ At the UNGASS on drugs in April 2016, for example, it specifically urged Member States to scale-up their public health responses to drugs and adopt evidence-based interventions such as OST and NSPs.⁽⁹⁵⁾ At the national level, the 2015 National Drug Control Strategy,⁽²⁴⁾ as well as the most recent HIV/AIDS⁽⁹⁶⁾ and viral hepatitis⁽³⁶⁾ strategies explicitly support the provision of OST and NSPs. The government has also demonstrated a renewed commitment to key populations, evidenced by the new US\$100 million PEPFAR fund for key populations (see funding section) announced in June 2016.⁽⁹⁷⁾

One significant development in relation to NSPs has been the amendment to the longstanding federal funding ban on these programmes, signed by President Barack Obama on December 18, 2015. The Consolidated Appropriations Act, 2016, as the provision is formally known, still prohibits the use of federal funds to purchase sterile needs or syringes to inject illegal drugs, but now allows federal funds to be used to support other facets of NSPs, such as HIV and HCV testing, naloxone training and provision, human resources, syringe disposal, human resources and syringe disposal.⁽¹³⁻¹⁵⁾

The twin epidemics of opioid use and overdose have also been driving American public policy towards a public health and harm reduction approach. These issues were a key focus for the US at the 59th Session of the Commission on Narcotic Drugs, in March 2016, and again at the UNGASS on drugs the following month. Since the *Global State* last reported, 13 US states have enacted some sort of Good Samaritan laws to protect people from arrest or prosecution when calling in an overdose, bringing the total number up to 37 states.⁽⁸⁷⁾ As of June 2016, all but three states (Kansas, Montana, Wyoming) had passed legislation designed to improve access to naloxone,⁽⁸⁹⁾ which has already resulted in 26,000 overdose reversals.⁽⁹⁰⁾ Finally, 24 states now have some form of medicinal cannabis legislation, and regulated markets for recreational cannabis use now exist in Alaska, Colorado, Oregon, Washington and the District of Columbia (Washington, DC).⁽¹⁵⁾

Following years of ideological opposition to harm reduction, Canada's new federal government has been vocal in its support of harm reduction in both national and international forums, including at the 59th Session of the Commission on Narcotic Drugs in March 2016. In a speech at this session, Canada described harm reduction as critical and announced its support not only of evidence-based harm reduction measures such as NSPs, but also – in a complete policy shift from the previous regime – supervised injection sites, stating that it anticipated more would be operating in the future.⁽⁹⁸⁾ The following month, at the UNGASS on drugs in New York, Canada's federal Health Minister publicly embraced harm reduction as a key pillar of the response to drugs, acknowledged the need to protect human rights and, making headlines worldwide, announced Canada's plan to legalise cannabis in 2017.⁽⁹⁹⁾

Following years of legal challenges, the Canadian government officially overturned the ban on heroin-assisted therapy (HAT) in September 2016.⁽²²⁾ Under the new regulations, physicians can prescribe pharmaceutical-grade heroin to patients for whom it is clinically indicated, including individuals who have tried other approaches, such as methadone and buprenorphine, without success. In response to the opioid overdose epidemic, the government also removed naloxone from the prescription drug list,^(16, 19) which enables over-the-counter provision and dramatically increases accessibility, and authorised the provision of nasal-spray naloxone (see overdose section).⁽⁹¹⁾ Alongside these developments, a Good Samaritan bill was introduced in Parliament and is currently before the House of Commons.⁽⁹³⁾ The bill

would amend the Controlled Drugs and Substances Act to give immunity from prosecution for the offences of simple possession of a controlled substance to anyone who calls 911 to report an overdose.

Civil society and advocacy developments for harm reduction

Civil society continues to be very active in the region, playing a strong role in advocating for harm reduction both regionally and internationally, and making significant accomplishments in the last two years. The 2016 UNGASS on drugs held in New York in April provided an unprecedented opportunity for regional civil society organisations to mobilise on drug policy reform, both at the national and international levels.⁽¹⁵⁾ In the US, the revival of the New York NGO Committee on drugs (NYNGOC) in preparation for the UNGASS was a major achievement for civil society engagement on drug policy issues and was instrumental in bringing a large number of geographically diverse organisations together.⁽¹⁵⁾ In terms of important policy development, the Harm Reduction Coalition worked closely with Congress and the Obama Administration to revise the longstanding federal funding ban for NSPs in the country.

In Canada, the new federal government's explicit support for harm reduction at the national level and in international forums are due in part to the campaign and advocacy efforts of civil society, many of whom have had the opportunity to meet with the Health Minister and her office to advocate for harm reduction in Canada and globally.⁽¹⁶⁾ In 2015, a national Working Group on Best Practice for Harm Reduction Programs in Canada, made up of people who use drugs, service providers, policy makers and researchers, produced the *Best Practice Recommendations for Canadian Harm Reduction Programs that Provide Service to People Who Use Drugs and are at Risk for HIV, HCV, and Other Harms: Part 2*, to help NSPs and other harm reduction programmes across the country improve service delivery to people who use drugs.⁽⁵⁰⁾

Given that harm reduction and drug policy advocacy and services were so under-resourced under the previous Canadian federal government, civil society has identified funding as a major advocacy priority in the coming years.^(16, 19) At the same time, urging the federal government to explicitly refer to 'harm reduction' as one of the key pillars of a new national drug policy will be another principal advocacy objective.⁽¹⁶⁾



Funding developments for harm reduction

One of the most important funding developments in the region since 2014 has been the modification to the federal funding ban on NSPs signed by the President on 18 December 2016. The revised policy still prohibits the use of federal funds to purchase sterile needles and syringes to inject illegal drugs, but makes allowances for these funds to be used to contribute to NSPs in other ways based on evidence of a demonstrated need by the state or local health department, and in consultation with the CDC.⁽¹³⁾ The change in the funding ban has allowed for new federal funding options and small programmes are being pushed to collaborate or merge with larger organisations to deliver broader health care services.⁽¹⁵⁾

Another noteworthy funding development in the United States was the PEPFAR announcement at the UN High Level Meeting on ending AIDS held in New York in June 2016, about the creation of a US\$100 million Key Populations Investment Fund. The Fund, which demonstrates the country's renewed commitment to key populations, will work to address the complex dynamics driving stigma and discrimination in order to expand access to evidence-based HIV prevention and treatment services for key populations.⁽⁹⁷⁾

Canada's National Anti-Drugs Strategy, a hangover from the previous federal government, was allocated CA\$515.9 million for 2012-2017.⁽¹⁰⁰⁾ With harm reduction entirely absent from this Strategy, however, funds could not be allocated for this purpose, and the majority (between 40%⁽¹⁰⁰⁾ and 70%⁽¹⁰¹⁾) has been spent on enforcement. Thankfully, this Strategy expires in March 2017 and it is hoped that funding allocations will be revised going forward. Meanwhile, with health care being a provincial mandate, harm reduction services are typically funded by provincial and territorial governments.⁽¹⁶⁾ For example, the Ontario Harm Reduction Distribution Program, which is funded by the province of Ontario's Hepatitis C Secretariat, Ministry of Health and Long-term Care, provides harm reduction supplies and other resources to needle and syringe programs across Ontario.⁽¹⁰²⁾ But while provincial and territorial governments are responsible for health care in their respective jurisdictions, the federal government holds responsibility for ensuring the availability of health services for specific populations, including Indigenous people and people incarcerated in federal prisons.⁽⁷⁰⁾ Considering these two populations are currently both the most in need of harm reduction services and less

likely to access them, the federal government should urgently devote more resources, including funding, to ensure that these key populations' fundamental rights are being fulfilled.

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Regional Overview




2.7 Oceania





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	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 ^b 	OST ^c 	DCR ^a 
Australia	93,000 (67,800-118,200) ^{(1)d}	1.7% ⁽²⁾	54 ⁽²⁾	4 ⁽²⁾	✓3,000+	✓2,589 ⁽³⁾ (B, M)	✓1 ⁽⁴⁾
Fiji	nk	nk	nk	nk	✗	✗	✗
New Zealand	12,840 ⁽⁵⁾	0.2% ⁽⁶⁾	50 ^{(7)e}	nk	✓192+	✓	✗
Papua New Guinea	nk	nk	nk	nk	✗	✗	✗
Samoa	nk	nk	nk	nk	✗	✗	✗
Timor Leste	53 ⁽⁸⁾	nk	nk	nk	✗	✗	✗

nk = not known

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

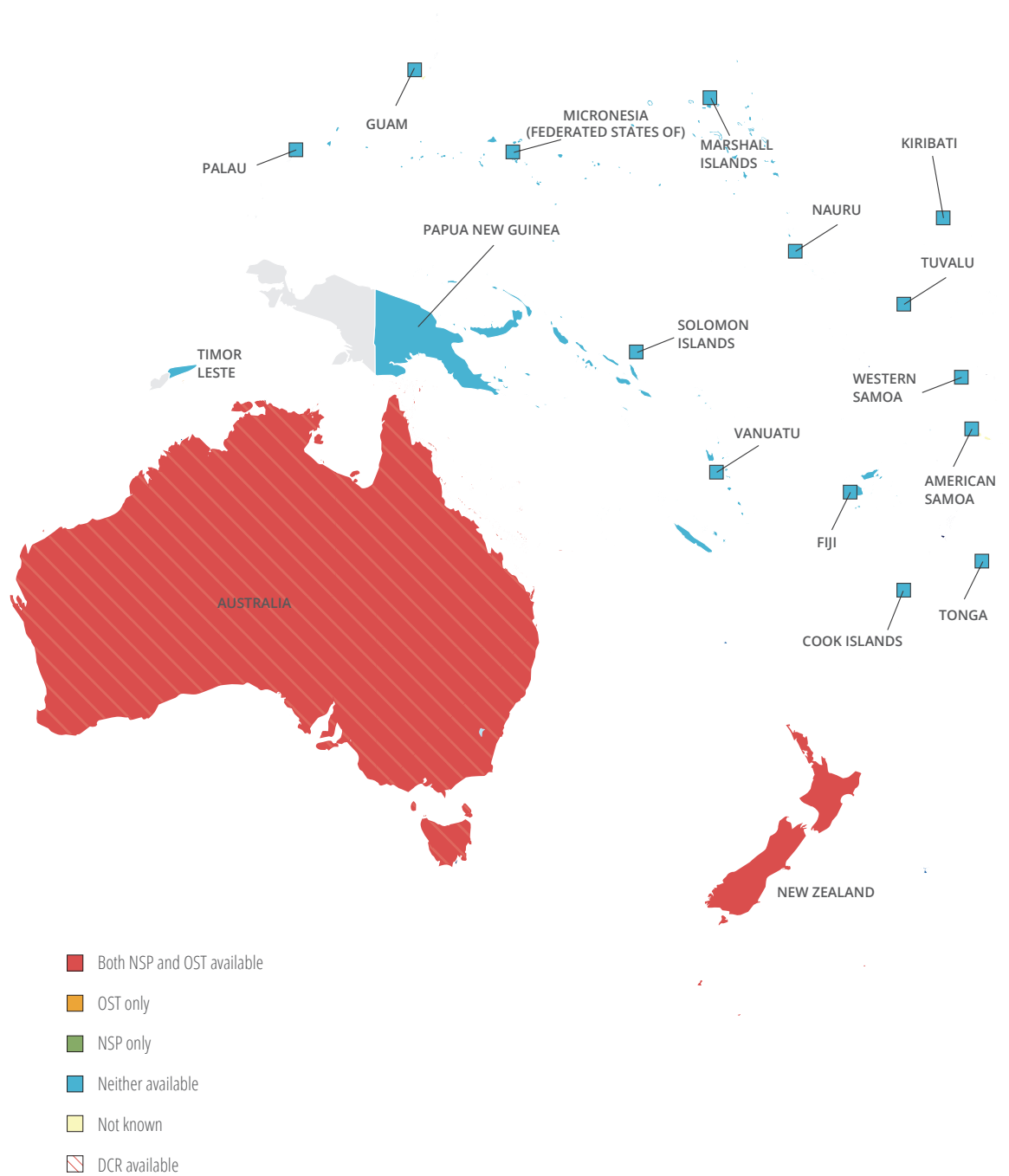
^b This includes all operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers.

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

^d Civil society believe this figure to be an underestimate as there is no distinction given between regular, frequent and occasional people who inject drugs.

^e The updated figure from the World Drug Report notes this has increased to 57%, however due to the sample size (n=700) figures have been taken from 2014 report.

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





Harm reduction in Oceania

Overview

The regional prevalence of injecting drug use in Oceania is limited to data from Australia, New Zealand and Timor Leste (please see Table 2.7.1). Since the 2014 edition of the *Global State*, there has been little new research into drug use or drug related harms undertaken in the Pacific Island countries and territories (PICTs).^f This remains a concern due to the reporting of injecting drug use, and the lack of harm reduction programmes in this region.⁽⁴⁾ Injecting drug use is not thought to be common within the PICTs,⁽⁹⁾ yet there appears to be a marked increase in the use of amphetamine-type stimulants (ATS).⁽⁹⁾ The most recent UNAIDS report to emerge from Fiji states only one case of HIV infection occurred through injecting drug use in 2014.⁽¹⁰⁾

Approximately 105,893 people inject drugs in Australia, New Zealand and Timor Leste combined. The use of heroin reportedly declined in Australia between 2010–2013.⁽¹¹⁾ However, there has been a small increase in HIV prevalence among people who inject drugs from 1.2% in 2014,⁽¹²⁾ to 1.7% in 2015.⁽¹³⁾ Although harm reduction initiatives have been well-established in Australia, there are still reportedly significant disparities in service provision among Indigenous Australians.⁽²⁾ Injecting drug use is less prevalent than other drug use among this population, yet there is a high incidence of unsafe injecting practices,⁽¹⁴⁾ and higher rates of HIV infection associated with injecting drug use.⁽¹⁵⁾

In both New Zealand and Australia severe side effects and low success rates of hepatitis C treatment had previously formed a significant barrier for people who inject and/or use drugs. Yet the availability of a free hepatitis C treatment using direct-acting antivirals in Australia since February/March 2016 has seen a rapid increase in the numbers of people seeking treatment.⁽¹⁶⁾ In New Zealand, uptake of testing and treatment for hepatitis C among people who use drugs remains extremely low, and there is an urgent need to amend the way hepatitis C is diagnosed and treated in the country.⁽¹⁷⁾

The rise of stimulant use in Australia

Stimulant use, although increasing in Australia, is estimated to have remained relatively stable in New Zealand, with approximately 26,000 people reporting use of amphetamine-type stimulants (ATS) in the past year.⁽¹⁸⁾ In Australia, however, findings from the Kirby Institute show a marked rise in methamphetamine use between 2010 and 2014, with methamphetamine reported as the last drug injected by one-third of respondents in the Australian Needle and Syringe Program Survey (ANSPS) in 2014.⁽¹³⁾ 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.⁽¹⁹⁾ National data indicate that methamphetamine injection has increased significantly from 27% in 2011, to 36% in 2014, overtaking heroin as the most commonly injected drug in the country.⁽²⁰⁾ In 2015, it continued to be the most commonly injected drug in the majority of jurisdictions, including New South Wales (32%), Queensland (34%), South Australia (53%), Tasmania (42%), and Western Australia (45%).⁽²⁰⁾ Crystal methamphetamine is also believed to be one of the most commonly injected drugs among gay and bisexual men living in Sydney.⁽²¹⁾

Not only does there appear to be a rise in the use of ATS and, in particular, an increase in crystal methamphetamine injecting in Australia, but there is also a rise in polydrug use.⁽²²⁾ This calls for an adapted harm reduction approach, as opioid substitution therapy (OST) is only indicated as a treatment for opioid drug use.⁽²³⁾ In response to the growth of ATS use, the politically conservative Australian government commissioned a report on ‘ice’.⁽¹⁹⁾ Although the report recommends a move away from law enforcement to local area focused health responses to ice use, it fails to mention harm reduction,⁽⁴⁾ which came as a profound disappointment to some civil society groups.^(4, 24)

At present there is little solid evidence relating to pharmacological treatment for amphetamine use.⁽²⁵⁾ However, harm reduction for people who use amphetamines follows the same fundamental principles as harm reduction for people who use opioids.⁽²⁵⁾

^f 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.

Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

It is estimated that approximately 10,000 people make use of NSP services in New Zealand, with 3 million new needles distributed each year.⁽⁶⁾ NSPs operate via 21 primary sites and approximately 170 pharmacies providing needles and syringes. These high coverage rates make HIV rates among people who inject drugs remain consistently low. In Australia, NSPs have been in place for many years and there are over 3,000 NSP outlets in operation, including mobile outreach services and vending machines.⁽⁴⁾

A scientific paper from Australia published in 2009 argued that sterile injecting equipment was limited by supply rather than demand, and estimated that needle and syringe distribution needed to double in order to reduce the annual incidence of hepatitis C virus infections in particular.⁽²⁶⁾ In response to this paper, the New South Wales Ministry of Health removed limits to the amount of equipment supplied when visiting a service, and people who inject drugs in this state can now access as many syringes as they require.^(27, 28) A further development in NSPs in Australia has been the ability of peers to legally provide injecting equipment in the Australian Capital Territory, Tasmania, the Northern Territory, and New South Wales.^(4, 28) Although there have been improvements in policy relating to NSPs, the ANSPS found that the prevalence of people re-using needles and syringes (including reuse of one's own syringes) in ranged from 21-25% between 2011 and 2015,⁽²⁰⁾ indicating the need to undertake more focused efforts to reduce this practice.⁽²⁸⁾

As previously noted in past editions of the *Global State*, there is a disparity of service provision among indigenous communities and indigenous people who inject drugs continue to be underrepresented in NSP services.⁽⁴⁾ Findings from the ANSPS show that the number of people from an Indigenous background accessing NSPs is increasing, from 5% in 1995, to 14% in 2014.⁽¹³⁾ However, between 2010 and 2014, 16% of all HIV diagnoses among Aboriginal and Torres Strait Islander people is attributed to unsafe injecting drug use, highlighting the urgent need for targeted harm reduction responses for these populations.⁽²⁾

While NSPs continue to operate across the country in many jurisdictions in Australia, some barriers to access remain, including limited after-hours service availability,

geographic access and stigma and discrimination experienced by some people who inject drugs when accessing harm reduction services.⁽²⁰⁾

Opioid substitution therapy (OST)

In 2015, there were 2,589 outlets providing OST in Australia covering 48,522 clients. OST provision has seen an increase of 564 sites in Australia since the *Global State* reported in 2014,⁽²⁹⁾ while the number of people receiving OST nationally has nearly doubled - from 1.3 to 2.1 per 1,000 population - since 1998.⁽³⁰⁾ The vast majority (88%) of OST in Australia is dispensed from pharmacies.⁽²⁹⁾ The ratio of clients per OST prescriber, however, decreased from 23 in 2013,⁽³¹⁾ to 19 in 2015.⁽²⁹⁾ Although there has been a scaling-up of OST provision in the country, the cost continues to be extremely prohibitive for people who use opioids, and has yet to be addressed. While the drug is provided free, dispensing fees are charged by participating pharmacies, meaning people who receive doses are charged between AU\$7 and AU\$10 every day.⁽⁴⁾ Similarly to NSP provision, Indigenous people continue to be underrepresented in OST services.⁽³⁾

In New Zealand, current levels of OST provision are unclear, but in 2009 it was estimated that approximately 4,600 people were receiving OST, predominantly in the form of methadone.⁽³²⁾ One of the main barriers to OST uptake is the banning of OST for those who are found to be continuing to use illicit drugs. Urine analysis is commonplace, with people removed from OST treatment if their urine is found to contain illicit drugs.⁽³³⁾ There can also be up to a six-month wait in New Zealand to accessing OST services.⁽³³⁾ However, civil society report that OST is now available through NGO services.⁽¹⁷⁾

Viral hepatitis

Historically, Australia has one of the best examples of harm reduction globally, however, the prevalence of antibodies to hepatitis C virus among people who inject drugs only declined from 60% in 1995 to 53/54% in all years between 2010-2014.⁽¹³⁾ This highlights the need for greater accessibility of hepatitis C treatment for people who use drugs, as well as better coverage of NSPs and other prevention services. High prevalences of lifetime hepatitis C diagnostic screening, ranging from 83% to 88%, were illustrated in a recent study with just over half (54%) of respondents having had a hepatitis C test in the previous 12 months in 2015.⁽²⁰⁾

In March 2016, the Australian government made direct-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.⁽³⁴⁾ The availability of these new treatments through the Pharmaceutical Benefits Scheme (PBS) is a significant positive step forwards, and is seen as a potential means to substantially reduce the growing burden of disease and interrupt ongoing transmission.⁽⁴⁾

Findings from a report published in September 2016 indicate that since the new treatments became available in March 2016, an estimated 26,360 people initiated treatment, compared with 7,296 in 2015.⁽¹⁶⁾ However, it is not known what proportion of those accessing these treatments are current or former people who inject drugs.

In New Zealand, the provision for hepatitis C testing and treatment for people who inject drugs remains extremely low. It is clear from the steady rate of hepatitis C among people who inject drugs in the country that an urgent change in treatment provision is necessary.

Tuberculosis (TB)

Tuberculosis (TB) continues to remain extremely low in both Australia and New Zealand, with six cases per 100,000 people in Australia⁽³⁵⁾ and seven cases per 100,000 people in New Zealand.⁽³⁵⁾

Although TB is covered to some extent in harm reduction policies in New Zealand, there is no evidence to suggest it is increasing among people who inject drugs.⁽³³⁾ 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.

Antiretroviral therapy (ART)

The prevalence of HIV among people who inject drugs in Australia and New Zealand has remained consistently low (please see Table 2.7.1). However, the proportion of Aboriginal Australians who have acquired HIV through unsafe injecting drug use is 13% higher than among non-Aboriginal people exposed to HIV through injecting drug use.⁽²⁾ Self-testing HIV screening kits are being increasingly used in Australia,⁽³⁶⁾ although more likely among men who have sex with men than among people who inject drugs. While access to HIV testing and treatment is available in the PICTs, it is unclear how many people who inject/use drugs receive treatment.

Harm reduction in prisons

Apart from Australia, data on harm reduction in prisons in the region continues to be scarce. In Australia, drug

offences currently represent the second most common criminal offence, with a 17% increase in sentences for drug offences registered in 2015 alone.⁽³⁷⁾ As a result, people who inject drugs comprise a large proportion of the country's prison population (approximately 50% in 2011)⁽³⁸⁾ and injecting drug use continues to take place in prison settings. A recent study on the prison economy of needles and syringes in New South Wales found that out of 30 prisoners from 12 different prisons, six reported injecting at a frequency of less than monthly, three more frequently than monthly, three more than weekly, three daily and five more than daily.⁽³⁹⁾ The most commonly injected drug is amphetamine, with the most recent national prison entrants' survey showing 59% of prisoners reporting it as the last drug injected.⁽⁴⁰⁾

The region of Australasia⁸ has been identified as having the second highest prevalence of HCV in prisons in the world after Asia.⁽⁴¹⁾ In Australian prisons, HCV prevalence has been found to be up to 38%⁽⁴²⁾ whereas HIV prevalence continues to be almost zero.⁽³⁸⁾ While there is very little data on the PICTs, a study undertaken in Fiji looking at a sample of prisoners post-release found that HIV prevalence was 1%, similar to that of the general population.⁽⁴³⁾ Although none of the participants involved in the study reported ever injecting drugs, one-third did not use condoms with casual sex partners, stating that this was due to a lack of availability.⁽⁴³⁾ Condom provision is also reportedly inadequate in prisons in Australia and New Zealand, with varying availability depending on the prison.^(4, 33)

OST, antiretroviral therapy, as well as diagnostics and treatment for HIV, HCV and TB, however, are reported to be available to prisoners in both countries.^(4, 33)

In Australia, OST can be initiated during incarceration if clinically directed, but measures are also in place to ensure continuity of OST for prisoners who were prescribed it prior to incarceration. While there is no data on coverage of OST in prisons at the national level, in the state of New South Wales, which houses one-third of the country's prisoners, coverage has been estimated at 43%.⁽⁴⁴⁾

NSPs are still not available in prisons in New Zealand and Australia, despite high rates of HCV and unsafe injecting reported in the latter.⁽⁴⁾ In Australia, a recent study found that prisoners were paying AU\$100-AU\$150 on average, and up to AU\$350, for one sterile needle/syringe, demonstrating the inherent value of sterile injecting equipment in prisons.⁽³⁹⁾ The study also found that there were far more blood-borne virus risks related to the informal prison needle/syringe economy than there were opportunities to mitigate these risks, and

⁸ Australasia, a region of Oceania, is comprised of Australia, New Zealand, the Island of New Guinea and the neighbouring islands in the Pacific Ocean.

concluded that provision of NSPs would greatly reduce the risk of disease transmission, as well as violence between inmates.⁽³⁹⁾ Although the ACT government has committed to an NSP trial at the Alexander Maconochie Centre (AMC) in Canberra, Australia, it continues to meet with fervent opposition from the Community and Public Sector Union (CPSU). Following years of deadlock on this issue, an NSP Working Group was appointed in 2015 and tasked with developing a prison NSP model that could be safely and effectively implemented in the prison.⁽⁴⁵⁾ Unfortunately, the prisons officers union recently rejected the proposed model by majority vote,⁽⁴⁵⁾ and now a new model will be developed and voted on.

Overdose

In Australia, deaths due to accidental overdose grew by 61% between 2004 and 2014, with a 14% rise between 2013 and 2014 alone.⁽⁴⁶⁾ Aboriginal people have been particularly affected by this epidemic, with accidental fatal drug overdoses per capita among this population increasing by 141% between 2004 and 2014 (from 3.9 to 9.4 per 100,000) in the five jurisdictions with Aboriginal data.⁽⁴⁶⁾ In the same time period, an increase of 45% was recorded among non-Aboriginal people.⁽⁴⁶⁾

In 2014, the *Global State* reported the implementation of pilot naloxone programmes for people who use drugs in four states (Australian Capital Territory, Western Australia, Victoria, and New South Wales), with evaluations showing a high degree of success.⁽⁴⁷⁾ Since these pilots, naloxone has been co-scheduled by the Therapeutic Goods Administration (TGA) as a Schedule 3 and 4 drug, meaning it can be accessed without a prescription from a pharmacist, and the introduction of take-home naloxone has occurred in numerous jurisdictions in the country.^(4, 28) Many of the programmes introduced receive government support, however, they are very small scale and there has been little broader uptake by general practitioners and other medical professionals.⁽⁴⁾ An on-going issue, despite the scheduling amendments to naloxone, is the necessity for a prescribing doctor or pharmacist to be involved, especially if clients on health care cards are to receive the drug at cost. Naloxone is available for purchase at a pharmacy but may cost upwards of AU\$40 for a single dose, although for those on a health care card and with a doctor's prescription, the cost is approximately AU\$6.⁽⁴⁾

Australia has a medically supervised injecting centre (also known as a DCR – please see Table 2.7.1), which provides sterile injecting equipment alongside a range of additional services for people who inject drugs. This

service has been found to significantly reduce calls to ambulance-attended opioid-related overdoses in the small area of Sydney where it is located.⁽⁴⁸⁾ However, demands for additional supervised injecting facilities and the introduction of inhalation as an additional route of administration within DCRs have been met with limited to little or no support from the government.⁽⁴⁾

In New Zealand, no overdose prevention programmes exist in the form of naloxone distribution among peers. However, civil society report that this is being discussed as an initiative.⁽¹⁷⁾ At present, overdose is handled through drug helplines and emergency services.⁽³³⁾ In the PICTs, information on overdose and prevention is unknown.

Policy development for harm reduction

Harm reduction has been a key pillar of successive Australian National Drug Strategies for over 20 years. Harm reduction is mentioned within various national policies and strategies including: the Seventh National HIV Strategy 2014-2017;⁽⁴⁹⁾ the Fourth National Hepatitis C Strategy 2014-2017;⁽⁵⁰⁾ the Second National Hepatitis B Strategy 2014-2017;⁽⁵¹⁾ the Fourth National Aboriginal and Torres Strait Islander Blood-Borne Viruses and Sexually Transmissible Infections Strategy 2014-2017;⁽⁵²⁾ and the National Drug Strategy 2010-2015.⁽⁵³⁾ However, it has been observed that Australia's political commitment to harm reduction is waning.^(4, 54) Australia made no reference to harm reduction in their statements at both the United Nations General Assembly Special Session (UNGASS) on drugs or the Commission on Narcotic Drugs (CND) meetings held in April 2016 and March 2016 respectively. New Zealand, however, did endorse harm reduction during their UNGASS statement. Despite previously being a world leader in harm reduction, civil society groups now lament the lack of progress and regression in Australian drug policy.⁽⁴⁾

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. In September 2014 the Alcohol and Other Drugs (AOD) Peaks Network was formed, providing a conduit for access to services in all jurisdictions of Australia, including harm reduction services.⁽⁵⁵⁾ Unharm was established in New South



Wales in 2014 to promote safe environments at parties where drugs may be used, and to promote realistic and positive alternatives to the stigmatisation of illicit drug use.⁽⁵⁶⁾ Drug Policy Australia was also established in 2014, to promote new approaches to minimise the health risks and other harms associated with both licit and illicit drugs in the country.⁽⁵⁷⁾

Harm Reduction Australia was set up in late 2015 to represent the concerns of people working in the drug sector or concerned about drug policy in Australia. Harm Reduction Australia focuses solely on advocacy and is self-funded by members.⁽⁴⁾ A National Naloxone Reference Group was established to provide structure and mode of delivery to existing naloxone programmes, map successes in implementation, look into the issues and challenges in implementation, evaluate the programmes, explore opportunities for expansion and engage professionals and community members.⁽⁵⁸⁾

The work of peer-based organisations continues in most jurisdictions, yet too often their funding is under pressure from government budgets that struggle to meet the demand of the sector.⁽⁴⁾ The Australian Injecting and Illicit Drug Users League (AIVL), has played an integral role in ensuring that harm reduction and policy reform issues are heard through their involvement on government committees.⁽⁴⁷⁾ In 2015, AIVL successfully retained its funding after funding threats and continues to conduct research and programming on stigma and discrimination towards people who use drugs.⁽⁵⁹⁾

In 2005, the Pacific Drug and Alcohol Research Network was established and met regularly since its inception, but ceased to operate in 2011.^(9,4) Further research is needed for the development and provision of harm reduction services in the PICTs as the evidence base

for these services has not yet been established. Currently many countries in the PICTs send people to New Zealand or Australia for drug and alcohol harm reduction interventions,⁽⁹⁾ which is an infeasible long-term option that highlights the necessity for further work to be undertaken in this part of the region.

In New Zealand, civil society organisations provide the majority of advocacy activities for people who inject drugs.⁽³³⁾ Two primary organisations in the country are the New Zealand Needle Exchange Program, and the New Zealand Drug Foundation.⁽¹⁷⁾ In the PICTs, although there is a Pacific Drugs and Alcohol Research Network (PDARN), the last meeting was held in August 2011. There has been a small increase in research in these territories, but further data gathering and advocacy should be undertaken regarding harm reduction approaches to drug use, particularly with the increase in ATS.

Funding developments for harm reduction

Financial support for harm reduction in Australia has predominantly been provided by the government. However, funding for harm reduction remains at low levels, estimated to be as low as 2%, when compared to law enforcement, and treatment and prevention of drug budgets.⁽⁴⁾ Funding for harm reduction has not increased over the years, despite the rise in injecting drug use among people who use ATS, and it is likely to be proportionally lower in the future.⁽⁴⁾

In New Zealand, harm reduction activities are government funded, yet similarly to Australia, funding is limited and more is required to scale-up services.⁽¹⁷⁾

Australian government spend on drugs⁽⁶⁰⁾

Policy domain	AU\$ million	Percentage
Prevention	156.8	9.2%
Treatment	361.8	21.3%
Harm Reduction	36.1	2.1%
Law Enforcement	1123.3	66%
Other	23.1	1.4%
TOTAL	1,701.1	100%

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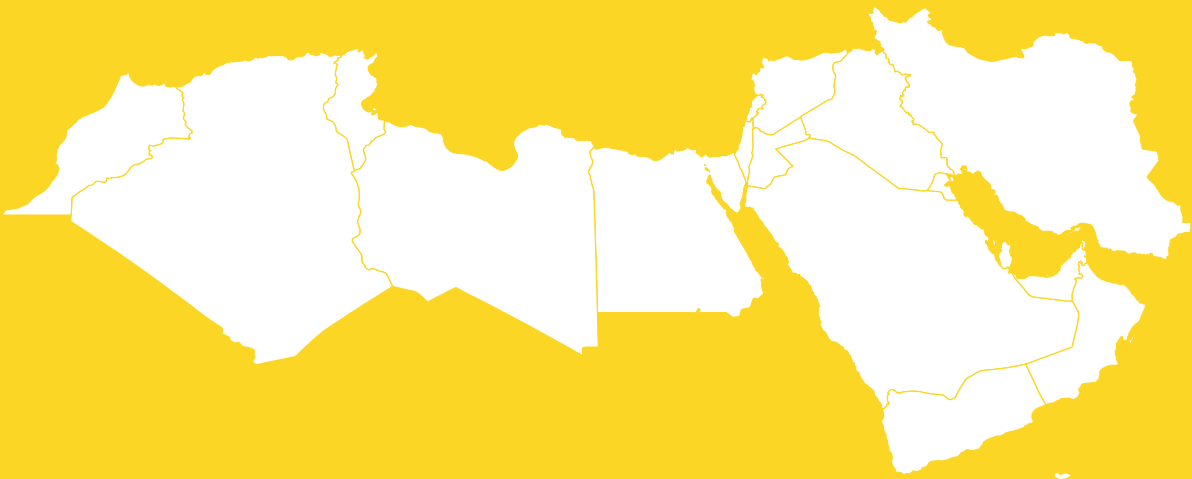
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Regional Overview



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 responses 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 (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction response	
					NSP ^a 	OST ^b 
Algeria	nk	nk	nk	nk	✗	✗
Bahrain	nk	55.8 ^{(1)c}	nk	nk	✗	✗(M) ^d
Egypt	31,000 ^{(2)e}	6.5–6.8 ⁽³⁾	49.4 (35.8–63) ⁽⁴⁾	13.5 (10.9–16) ⁽⁴⁾	✓9 ⁽⁵⁾	✗
Iran	200,000 ⁽⁶⁾	13.8 ^(6, 7)	50.2 (34.5–65.9) ⁽⁴⁾	17.3 (3.7–30.9) ⁽⁴⁾	✓580 ^{(6)f}	✓75,983 (M, B, O) ⁽⁶⁾
Iraq	34,673 ^{(8)g}	nk	nk	nk	✗(P)	✗
Israel	nk	nk	67.6 ⁽⁴⁾	2.8 ⁽⁴⁾	✓5 ^{(9)h}	✓(B, M)
Jordan	nk	6 ⁽¹⁰⁾	nk	nk	✓2 ⁽⁵⁾ⁱ	✗
Kuwait	nk	0 ⁽¹¹⁾	54 ^{(11)j}	nk	✗	✗
Lebanon	3,114 ⁽¹²⁾	1 ⁽¹³⁾	52.8 ⁽¹⁴⁾	nk	✓2 ^{(5)k}	✓ ^l
Libya	7,206 ^{(8)m}	87 ⁽¹⁵⁾ⁿ	94 ⁽¹⁵⁾	5 ⁽¹⁵⁾	✗	✗
Morocco	18,500 ⁽¹⁶⁾	11.4 ⁽¹⁷⁾	57 ⁽¹⁸⁾	nk	✓4 ⁽¹⁹⁾	✓6 ⁽¹⁹⁾
Oman	nk	3.8 ^{(20)o}	nk	nk	✗	✗
Palestine	nk	0 ⁽³⁾	nk	nk	1 ⁽²¹⁾	✗
Qatar	nk	nk	nk	nk	✗	✗
Saudi Arabia	10,000 ⁽²²⁾	3.5 ^{(23)p}	49.8 (14.1–85.4) ⁽⁴⁾	49.8 (14.1–85.4) ⁽⁴⁾	✗	✗
Syria	10,000 ⁽²²⁾	nk	60.5 ⁽⁴⁾	60.5 ⁽⁴⁾	✗	✗
Tunisia	9,000 ⁽¹⁷⁾	3 ⁽¹⁷⁾	nk	nk	✓3 ⁽²⁴⁾	✗
United Arab Emirates (UAE)	nk	nk	nk	nk	✗	✗ ^{(25)q}
Yemen	nk	nk	nk	nk	✗	✗

nk = not known

^a All operational needle and syringe exchange programme (NSP) sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = pharmacy availability.

^b Opioid substitution therapy (OST), including methadone (M), buprenorphine (B) and any other form (O) such as morphine and codeine.

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

^d Although methadone is available for people who inject drugs in Bahrain, it is for detox purposes only.

^e Sub-national data based on greater Cairo (30,000) and Menia (1,000). At the time of reporting there was no national estimate for Egypt.

^f 580 refers to free state welfare organisation NSP provision and does not include needles and syringes that can be purchased at pharmacies.

^g Figure based on a literature review between 1998 and 2005.

^h Figure relates to the number of cities that operate NSPs in Israel, rather than the number of sites.

ⁱ Figure relates to the two known organisations providing NSPs in Jordan, rather than the number of sites.

^j Figure based on a sub-sample of 98 people who inject drugs in a treatment centre.

^k Figure relates to the two known organisations providing NSPs in Lebanon, rather than the number of sites.

^l OST available only in the private sector.

^m Figure based on a literature review between 1998 and 2005.

ⁿ Figure based on sub-national data from Tripoli and Benghazi.

^o Figure based on facility-based mandatory testing and not on representative bio-behavioural surveys.

^p 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.

^q Although OST is available for people who inject drugs in UAE, it is for detox purposes only and only available at the National Rehabilitation Centre in Abu Dhabi.

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



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



Harm reduction in Middle East and North Africa

Overview

People who inject drugs, men who have sex with men, and female sex workers remain the most affected groups in terms of HIV, hepatitis C and hepatitis B in the Middle East and North Africa (MENA) region.⁽¹⁷⁾ Newly identified HIV infections have increased in MENA by 31% since 2001.⁽²⁶⁾ From an estimated 240,000 (150,000–320,000) people living with HIV, 57% of all new adult infections are among people who inject drugs.⁽²⁷⁾

Within MENA, the number of people who inject drugs ranges between 299,000 and 1,128,000,⁽²⁸⁾ the wide range highlighting the uncertainty around current estimates of population size. In most countries, population size estimates are infrequently updated and there is a lack of bio-behavioural data. Instead, there is an over-reliance on HIV case reporting and detoxification-facility-based surveillance on HIV, viral hepatitis and tuberculosis (TB) among this group.⁽²⁹⁾

New data on injecting drug use have emerged in some countries. The UNODC conducted a population size estimate of key populations in Egypt in 2014,⁽³⁰⁾ and the Middle East and North Africa Harm Reduction Association (MENAHRRA) collaborated with the National AIDS Program in Lebanon to undertake a size estimation, risk behaviour assessment and disease prevalence study among people who inject drugs.⁽¹²⁾

Iran remains the only country in the region to have consistently scaled up harm reduction services. However, coverage levels of NSP provision are still considered low by UN standards. Morocco, the second country in the region to implement a nationwide harm reduction strategy after Iran,⁽³¹⁾ has seen a steady increase in the number of people who use drugs in the north of the country over the last two decades.⁽¹⁹⁾ Harm reduction services have not yet been sufficiently scaled up to meet the increasing need.⁽⁵⁾

In Saudi Arabia, although harm reduction services are not yet in existence, the National AIDS Program is working on implementing a project to improve access to services for people who use drugs.⁽³²⁾ However, it is unclear whether any of these services will include NSP or OST. At present, services for people who use drugs consist only of rehabilitation centres, an approach not recommended as a first line of treatment for people who use/inject opioids.⁽³³⁾

There have been some indications of harm reduction implementation progress in the region since *Global State 2014*. The United Nations Office on Drugs and Crime (UNODC) has convened a National Opioid Substitution Therapy Taskforce in Egypt, commissioning a feasibility study to select, approve and procure the most appropriate controlled substances for piloting OST. At the time of reporting, the pilot programme was pending government approval.⁽³⁴⁾ Three organisations in Egypt have also been provided with funds through MENAHRRA to implement NSP outreach.⁽³⁵⁾ Jordan had planned to scale up NSP outreach. However, harm reduction activities in Jordan during 2015 slowed down considerably due to governmental restrictions on external funding to NGOs, with money released only in the summer of 2016.⁽⁵⁾

The most common response to drug use in the region is detoxification and rehabilitation, requiring the involvement of psychiatrists and physicians. Drug-related services in over half of the MENA countries are all abstinence-based, with no availability of evidence-based harm reduction initiatives such as the implementation of NSP and OST.⁽³⁶⁾ Punitive responses to drug use are among the most extreme seen globally. Of the 549 reported executions for drug offences carried out around the world in 2013, the majority were in Iran and Saudi Arabia.⁽³⁷⁾ Iran executed 367 people for drug-related offences in 2014; however, this number is likely to be an underestimate.⁽³⁷⁾

While there is no evidence to suggest that the death penalty for drugs serves as a deterrent to drug offences, the extremely punitive environment certainly hampers the extent to which harm reduction services can be delivered. Civil society reports that many people are often frightened to approach harm reduction services as they have experienced high levels of stigma, including frequent episodes of verbal and physical abuse by wider society and law enforcement figures, and a refusal of housing and employment as a result of being identified as someone who uses drugs.⁽⁵⁾

Few harm reduction services are tailored for women,⁽³⁸⁾ and further attention is required to ensure an appropriate response in the region to the health and social needs of women who inject drugs.⁽³⁹⁾ A regional capacity-building workshop on gender equality in harm reduction services was held in September 2015 by the Harm Reduction Consortium, comprising seven of the

leading international and regional harm reduction, drug policy and drug user networks. A number of civil society organisations from the MENA region participated in discussions on how to incorporate gendered services in harm reduction, and a manual entitled *Integrating Gender-Specific Services to Harm Reduction Programs in the MENA Region* has been developed and is awaiting publication. The manual includes a compilation of recommendations on how to address the gaps in providing harm reduction services to women, such as advocating for laws that specify access to services for females, and the recruitment of female outreach workers.⁽³⁵⁾

Ongoing conflicts in MENA countries have led to large numbers of internally displaced, refugee and migrant populations in the region, and there is a need to explore the extent to which injecting drug use occurs among these groups and to establish the required harm reduction response.⁽³⁹⁾ More than half of the world's refugees are located in Pakistan, Iran, Jordan and Lebanon,⁽³⁶⁾ which are also countries that sit along key drug-trafficking routes. These factors are a challenge to the fostering, implementation and scale up of harm reduction in the region.⁽³⁶⁾

Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

Within the MENA region, NSPs are available only in Israel, Egypt, Jordan, Iran, Lebanon, Morocco, Palestine and Tunisia. However, even where available, these services continue to fall short of need. Only in Iran, where unsafe injecting drug use continues to be the greatest contributor to HIV incidence, is NSP provision substantial, with 580 sites across the country.⁽⁶⁾ NSP provision has steadily increased over the last five years, with coverage going from 26 to 35 syringes per person who injects drugs per year in 2012,⁽²⁴⁾ to 44 to 60 syringes in 2015. However, this is still considered to be low coverage by UN standards.⁽⁶⁾ In 2015, 81.5% of people who inject drugs reported using sterile injecting equipment,^(6, 7) with specific NSP sites, together with pharmacy provision, believed to contribute to relatively low unsafe injecting in the country.⁽⁶⁾ In total, 10,136,060 free sterile needles and syringes were provided to people who inject drugs in 2015 via the state welfare organisation.⁽⁶⁾

Since 2014, MENAHRA has financially supported organisations involved in NSP provision in Egypt, Jordan

and Lebanon via the Global Fund regional grant. In Egypt, MENAHRA worked with two organisations, Friends of HIV+ and the Friends Association, to provide 21,235 and 19,972 sterile needles and syringes respectively between July and December 2015.⁽⁵⁾ UNODC also assisted with increased coverage of NSP provision in the Luxor and Alexandria governorates, distributing 4,000 syringes between April and June 2015.⁽⁴⁰⁾ In Lebanon, Soins Infirmiers et Développement Communautaire (SIDC) reached a total of 176 people who inject drugs with NSP services in 2015, distributing a total of 89,523 needles and syringes.⁽⁵⁾ Skoun, a smaller NGO in Lebanon, also provided NSP outreach, distributing a total of 480 needles and syringes in the same year.⁽⁵⁾ In Jordan, both Forearms of Change Center to Enable Community (FOCCEC) and Friends of Development and Investment Society (FDIS) delivered NSP through outreach and fixed sites in 2015, delivering 63,396 and 80,368 sterile needles and syringes respectively.⁽⁵⁾

UNODC, in close partnership with civil society organisations, continues to provide comprehensive HIV services for people who inject drugs through drop-in centres and outreach programmes in Palestine (specifically the West Bank and Gaza). In 2015, 456 people who inject drugs benefited from harm reduction services, with 22,790 needles distributed and 1,396 information, education and communication materials given to beneficiaries.⁽⁴⁰⁾ In Morocco, 238,946 syringes were provided to people who inject drugs (80 per person who injects drugs per year) during 2014, considered low coverage by UN standards.⁽¹⁹⁾ In Israel, where NSPs operate in five cities, a total of 214,777 sterile needles and syringes were distributed in 2015.⁽⁹⁾

Although the primary mode of HIV transmission in Bahrain is unsafe injecting drug use, there is still no NSP provision in the country and people are often arrested for possession of syringes.⁽¹⁾ In Jordan, FDIS and FOCCEC organised a stakeholders' meeting in Amman to raise awareness of the benefits of NSP as a vital harm reduction service, and to disseminate the positive impact of the NSPs running in Jordan across the wider regional community.

There continues to be a complex interplay between political, legal and social commitments to harm reduction initiatives for people who inject drugs in the MENA region. Many countries, such as Bahrain, Kuwait, Qatar, Algeria, Saudi Arabia, UAE, Yemen and Iraq, continue to offer only abstinence-based detoxification services for people who use drugs, ignoring the individual and public health benefits a harm reduction approach could bring.

[†] According to the 2012 revised WHO, UNODC and UNAIDS target-setting guide, less than 100 syringes distributed per person who injects drugs per year is considered low coverage (100 to 200 is medium coverage and more than 200 is high coverage).



Opioid substitution therapy (OST)

Five countries in the region provide OST: Iran, Israel, Lebanon, Morocco and Palestine. However, many of the OST services fall short of need.

Iran presently runs the largest OST service in the region, but even its coverage levels are only just considered high by UN standards, with 41.2% of people who had injected drugs in 2014 in receipt of OST.⁽⁷⁵⁾ Iran has since continued expansion of its OST programme, going from 4,275 sites in 2014 to 5,983 sites in 2016.⁽⁶⁾ According to UNAIDS, Morocco has also expanded its OST provision, enrolling 628 people who inject drugs onto its methadone programme during 2014.⁽¹⁹⁾ Despite this increase in provision, OST continues to have long waiting lists in both Morocco and Iran, with additional barriers in Morocco such as limited geographical coverage, restrictive prescription and delivery regulations for methadone (limited to a psychiatrist or physician specialising in drug use) as well as a lack of high-dosage buprenorphine.⁽³⁶⁾

Global State 2014 reported no OST in Egypt. Since then, however, 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.⁽³⁴⁾ A pilot OST programme is now pending approval in Egypt.⁽³⁵⁾

Following the first pilot of methadone maintenance treatment (MMT) in Ramallah, Palestine, which was initiated in May 2014, the Ministry of Health opened its first permanent OST site in Ramallah.⁽⁴⁰⁾ Prior to its inception, the UNODC conducted a one-week specialised training course on OST for 15 healthcare service providers in the Ministry of Health. The training covered all aspects of a diversified, accessible and quality drug dependence treatment service, including opioids and other drugs, maintenance treatment (the medicines, the evidence, effective practices – such as evaluation, initial dose and management of dose – and tapering procedures), clinical care detoxification, dual diagnosis and relapse prevention. By the end of September 2015, 65 people had benefited from this new harm reduction service.⁽⁴⁰⁾

Viral hepatitis

There continues to be little data on the prevalence of viral hepatitis among people who inject drugs in countries within the MENA region. However, since *Global State 2014*, the hepatitis response in the region has entered a nascent stage, with some countries beginning to offer rapid screening for the hepatitis B

and C viruses, alongside HIV screening.⁽⁵⁾ In Jordan, for example, rapid screening as part of outreach programmes for people who inject drugs became available in August 2014. In Lebanon, rapid hepatitis C testing is available at voluntary counselling and testing centres and via outreach programmes for people who use drugs.⁽³⁵⁾

The World Health Assembly adopted the Global Health Sector Strategy on Viral Hepatitis 2016–2021 in May 2016. This strategy includes the term ‘key populations’ and highlights the need for a tailored response to tackling hepatitis among these groups.⁽⁴¹⁾ Within this framework, there is an action plan for WHO’s Eastern Mediterranean Regional Office to focus its support on establishing national leadership and coordination in hepatitis control, and on collecting and analysing strategic information to guide the response, including the revision of policies. This work will also seek to strengthen services for the prevention and treatment of hepatitis by setting prevention, diagnosis and treatment targets for people who inject drugs; to collect and disseminate data; to promote policy dialogue to address barriers to harm reduction; to increase access to affordable medicines; and to monitor and evaluate the response for people who inject drugs.⁽⁴¹⁾

In light of the increasing hepatitis C epidemic, Egypt launched the first domestically funded national free treatment programme for hepatitis C in the region in 2015.⁽⁴²⁾ This treatment is for people who are co-infected with HIV, but it is unclear how accessible the service is for people who inject drugs.⁽⁵⁾

At the end of 2014 the Lebanese Ministry of Health invited MENAHRA to collaborate in the roll out of a national hepatitis B vaccination programme for people who inject drugs. In April 2015 they held a training day for NGOs who were interested in participating. The aim of the training was to present the hepatitis B vaccination project elements to the participants and to review the developed documentation and evaluation tools. In August 2015, the project protocol was sent to the NGOs involved in order to begin implementing the project. Later that year 840 hepatitis B tests and 500 hepatitis C tests were distributed to the organisations.⁽³⁵⁾

Although many countries in the region report hepatitis diagnostics and treatment availability to people who inject drugs (Bahrain, Egypt, Oman, Iraq, Iran, Kuwait, Qatar), it is clear that the lack of testing for people who inject drugs, problematic structures regarding referrals, stigma and inaccessibility of services, plus limited government support for this population, continue to

⁵ The 2012 revised WHO, UNAIDS and UNODC target-setting guide categorises OST coverage levels as follows: low coverage is less than 20%, medium coverage is between 20% and 40% and high coverage is more than 40% of opioid-dependent people who inject drugs on OST.

pose great barriers to eliminating the hepatitis C virus among people who inject drugs.

Amphetamine-type stimulants (ATS)

Use of amphetamine-type stimulants appears to be increasing in certain countries in the region, with injecting becoming more prevalent. For example, among those who had injected within the last month in Iran, 20.7% had mostly used methamphetamine, with 21.1% injecting.^(6, 7) Captagon, an ATS, has seen an increase in use in many countries in the Middle East, in particular Lebanon, Saudi Arabia and Syria.⁽⁴³⁾

Although an increase in ATS use is reported, only Iran has prepared a guideline, yet to be published, for the integration of ATS harm reduction strategies into current harm reduction initiatives in the country, which is in the piloting phase.⁽⁵⁾ In Bahrain, training has been put in place for a national drug information expert team to update the previously conducted drug situation assessment in order to provide a more accurate picture of the recent emergence of ATS in the country.⁽⁴⁰⁾

Tuberculosis (TB)

There is very little data on TB among people who inject drugs in countries in the MENA region. Although the WHO recommends diagnosis and treatment of TB as an integral component of the harm reduction package, targeted TB services for people who inject drugs are rarely in place. Within the region, only Morocco,⁽¹⁸⁾ Oman⁽²⁰⁾ and Iran (by referral only)⁽⁶⁾ document the availability of TB diagnosis and treatment for people who inject drugs.⁽⁴²⁾ However, TB screening targeting people who inject drugs is not evidenced.

Antiretroviral therapy (ART)

According to a report from UNAIDS, there are very low rates of HIV testing among people who inject drugs in the MENA region.⁽⁴⁴⁾ Many countries in the region are yet to offer harm reduction services, and where HIV testing and treatment for people who inject drugs is integrated or linked with harm reduction programmes, a lack of proper coordination between services reduces the effectiveness of such initiatives.⁽⁵⁾

There are some examples of good practice, however. In Iran, 68 facilities out of 269 offering ART also have OST services in place, with a further 142 sites linking clients with OST services if requested.⁽⁶⁾ Capturing the number of people who inject drugs who have received HIV testing and treatment is often complex, and data are not disaggregated by population. However, Iran reported

that 2,404 people who inject drugs were on ART in 2013.⁽⁶⁾ In 2015 SIDC in Lebanon provided testing for HIV, HCV and HBV to 217 people who inject drugs and FOCCEC in Jordan reached 146 people with the same tests.⁽⁵⁾ UNODC, in close partnership with civil society organisations, also continued to provide comprehensive HIV services for people who inject drugs in drop-in centres and outreach programmes in Palestine.⁽⁴⁰⁾

Although ART provision is available to all in the MENA region, civil society reports that people who use drugs have been marginalised and stigmatised within HIV treatment settings, which discourages service access and utilisation. Further reported barriers include weak referral systems to clinics providing care and treatment after HIV diagnosis and the geographical distance people are required to travel to get to ART sites. Many people who inject drugs in the region are deemed ineligible for ART due to a requirement for detoxification prior to initiating treatment.⁽⁵⁾

Harm reduction in prisons

There are approximately 625,413 prisoners in the MENA region,⁽⁴⁵⁾ one-third of whom are reported to be incarcerated on drug-related charges.⁽⁴⁶⁾ Considering that conviction and punishment of people who use drugs is the primary approach for combating illicit drug use in the region,⁽⁴⁶⁾ with countries like Bahrain even arresting people for simply possessing syringes,⁽⁴⁷⁾ these figures are not very surprising. Injecting drug use in prison has been documented in several MENA countries, including Iran, Lebanon, Morocco, Oman, Palestine and Syria.^(48, 49) A recent study on HIV and HCV prevalence and incarceration-related risks in three Palestinian governorates, for example, found that 83.6% of a sample of 288 people who inject drugs had spent time in prison, with nearly half reporting that they had injected while in prison.⁽⁴⁹⁾

Unsafe injecting drug use is considered the main mode of HIV and HCV transmission among prisoners in the MENA region.^(48, 49) A recent review synthesising all available data on HIV and HCV in MENA prisons found a median HIV prevalence among incarcerated populations of 0.01% in Egypt, 2.5% in Iran, 0% in Iraq, 0.1% in Jordan, 0.05% in Kuwait, 0.7% in Lebanon, 18.0% in Libya, 0.7% in Morocco, 0.3% in Oman, 0% in Palestine, 1.2% in Saudi Arabia, 0.04% in Syria, 0.05% in Tunisia and 3.5% in Yemen. Although very few countries in the region had data on HCV in prisons, a median prevalence of 23.6% was found in Egypt, 28.1% in Lebanon, 37.8% in Iran, 1.5% in Syria and 23.7% in Libya.⁽⁴⁸⁾

[†] This number does not include Palestine, where there are still no prisoner estimates available.



While these findings highlight the need to implement comprehensive harm reduction services in MENA prisons, the regional response continues to be weak. Since *Global State 2014*, Iran has reportedly ceased to provide NSPs in prisons, regrettably signifying the end of prison-based NSP provision in the region. OST continues to be available in more than 50% of Iranian prisons,⁽⁵⁰⁾ although with around 43,500 prisoners accessing OST in 2014, coverage still remains inadequate.⁽⁶⁾ Dwindling focus on, and support for, harm reduction, both in prisons and in the broader community, has been identified as an emerging concern in Iran, with the expansion of harm reduction services currently under serious threat due to severe financial constraints.⁽⁶⁾

More encouragingly, OST has reportedly been initiated in Nador and Al Hoceima prisons in Morocco,⁽¹⁸⁾ and OST pilots (accessible only to prisoners who were prescribed OST prior to their arrest) were launched in some Lebanese prisons.^(5, 51) OST is also reported to be available in some Israeli prisons.⁽⁵²⁾

Testing for HIV, which is often mandatory, and ART are reported to be provided to prisoners in just over one-third of the region's countries, including Egypt,⁽⁴²⁾ Iran,⁽⁶⁾ Israel,⁽⁹⁾ Lebanon⁽¹³⁾ Libya,⁽⁵³⁾ Morocco⁽⁵⁾ and Saudi Arabia⁽³²⁾. The provision of HCV diagnosis and treatment, however, is much more infrequent, reportedly only available to prisoners in Egypt, Kuwait, Lebanon and Oman.^(5, 11) TB diagnosis and treatment within prisons is also scarce throughout the region. Evidence of diagnosis and treatment of TB in prisons could be found only in Egypt (limited), Iran, Kuwait (limited), Morocco, Lebanon and Oman. It is not known whether these services are available in other countries. Condoms are available to prisoners in Egypt, Iran (limited to conjugal visits), Lebanon and Morocco only.⁽⁵⁾

Overdose

Data on fatal and non-fatal overdose remain extremely limited in the region. The availability of naloxone (a highly effective opioid antagonist that reverses the effect of overdose) is restricted to hospitals in most MENA countries, and so remains unavailable for peer distribution.⁽⁵⁾

In Lebanon, civil society organisations have taken action to end hospital reporting of overdose cases to the police – a practice that is known to deter people witnessing an overdose from calling emergency services. Skoun and MENAHRA conducted a nationwide campaign to change hospital policies that prevent people from seeking help when in need.⁽⁵⁾ Following these advocacy efforts,

the Ministry of Health in Lebanon issued an official statement to all hospitals requesting that they refrain from reporting any overdose case to the police.⁽⁵⁴⁾

Policy developments for harm reduction

As noted in *Global State 2014*, very few countries in the region make explicit mention of harm reduction in their national strategies. Only Egypt,⁽⁵⁵⁾ Iran,⁽⁶⁾ Morocco,⁽¹⁸⁾ Syria⁽⁵⁶⁾ and Tunisia⁽³⁾ specifically mention harm reduction for people who inject drugs. Iran's national guideline promotes the inclusion of people who inject drugs in all aspects of a comprehensive package of HIV services.⁽⁶⁾ Lebanon's updated national strategic plan notes a focus on most-at-risk populations, including people who use/inject drugs.⁽³⁵⁾ Algeria,⁽⁵⁷⁾ Jordan⁽¹⁰⁾ and Saudi Arabia⁽³²⁾ all mention high risk or key populations, but without specific reference to harm reduction for these groups. The national HIV strategy for Libya is currently being redrafted.⁽⁵³⁾

In 2014 Oman took steps towards updating its national AIDS strategy, but the new document, finalised in June 2016, will include no explicit mention of key populations or harm reduction.⁽²⁰⁾ However, Oman's national strategies for drug use control and prevention for 2016 to 2020 and for HIV/AIDS control and prevention specifically mention harm reduction.⁽²⁰⁾ In addition, the national narcotic law in Oman has been updated and guidelines to deal with psychoactive substances in health institutions and pharmacies have recently been established.⁽⁵⁾ In November 2015, the WHO also developed a harm reduction protocol with a focus on MMT in the country.⁽⁵⁾ Thanks to the national strategies for drug use control and prevention and for HIV/AIDS control and prevention, there has also been an increase in voluntary testing and counseling in the Muscat region of Oman.⁽⁵⁾

In 2015 UNODC, in collaboration with the WHO, translated two key guidelines into Arabic: the guidelines for countries to set targets for universal access to HIV prevention, treatment and care for people who inject drugs,⁽⁵⁸⁾ and the guidelines for the psychosocially assisted pharmacological treatment of opioid dependence.⁽⁵⁹⁾ Both will help to fill existing technical gaps and open new windows of opportunity for evidence-based harm reduction and drug treatment services.⁽⁵⁾ In Iran, based on identified barriers during a recent assessment on HIV testing and treatment, policy changes have been made to enable the integration of HIV treatment and care within OST sites.⁽⁶⁰⁾

^u Based on the national AIDS strategy for the Syrian Arab Republic developed in 2011. Given the ongoing state of conflict in the country, this information has not been updated.

Civil society and advocacy developments for harm reduction

Civil society networks and organisations in the region continue to play a consistent and vital role in advocating and implementing harm reduction approaches. MENAHRA has played a long-standing role as the regional harm reduction network, and its advocacy, capacity building, development of publications and other tools and support for harm reduction service delivery across 20 countries has continued since *Global State 2014*.

MENAHRA led the civil society engagement in the recent high-level processes of the United Nations General Assembly Special Session (UNGASS) on the drugs in April 2016 and at the UN High-Level Meeting on HIV in June 2016. In October 2015 MENAHRA participated in the Regional Dialogue on Drug Policy and HIV, contributing to ongoing national and regional discussion in advance of UNGASS.⁽⁶¹⁾ In an effort to highlight the rights of drug users to policy makers in the region, MENAHRA also developed and disseminated four position statements to coincide with different occasions in 2015: The International Day Against Drug Abuse and Illicit Trafficking on 26 June,⁽⁶²⁾ World Hepatitis Day on 28 July,⁽⁶³⁾ International Drug Users Day on 1 November⁽⁶⁴⁾ and World AIDS Day on 1 December⁽⁶⁵⁾. Unfortunately, political commitment and support for harm reduction by country representatives within the region during the UNGASS process was absent.

MENAHRA works closely with civil society partners throughout the region, as well as other regional bodies that cover harm reduction in their remit. Between 8 and 10 December 2015 in Beirut, Lebanon, MENAHRA and the Regional Arab Network Against AIDS (RANAA) convened a regional dialogue meeting to consult stakeholders on current regional and national harm reduction needs and priorities.⁽³⁵⁾

MENAHRA also coordinated the 'Support Don't Punish' campaign action within the region (please see report overview for further information on the campaign). Thirteen countries in the region took part: Bahrain, Egypt, Iran, Jordan, Kuwait, Lebanon, Morocco, Pakistan, Palestine, Saudi Arabia, Syria, Tunisia and UAE. Activities included theatre acts, video messages from key harm reduction decision makers and activists, seminars and position statements.⁽⁵⁾

In Egypt, 15 civil society organisations are part of the Network of Associations for Harm Reduction, established

in 2010 to strengthen collaborations among harm reduction service providers and to reduce the stigma and discrimination faced by key populations.⁽⁴²⁾ The Middle East and North Africa Network of People who Use Drugs (MENAPUD), a regional network of people who currently use or formerly used drugs, was initiated, with support from MENAHRA, in 2011. In 2014, funds were secured via the MENAHRA Global Fund grant to appoint a coordinator and MENAPUD is currently working to facilitate its registration as an NGO.⁽³⁵⁾

Religious leaders have significant influence on the acceptance of harm reduction practices in many countries within the MENA region. A regional advocacy meeting on harm reduction was held for religious leaders in December 2012. It issued a declaration on the rights to health and harm reduction for people who use drugs. The regional religious leaders group contributed to the development of guidelines for religious leaders on harm reduction during 2014 and 2015.⁽³⁵⁾

Funding developments for harm reduction

The Global Fund continues to be one of the most significant financial contributors to harm reduction in MENA. MENAHRA, principal recipient of the regional harm reduction grant in the MENA region, is approaching the end of its round 10 Global Fund grant, which aimed to strengthen civil society to advocate for a more conducive environment for implementing harm reduction in 13 countries in the region.⁽⁵⁾ Thus far, this grant has assisted harm reduction programming and advocacy in Egypt, Iran, Jordan, Lebanon, Libya, Morocco, Palestine, Syria and Tunisia.⁽⁵⁾ In 2016, within the context of the Global Fund's new funding model, MENAHRA and RANAA submitted a joint concept note for further funding, bringing together the two regional organisations in an effort to provide complementary advocacy, research and services in the region for people who inject drugs, men who have sex with men, sex workers and people living with HIV.⁽³⁵⁾ If successful, the regional grant will fund harm reduction initiatives for these key populations from 2017 to 2019.

In Iran, with the highest population of people who inject drugs in the region, the Global Fund grant covers the majority of the harm reduction programmes in the country, currently delivered via outsourcing to private or non-government sectors.⁽⁶⁾ This grant will end in 2018. While Iran is one of the few countries in the region where the national government invests in harm reduction, the extent of current investment is unclear.⁽⁶⁾



Given the high numbers of people who inject drugs in the country, the imperative for Global Fund financial support to be extended via the new funding model is clear.

National government funds also go towards harm reduction in Oman and Morocco.⁽¹⁸⁾ Although the Global Fund has consistently funded harm reduction in Morocco, the head of state, King Mohammed VI, recently funded a harm reduction building through the Mohammed V Foundation.⁽³⁶⁾

Investment by national governments in harm reduction is negligible in most MENA countries, with the vast majority of harm reduction funds coming from international donors.⁽⁵⁾ In Egypt, for example, the Global Fund (through a national grant and via MENAHRA), the Drosos Foundation, FHI 360 and UNODC have assisted harm reduction services and advocacy efforts.⁽⁴²⁾

Although it is widely acknowledged that harm reduction funding in the region falls far short of need, evidencing the amount spent is challenging and requires dedicated research. In light of this, MENAHRA, with funding from UNODC, is piloting an investment tracking tool for harm reduction in two countries (Morocco and Egypt) between 2015 and 2016. This tool, developed by Harm Reduction International, has been used in other regions and will serve to illustrate spend versus need, increasing evidence-based advocacy for continued funding for vital harm reduction programmes. There are presently plans to expand the investment tracking tool project into three other countries (yet to be identified) in the region during 2017 with funding from the Robert Carr Foundation.⁽³⁵⁾

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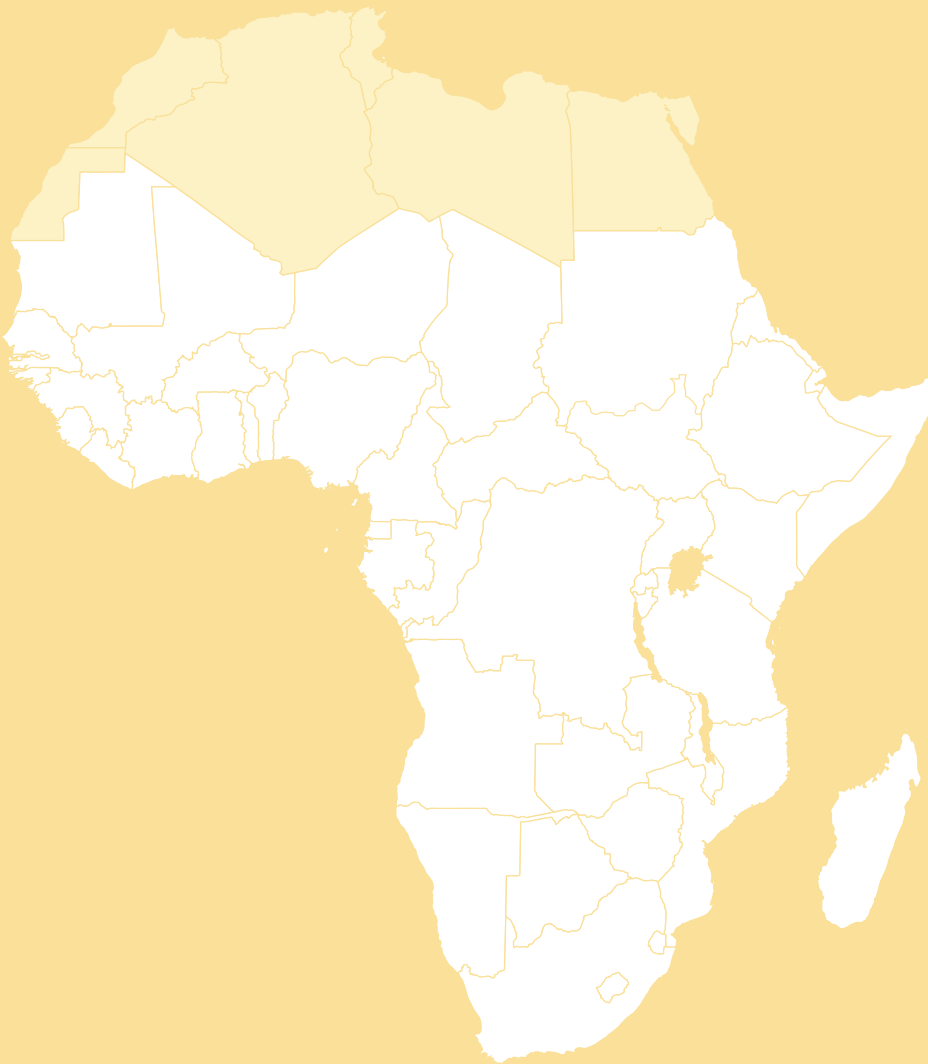


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Regional Overview

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 ^a	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 ^b ■	OST ^c ■
Burkina Faso ^d	nk	nk	nk	nk	✗	✗
Côte d'Ivoire	nk ^{(1)e}	nk ^{(1)f}	nk	nk	✗	✗
Ghana	6,314 ^{(2)g}	nk	nk	3.1 ⁽¹⁾	✗	✗
Kenya	18,327 ⁽³⁾	18.3 ⁽³⁾	51.4 (42.2–60.6) ⁽⁴⁾	6.4 ⁽⁴⁾	✓13 ⁽⁵⁾	✓5 ⁽⁵⁾
Liberia	nk	3.9 ⁽⁶⁾	nk	nk	nk	nk
Malawi	nk	nk	nk	nk	✗	✗
Mauritius	11,677 ⁽⁷⁾	44.3 ⁽⁷⁾	96.5 ⁽⁸⁾	6.7 ⁽⁸⁾	✓49 ⁽⁷⁾	✓18 ⁽⁷⁾
Mozambique	2,204 ^{(9)h}	50.3–73.1 ⁽¹⁰⁾	61.7–77.3 ⁽⁹⁾	32.1–36.4 ⁽⁹⁾	✗	✗
Nigeria	19,000 ⁽¹¹⁾	3.4 ⁽¹¹⁾	nk	nk	✗	✗
Senegal	1,324 ⁽¹²⁾ⁱ	9.1 ⁽¹³⁾	38.85 ⁽¹²⁾	nk	✓	✓(1) ⁽¹⁴⁾
Seychelles	346 ⁽¹⁵⁾	5.8 ⁽¹⁵⁾	53.5 ⁽¹⁵⁾	0.1 ⁽¹⁵⁾	✗	✓(1) ⁽¹⁵⁾
South Africa	75,000 ^{(16)j}	14 ⁽¹⁶⁾	nk	nk	✓3 ⁽¹⁶⁾	✓(M,B) ^(k)
Tanzania	30,000 ^(17,18)	35 ⁽¹⁸⁾	28 ⁽¹⁹⁾	nk	✓5 ^{(20) l,m}	✓3(M,O) ⁽²⁰⁾
Uganda	nk	nk ⁽²¹⁾	nk	nk	✗	✗
Zanzibar	nk	11.3 ⁽²²⁾	nk	nk	✗	✗

nk = not known

^a The countries included in this table are those with reported injecting drug use according to the 2008 United Nations Reference Group systematic review and/or with operational NSPs or OST at the time of data collection. HRI also found data on injecting drug use in Angola, Benin, Burkina Faso, Cameroon, Cape Verde, Djibouti, Ethiopia, Gabon, Gambia, Guinea, Malawi, Mali, Niger, Rwanda, Sierra Leone, Somalia, Togo, Zambia and Zimbabwe, but did not find verified data to include on these countries.

^b All operational needle and syringe exchange programme (NSP) sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers.

^c Opioid substitution therapy (OST), including methadone (M), buprenorphine (B) and any other form (O) such as morphine and codeine.

^d Global State of Harm Reduction 2014 reported that Burkina Faso had one OST site in operation. This information was incorrect and has therefore been omitted from this 2016 report.

^e Estimates based on sub-national data from Abidjan, there are believed to be 3,521 drug users who had used heroin and/or cocaine (both injecting and non-injecting) in the past year (see Overview below).

^f Estimates based on sub-national data from Abidjan, the HIV prevalence rate among people who inject drugs is 5.2%, but this is based on a sample size of 57 (see Overview below).

^g Estimates based on sub-national data in four areas: Accra, Tema, Cape Coast and Sekondi-Takoradi.

^h Estimates based on median Integrated Biological and Behavioral Surveillance (IBBS) findings conducted in Maputo and Nampula, which looked at lifetime injecting.

ⁱ Estimates based on sub-national data from the Dakar region referring to people who use injectable drugs inclusive of heroin and cocaine.

^j In late 2015 a stakeholder meeting hosted by the South African National AIDS Council to review the estimates on people who inject drugs, based on expert consultation and the available data, revised the previous estimate of 67,000 to 75,000.

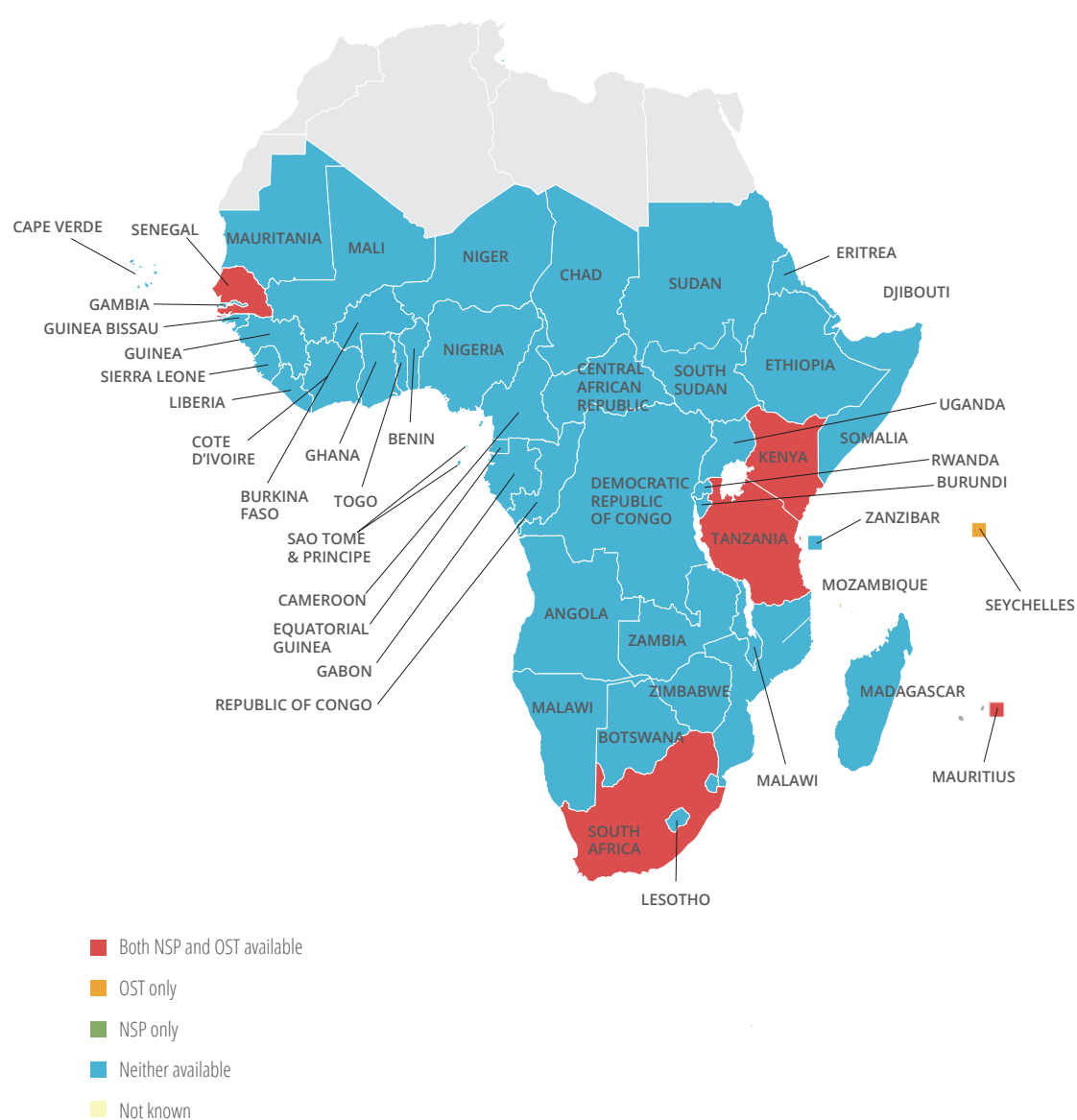
^k It is not possible to put a figure on the exact number of OST sites in operation within South Africa as OST is also available in private clinics and government hospitals (the latter use it for detoxification only).

^l Médecins du Monde and its partner NGO Mukikute are the only two NGOs implementing NSPs in Dar es Salaam through five fixed sites and 56 outreach sites with the support of external donors.

^m NSPs operate in five fixed sites in three districts (Temeke, Ilala and Kinondoni). Outreach workers also provide NSP in 107 hotspots within the three districts.

ⁿ Based on a study conducted in Kampala in 2012, HIV prevalence among people who inject drugs was 16.7%, but this is based on a sample size of 54 (see Overview below),

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





Harm reduction in Sub-Saharan Africa

Overview

An estimated 25.6 million people are living with HIV in the region of sub-Saharan Africa. UNAIDS reports substantial gains against HIV in the region since 2010, including a decline in the number of new HIV infections. This decline is most marked in eastern and southern Africa, where HIV incidence was 4% lower in 2015 than it had been in 2010, with 40,000 fewer people becoming HIV-positive. Similarly, coverage of antiretroviral treatment (ART) doubled in the region between 2010 and 2015, meaning that over half of those in need now receive HIV treatment.⁽²³⁾

The proportion of new HIV infections attributed to unsafe injecting drug use is relatively small compared with that in other regions: 0.4% of new HIV infections in western and central Africa, and 2% in eastern and southern Africa.⁽²³⁾ In real terms, however, these proportions, which are based on a dearth of data and believed to be underestimates, add up to tens of thousands of people whose acquisition of HIV via unsafe injecting could have been prevented through the provision of harm reduction services. Indeed, new research on drug injecting from several countries in the region illustrates the potential for rapid expansion of the HIV epidemic through unsafe injecting and clearly shows the urgent need for harm reduction implementation and scale-up. For example, research has shown that between half and three-quarters of the people who inject drugs in Mozambique are living with HIV,⁽¹⁰⁾ and over three-quarters are living with the hepatitis C virus (HCV).⁽⁹⁾

Since the *Global State of Harm Reduction 2014*, there has been an increase in international donor support for harm reduction activities in several countries in the region. This support covers essential academic research, advocacy and civil society strengthening as well as the establishment and implementation of programmes. Sub-Saharan Africa is likely to be the only region experiencing an increase in harm reduction funding, as the wider context is one of donor retreat from investment in middle-income countries in favour of directing support towards low-income countries. It is vital to note, however, that although harm reduction funding may be increasing, it is still supporting advocacy and programming in only a handful of the 54 countries that make up the African Union.

More research on injecting drug use has begun to emerge from the region, some of which was featured in a special issue of the *International Journal of Drug Policy* on sub-Saharan Africa in 2016.^P A handful of countries do operate harm reduction services, although some of these are still in their infancy and operate on a small scale. After a long period of political rejection of harm reduction services, Kenya now has both NSP and OST facilities, with its NSP service being steadily scaled up over the last decade to 13 NSP sites in operation. Since the *Global State 2014*, five OST sites are now in operation where previously there were none.⁽⁵⁾ According to the National AIDS and STI Control Programme data from 2014 to 2016, 20 needles and syringes are distributed per person who injects drugs per year in Kenya. This provision is still significantly below internationally recommended standards, but it is a step forward in Kenya's harm reduction response.

For the first time since the inception of the *Global State of Harm Reduction* report in 2008, information has become available on injecting drug use in Côte d'Ivoire, where, thanks to international donor support, the NGO Médecins du Monde (MdM) is working with local partners to develop harm reduction strategies for people who use drugs. As the primary form of heroin and cocaine consumption is smoking, MdM, alongside local partners, distributes information on safer pipe smoking to ensure people do not have to share equipment. They also provide medical care and support, including HIV testing.⁽²⁴⁾ In a study involving 450 people who use drugs in Abidjan, Côte d'Ivoire, almost all respondents (98.2%) reported consuming heroin, with 12.7% reporting injecting. Only one respondent noted that he had shared a syringe.⁽¹⁾ Civil society reports that syringes are available from pharmacies at low cost and without a medical prescription, but states the need for a harm reduction strategy to be put in place.⁽²⁴⁾

In Kampala, Uganda, a study conducted in 2012 found that 16.7% of people who inject drugs tested positive for HIV.⁽²¹⁾ In Ghana, a study estimated that 6,000 people were injecting drugs, and highlighted the sharing of needles as well as the use of discarded injecting equipment found in hospital waste.^(2, 25, 26) In Nigeria, a study undertaken in 2010 found that HIV prevalence rates among people who inject drugs ranged from 3% to 9.3%,⁽²⁷⁾ with 72% of respondents residing in the Federal Capital Territory reporting sharing needles.⁽²⁷⁾ Despite these findings, and the clear and urgent need

⁹ In terms of HIV prevalence among people who inject drugs, many of the figures cited in Table 2.9.1 often stem from sub-national data and should therefore be viewed with caution.

^P The *International Journal of Drug Policy's* special issue on sub-Saharan Africa (published in April 2016) is available from: [www.ijdp.org/issue/S0955-3959\(16\)X0004-7](http://www.ijdp.org/issue/S0955-3959(16)X0004-7).

they illustrate, harm reduction interventions have yet to be implemented in the Côte d'Ivoire, Nigeria, Ghana, Mozambique or Uganda.

Although there has been progress in expanding the harm reduction response in some countries, there remains a predominantly punitive response to drug use in the region, with incarceration of people who use drugs on the rise.⁽²⁸⁾ Through continued civil society advocacy, academic research and international donor support, knowledge and awareness of harm reduction is increasing in several countries and pushes against the tide of negative and stigmatising attitudes and policies towards drug use. As in other regions, political and financial support for harm reduction is often precarious.

Changes in the political landscape can have a direct impact on the provision of harm reduction services. For example, a change in government in Mauritius in late 2014 resulted in a severe scaling down of the national harm reduction response. *Global State 2014* reported on Mauritius's unique place in the region as a leader in harm reduction, with political and financial support from the national government for the provision of both NSPs and OST. Since then, the new government has moved OST distribution away from the health service to police stations with daily fixed times for people who use drugs to attend, and the number of needles and syringes that NGOs are able to provide has been greatly restricted⁽²⁹⁾ Tanzania's 2015 change in government has also led to a stagnation of the harm reduction services available, with OST programmes in the country accepting no new clients.^(5, 16)

Policies that greatly restrict the implementation of harm reduction remain in place in many countries in this region, despite a regional call by the African Union for harm reduction scale-up.⁽³⁰⁾ In Nigeria, for example, there continues to be no harm reduction policy or programme that is nationally approved,⁽³¹⁾ even though the national policy for the control of viral hepatitis called for these essential services to be implemented.⁽³²⁾ In Uganda, the government is reluctant to amend certain sections of the Anti-Narcotics Act, which provides for long custodial sentences for non-violent drug-related offences.⁽³³⁾

Since *Global State 2014*, there have been some significant developments in South Africa in relation to harm reduction research, policy and practice. Although the scale-up of harm reduction services remains slow, these programmes are now recognised by the Departments of Health and Social Development and by the Central Drug Authority as essential.^(16, 34) The implementation of new NSP sites in different parts of

the country is evidence of this positive step forward.^(16, 34) Political acceptance for harm reduction approaches is a welcome and an important progression, particularly in light of reports of high levels of the sharing of injecting equipment among people who inject drugs in South Africa.⁽³⁵⁾

Although harm reduction services are improving in some countries in sub-Saharan Africa, it is clear that there is still discordance between the levels of HIV and HCV among people who inject drugs and the adequacy of service provision. Significant structural barriers in the form of drug policy, criminal laws, law enforcement and political priorities remain firmly in place for harm reduction in much of the region. Even where NSP and OST services are operating, people who use drugs often feel stigmatised and discriminated against when seeking out HIV testing and treatment, with a lack of integrated service provision for this key population group.^(16, 29, 34, 36, 37) In addition, as in other regions, HCV treatment remains beyond the grasp of the vast majority of people (both people who use drugs and those who do not) due to its exorbitant costs. Many of the newer HCV direct-acting antivirals are not widely registered in the region, causing additional barriers.^(16, 38)

Civil society organisations and drug user networks are attempting to overcome many of the structural hurdles in place and are steadily gaining a stronger voice within the political landscape of drug policy and harm reduction. In Senegal, the first association of people who use drugs, Health Life Hope (SEV), has begun advocating for a risk reduction rather than a punitive approach to drug policy in the country.⁽¹⁴⁾ In South Africa, advocacy efforts preceded the launch of three NSP sites,⁽¹⁶⁾ and two drug user networks were formed in Cape Town and Pretoria in 2015.⁽³⁴⁾

With planned further research on injecting drug use in certain countries in the region emerging (from government departments, civil society groups and academics), continued funding from multilaterals such as the Global Fund, a growing civil society movement, the inclusion of drug user networks in the discourse, and umbrella advocacy groups (such as the West African Harm Reduction Network and the East Africa Harm Reduction Network) forming across territories, it is hoped that harm reduction will continue to gain strength in sub-Saharan Africa. However, it must be noted that in the majority of countries in the region there continues to be a rejection of harm reduction approaches, and further work on advocacy and awareness is essential.



Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

As illustrated in Table 2.9.1, only five countries (of the 54 countries that make up the African Union) provide NSP services for people who inject drugs: Kenya, Mauritius, Senegal, South Africa and Tanzania.

Kenya estimated HIV prevalence rates for people who inject drugs, between May and December 2012, as 14.5% in Nairobi and 20.5% in the coastal regions, with a reported 23% of people in Nairobi sharing needles.⁽³⁹⁾ In 2012 the Kenyan government announced the initiation of NSPs in the country, resulting in ten newly operational sites by 2014 reaching 4,500 people who inject drugs.⁽⁴⁰⁾ The model used combined fixed-site NSPs alongside NSP outreach.⁽⁴¹⁾ Prior to the inception of this service, UNAIDS estimated that 51.6% of people reported using sterile injecting equipment.⁽³⁾ In 2016 the Community Action on Harm Reduction (CAHR) project found that 88.8% of people reported using sterile needles,⁽⁴²⁾ which is suggestive of the NSPs' success. Given these figures, the Global State can now report Kenya's consistent scaling up of NSP site provision, with civil society reporting up to 12,000 people who inject drugs accessing these services.⁽⁵⁾ This rise in harm reduction service provision is thanks to both national and international advocacy efforts in the country, alongside increased international donor funding and government support (both political and financial).⁽⁵⁾

Global State 2014 reported on a planned harm reduction demonstration project in South Africa, due to begin in Cape Town, Durban and Pretoria.⁽⁴³⁾ This project, an initiative of the US Centers for Disease Control and Prevention, was established in 2014 by civil society organisations (TB/HIV Care Association and OUT LGBT Wellbeing) and provided over 400,000 needles and syringes within its first year of operation, alongside HIV testing and links to care for key populations in these areas. Thanks to this project there are now three NSPs operating in South Africa and, for the first time, a sub-district of the Department of Health in the Western Cape provided a consignment of needles. The only NSP that operated previously (for men who have sex with men (MSM) and funded by Aids Fonds) came to an end in 2014. The beneficiaries of this service have been referred to the new NSPs in operation.⁽¹⁶⁾

Although injecting is not reported to be the main form of heroin use in Tanzania, with many people smoking

cocktail (cannabis, tobacco and heroin), unsafe needle sharing is commonplace among those who do inject,⁽⁴⁴⁾ and HIV and HCV prevalence rates among people who inject drugs are estimated to be 51.1% and 75.6% respectively.⁽⁴⁵⁾ Smoking is also more commonplace than injecting in Senegal. However, amongst people who inject drugs in Senegal, HIV and HCV prevalence rates are lower, at 9.4% and 38.85% respectively.⁽¹²⁾ In Tanzania, Médecins du Monde and its partner NGO Mukikute are the only two NGOs implementing an NSP service in Dar es Salaam, with five fixed sites and 107 mobile outreach units.⁽²⁰⁾ Senegal's NSP services began in 2011 in the Dakar region and are provided through the NGO Centre de Prise en Charge Intégrée des Addictions de Dakar (CEPIAD).⁽³⁷⁾ Given the rise in drug use in Tanzania, and the clear need of people who inject drugs in both Tanzania and Senegal, there is a definite requirement for further implementation of harm reduction services in these countries.^(12, 14, 44) It seems that there has not been a major expansion of services in either Tanzania or Senegal since 2014.^(14, 20) Civil society in Senegal reports that NSP implementation and scale have been hampered by the lack of a regulatory framework for the sustainability and safety of both NSP workers and those in receipt of the service.⁽¹⁴⁾

Despite the increasing number of NSP sites in sub-Saharan Africa, coverage remains extremely low, with many countries where injecting is known to occur not providing this essential service.⁹ The government of Nigeria does not politically support the provision of NSPs as a service for people who inject drugs. However, NGOs working in the field do try to provide sterile syringes.⁽³¹⁾ Needles are reported to be widely available at pharmacies and medicine stores,⁽⁴⁶⁾ but it is unclear how accessible pharmacy provisions are to people who inject drugs. In the Seychelles, it has been found that high percentages of people who inject drugs practice unsafe injecting behaviour,⁽¹⁵⁾ but an NSP service is yet to be established.

In those countries where NSP sites do exist, there is often intense social stigma around injecting drug use and the use of the programmes. For example, people accessing NSPs in South Africa may be subjected to multiple rights infringements, including harassment, arrest without cause and the confiscation of and breaking of injecting equipment by police.⁽¹⁶⁾

NSP sites in Mauritius, although still operational and financially supported by both the government and the Global Fund, are restricted by a fixed quota of 30,000 needles per month.⁽²⁹⁾ This restriction has emerged since a new government came to power in December 2014,

⁹ Angola, Benin, Burkina Faso, Cameroon, Cape Verde, Côte d'Ivoire, Djibouti, Ethiopia, Gabon, Gambia, Ghana, Guinea, Liberia, Malawi, Mali, Mozambique, Niger, Nigeria, Rwanda, Seychelles, Sierra Leone, Somalia, Togo, Uganda, Zambia, Zanzibar, Zimbabwe.

even though the number of people who inject drugs in the country is increasing.⁽²⁹⁾ Previously the provision of injecting equipment was responsive to need. However, due to the lack of materials provided by the Ministry of Health, provision has now been restricted to a quota of five syringes per person per visit, falling vastly short of the requirement for this population.⁽²⁹⁾

Women, health and harm reduction

Women who inject drugs often experience disproportionately higher levels of negative health outcomes^(19, 47) and face a greater risk of HIV than their male counterparts. This disparity has been documented in various countries:

- In Senegal, HIV prevalence among female drug users was found to be over four times that of male drug users (13.0% and 3.0% respectively).⁽¹²⁾
- In Tanzania, HIV prevalence rates reach 71% among women who inject drugs,⁽⁴⁸⁾ over four times higher than the national HIV prevalence estimate for all people who inject drugs (15.5%).⁽¹⁷⁾
- In Nigeria, women who inject drugs were found to have higher HIV prevalence rates than men in all four states surveyed, aside from the Federal Capital Territory.⁽²⁷⁾

In South Africa, NSPs are still experiencing challenges in reaching women who inject drugs with their services⁽¹⁶⁾. To ensure that services are well-equipped to reach women who inject drugs, service providers, including medical institutions providing HIV testing and treatment, must gain the trust of women who inject drugs. This trust can be established via the medium of women peer workers, multiple encounters and making personal connections with women who inject/use drugs.⁽⁴⁸⁾

In Kenya, NSP services are using community-based outreach enabling access to equipment for women who do not wish to be seen seeking services.^(5, 40, 49) Women who inject drugs have played a significant role in the development and implementation of harm reduction services in the CAHR project.⁽⁴²⁾

It has also been suggested that interventions directed towards sexual risk reduction in combination with harm reduction should be used for women who inject drugs.

⁽⁵⁰⁾ This approach recognises the link that may exist in

some settings between heroin use, HIV and low condom use during sex work, serving to further increase the risk for women.⁽²⁷⁾

Opioid substitution therapy (OST)

As with NSP, the majority of countries in sub-Saharan Africa with reported drug use have not yet introduced OST programmes (see Table 2.9.1 and Map 2.9.1). OST remains largely unavailable, with only six countries in the region implementing this as a public service.

In Kenya, OST was introduced outside of private providers in December 2014.⁽⁵¹⁾ Although the scale of this service is small at present, three fixed sites have been initiated within two years in hospitals in Nairobi, Malindi and Mombasa, and two further independent sites were launched in 2016.⁽⁵⁾ Mathematical modelling has shown that approximately 10% coverage of OST over a five-year period could reduce the HIV incidence among people who previously injected drugs by between 5% and 10%, and if coverage attains 40% the reduction could reach 20%.⁽⁵¹⁾ Since the inception of the OST programme in 2014, 1,100 people have enrolled in this service.⁽³²⁾ However, in-depth interviews with people who inject drugs in Kenya show that while some are able to access the programmes successfully, others report hardship, stigma and the challenge of discrimination by clinic staff.⁽⁵²⁾

In South Africa, the small pilot project in the Western Cape has been joined by a government-funded and NGO-run OST site in Cape Town, providing buprenorphine-naloxone to people who inject opiates.^(16, 53) The city of Tshwane in Gauteng has entered into an agreement for OST to be made available at selected primary healthcare centres, and an OST demonstration project is at the planning stage in Durban, with political support from the provincial Department of Health.⁽¹⁶⁾ These are important developments within South Africa, where, until recently, OST provision was largely limited to the private sector.

Tanzania continues to have the largest government-run OST programme in sub-Saharan Africa. The first OST clinic offering methadone was launched in February 2011 at the Muhumbili National Hospital in Dar es Salaam⁽⁵⁴⁾ and the programme continues to operate from three OST sites.⁽²⁰⁾ Since the change of government in 2015, however, no new clients have been accepted onto the OST programme.^(5, 16)

In Senegal, OST has also been established in a medical centre in Dakar. There has also been a greater focus on



mapping injecting drug use in Senegal in recent years, with early findings showing that heroin is the most popular drug of choice, but it is often smoked rather than injected.⁽¹²⁾ These findings illustrate the urgent need to scale up OST availability for people who use (including those who smoke) opiates.

In Mauritius, under the new government elected in 2014, OST distribution has been moved from the health service to police stations, with daily fixed times (6.00 to 8.00 am) for people who use drugs to attend.⁽²⁹⁾ OST from government-supported services is available only to people who had initiated treatment prior to the inception of new policies in January 2015, including those on maintenance therapy before that date.⁽²⁹⁾ Instead, Suboxone and Naltrexone are available, but selection criteria for this new treatment are uncertain.⁽²⁹⁾ The retreat from a well-established and government-supported harm reduction programme encompassing 52 NSP sites and 16 OST sites is of international concern. Mauritius, which had been a harm reduction champion in the region, is now facing an increase in HIV and HCV infection among the estimated 10,000 people who inject drugs there.⁽⁵⁵⁾

Viral hepatitis

Data on the extent to which people who inject drugs are affected by hepatitis C (HCV) in sub-Saharan Africa remain extremely limited. From the estimates available, it is clear that the prevalence of HCV is very high among people who use drugs when compared with national estimates. HCV prevalence among people who inject drugs in the Kinondoni municipality of Dar es Salaam, Tanzania is reported to be 75.6%,⁽⁴⁵⁾ over 2.5 times higher than the national average of 28.0%.⁽¹⁹⁾ The Integrated Biological and Behavioral Surveillance Survey (IBBS) in Mozambique, a study undertaken between October 2013 and March 2014 in the Maputo and Nampula districts, showed HCV screening results for a sample of people who inject drugs to be 77.3%.⁽⁹⁾ In preliminary studies in Dakar, Senegal in 2011, HCV prevalence in this population was 38.85%.⁽¹²⁾

The lack of availability of HCV testing and treatment is partly due to the prohibitive cost to both the service provider and the service user. In Tanzania, the cost of treatment for HCV is over €10,000 per patient,⁽⁵⁶⁾ rendering it beyond the reach of most people. In Mauritius, HCV testing is available for people who inject drugs. Although it is estimated that 97% are living with the HCV affordable treatment remains unavailable.⁽²⁹⁾ In South Africa, HCV testing is limited to less accessible facilities in the form of regional hospitals, and there is

a dearth of data on the burden of viral hepatitis among people who inject drugs. To combat the lack of data, civil society organisations and academia are working together to conduct a cross-sectional survey in South Africa, recruiting 1,200 people who use drugs in Cape Town, Pretoria and Durban and using a range of HCV testing modalities to develop recommendations for local guidelines on HCV testing and treatment.⁽¹⁶⁾

An initiative is under way to allow low- and middle-income countries to avoid the exorbitant cost of HCV treatment. In sub-Saharan Africa and other regions, Gilead (the pharmaceutical company that has developed medicine suitable for treating HCV) is working with regional partners to introduce the low-cost generic Sovaldi® (one of the new HCV treatment drugs recommended by the World Health Organization) for use in low- and middle-income countries.⁽⁵⁷⁾ Even with these initiatives, however, it is thought that the medicines will still be very expensive.

Tuberculosis (TB)

TB prevalence rates in sub-Saharan Africa are extremely high, with 28% of the world's cases found in this region.⁽⁵⁸⁾ Although TB testing and treatment are available to everyone in principle, they remain out of reach for much of the population in practice, and there is a great paucity of data regarding TB prevalence and treatment access among people who inject drugs.

Whilst the majority of those who have been diagnosed will not develop active TB, people who use, and particularly those who inject, drugs, together with prisoners, are more vulnerable to progressing to active TB due to increased HIV co-infection and the poor prison conditions in some countries.⁽⁵⁹⁾ A study from Côte d'Ivoire, for example, found that people living in the *fumoirs* (crowded spaces where heroin and cocaine are smoked, often located in urban slums) were nearly nine times more likely to have TB, with almost half of the participants also having been incarcerated at least once.⁽¹⁾

The criminalisation of drug use, which is inextricably linked with the intense social stigma and discrimination faced by people who use drugs in the region, often leads to poor health-seeking behaviours and deters individuals from accessing TB services.

Antiretroviral therapy (ART)

It is not clear to what extent people who inject drugs have benefited from the dramatic recent scale-up of ART access in sub-Saharan Africa. Data on the numbers of

people who inject drugs receiving ART within the sub-Saharan Africa region are sparse. In the Seychelles, for example, it is reported that 63% of people who inject drugs have ever had a HIV test,⁽¹⁵⁾ but it is unclear how many receive ART.

Enrolling people who inject drugs into ART programmes is imperative, and integrated services serve to enable access. However, a study conducted in Tanzania concluded that people receiving OST often had to wait weeks to receive their test results, and ART initiation was conducted off-site, creating an additional barrier to seeking essential HIV treatment.⁽⁶⁰⁾ Clients described the increased stigmatisation they felt at the HIV clinic due to their drug use, with women experiencing even greater levels of stigma due to assumptions of sex work with drug use and HIV.⁽⁶⁰⁾ Although integrated care is the recommended gold standard by the World Health Organization (WHO),⁽⁶¹⁾ it is often not in place and poor linkages between harm reduction service providers and HIV testing and treatment services create further barriers for people who use drugs to access treatment.

Civil society reports from Mauritius, Nigeria and South Africa echo these challenges on ART access. While HIV testing and treatment are services that are available to all in principle, the criminalisation of drug use, coupled with experienced or perceived risk of stigma and discrimination in healthcare settings, act as deterrents to service access.^(16, 29)

In Uganda, ART coverage is hoped to be increased to 50% and eventually to 80% over time, and to include people who use drugs.⁽⁶²⁾ However, no tailored service for this key population is available, and civil society report that people who use drugs face violence and police harassment at clinics.⁽³³⁾

Over the course of the CAHR project between 2011 and 2015, the number of people who inject drugs in Kenya who registered for ART went from 6% at baseline to 54%.⁽⁴²⁾ This finding illustrates the positive impact of investing in an integrated harm reduction service provision approach for people who use drugs.

Harm reduction in prisons

Punitive drug policies and law enforcement contribute to a high proportion of people who inject drugs in sub-Saharan Africa being incarcerated. A study involving people who inject drugs in the Seychelles found that just over half had been arrested in the previous twelve months.⁽¹⁵⁾ In a study of people who use drugs in Dakar, Senegal, a history of incarceration was reported by 61.9% (n=506), with 29.2% acknowledging that they consumed drugs whilst in prison.⁽¹²⁾

High-risk injecting practices in prisons in the region may be a significant contributor to accelerating HIV transmission.⁽⁶³⁾ Yet the only country to implement harm reduction services in prison is Mauritius. Methadone maintenance treatment (MMT) was available in prisons in Mauritius when the *Global State* last reported in 2014. However, since the change of government in 2014, this service has been limited to those who already received OST prior to incarceration. New prisoners seeking OST are now offered either buprenorphine or naloxone.

Kenya, Uganda, Tanzania, Seychelles, Mauritius and South Africa all provide HIV testing and ART for prisoners. Access to ART, TB diagnostics and treatment and condoms in South African correctional facilities has reportedly improved since *Global State 2014*, following the prioritisation of these services by government in recent years.⁽¹⁶⁾ However, HCV testing and treatment remains unavailable. In Mauritius, HIV testing is compulsory within the prison setting, with ART being provided to those who require it. TB testing and treatment are also provided. HCV testing is available, but there is currently no treatment for this, and condoms are not made available.⁽²⁹⁾ HIV and TB testing and treatment are also available in prisons in Tanzania, but HCV diagnostics and treatment are not.⁽²⁰⁾

There is no HIV, HCV, TB testing or treatment available in Nigerian prisons, and condoms are not made available to prisoners.⁽³¹⁾ Indeed, it appears that only South Africa and Lesotho distributes condoms in prisons.⁽⁷¹⁾ It is clear from the few studies available that harm reduction services in prisons are greatly needed.

Overdose

There continues to be a dearth of data on the prevalence of and response to overdose in the sub-Saharan Africa region. The latest data from Kenya indicate that, in 2011, approximately 58% of people who injected drugs reported knowing at least one person who had experienced a fatal overdose, and the overdose cases were 83% to 90% higher in Nairobi than in the coastal areas.⁽⁶⁴⁾

Naloxone, a highly effective opioid antagonist used to reverse the effects of opioid overdose, is reportedly available only in Kenya and Tanzania, via health clinics and outreach sites as part of the state health system. Peer distribution of naloxone has been discussed and advocated for in both Kenya and Tanzania, but has not yet been implemented.^(5, 20)

Overdose prevention, in the form of training in behavioural change is available in South Africa as part of



NSP and HIV prevention services, but naloxone is yet to be established as a part of the response.⁽¹⁶⁾ In Mauritius, there is a distinct lack of knowledge and training regarding overdose prevention and no naloxone provision, in spite of the established harm reduction programme.⁽²⁹⁾

Policy developments for harm reduction

Although harm reduction implementation is increasing in some countries in the region of sub-Saharan Africa, it is clear that punitive drug policies and a lack of political will still form significant barriers to the implementation and success of a harm reduction approach to drugs. For example, in late 2014 Uganda's parliament passed the Narcotics Law which when implemented, will result in much longer sentences for those convicted of drug-related offences in the country.⁽⁶⁵⁾

Harm reduction was previously endorsed in the Tanzanian *National Strategy for Noncommunicable Diseases, 2009–2015*.⁽⁶⁶⁾ This policy is currently being revised with input by civil society organisations, although it is uncertain whether harm reduction will be mentioned in the new strategy.⁽²⁰⁾ In Nigeria, where there are no formal active harm reduction services, there remains a mention of harm reduction within the national hepatitis policy,⁽⁶⁷⁾ but not in the country's HIV/AIDS strategy or drug control master plan (2015–2019). Similarly, harm reduction has not been included in any of Uganda's national policies, despite a significant need for these services.⁽³³⁾

South Africa's *National Drug Master Plan 2013–2017*⁽⁶⁸⁾ and *National Strategic Plan on HIV, STIs and TB 2012–2016*⁽⁶⁹⁾ both make explicit reference to harm reduction, highlighting the gradual endorsement of these services for people who use drugs in South Africa.

Despite advances in some countries, policies in much of the region continue to focus on supply reduction and the criminalisation of people who use drugs, overshadowing any harm reduction response or even demand reduction response. However, the African Union, in its common position for the United Nations Special Session (UNGASS) on the drugs, committed to achieving a balanced and integrated approach among supply reduction, demand reduction and harm reduction.⁽³⁰⁾

Civil society and advocacy developments for harm reduction

Civil society organisations have been increasingly active in sub-Saharan Africa, both in implementing harm reduction services and in working to increase awareness of the need for harm reduction. This mobilisation has led, in some countries, to increased levels of support for harm reduction interventions.

In South Africa, civil society organisations were supported by local government to host a Drug Policy Week in Cape Town in 2016, bringing together over 80 representatives of national, provincial and local government, academia and civil society as well as participants from western and southern Africa and the Indian Ocean islands for three days of presentations and deliberations on drug policy reform. The initiative resulted in the creation of a website to share drug policy information among all participants^r and increased levels of support for harm reduction interventions⁽¹⁶⁾ Advocacy efforts also preceded the three NSP site launches in South Africa, and a series of discussions and workshops with law enforcement officials have since taken place covering issues relating to NSP provision.^(16, 34) In April 2016 the Central Drug Authority and the South African National AIDS Council met to discuss a joint strategy around HIV prevention and treatment for people who use drugs, where explicit support for NSP and OST services was highlighted. Although drug user networks do not exist in the country at present, the TB/HIV Care Association is supporting the establishment of two networks, in Pretoria and Cape Town, with input from both the International Network of People who Use Drugs (INPUD) and CoAct.⁽³⁴⁾

South Africa also hosted the 21st International AIDS Conference in July 2016 in Durban. The extent to which this event could serve as a platform to raise awareness and promote harm reduction in the region and beyond was minimised by a distinct absence of harm reduction and drug-related presentations in the main programme. In the fringes of the conference, the drug user and harm reduction networking zone in the Global Village^s ran around 40 sessions, which included presenters from Nigeria, Kenya and South Africa discussing harm reduction, drug policy and the situations faced by people who use drugs in these countries.^t

The Tanzanian Network of People who Use Drugs (TaNPUD) is working to secure small but vital improvements in harm reduction provision, but is as

^r See www.sadrugpolicy.com.

^s Convened by The Urban Futures Centre at Durban University of Technology, in partnership with TB/HIV Care Association in the Global Village with financial support from the AIDS and Rights Alliance for Southern Africa (ARASA).

^t The programme for the drug user and harm reduction networking zone is available at: www.sadrugpolicyweek.com/news/pwud-harm-reduction-zone-aids2016.

yet not attached to any broader network such as the East African Harm Reduction Network.⁽²⁰⁾

The Ugandan Harm Reduction Network (UHRN) is also continuing to advocate for the implementation of harm reduction programmes. It sits on the Key Populations Technical Working Committee, alongside the Ministry of Health, to advance the response to issues faced by people who use drugs.⁽³³⁾ UHRN also sits on the Most At Risk Populations (MARPS) Steering Committee at the Uganda AIDS Commission (UAC), which monitors HIV/AIDS programming in the country. Although at present no harm reduction initiatives operate in Uganda, UHRN's participation in these forums is a positive step forward.

Since *Global State 2014*, a Civil Society Coalition on Drugs has formed in Nigeria, and now advocates for national drug policy reform. YouthRISE has also been undertaking advocacy efforts involving young people who use drugs in Nigeria.⁽³⁰⁾

In 2014 the Africa Key Population Experts Group was formed. At its third meeting in 2015, the group agreed on a strategic framework that noted the importance of the development of monitoring and evaluation tools for key populations in the region, and advocated for the meaningful inclusion of key populations.⁽⁷⁰⁾ With several national and regional Global Fund grants including harm reduction components, harm reduction for people who use drugs is now firmly on the agenda in Global Fund Country Coordinating Mechanisms. The East African Harm Reduction Network and the East and Southern Africa Regional Harm Reduction and Drug Policy Group also serve as regional platforms for harm reduction discussions and the sharing of policy and practice from across the differing countries. The West African Harm Reduction Network, consisting of 42 civil society organisations, issued a statement ahead of UNGASS calling for the acceptance of harm reduction.⁽³⁷⁾

Funding developments for harm reduction

Multilateral agencies and international donors still provide the majority of harm reduction funding in sub-Saharan Africa, with the Global Fund being the largest contributor, as in other regions. In 2015 the East African Harm Reduction Network obtained a grant from the Global Fund to implement harm reduction interventions and improve advocacy efforts in Burundi, Ethiopia, Kenya, Mauritius, Seychelles, United Republic of Tanzania (mainland and Zanzibar) and Uganda.⁽²⁹⁾

Nigeria was approved for a Global Fund grant for harm reduction advocacy and service implementation in 2015 and received US\$8 million. However, it is unclear how these funds have been disbursed in the country and the extent to which they have gone towards harm reduction programme planning and services. Prior to receiving the grant, the Nigerian Agency for the Control of AIDS requested that these funds be diverted to sexual transmitted infections (STI) prevention programmes as it was not in support of harm reduction. Such a diversion of funds runs contrary to harm reduction need and represents a tragic missed opportunity to increase harm reduction awareness and implement services.⁽³¹⁾

In South Africa, civil society will receive funding from the Global Fund through the South African National AIDS Council's work to implement harm reduction for people who inject drugs in four metropolitan areas.⁽¹⁶⁾ This funding will provide support until 2019. Funding has also been provided by Mainline, through Bridging the Gaps, which will also run until 2019. The Open Society Foundations and AmfAR (The Foundation for AIDS Research) have funded policy, human rights and advocacy work in the country. US government grants via PEPFAR (US President's Emergency Plan for AIDS Relief)/ CDC (Centers for Disease Control and Prevention) have included people who inject drugs in their key population prevention programmes in South Africa, which will run from 2016/17 to 2021/22; the scope and specific funding allocations are yet to be announced.⁽³⁴⁾

Through the Global Fund grant, and via the Kenya AIDS NGOs Consortium (KANCO), UHRN is implementing a three-year project on HIV and harm reduction in eastern Africa, which aims to build policy support and technical capacity for harm reduction interventions.

Although harm reduction is beginning to receive financial support from national governments in South Africa,⁽¹⁶⁾ Senegal,⁽³⁷⁾ Tanzania and Mauritius, programmes are still largely dependent on international donor support. The Mauritian government, for example, provides only 25% of current funding for harm reduction, with the remaining 75% covered by the Global Fund.⁽²⁹⁾ In Tanzania, the Elton John AIDS Foundation (EJAF) funding that supported Mdm's harm reduction efforts in Dar es Salaam came to an end in May 2016. It is unclear how services in the country will be affected by this development, and whether other donors will provide money for much needed harm reduction services in the country.⁽²⁰⁾



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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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