1.1 Harm Reduction: A Global Update

In 2010 the state of harm reduction around the world remains very limited, particularly in low- and middle-income countries. However, there have been several significant developments in research, policy and implementation in the past two years. Among these is the greater emphasis placed on the gathering of reliable epidemiological and coverage monitoring data from civil society and UN agencies, within the context of scaling up towards universal access to HIV prevention, treatment, care and support.[1 2 3 4]

Injecting drug use occurs in at least 158 countries and territories around the world.[1] The latest available data estimate that 15.9 million (range 11 to 21 million) people inject drugs globally.[2] The largest injecting populations are found in China, the United States and Russia. In 120 countries, there are reports of HIV infection among people who inject drugs.[2] In eight countries – Argentina, Brazil, Estonia, Indonesia, Kenya, Myanmar, Nepal and Thailand – HIV prevalence among people who inject drugs is estimated to be over 40%.[a] Worldwide, approximately three million (range 0.8 to 6.6 million) people who inject drugs are living with HIV.[2] (See Section 2 for more details.)

Extremely high proportions of people who inject drugs in all regions of the world are also affected by viral hepatitis (in particular, hepatitis B and C), often with HIV co-infection. They are also at greater risk of tuberculosis, which is a leading cause of death among people who inject drugs, particularly those living with HIV. Overdose is another major cause of death among injecting populations around the world. Other major health harms faced by this group are injection-related bacterial infections, some of which can be fatal. (See Section 3 for more details.)

The Global Harm Reduction Response

International policy developments for harm reduction

In the past two years there have been a number of significant developments within international policy that have implications for harm reduction.

- The term 'harm reduction' remains controversial in international drug policy fora. At the Commission on Narcotic Drugs (CND), the term was struck from the final version of the Political Declaration on Drugs in 2009, a situation about which twenty-six states formally expressed their disagreement.[5] It also failed to be included in a resolution on universal access to HIV services in March 2010.[6] Where harm reduction was omitted, agreed text included terms such as 'comprehensive' services, specifically those in line with guidelines from WHO, UNAIDS and UNODC, which include needle and syringe exchange and opioid substitution therapy.
- In July 2009 'harm reduction' appeared in a resolution on the work of UNAIDS agreed by UN Member States of the Economic and Social Council, a UN body senior to the CND.[7] It was also included in a Human Rights Council resolution on human rights and HIV/AIDS, agreed by Member States, including those that opposed the term at the CND (e.g. Japan and Russia).[8]
- The election of President Barack Obama and the subsequent lifting of a long-standing ban on federal funding of needle exchange in the United States could potentially increase financial support for harm reduction nationally and internationally through funds from the President's Emergency Plan for AIDS Relief (PEPFAR).
- The 24th UNAIDS Programme Coordinating Board (PCB) meeting held in Geneva, Switzerland in June 2009 dedicated time to the issue of HIV prevention among people who inject drugs.[9] The PCB called on the UNAIDS programme, including UNODC, to 'address the uneven and relatively low coverage of services', to 'facilitate greater resource mobilization', to work with 'Member States to further harmonize laws governing HIV and drug use' and to improve data collection. They also called for the development of guidance and models for harm reduction tailored towards sub-groups of drug users such as women, sex workers, young people, migrants and stimulant users.[9]
- Countries have submitted their first reports on progress against national targets on scaling up towards universal access to HIV prevention, treatment and care. An analysis of country progress reports indicated that on average only 26% of injecting populations had accessed voluntary HIV counselling and testing and received a test result (from twenty-six reporting countries). It also found that among 149 low- and middle-income countries, only forty-one had conducted systematic surveillance of HIV among people who inject drugs.[3]

a Updated information for Ukraine resulted in its removal from this list.

A conducive environment for harm reduction

In 2010 there are ninety-three countries and territories worldwide that support a harm reduction approach, eleven more than the number reported in 2008[1] (see Table 1.1). This support is explicit either in national policy documents (seventy-nine countries – eight more than in 2008) and/or through the implementation or tolerance of harm reduction interventions such as needle exchange (eighty-two countries – five more than in 2008) or opioid substitution therapy (seventy countries – seven more than in 2008).[b]

A substantial number of countries also continue to support harm reduction through assistance to programmes in other countries (or providing funds to international agencies) or by making explicit supportive references to harm reduction in international fora such as at the CND or at the UNAIDS PCB. These include countries in Western Europe, Oceania, the Caribbean, the Middle East and North Africa and Latin America.

Table 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	Needle exchange programmes operational	Opioid substitution programmes operational	Drug consumption room(s)
ASIA				
Afghanistan	✓	✓	✓	x
Bangladesh	✓	✓	x	x
Cambodia	✓	✓	x	x
China	✓	✓	✓	x
Hong Kong	✓	x	✓	x
India	✓	✓	✓	x
Indonesia	✓	✓	✓	x
Malaysia	✓	✓	✓	x
Maldives	x	x	✓	x
Mongolia	x	✓	x	x
Myanmar	✓	✓	✓	x
Nepal	✓	✓	✓	x
Pakistan	✓	✓	x	x
PDR Laos	✓	x	x	x
Philippines	✓	✓	x	x
Taiwan	✓	✓	✓	x
Thailand	✓	✓	✓	x
Vietnam	✓	✓	✓	x
CARIBBEAN				
Puerto Rico	nk	✓	✓	x
Trinidad and Tobago	✓	x	x	x
EURASIA				
Albania	✓	✓	✓	x
Armenia	✓	✓	✓	x
Azerbaijan	x	✓	✓	x
Belarus	✓	✓	✓	x
Bosnia and Herzegovina	✓	✓	✓	x
Bulgaria	✓	✓	✓	x
Croatia	✓	✓	✓	x
Czech Republic	✓	✓	✓	x
Estonia	✓	✓	✓	x
Georgia	✓	✓	✓	x
Hungary	✓	✓	✓	x
Kazakhstan	✓	✓	✓	x
Kosovo	x	✓	x	x
Kyrgyzstan	✓	✓	✓	x
Latvia	✓	✓	✓	x
Lithuania	✓	✓	✓	x
Macedonia	✓	✓	✓	x
Moldova	✓	✓	✓	x
Montenegro	✓	✓	✓	x
Poland	✓	✓	✓	x
Romania	✓	✓	✓	x
Russia	x	✓	x	x
Serbia	✓	✓	✓	x
Slovakia	✓	✓	✓	x
Slovenia	✓	✓	✓	x
Tajikistan	✓	✓	x	x
Turkmenistan	x	✓	x	x
Ukraine	✓	✓	✓	x
Uzbekistan	✓	✓	x	x
LATIN AMERICA				
Argentina	✓	✓	x	x
Brazil	✓	✓	x	x
Colombia	✓	x	✓	x
Mexico	✓	✓	✓	x
Paraguay	✓	✓	x	x
Uruguay	✓	✓	x	x
MIDDLE EAST and NORTH AFRICA				
Egypt	x	✓	x	x
Iran	✓	✓	✓	x
Israel	✓	✓	✓	x
Lebanon	✓	✓	✓	x
Morocco	✓	✓	x	x
Oman	x	✓	x	x
Palestine	x	✓	x	x
Tunisa	x	✓	x	x

b While the total NSP and OST figures are the same as those published by the UN Reference Group, there are some differences behind the figures. For example, IHRA has included Hong Kong, Kosovo and Zanzibar as separate countries/territories, has included information on developments since the UN Reference Group research was carried out (e.g. OST in Armenia) and has not included services in UAE and Sierra Leone as these were disputed by civil society and UN representatives.

c This includes countries that have harm reduction in their national policies or strategy documents on HIV, hepatitis C and/or drug use. In many countries, harm reduction may appear in one or more of such policies, but not all. For example, the US national HIV policy and the national strategy on hepatitis C include the term, whereas the national drug policy does not.

Country or territory	Explicit supportive reference to harm reduction in national policy documents	Needle exchange programmes operational	Opioid substitution programmes operational	Drug consumption room(s)
NORTH AMERICA				
Canada	✓	✓	✓	✓
United States	✓	✓	✓	x
OCEANIA				
Australia	✓	✓	✓	✓
New Zealand	✓	✓	✓	x
SUB-SAHARAN AFRICA				
Kenya	✓	x	✓	x
Mauritius	✓	✓	✓	x
Senegal	x	x	✓	x
Seychelles	x	x	x	x
South Africa	x	x	✓	x
Tanzania	✓	x	x	x
Zanzibar	✓	x	x	x
WESTERN EUROPE				
Austria	✓	✓	✓	x
Belgium	✓	✓	✓	x
Cyprus	✓	✓	✓	x
Denmark	✓	✓	✓	x
Finland	✓	✓	✓	x
France	✓	✓	✓	x
Germany	✓	✓	✓	✓
Greece	✓	✓	✓	x
Iceland	nk	x	✓	x
Ireland	✓	✓	✓	x
Italy	✓	✓	✓	x
Luxembourg	✓	✓	✓	✓
Malta	✓	✓	✓	x
Netherlands	✓	✓	✓	✓
Norway	✓	✓	✓	✓
Portugal	✓	✓	✓	x
Spain	✓	✓	✓	✓
Sweden	✓	✓	✓	x
Switzerland	✓	✓	✓	✓
United Kingdom	✓	✓	✓	x

nk = not known

Civil society

Non-governmental organisations (NGOs) and networks continue to be the drivers behind the harm reduction response in many parts of the world. At the international level, numerous health and development NGOs support and advocate for a harm reduction approach, as do some in the human rights field, such as Human Rights Watch.

Harm reduction networks now exist in every region of the world and continue to make important contributions at the regional and international levels. Regional networks include the Asian Harm Reduction Network (AHRN), Eurasian Harm Reduction Network (EHRN), Caribbean Harm Reduction Coalition (CHRC), Middle East and North African Harm Reduction Association (MENAHRA), Intercambios Asociación Civil, Sub-Saharan African Harm Reduction Network (SAHRN) and the most recently formed European Harm Reduction Network (EuroHRN).

In addition, there are global networks that include harm reduction as a core part of their work, for example YouthRISE, International Network of People Who Use Drugs (INPUD), International Nursing Harm Reduction Network (INHRN), Coalition of Police Supporting Harm Reduction (COPS-HR), Women's Harm Reduction International Network (WHRIN) and the International Drug Policy Consortium (IDPC).

The harm reduction 'network of networks', which has collectively issued statements on harm reduction resourcing[10] and UN system-wide coherence,[11] also includes some national harm reduction networks, such as the Canadian Harm Reduction Network (CHRN), Colectivo por Una Política Integral Hacia las Drogas (CUPIHD, based in Mexico) and the Harm Reduction Coalition (HRC, based in the US).

The engagement of civil society in national policy making on drugs varies dramatically from country to country. At the international level, there has been some progress in this regard. For example, the 'Beyond 2008' regional and global fora provided a means for civil society to have an input into the 1998 to 2008 review of the UN General Assembly Special Session on Illicit Drugs. The process culminated in the agreement of a civil society consensus statement, which included explicit support for harm reduction. Crucially, the term 'harm reduction' was not included in the final Political Declaration.[12]

Meaningful engagement at the CND still does not compare with that of parallel UN meetings.[13] [14] At CND 2009, it is estimated that 200 NGO delegates, representing sixty-five official organisations, attended the proceedings. The IDPC reported that at least ten of the fifty-three CND delegations included NGO representation.[d] [15]

The representation of people who use drugs in international policy-making fora has seen some advances in recent years, in large part due to the work of INPUD. Progress includes representation on the UK delegation at CND 2009 and 2010 and increased engagement with and representation on the UNAIDS PCB. Since 2008 INPUD has become an increasingly important partner for wider civil society and UN agencies on harm reduction and other drug policy issues.

d Albania, Georgia, Kyrgyzstan, Lithuania, Mexico, the Netherlands, New Zealand, St Lucia, Ukraine and the UK.

Global coverage of harm reduction services

The lack of available coverage estimates before 2010 makes it difficult to assess progress over the past two years. However, in general, data indicate that more services have become available in the countries where harm reduction already existed. In addition, several countries have introduced needle and syringe programmes and/or opioid substitution therapy in the past two years. Despite this, the extent of harm reduction coverage, particularly in low- and middle-income countries, remains poor.

Needle and syringe exchange programmes (NSPs)

In 2010 there are eighty-two countries and territories providing some level of needle and syringe exchange programming, whether through community-based outreach, specialist NSPs, pharmacy-based schemes or vending machines. Data indicate that there have been increases in the number of services operating in several countries, including countries with significant HIV epidemics among injecting populations, such as Ukraine and Iran. NSPs have also started operating in new countries including Mongolia, the Philippines, Kosovo and Tunisia.

There is considerable variation between countries in the number of operational NSP sites as well as the coverage of these services. In general, coverage is higher in high-income countries, with several Western European countries and Australia reaching the international recommended coverage of 200 needles and syringes distributed per person who injects drugs per year. In low- and middle-income countries, the average coverage level is considerably lower, with countries in Latin America, the Caribbean, the Middle East and Africa distributing less than one needle per person per year.[4]

Seventy-six countries and territories where injecting drug use is reported (thirty-eight of them with HIV reported among people who inject drugs) remain without any available needle and syringe exchange.

Drug consumption rooms (DCRs)

In 2010 sixty cities around the world have one or more DCR, which allows people to use drugs under the supervision of trained staff and without fear of arrest. The majority of these are in Western Europe, where there are a total of ninety operational DCRs across the Netherlands, Germany, Luxembourg, Norway, Spain and Switzerland. In addition, there is one DCR in Sydney, Australia and one in Vancouver, Canada.

Opioid substitution therapy (OST)

Opioid substitution is prescribed for maintenance therapy in seventy countries and territories around the world. Methadone and buprenorphine are mainly used, but in some countries slow-release morphine and codeine, and heroin-assisted treatment are also offered.

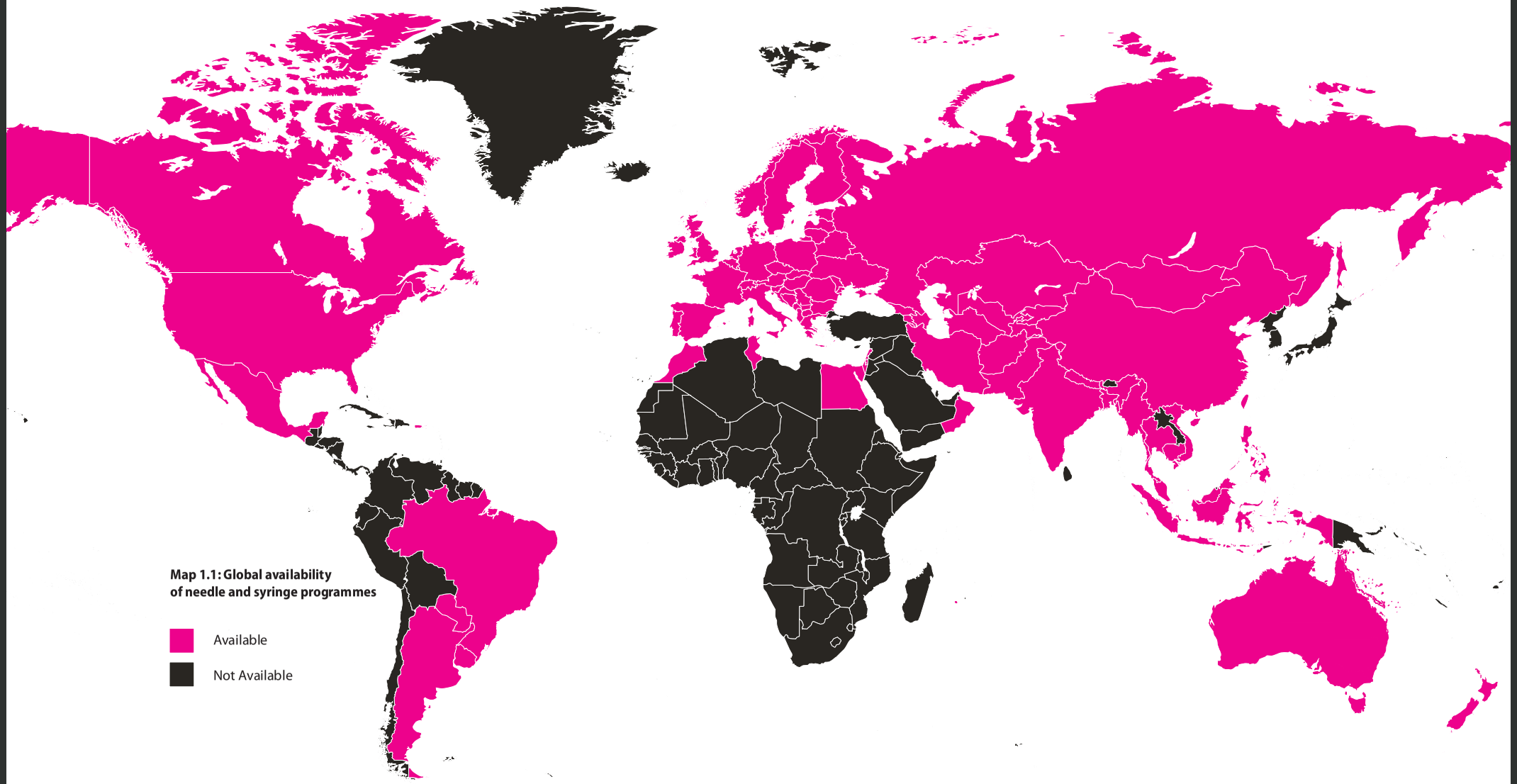
There are indications that a number of countries, including China, India and Iran, have made considerable efforts to scale up the number of OST sites since 2008. OST has been newly introduced in several countries, including Afghanistan, Armenia, Colombia, Kazakhstan, the Maldives and Senegal.

Coverage of this intervention varies considerably around the world. In general, the number of OST sites and the numbers of people receiving OST are higher in high-income countries; for example, there are sixty-one OST recipients for every 100 people who inject drugs in Western Europe. Iran has the highest OST coverage outside Western Europe at fifty-two OST recipients for every 100 people who inject drugs.

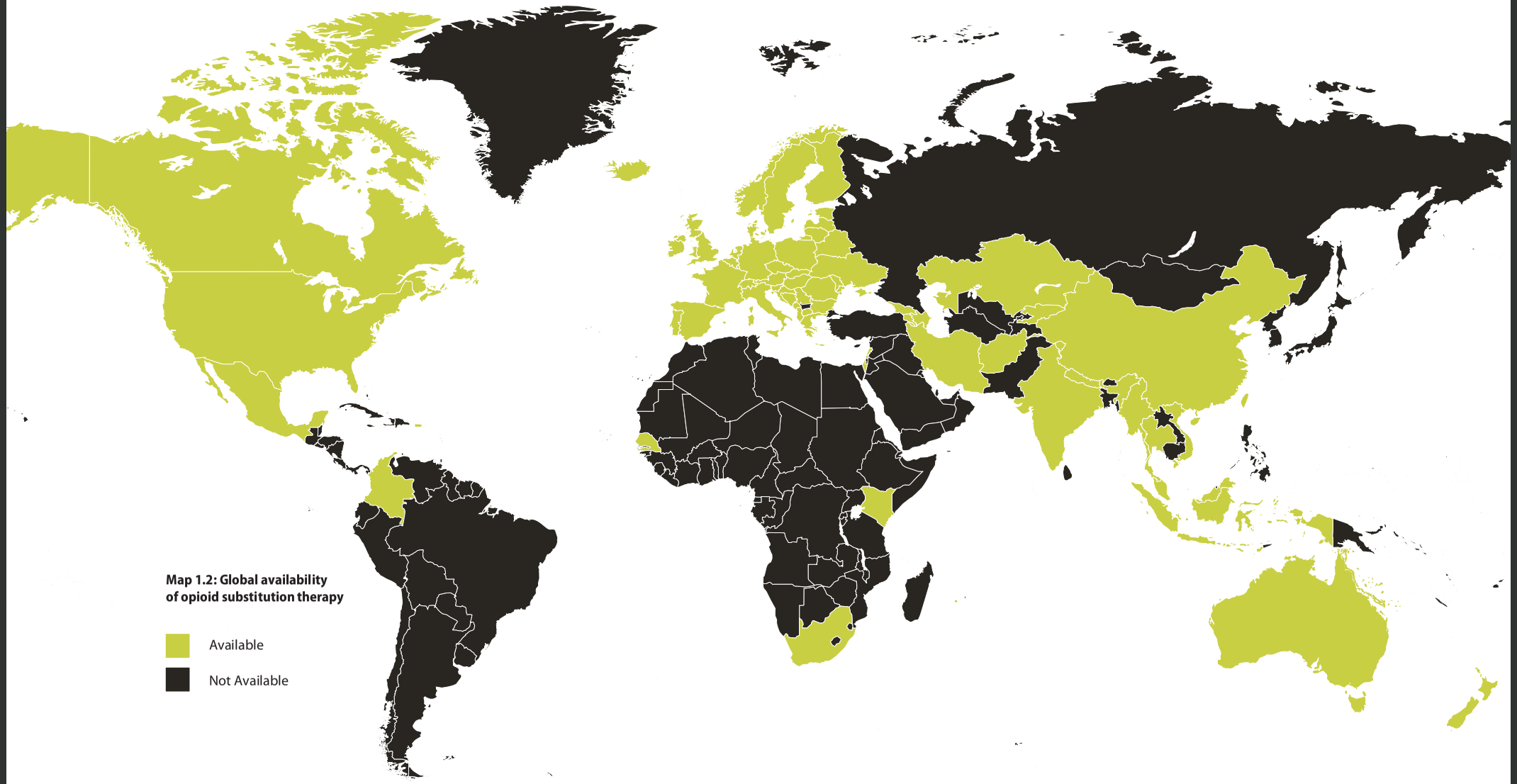
However, across Central Asia, Latin America and Sub-Saharan Africa, OST coverage equates to less than or the equivalent of one person for every 100 people who inject drugs. At the global level, it is estimated that there are between six and twelve recipients of OST for every 100 people who inject drugs.

Eighty-eight countries and territories where injecting drug use has been reported (fifty of them with reports of HIV among this population) remain without any available OST.

Map 1.1: Global availability of needle and syringe programmes



Map 1.2: Global availability of opioid substitution therapy



Harm reduction in prisons

The availability of NSPs, OST and other harm reduction services within prisons and other places of detention remains poor. Many countries that have adopted harm reduction in their responses to drug-related harms outside prisons fail to do so in prisons and other places of detention. To date, only ten countries have NSPs operating in at least one prison and less than forty countries have some form of OST available in at least one prison. Many of these interventions reach very small numbers. There is an urgent need to introduce comprehensive programmes and to scale up rapidly.

Other harm reduction services

The extent to which harm reduction interventions other than NSP and OST are reaching people who inject drugs around the world is less well researched on a global scale. It is difficult to determine, for example, the numbers who are in need of or have received treatment for hepatitis B or C, or for tuberculosis (TB). These interventions are included within the WHO, UNAIDS and UNODC comprehensive package of interventions recommended for people who inject drugs. However, available information suggests that while these affect vast numbers of people who inject drugs, very few have access to treatment, particularly in low- and middle-income countries.

Similarly, research on overdose mortality rates and overdose prevention service coverage shows that while this is a leading cause of death among people who use drugs, particularly those who inject, the numbers in receipt of prevention information or life-saving naloxone remain very low.

Other important health harms frequently experienced by people who inject drugs are injecting-related bacterial infections. These infections are likely to cause significant problems among people that inject drugs in all countries and there is a need to invest further in the harm reduction interventions that prevent and treat these infections.

In addition, the response to harms related to use of non-opiate drugs such as amphetamines remains underdeveloped when compared with the response to opiates and injecting-related harms. Programmes do exist and new guidance is being compiled, but there is a need for evaluation, further documentation of experiences and expansion of effective interventions.

Scale-up requires scaled-up investment

In calling for increased access to services, it is important to assess the finances that are currently available for the harm reduction response. IHRA estimates that US$160 million was spent on HIV-related harm reduction in low- and middle-income countries in 2007.[16] This works out at less than three US cents per day per person injecting drugs in these countries, which is clearly insufficient. It also means that the biggest investors in harm reduction are people who inject drugs themselves. The expenditure on harm reduction supplies (e.g. needles and syringes) and on drug treatment mainly comes from the out-of-pocket expenses of people who use drugs, rather than from harm reduction services.

In order to have an impact on HIV and other harms faced by people who use drugs, interventions must be scaled up, but this will only be possible with substantially increased investment from governments and international donors.

The regional updates in **Section 2** of this report provide further detail on the state of the harm reduction response around the world, particularly highlighting developments since 2008. **Section 3** explores issues that are integral to assessing the global state of harm reduction, but that have, in general, received less attention within research and in harm reduction responses. These include the response to amphetamine-related harms; harm reduction in prisons; the reduction of various drug-related health harms including bacterial infections, tuberculosis, viral hepatitis and overdose; and the extent to which financial resources for harm reduction are available.

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