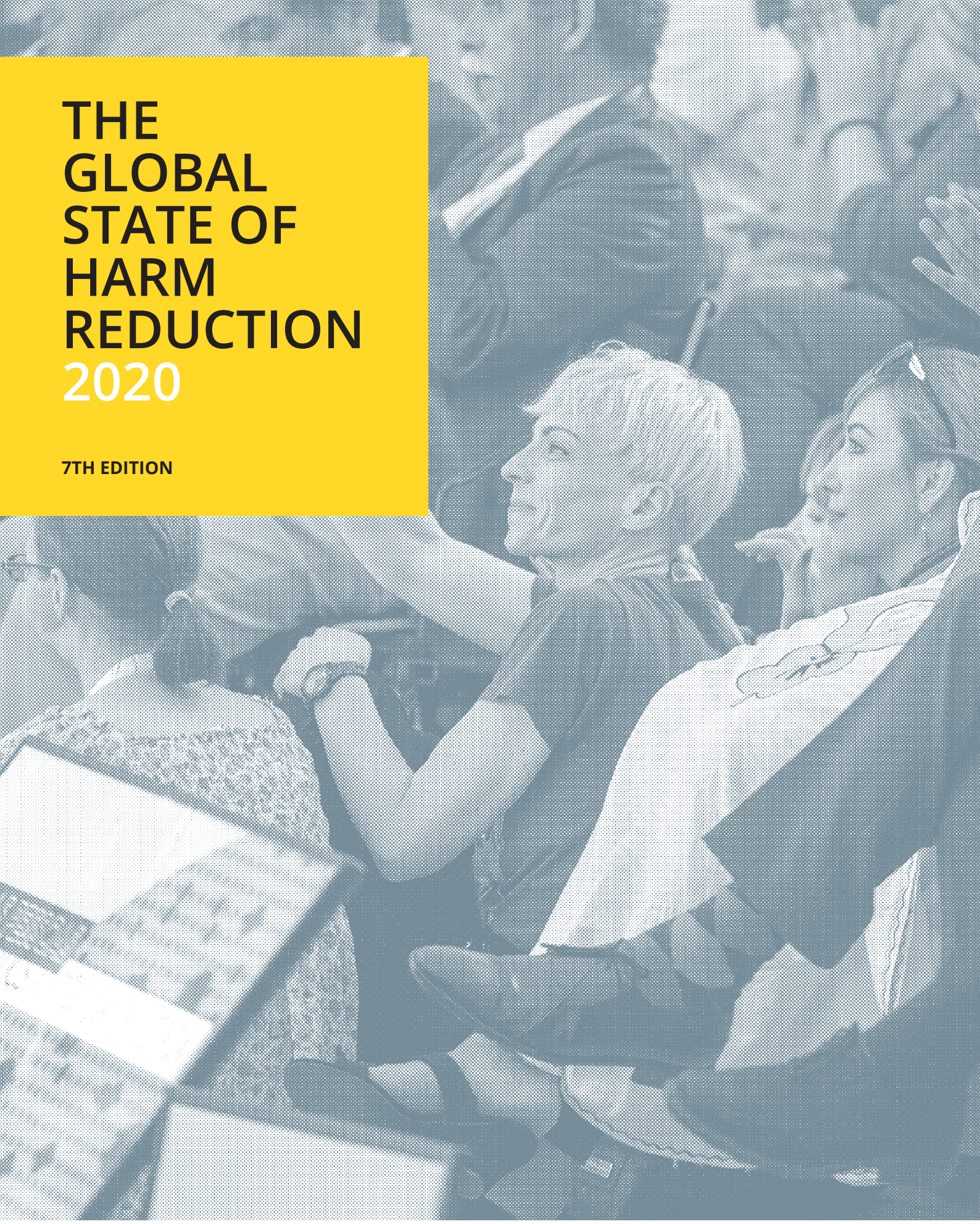
THE GLOBAL STATE OF HARM REDUCTION 2020

7TH EDITION



THE GLOBAL STATE OF HARM REDUCTION

HARM REDUCTION INTERNATIONAL

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Contents

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Foreword by Dr Tlaleng Mofokeng

Everyone has a right to health and to be treated with respect and equality - regardless of gender, sexuality, race, nationality, legal status or drug use. The compassionate and inclusive approach that guides harm reduction is essential to achieving good health for all. Harm reduction can be a model of integrated service delivery that centres the person, takes into account their intersectional vulnerabilities, and provides programmes that help them achieve better health.

Good health is at the core of a life lived with dignity. The COVID-19 pandemic has exposed enormous disparities that impact the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. It has also made painfully clear that until we ensure that *everybody* can enjoy their right to health, we will not be a thriving society.

Stigmatisation, criminalisation and discrimination are all public health issues because they contribute to negative health outcomes for individuals and communities by pushing people to the margins. People who use drugs experience stigma, hostile laws, and in many instances are criminalised. As a result, their access to essential health goods, services and facilities is not guaranteed, which may lead to abuses of the right to health and the impairment of the enjoyment of other human rights. Harm reduction as an approach lessens the negative impact on the health and wellbeing of people who use drugs.

Harm reduction, as a person-centered and rights-based approach, is a far more effective and positive public health solution. Yet, we see an increase in punitive responses to drugs in many countries, particularly in Asia, Eurasia, Africa, and Central and Latin America. Far from safeguarding individual and public health, these responses drive further stigmatisation and discrimination of people who use drugs, and violate their human rights.

While we have seen progress in harm reduction service provision over the last few decades, the *Global State of Harm Reduction 2020* reveals enormous gaps in access to these services. Vulnerable communities are further marginalised by hostile laws and policies designed to exclude and punish. These laws and policies fail to provide services for and meet the unique needs of women, of people living in rural areas, people in prison, and people of African descent and Indigenous peoples around the world. And in doing that, they create worse health outcomes for these communities. We also see this in the difference in the number and nature of harm reduction services available to people in high-income countries versus in low- and middle-income countries, and in the funds allocated to these services.

These gaps are compounded by a lack of comprehensive, disaggregated data. If we are to achieve the right to health for all, we need to also urgently address this data deficit. Quality data will tell us who is being left behind, and will help us better utilise available funds and make sure that the services we are providing are meeting the needs of people who use drugs.

Everyone has a right to health and to be treated with respect and equality - regardless of gender, sexuality, race, nationality, legal status or drug use. The compassionate and inclusive approach that guides harm reduction is essential to achieving good health for all. Harm reduction can be a model of integrated service delivery that centres the person, takes into account their intersectional vulnerabilities, and provides programmes that help them achieve better health.

And that is the essence of protecting and promoting the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Dr Tlaleng Mofokeng
United Nations Special Rapporteur on the Right to Health

Introduction and Methodology

In 2008, Harm Reduction International (HRI) released the first *Global State of Harm Reduction*, a report that mapped responses to drug-related HIV, viral hepatitis and tuberculosis (TB) 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 2008, the biennial report has become a key publication for researchers, policymakers, civil society organisations, UN agencies and advocates, mapping harm reduction policy adoption and programme implementation globally. Over the last decade, reports of injecting drug use and the harm reduction response have increased; harm reduction programmes are currently operating at some level in almost half of the 179 countries in the world where injecting drug use has been documented.

The *Global State of Harm Reduction* has always relied heavily on local knowledge and the experience of those working on the ground. In this edition, we expanded this cooperation and asked regional experts to lead on chapters in Asia, Eurasia, Latin America, the Middle East and North Africa and sub-Saharan Africa. Though the methodology used was the same in every region, we hope that the involvement of regional experts and harm reduction organisations will contribute to a more comprehensive, thorough analysis in the *Global State of Harm Reduction 2020*.

The structure of this year's report is slightly different from the previous versions. Following consultations after the *Global State of Harm Reduction 2018*, we merged the Latin America and Caribbean regions, and introduced thematic chapters on hepatitis C and TB. We also added a separate thematic COVID-19 chapter describing the impact of the pandemic on harm reduction service delivery.

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

Harm Reduction International defers to, and respects local and regional terminology preferences, and is committed to the use of non-stigmatising, accurate language. We take this approach and use the term opioid agonist therapy (OAT) for the purpose of standardising our global publications. This decision is based on consideration of the *Language Statement and Reference Guide*,[1] from the International Network of People Who Use Drugs (INPUD) and the Asian Network of People Who Use Drugs (ANPUD), which suggests that the word 'substitution' is potentially misleading, stigmatising, and does not accurately describe the effect of the treatment. Harm Reduction International is committed to being inclusive and anti-racist, and we capitalise Black in a racial, ethnic or cultural sense, and capitalise Indigenous in reference to original inhabitants of a place.

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 intergovernmental organisations, 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, hepatitis C, TB, drug use and harm reduction. Harm Reduction International also enlisted support from regional harm reduction networks and researchers to gather qualitative information on key developments[1] and to review population size estimates, prevalence data on HIV and viral hepatitis among people who inject/use drugs, and the extent of provision for needles and syringes, opioid agonist therapy, naloxone, drug checking services, and drug consumption rooms.

Quantitative data for the tables at the beginning of each chapter in Section 2 has 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 September 2020). Where no source was available, the data were unpublished or their reliability questioned by civil society organisations, researchers or other experts, we have sought expert opinion to identify additional sources and verify their reliability.

Epidemiological data in many of the regional chapters has been sourced from two global systematic reviews, published in the Lancet Global Health in 2017, supplemented by national or regional experts.[2,3] These reviews identified the prevalence of injecting drug use, the sociodemographic characteristics of, and risk factors for people who inject drugs, the prevalence of blood-borne viruses;[2] and coverage of needle and syringe programmes, opioid agonist therapy, HIV testing, anti-retroviral therapy (ART) and

1 A copy of the *Global State of Harm Reduction 2020* questionnaire can be obtained by contacting office@hri.global.

condom programmes.[3] The data from Western Europe and some countries in Eurasia has been sourced from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), unless otherwise stated in the text. Footnotes and references are provided for all estimates reported, together with any discrepancies in the data. Where information in the tables is outdated, we have provided footnotes with a year of estimate.

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 different regional 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, Latin America and the Caribbean, 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

In 2017, two global systematic reviews on the prevalence of injecting drug use and prevalence of HIV and hepatitis, and on the coverage of interventions to prevent and manage HIV and hepatitis were published in the Lancet Global Health.[2,3] These reviews were welcomed by the international community as an independent source of data and analysis. Such comprehensive, independent reviews have not been published since. In 2019, however, a global, regional and national estimate on hepatitis C prevalence among people who have recently injected drugs was published in the Addiction journal, supporting global hepatitis C elimination efforts.[4] For Western European countries and some countries in Eurasia, the EMCDDA has continued to be a crucial source of reliable data for this edition of the *Global State of Harm Reduction* as in past editions. Other sources include global AIDS response progress reports submitted by governments to UNAIDS in 2018/2019/2020, data published by the UNODC in the *World Drug Report* in 2020, 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 2018* [5] has been included, with footnotes provided on dates of estimate where necessary.

Our data on epidemiology and coverage represents 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; as such it has limitations. It does not evaluate the quality of the services that are in place, although where possible it does highlight areas of concern.

While the *Global State of Harm Reduction 2020* 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 legal or illegal substance use.

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1.1 EXECUTIVE SUMMARY

The Global Harm Reduction Response

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

Country or territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room	Peer distribution of naloxone	OAT in at least one prison	NSP in at least one prison
ASIA							
Afghanistan	✓	✓	✓	×	✓	✓	×
Bangladesh	×	✓	✓	×	×	×	×
Bhutan	✓	×	×	×	×	×	×
Brunei Darussalam	×	×	×	×	×	×	×
Cambodia	✓	✓	✓	×	×	×	×
China	×	✓	✓	×	×	×	×
Hong Kong	×	×	✓	×	×	×	×
India	✓	✓	✓	×	✓	✓	×
Indonesia	×	✓	✓	×	×	✓	×
Japan	×	×	×	×	×	×	×
Laos	×	×	×	×	×	×	×
Macau	✓	✓	✓	×	×	×	×
Malaysia	✓	✓	✓	×	×	✓	×
Maldives	×	×	✓	×	×	×	×
Mongolia	×	×	×	×	×	×	×
Myanmar	✓	✓	✓	×	✓	×	×
Nepal	✓	✓	✓	×	×	×	×
Pakistan	×	✓	×	×	×	×	×
Philippines	×	×	×	×	×	×	×
Singapore	×	×	×	×	×	×	×
South Korea	×	×	×	×	×	×	×
Sri Lanka	×	×	×	×	×	×	×
Taiwan	✓	✓	✓	×	×	×	×
Thailand	✓	✓	✓	×	×	×	×
Vietnam	✓	✓	✓	×	✓	✓	×
EURASIA							
Albania	✓	✓	✓	×	×	✓[a]	×
Armenia	✓	✓	✓	×	×	✓	✓
Azerbaijan	×	✓	✓	×	×	×	×
Belarus	✓	✓	✓	×	×	×	×
Bosnia and Herzegovina	✓	✓	✓	×	×	✓	×
Bulgaria	✓	×	✓	×	×	✓	×
Croatia	✓	✓	✓	×	×	✓	×
Czechia	✓	✓	✓	×	×	✓	×
Estonia	✓	✓	✓	×	✓	✓	×
Georgia	✓	✓	✓	×	×	✓[b]	×
Hungary	✓	✓	✓	×	×	✓[b]	×
Kazakhstan	✓	✓	✓	×	×	×	×
Kosovo	✓	✓	✓	×	×	×	×
Kyrgyzstan	✓	✓	✓	×	×	✓	✓
Latvia	✓	✓	✓	×	×	✓[a]	×
Lithuania	✓	✓	✓	×	×	✓[a]	×
Moldova	✓	✓	✓	×	×	✓	✓
Montenegro	✓	✓	✓	×	×	✓[a]	×

a OAT cannot be initiated within the prison, but is available as a continuation of medication
b OAT is available only for short detoxification but not for long term maintenance treatment

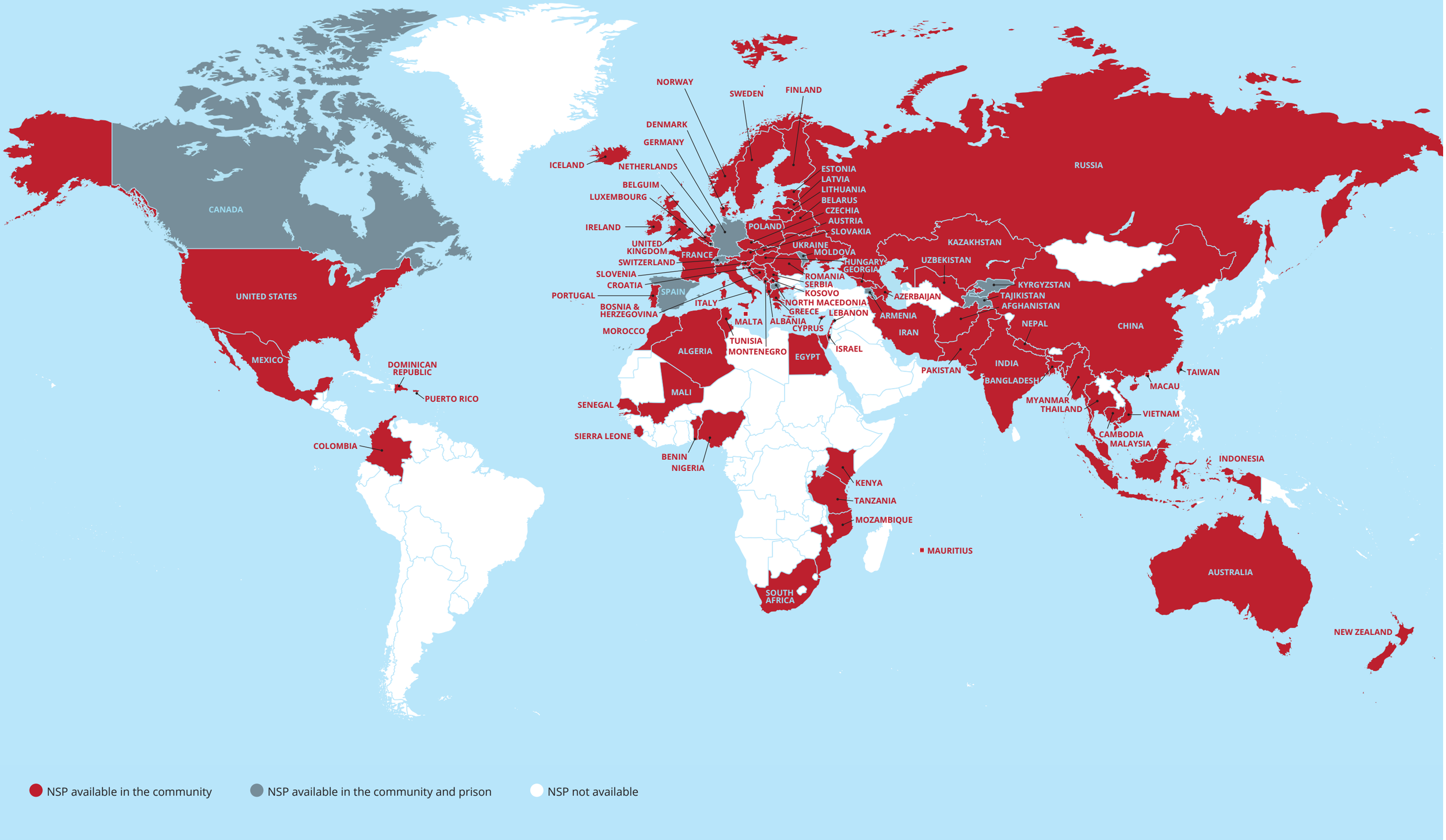
Country or territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room	Peer distribution of naloxone	OAT in at least one prison	NSP in at least one prison
North Macedonia	✓	✓	✓	×	×	✓	✓
Poland	✓	✓	✓	×	×	✓	×
Romania	✓	✓	✓	×	×	✓	×
Russia	×	✓	×	×	×	×	×
Serbia	✓	✓	✓	×	×	✓[a]	×
Slovakia	✓	✓	✓	×	×	×	×
Slovenia	✓	✓	✓	×	×	✓	×
Tajikistan	✓	✓	✓	×	×	✓	✓
Turkmenistan	×	×	×	×	×	×	×
Ukraine	✓	✓	✓	×[c]	✓	✓	×
Uzbekistan	✓	✓	×	×	×	×	×
LATIN AMERICA AND THE CARIBBEAN							
Argentina	✓	×	✓	×	×	×	×
The Bahamas	✓	×	×	×	×	×	×
Bolivia	×	×	×	×	×	×	×
Brazil	×	×	×	×	×	×	×
Chile	×	×	×	×	×	×	×
Colombia	✓	✓	✓	×	×	×	×
Costa Rica	✓	×	×	×	×	×	×
Dominican Republic	✓	✓	×	×	×	×	×
Ecuador	✓	×	×	×	×	×	×
El Salvador	×	×	×	×	×	×	×
Guatemala	×	×	×	×	×	×	×
Guyana	×	×	×	×	×	×	×
Haiti	×	×	×	×	×	×	×
Honduras	×	×	×	×	×	×	×
Jamaica	×	×	×	×	×	×	×
Mexico	✓	✓	✓	×[d]	✓	×	×
Nicaragua	×	×	×	×	×	×	×
Panama	×	×	×	×	×	×	×
Paraguay	×	×	×	×	×	×	×
Peru	×	×	×	×	×	×	×
Puerto Rico	✓	✓	✓	×	✓	×	×
Suriname	×	×	×	×	×	×	×
Uruguay	✓	×	×	×	×	×	×
Venezuela	×	×	×	×	×	×	×
MIDDLE EAST AND NORTH AFRICA							
Algeria	×	✓	×	×	×	×	×
Bahrain	×	×	×	×	×	×	×
Egypt	✓	✓	×	×	×	×	×
Iran	✓	✓	✓	×	×	✓	×
Iraq	×	×	×	×	×	×	×
Israel	✓	✓	✓	×	×	✓	×
Jordan	×	×	×	×	×	✓[a]	×
Kuwait	×	×	×	×	×	×	×
Lebanon	✓	✓	✓	×	×	✓[a]	×

c There is one harm reduction site that allows drug use on its premises, but it is not recognised officially as a DCR.
d Though one DCR operates in Mexicali, Mexico, this is not officially sanctioned by the state.

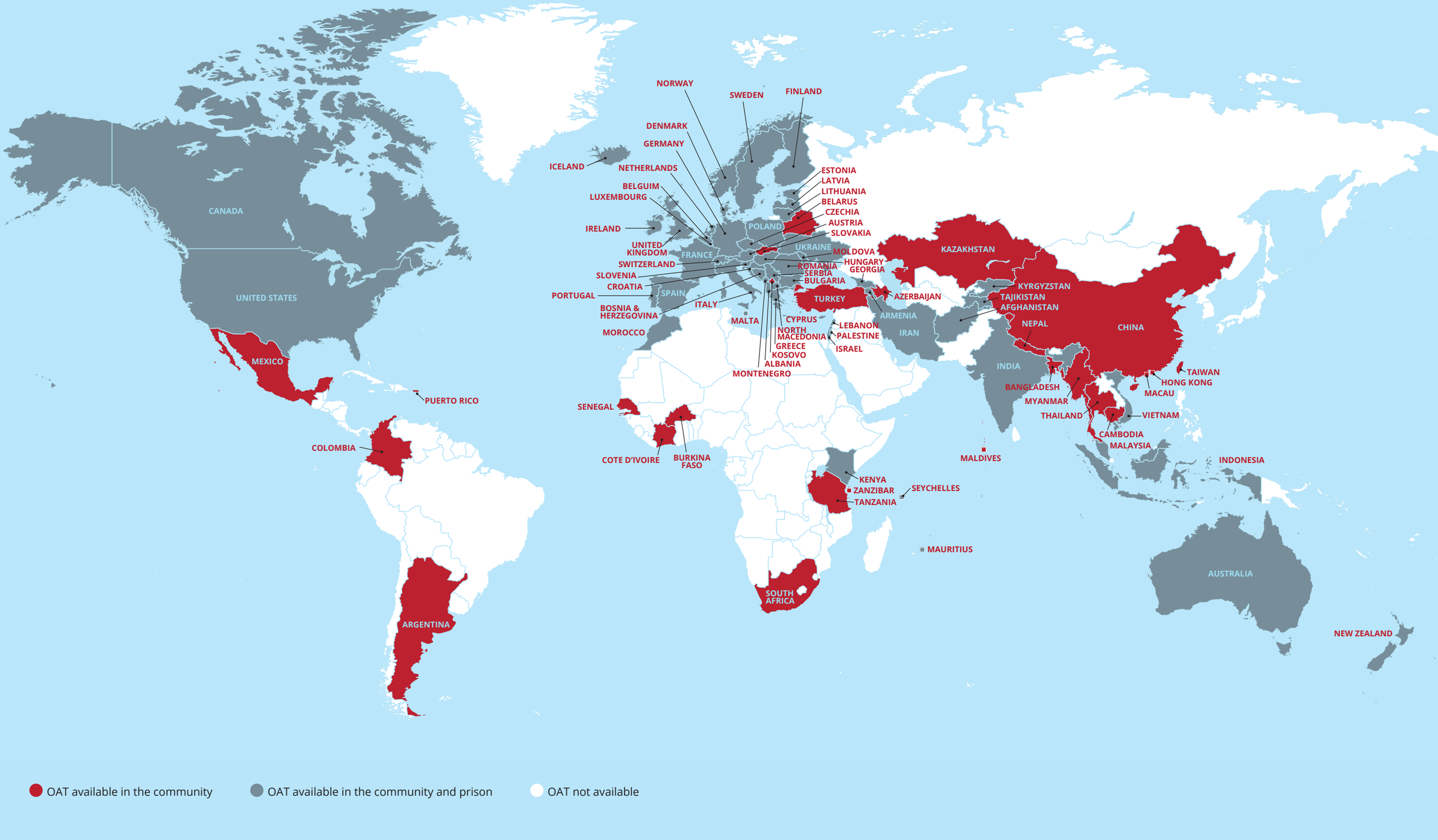
Country or territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room	Peer distribution of naloxone	OAT in at least one prison	NSP in at least one prison
Libya	×	×	×	×	×	×	×
Morocco	✓	✓	✓	×	×	✓[a]	×
Oman	✓	×	×	×	×	×	×
Palestine	✓	×	✓	×	×	✓	×
Qatar	×	×	×	×	×	×	×
Saudi Arabia	×	×	×	×	×	×	×
Syria	×	×	×	×	×	×	×
Tunisia	×	✓	×	×	×	×	×
UAE	×	×	×	×	×	×	×
Yemen	×	×	×	×	×	×	×
NORTH AMERICA							
Canada	✓	✓	✓	✓	✓	✓	✓
United States	✓	✓	✓	×	✓	✓	×
OCEANIA							
Australia	✓	✓	✓	✓	✓	✓	×
Fiji	×	×	×	×	×	×	×
Kiribati	×	×	×	×	×	×	×
Marshall Islands	×	×	×	×	×	×	×
Micronesia	×	×	×	×	×	×	×
New Zealand	✓	✓	✓	×	✓	✓	×
Palau	×	×	×	×	×	×	×
Papua New Guinea	×	×	×	×	×	×	×
Samoa	×	×	×	×	×	×	×
Solomon Islands	×	×	×	×	×	×	×
Tonga	×	×	×	×	×	×	×
Vanuatu	×	×	×	×	×	×	×
SUB-SAHARAN AND WEST AFRICA							
Angola	×	×	×	×	×	×	×
Benin	×	✓	×	×	×	×	×
Burkina Faso	×	×	✓	×	×	×	×
Burundi	×	×	×	×	×	×	×
Cameroon	×	×	×	×	×	×	×
Cape Verde	×	×	×	×	×	×	×
Central African Republic	×	×	×	×	×	×	×
Chad	×	×	×	×	×	×	×
Côte d'Ivoire	×	×	✓	×	×	×	×
Democratic Republic of the Congo (DRC)	×	×	×	×	×	×	×
Djibouti	×	×	×	×	×	×	×
Ethiopia	×	×	×	×	×	×	×
Gabon	×	×	×	×	×	×	×
Gambia	×	×	×	×	×	×	×
Ghana	✓	×	×	×	×	×	×
Guinea	×	×	×	×	×	×	×
Kenya	✓	✓	✓	×	×	✓	×
Lesotho	×	×	×	×	×	×	×

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 agonist therapy programme operational	At least one drug consumption room	Peer distribution of naloxone	OAT in at least one prison	NSP in at least one prison
Liberia	×	×	×	×	×	×	×
Madagascar	×	×	×	×	×	×	×
Malawi	×	×	×	×	×	×	×
Mali	×	✓	×	×	×	×	×
Mauritius	✓	✓	✓	×	×	✓	×
Mozambique	×	✓	×	×	×	×	×
Niger	×	×	×	×	×	×	×
Nigeria	✓	✓	×	×	×	×	×
Rwanda	×	×	×	×	×	×	×
Senegal	✓	✓	✓	×	×	×	×
Seychelles	✓	×	✓	×	×	✓	×
Sierra Leone	×	✓	×	×	×	×	×
Somalia	×	×	×	×	×	×	×
South Africa	✓	✓	✓	×	×	×	×
Tanzania	✓	✓	✓	×	×	×	×
Tanzania (Zanzibar)	✓	×	✓	×	×	×	×
Togo	×	×	×	×	×	×	×
Uganda	✓	×	×	×	×	×	×
Zambia	✓	×	×	×	×	×	×
Zimbabwe	×	×	×	×	×	×	×
WESTERN EUROPE							
Andorra	nk	nk	nk	×	nk	nk	nk
Austria	✓	✓	✓	×	×	✓	×
Belgium	✓	✓	✓	✓	×	✓	×
Cyprus	✓	✓	✓	×	×	✓	×
Denmark	✓	✓	✓	✓	✓	✓	×
Finland	✓	✓	✓	×	×	✓	×
France	✓	✓	✓	✓	×	✓	×
Germany	✓	✓	✓	✓	×	✓	✓
Greece	✓	✓	✓	×	×	✓	×
Iceland	✓	✓	✓	×	×	✓	×
Ireland	✓	✓	✓	×	×	✓	×
Italy	✓	✓	✓	×	✓	✓	×
Luxembourg	✓	✓	✓	✓	×	✓	✓
Malta	✓	✓	✓	×	×	✓	×
Monaco	nk	nk	nk	×	nk	nk	nk
Netherlands	✓	✓	✓	✓	×	✓	×
Norway	✓	✓	✓	✓	✓	✓	×
Portugal	✓	✓	✓	✓	×	✓	×
San Marino	nk	nk	nk	×	nk	nk	nk
Spain	✓	✓	✓	✓	×	✓	✓
Sweden	✓	✓	✓	×	×	✓	×
Switzerland	✓	✓	✓	✓	×	✓	✓
Turkey	×	×	✓	×	×	×	×
United Kingdom	✓	✓	✓	×	✓	✓	×
TOTALS	87	86	84	12	16	59	10

MAP 1.1:
Global availability of needle and syringe programmes (NSPs) in the community and in prisons



MAP 1.2:
Global availability of Opioid Agonist Therapy (OAT)
in the community and in prisons



Executive Summary

1. Global Overview – behind the numbers

This is the seventh edition of the *Global State of Harm Reduction*, compiled in a year when public health was leading the news agenda around the world. COVID-19 and the related measures introduced worldwide continue to disrupt life as we know it. We have monitored harm reduction services working on the ground for the past two years, where possible. This year we added a new chapter dedicated to the impact of COVID-19 on harm reduction service delivery and people who use drugs. We have also added dedicated chapters on hepatitis C and tuberculosis (TB) to broaden the focus, in pursuit of a global health perspective.

According to the latest report from the United Nations Office on Drugs and Crime (UNODC), an estimated 11.3 million people inject drugs globally, while HIV prevalence is estimated to be 12.6% and hepatitis C prevalence 48.5% among this population. However, while 179 of 206 countries report some injecting drug use, 110 countries and territories worldwide have no data on its prevalence. This data gap highlights the need for more and higher quality data to inform our efforts to implement appropriate harm reduction services that can address public health issues, including HIV and hepatitis C, soft tissue infections, and overdose.

Harm reduction implementation has worsened since our last report in 2018, after having stalled since 2014. The number of countries where needle and syringe programmes (NSPs) remained level at 86, and the number of countries where opioid agonist therapy (OAT) is available decreased by two to 84. There are also large differences between the regions in terms of harm reduction implementation: while NSPs and OAT are available in most countries in Eurasia, North America and Western Europe, these core harm reduction interventions are severely lacking in the majority of countries in other regions. An unfavourable drug policy environment hinders harm reduction service implementation in many countries across Asia, Latin America and the Caribbean, the Middle East and North Africa (MENA), and sub-Saharan Africa. Several countries have adopted more punitive drug strategies since the *Global State of Harm Reduction* last reported in 2018, including Bangladesh, Brazil and Sri Lanka.

Even where harm reduction services are available, there is often insufficient coverage and quality, or a lack of access to these services. Significant geographical gaps and an uneven distribution of services exist even in countries pioneering harm reduction or in countries where harm reduction has been available for decades. Rural communities are particularly underserved in many countries and regions. In addition to the geographical gaps in coverage, there are sub-groups of people who use drugs that experience barriers in access because harm reduction services aren't tailored to their unique needs. These groups include women who use drugs, men who have sex with men, people who use stimulants and/or non-injecting methods, and people experiencing homelessness.

Overarching structural problems also negatively affect access to services. Criminalisation, racism and discrimination against Indigenous, Black and brown people results in low household incomes, unemployment, food insecurity, poor housing and lower levels of education. This, in turn, results not only in worse health outcomes for these communities but also in people from these communities disengaging or actively avoiding health services.

Women who use drugs are still frequently overlooked despite the complex harms, stigmatisation and structural violence they face. A substantial increase in gender-sensitive services is necessary to appropriately address their needs.

For all people who use drugs, stigma and discrimination are public health issues creating barriers precisely where more support is needed. Harm reduction services are equipped to address these gaps, as non-judgmental, community-based service delivery is among the core principles of harm reduction.

Despite the grave situation in the context of the global COVID-19 pandemic, this year brought some examples of important positive changes that could serve as evidence for the feasibility of less restrictive service delivery. OAT regulations were eased, longer take-home periods were allowed, and easier initiation and provision in community settings were introduced – all without any increase in diversion or overdoses. These cases – explored further in the COVID-19 Chapter 1.2 – prove that such initiatives, which the harm reduction community have long advocated for, are realistic, feasible goals that not only lead to a better quality of life for people who use drugs, but result in better public health outcomes overall.

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AN ESTIMATED

11.3 MILLION

PEOPLE INJECT DRUGS GLOBALLY

HARM REDUCTION IMPLEMENTATION HAS WORSENED SINCE OUR LAST REPORT IN 2018, AFTER HAVING STALLED SINCE 2014.

86 =

THE NUMBER OF COUNTRIES WHERE NEEDLE AND SYRINGE PROGRAMMES ARE AVAILABLE REMAINED LEVEL

↓84

THE NUMBER OF COUNTRIES WHERE OPIOID AGONIST THERAPY IS AVAILABLE DECREASED BY TWO

2. Developments in harm reduction implementation

2.1 NEEDLE AND SYRINGE PROGRAMMES (NSPs)

The number of countries with NSPs implemented has remained level since the *Global State of Harm Reduction 2018*. As of 2020, 86 countries globally have at least one NSP, though on the ground this has meant NSP closures and openings in several countries since 2018. Algeria opened NSPs in the Middle East and North Africa region, but in Palestine and Jordan, NSPs stopped completely; in Asia, NSPs closed in Mongolia; in sub-Saharan Africa, NSPs opened in Benin, Nigeria and Sierra Leone, while in Uganda NSPs ceased to operate. Eurasia, North America, Oceania and Western Europe remained the regions where almost all countries with reported injecting drug use implemented NSPs.[1]

The availability of NSPs, however, does not ensure adequate coverage and accessibility. There is a large disparity in NSP implementation globally. While NSPs in Australia distribute almost 700 syringes per person who injects drugs per year, in Benin in sub-Saharan Africa, only ten syringes are given in a month to a client visiting the programme.[2] In Macau, Asia, the number of NSPs has decreased since 2018, and only one NSP is still open. While NSPs are available in the majority of countries in Eurasia, there are several countries where coverage is very limited as services are implemented solely on a volunteer basis.[3,4] New estimates from India suggest that just 35 syringes (down from 250) are distributed per person who injects drugs, despite an increase in the number of NSP sites in the country. Coverage could also vary within a country. In Western Europe, for example, the coverage of NSPs in urban areas is sufficient and there are no major barriers in access, but rural areas have less coverage in many countries (e.g. Austria, Belgium, the Netherlands, Germany and Portugal).[5–9] Rural populations are also underserved in both the United States and Canada, and an uneven geographical distribution of NSPs is a problem in Australia and New Zealand.[10,11]

Stigma and discrimination against people who inject drugs continue to exist and hinder service access in all contexts,[12–15] [16] affecting organisations implementing NSPs. In South Africa, for example, one NSP was closed in 2018 due to concerns of insufficient stakeholder consultation and the systems available for waste management.[17] Though the service was reinstated in late June 2020, programme staff have yet to reach the previous cohort of clients that had accessed the service before its closure.[18]

In addition to geographical gaps and stigmatisation of people who inject drugs, there are groups of people who inject drugs that experience barriers to access. The lack of appropriate, gender-specific programmes for women who use drugs is a recurring issue throughout most regions. Furthermore, the needs of Indigenous people are not appropriately met in Oceania,[10,11] and there are reports of migrants who inject drugs facing barriers to accessing harm reduction services in Western Europe.[6,9,19] NSP provision for people who use stimulants is suboptimal in many regions despite the risks involved. In Western Europe, for example, stimulant injecting has been associated with local HIV outbreaks in five countries in the past five years.[20–22]

2.2 OPIOID AGONIST THERAPY (OAT)

The number of countries in which OAT is available has decreased since 2018, from 86 to 84. Three countries (Costa Rica, Bahrain and Kuwait) stopped OAT provision. In Costa Rica, prescription opioids are only used as pain relief for people in palliative care. In Bahrain, the OAT pilot programme highlighted in the *Global State of Harm Reduction 2018* has ceased to operate, and both Bahrain and Kuwait are among those countries where legal and technical barriers (related to methadone import and storage) hinder provision. OAT has been introduced in one country since 2018, Burkina Faso, where methadone is now listed as an essential medicine and delivered in a hospital setting in one addictology department.[23]

The most frequently prescribed OAT medications have not changed since the last report. Methadone continues to be the most commonly prescribed substance where OAT is available, followed by buprenorphine or buprenorphine-naloxone. Long acting subcutaneous and subdermal formulations of buprenorphine are also available in some regions, for example it has been introduced in Australia and became available from April 2020.[10,24] Heroin-assisted treatment (HAT) using diamorphine (also known as pharmaceutical heroin) is available in six countries in Western Europe (Denmark, Germany, Luxembourg, the Netherlands, Switzerland and the United Kingdom), and in Canada.

2 WHO has set NSP coverage target to 300 syringes per person who injects drugs per year to reach hepatitis elimination goals by 2030.[2]

OAT provision is insufficient in many regions. OAT is now available in eight out of 49 countries with reported presence of injecting drug use in the sub-Saharan Africa region. OAT remains unavailable in Zimbabwe and Nigeria, despite significant populations of people who inject opioids and high HIV prevalence in both countries. In Latin America and the Caribbean, OAT is only available in Argentina, Colombia, Mexico and Puerto Rico, and it is increasingly administered in abstinence-focused settings rather than harm reduction ones.[25–28]

Even where OAT is available, significant barriers exist in the accessibility of OAT for certain communities. Women, the transgender community, and people experiencing homelessness all face significant barriers to access in all regions. There is a lack of tailored services for women, Indigenous communities and young people in Canada,[13,14] while young people who use drugs were reported as a subpopulation for whom OAT is unavailable in Switzerland.[29]

Cost was reported as a serious barrier in access to OAT in many countries. For example, in Mexico, OAT is available only in private clinics at a high cost to the client; high dispensing fees are hindering access to OAT in Australia; and in Lebanon, OAT clients have to pay for the mandatory urine tests out of pocket, generating a serious financial burden for clients. Similarly to NSP implementation, uneven geographical distribution of OAT provision is a problem in almost every region, with rural areas especially underserved.

2.3 AMPHETAMINE-TYPE STIMULANTS (ATS), COCAINE AND ITS DERIVATIVES, AND NEW PSYCHOACTIVE SUBSTANCES (NPS)

Stimulants, including amphetamine-type stimulants (ATS, such as methamphetamine and MDMA) and cocaine and its derivatives, are widely used around the world. After cannabis, ATS are the second most commonly used substances globally. Among stimulants, amphetamine and methamphetamine are the most prevalent stimulants in MENA and sub-Saharan Africa, and cocaine is the most used stimulant in North America, Latin America and the Caribbean, Oceania and Western Europe. Growing prevalence of new psychoactive substances (NPS) was reported in Eurasia and Asia, while NPS use increased among young people in Latin America,[1,30] and NPS use is disproportionate among marginalised populations in Western Europe.[31–33]

Few stimulant-specific harm reduction responses are implemented globally. Though NSPs and drug consumption rooms (DCRs) can be accessed by people who use stimulants, existing harm reduction services might not always be adequate for their needs.[34] For example, stimulant use is associated with more frequent injection than opioids, but limits in NSPs on the number of syringes that can be acquired at any one time represent a particular barrier for those injecting stimulants. Stimulants are also more likely to be smoked or inhaled than opioids, but not all DCRs permit inhalation on premises, and smoking equipment is rarely distributed. However, safer smoking kits for crack cocaine, cocaine paste and ATS are distributed in several territories, including Portugal[5] and Puerto Rico,[35] and harm reduction programmes for people who use non-injectable cocaine derivatives are in place in several countries in Latin America. There have been promising pilot programmes in Asia focusing on people who use methamphetamine, including outreach programmes distributing safer smoking kits, plastic straws, harm reduction education, and access to testing and treatment for HIV, hepatitis C, TB and other sexually transmitted diseases (see page 75 in Asia Chapter 2.1).

Drug checking (services that enable people to voluntarily get the contents of their drugs analysed) is an important harm reduction intervention for people who use stimulants. These services are implemented in at least nine countries in Western Europe[3], are available in the United States, Australia and New Zealand, and are increasingly available in

3 Austria, France, Italy, Luxembourg, the Netherlands, Portugal, Spain, Switzerland and the United Kingdom

Latin America[4]. Eight countries in Eurasia[5] have some form of drug checking services through distribution of reagent test kits at music festivals and nightlife settings. Other methods of drug checking include the use of mobile testing equipment to determine the contents of what is sold using tiny samples of the product, allowing for identification of both drugs and contaminants. Though availability of drug checking is growing globally from a low baseline, implementation faces serious legal barriers in many countries as it involves handling controlled substances, and drug checking services often require formal exemption from drug laws in order to operate legally.

No approved substitution therapy for ATS exists, although pharmacologically-assisted treatment with methylphenidate for ATS users was authorised by the government in Czechia during the COVID-19 pandemic, and in Canada, the British Columbia Centre on Substance Use released interim clinical guidance recommending the prescription of dexamphetamine and methylphenidate to people who use stimulants.[36]

2.4 OVERDOSE RESPONSE AND DRUG CONSUMPTION ROOMS (DCRs)

DCRs, also known as safe injecting facilities or safe injecting sites (SIFs/SISs), are professionally supervised healthcare facilities where people can consume their own drugs in a safe environment. DCRs are key interventions to prevent overdose deaths, as well as to reduce transmission of HIV and viral hepatitis and soft tissue infections.[37] These services attract populations who may generally use drugs in higher-risk conditions, and reduce morbidity and mortality by providing a safe environment and training people on safer drug use.

The number of countries where DCRs are officially implemented[6] has increased since 2018, with Portugal opening a mobile service in 2019.[5,38] Globally, there are a total of 12 countries in three regions where DCRs operate: Australia, Canada, Belgium, Denmark, France, Germany, Luxembourg, Netherlands, Norway, Portugal, Spain and Switzerland. Canada has the highest number of DCRs in the world, 40 (up from 24 in 2018). In addition, at least 20 primarily volunteer-run and funded overdose prevention sites have been opened in the country.[13] There are two DCRs in Australia, the second facility opened in 2018 in Melbourne, and an independent review of the first 18 months of its operation found that the DCR reduced harms for service users, and the provision of complex services was beneficial in providing access to other health and support services.[39] There are at least 88 DCRs in Western Europe, where these services increasingly include supervised inhalation spaces alongside those for injecting, in order to adapt to the needs of people who smoke drugs and the decline in injecting in some contexts.[40]

Naloxone distribution is another intervention addressing opioid overdose. Naloxone is a highly effective opioid antagonist used to reverse the effects of an opioid overdose in minutes, and can be delivered in various ways (intra-nasal, sublingual and buccal). It can, however, only be effective if it is accessible.[41] In 2014, the World Health Organization (WHO) recommended that naloxone be made available to anyone likely to witness an opioid overdose.[42] In an evaluation of community-based opioid overdose prevention, researchers found 83% to 100% survival rates among those who experienced an overdose and received naloxone, demonstrating that non-medical bystanders trained in community-based opioid prevention techniques were able to effectively administer naloxone.[41]

Despite international recommendations and scientific evidence, naloxone is available only in medical, emergency or treatment settings in many countries. The restrictive legal environment remains a serious barrier to the implementation of naloxone distribution programmes. However, there are a few countries in every region where naloxone is available. For example, in the MENA region, naloxone is available in Iran at overdose prevention programmes and in take-home form (where people who use drugs or anyone likely to witness an opioid overdose can get and carry naloxone). In Latin America and the Caribbean, there is a peer distribution network of naloxone in northern Mexico, and naloxone became available in Puerto Rico after a long advocacy campaign by civil society. Afghanistan, India, Myanmar and Vietnam are the only four countries in Asia which have some form of naloxone distribution in operation. Naloxone is available in several countries in Eurasia, however Ukraine is the only country in

4 Drug checking is currently available in at least three countries: Colombia, Peru and Uruguay

5 Slovenia, Hungary, Estonia, Czechia, Lithuania, Ukraine, Georgia and Poland

6 Only DCRs officially sanctioned by the state are included here. There are 'underground' DCRs around the world; we decided not to include them because listing such DCRs could expose them, attract opposition and hinder their efforts.

the region where naloxone is available without prescription. In sub-Saharan Africa, naloxone remains largely unavailable or difficult to access. The peer distribution of naloxone, whereby individuals can pass on naloxone without each recipient requiring a personal prescription, is available in 16 countries[7] globally, up from 12 in 2018.

2.5 VIRAL HEPATITIS, TUBERCULOSIS (TB) AND HIV

Globally, the prevalence of hepatitis C antibodies among people who inject drugs is estimated to be 48.5%, hepatitis B surface antigens to be 8.3%, and HIV 12.6%.[43] Scaling up of, and access to, harm reduction interventions (like NSP, OAT, naloxone distribution and community-based testing and treatment) are included among key measures in decreasing the prevalence of HIV and hepatitis in international and regional guidelines.[44–47] People who inject drugs are particularly vulnerable to HIV and hepatitis viruses, but other groups, such as people who smoke opioids or stimulants, are also at greater risk than the general population.[48,49] For example, sharing of pipes and higher-risk sexual practices among people who use stimulants are associated with increased hepatitis C infection.[1,50,51]

There is significant regional variation in prevalence of blood-borne viruses among people who inject drugs. The early implementation of harm reduction approaches (such as NSPs and OAT), and the sustained harm reduction response is credited with maintaining low prevalence of HIV among people who inject drugs in Australia, New Zealand and Switzerland, among others.[52–54] Seven out of the twelve countries globally on track to meet WHO hepatitis C elimination targets are in Western Europe.[55] Conversely, hepatitis C prevalence among people who inject drugs remains high in Eurasia.[56]

One of the most reported barriers to HIV and hepatitis C testing and treatment is placement of services in settings that are not appropriate to the needs of key populations, though cases of good practice exist. Hepatitis C services in Canada, for example, are often integrated into harm reduction services to increase accessibility for people who use drugs.[13] There are 'one-stop' clinics for women in India, offering HIV counselling, testing and treatment in harm reduction services alongside other health and gender-sensitive programmes.[57] Restrictions still exist on access to hepatitis C treatment for those actively using drugs, despite evidence showing strong treatment benefit with current treatment regimens for such patients.[58,59] Stigma and discrimination towards people who use drugs, as well as unstable housing, poverty, criminalisation and incarceration, continue to act as major barriers to people accessing testing and treatment in every region.

An important issue to consider for the future is that HIV prevention, treatment and care among people who use drugs has focused on the needs of people who inject drugs, and mainly on those who inject opioids. In Latin America, data shows that use of stimulant drugs has also been associated with higher risk of HIV transmission through unsafe sexual behaviours.[60,61] Community-based programmes are an effective way to reduce the barriers to diagnosis and treatment for key populations beside people who use drugs, like transgender people and people experiencing homelessness.

People who use drugs represent a disproportionate number of TB cases and are at greater risk of developing more serious TB disease.[62] People living with HIV who inject drugs are two to six times more likely to develop TB disease than the general population,[63–65] and TB is the leading cause of mortality in this group.[66] People who use drugs are overrepresented in prisons and custodial settings, where the risk of TB increases to twenty-three times that of the general population.[67] However, data on people who use drugs and have TB is lacking at global, regional and national levels, leading to harm reduction programmes not including TB services, and TB programmes lacking outreach programmes aiming for people who use drugs.

7 Afghanistan, Australia, Canada, Denmark, Estonia, France, Italy, India, Mexico, Myanmar, Norway, Puerto Rico, Ukraine, the United Kingdom, the United States and Vietnam.

2.6
HARM REDUCTION IN PRISONS

The world prison population has grown by 24% since 2000, which is about the same as the estimated increase in the world's general population.[68] Cannabis is the drug for which the most people are brought into contact with the criminal justice system globally, accounting for more than half of all drug offences.[69] Yet cocaine-related offences are particularly prevalent across Latin America.[70] It is estimated that 61% of people arrested globally for drug offences are arrested for drug possession for personal use.[69] Imprisoning people for drug use is not only costly, but it is also demonstrably disproportionate and systematically discriminatory.[71] Furthermore, punitive drug policies and the demonisation of people who use drugs have continued to result in mass incarceration and the overcrowding of jails in Asia, Latin America and the Caribbean, North America and sub-Saharan Africa.[72,73]

Women are disproportionately sentenced for drug-related offences, and are particularly vulnerable to negative health and social outcomes once incarcerated.[69] Criminal justice systems are often ill-equipped to address the unique needs of women because services and procedures are designed for men. Women also face discrimination and stigmatisation within the criminal justice system and by their families because of gender stereotypes.[69] These gender stereotypes hold women to different standards than men, and result in greater stigma toward both drug use and incarceration.[70]

People in prison settings are one of the most vulnerable groups facing barriers to treatment due to discrimination and stigma,[69] while interruption of treatment due to incarceration or after release is also an issue. Ensuring access to testing and treatment services in prisons is a legally binding human rights obligation,[74,75] and essential to protecting public health because people in prisons are more vulnerable to infections such as HIV, hepatitis C and TB than the general population.[76] HIV and hepatitis C testing and treatment in prisons are widely available in Western Europe, North America, Australia and New Zealand, though stigma and a lack of confidentiality impede access in these regions too. In Eurasia, HIV testing and treatment are available in prisons in every country, while only five countries offer these for hepatitis C in all prisons. Asia, the Middle East and North Africa, Latin America and the Caribbean and sub-Saharan Africa are the regions where HIV and hepatitis service implementation is more fragmented, with serious barriers to access. For example, in sub-Saharan Africa, HIV prevention programmes are rarely available in prisons and many people in prison settings with HIV are unable to access antiretroviral therapy (ART).[77,78] However there has been a degree of progress in the MENA region where UNODC, in cooperation with local government agencies, implemented a prison HIV project in several countries which delivered HIV, hepatitis C, hepatitis B and TB counselling, testing and treatment services. The project included women's prisons, addressing the gender gap and limited services delivered to women in prisons (see page 124 MENA chapter).

Drug use is present in most, if not all, prison settings, with approximately one third of people in prisons worldwide estimated to have used drugs at least once while incarcerated.[79] New psychoactive substances (NPS) use in prisons was reported by 22 countries across Western Europe and Eurasia, with most of those countries identifying synthetic cannabinoids as the main substance used.[69,80] Injecting drug use also occurs in prisons. For example, 32% of recently imprisoned NSP clients reported injecting in prison in Australia,[81] and in Uganda, evidence indicates that many people incarcerated for non-injecting drug use transition to injecting during their incarceration, and then continue to inject after release.[82] In Latvia, new synthetic opioid use in prison has been linked to an increase in injection, syringe sharing and overdoses.[83] Without appropriate access to sterile injecting equipment, injecting drug use in prison poses serious health risks; according to an Australian study (where there is no NSP in prisons), syringes in prison settings are reused an estimated 100 times.[16] The number of countries where NSPs are available in prisons has not changed since the last report: there are still only 10 countries globally where this service is available in at least one prison setting and coverage and access remain inadequate in these settings. For example, in Germany, one syringe dispensing machine is installed in one women's prison in the country,[84] in Canada only 25% of federal prisons are covered by NSPs, and significant barriers to access (lack of information about availability, limited confidentiality, high rejection rates from the programme) make the services largely unavailable in practice.[13,14,85] However, Canada is also home to a significant development in this area: the world's first prison DCR opened in Alberta in June 2019.[13] While this is a positive step, a DCR cannot be considered a replacement for an effective prison NSP.

There are large differences in OAT availability in prisons

between regions. In Western Europe, North America and Oceania, and most of Eurasia and MENA, some OAT is available in prisons. However, OAT in prisons is largely absent in Latin America, the Caribbean and sub-Saharan Africa. In 2020, 59 countries are providing OAT in at least one prison, five more than when we last reported in 2018. OAT availability in prisons does not mean accessibility, and the most typical barrier to access is that it is available only to those who had been on OAT prior to incarceration. People who are released from prison are particularly vulnerable to opioid overdose,[86] making it essential that people in and those released from prison have access to naloxone. An evaluation of an overdose education and naloxone distribution project in San Francisco found that the majority of the respondents had never been trained to use naloxone outside prison, and one third used naloxone later to reverse an overdose.[87] However, overdose prevention training and take-home naloxone programmes are implemented in prisons in only five countries in North America and Western Europe, though naloxone is not available in all prisons in these countries either. Estonia is a good example of how practice of implementation can hinder access to services. Naloxone training is only available upon release from prison in the country if requested, which rarely happens for fear of being denied parole as a consequence of intention to use drugs.

2.7 HARM REDUCTION AND THE COVID-19 PANDEMIC

At the time of writing, the COVID-19 pandemic is still ongoing and the consequences to people who use drugs and to harm reduction services are still unfolding. However, we closely monitored the situation in 2020, and collected information from each region on harm reduction service delivery during the pandemic.

It is important to highlight that people who inject drugs are a population vulnerable to COVID-19.[88] They can have underlying medical conditions, including a higher prevalence of HIV and hepatitis C than the general population.[43] Coinfection with tuberculosis is also a serious issue that increases their risks.[88] Inadequate living conditions or homelessness could add to susceptibility. Lockdown measures combined with criminalisation and over-policing have created a situation that further increased hardships for people who use drugs experiencing homelessness. Furthermore, people who use drugs may be less able or willing to adhere to quarantine and physical distancing measures in general, since they may need to seek out harm reduction services like NSPs and OAT programmes, or need to procure drugs to avoid withdrawal symptoms.[88] COVID-19-related risks are increased for people who smoke or inhale drugs, as this type of administration is associated with pulmonary and respiratory problems.[89] In the US, a recent review found that those with opioid use disorder are ten times more likely to contract COVID-19 than the general population, and nearly 30% more likely to die from COVID-19 than other patients diagnosed with the coronavirus.[90, 128]

Peer networks were among the first to react to the pandemic, both in terms of practical guidance and in advocacy. Early in the pandemic, the International Network of People Who Use Drugs (INPUD) and Harm Reduction International (HRI) developed a statement in cooperation with civil society organisations to protect the health and human rights of people who use drugs in light of the COVID-19 crisis.[91] INPUD, in collaboration with the European Network of People Who Use Drugs (EuroNPUD), were the first to develop guidelines for people who use drugs, available in 20 languages, and developed a set of harm reduction tips for people who use drugs for avoiding COVID-19.[92,93] Peers played a crucial role beyond advocacy during the pandemic, they contributed to service delivery and filling the gap in service provision with peer-to-peer syringe distribution, providing input for professionals working in harm reduction, and disseminating information to fellow people who use drugs.

The lockdown measures and physical distancing rules introduced during the pandemic seriously disrupted harm reduction service delivery. This exacerbates the harms to public health, as interruption of harm reduction services – whether through closures, staffing restrictions, decreasing coverage or reducing funds – can lead to a spike in HIV and hepatitis C infections.[94] While harm reduction services in Western Europe, North America, and parts of Eurasia have been able, in general, to maintain a relatively good level of coverage, services in other regions suffered more serious disruptions. For example, a regional survey in Asia found that young key populations experienced delays in accessing HIV and harm reduction services.[95] In Latin America, contact with harm reduction programmes

3. Funding for harm reduction

has been limited due to physical distancing and the already limited number of services available in most of the countries in the region. In the Middle East and North Africa (MENA) region, harm reduction services had to reduce the number of working days or close entirely in all countries in the region. In sub-Saharan Africa, OAT services were suspended in some countries during COVID-19 as take-home OAT is rarely available in the region, and travel to health facilities was restricted. In the United States, interruption of services from NSP to addiction treatment, combined with isolation and the way in which COVID-19 has overwhelmed health and emergency services, all contributed to an increase in overdose deaths in the country.[96][97]

Despite calls from international actors urging governments to limit arrests, promote alternatives to punishment and incarceration, and urgently release people in prison charged or convicted for minor or non-violent offences, including drug offences,[98,99] 25% of countries that implemented prison decongestion schemes explicitly excluded people detained for certain drug offences, regardless of whether they met other eligibility criteria.[100] The inevitable effect was that many people who use drugs in prison did not benefit from these schemes and remain behind bars.

However, there were positive changes in service delivery during the pandemic. Most importantly, OAT regulations were eased in many countries. Out of the 84 countries where OAT is available, HRI identified evidence of 47 countries expanding take-home periods for OAT medications and 23 making distribution more accessible with home delivery or OAT distribution in outreach services. Nine countries expanded induction practices, including facilitated or rapid initiation.[101] The COVID-19 crisis has also shown that harm reduction services can adapt quickly and effectively, and are able to adjust service delivery and integrate innovative methods. To compensate for decreased coverage, mail delivery of harm reduction equipment, and increased outreach activities were common, including provision of more services in low threshold and community settings. Phone or video consultations were introduced as a common tool in some settings to compensate for the reduced availability of services.

In 2018, the *Global State of Harm Reduction* reported that harm reduction funding in low- and middle-income countries amounted to USD 188 million,[102] just 13% of the UNAIDS estimate for an adequate harm reduction response.[103] This situation is unlikely to have changed dramatically in the past two years, but there have been some important developments with implications for harm reduction funding during this time.

The global COVID-19 pandemic poses a threat to the already precarious funding situation for harm reduction. In May 2020, INPUD and HRI called upon donors and governments to safeguard harm reduction funding, provide additional funding to help services adapt, and to invest in communities and community leadership to ensure sustainable harm reduction financing.[104]

The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) is still the largest donor for harm reduction and, in 2019, harm reduction advocates around the world joined calls for donors and governments to ensure a successful Global Fund replenishment. More than 155 organisations and advocates signed onto the People Before Politics Call to Action.[105] The USD 14 billion pledged to fight against AIDS, TB and malaria through 2021-2023 met the request made by the Global Fund in its investment case,[106] and marked the largest amount ever raised by a multilateral health organisation.[107] It fell short, however, of the amount advocates estimated necessary to meet global targets.[108] The Call to Action also called for the safeguarding of Global Fund catalytic investments, which provide a vital lifeline for community-led and civil society advocacy for harm reduction.[109]

Encouragingly, Global Fund HIV country envelopes (the amount allocated to countries for their HIV programmes, based on country income status, disease burden and a 'qualitative adjustment' process intended to take into account other factors) have increased for the majority of countries with high harm reduction need that are eligible for Global Fund support. However, this does not necessarily translate into an increase of funding for harm reduction. Decisions within Country Coordinating Mechanisms will determine the extent to which harm reduction funding is requested within grant applications, which is where poor political support for harm reduction and a lack of community representation remain a concern.[110] In March 2020, to support the development of country grant proposals,[111] the Global Fund published updated guidance on harm reduction and people who use drugs.

At the time of writing, harm reduction appears to have lost a major international donor with the Dutch Ministry of Foreign Affairs not renewing its bilateral support, under the auspices of a shift in funding priorities from HIV to sexual and reproductive health. A global leader for ensuring the health and human rights of people who use drugs, the Netherlands had been lauded for its commitment among a shrinking cohort of bilateral harm reduction donors. In July 2020, the harm reduction and drug policy sectors sent an urgent appeal to the Dutch Minister of Foreign Trade and Development Cooperation to recommit the brave and long-standing political and financial support for the health and rights of people who use drugs.[112]

25% of countries that implemented prison decongestion schemes explicitly excluded people detained for certain drug offences, regardless of whether they met other eligibility criteria.[100]

Harm reduction and the next global AIDS strategy

The development of the 2021-2025 UNAIDS strategy marks another important moment for harm reduction. This will serve as a roadmap for the world to end AIDS by 2030 as enshrined in the Sustainable Development Goals and will include new targets and resource needs estimates. The world has failed to meet most of the UNAIDS 2020 targets and the majority of new HIV infections are now among key populations, including people who use drugs, and their sexual partners.

It is therefore crucial that the new global AIDS strategy upholds and strengthens the rights of people who use drugs and gives due priority to harm reduction. This message was taken to the UNAIDS Programme Coordinating Board (PCB) in September 2020 by 33 civil society and community-led organisations. They called on the PCB to ensure that key populations, including people who inject drugs, are prioritised in the new global AIDS strategy; harm reduction services are available, scaled-up and fully funded to meet the HIV prevention and health needs of people who use drugs wherever needed; communities, including community-led services, and civil society are at the front and centre of the HIV response; and barriers to services, including criminalisation, stigma, discrimination, punitive laws and policies, are removed.[113] This prompted a positive response from UNAIDS Executive Director, Winnie Byanyima, outlining her commitment to 'ensuring that the entire Joint United Nations Programme on HIV/AIDS, donors, Member States and other actors are accountable in implementing commitments under this new strategy and in defending the human rights of people who use drugs.'

The new global AIDS strategy will have profound implications - either by compounding or alleviating the political invisibility of people who use drugs. The strategy will directly influence the development of the 2021 Political Declaration on HIV and AIDS and member states' commitment to ending AIDS, including among people who use drugs. It will also directly inform the next Global Fund strategy which will determine the priorities of donors and governments in the years to follow.

4. International commitments on harm reduction and human rights

There have been a number of important developments on harm reduction and human rights at the international level since 2018, with drug laws and policies increasingly scrutinised through a human rights lens, and significant efforts undertaken to help ensure human rights compliance in the design and implementation of international drug control.

A clear signal was given by the 2019 Ministerial Declaration adopted during the 62nd UN Commission on Narcotic Drugs. Governments acknowledged the shortcomings of the current drug control strategy, including the fact that 'health services continue to fall short of meeting needs and deaths related to drug use have increased' - and reiterated the need for drug laws and policies to respect international human rights obligations.[114]

The Declaration came just weeks after the adoption of the 'UN System Common Position on supporting the implementation of the international drug control policy through effective inter-agency cooperation' *(UN Common Position)*. With this unprecedented document, all 31 UN agencies and entities agreed on a shared vision for drug control, committing to 'supporting Member States in developing and implementing truly balanced, comprehensive, integrated, evidence-based, human rights-based, development-oriented, and sustainable responses to the world drug problem.' Among other commitments, the UN system pledged to 'promote the increased investment in measures aimed at minimising the adverse public health consequences of drug abuse, by some referred to as harm reduction, which reduce new HIV infections, improve health outcomes and deliver broader social benefits by reducing pressure on health-care and criminal justice systems.'[115]

The UN Common Position also established a dedicated UN Coordination Task Team, entrusted with ensuring coherent efforts are undertaken to realise the above-mentioned shared commitments. In March 2019, the Task Team published a sobering report on the state of drug control which also denounced the lack of evidence-based health services for people who inject drugs in many parts of the world.[116]

Another landmark development was the launch, in March 2019, of the International Guidelines on Human Rights and Drug Policy, jointly developed by the International Centre on Human Rights and Drug Policy at the University of Essex and the UN Development Programme (UNDP), and co-sponsored by UNAIDS, the UN Office of the High Commissioner for Human Rights (OHCHR) and WHO. The result of a broad consultative process involving UN agencies, policymakers, academics and experts, the guidelines spell out a clear set of international standards to help maximise human rights protections in the design and implementation of drug control laws and policies.[117] In the first eighteen months since their adoption, the guidelines have been used as a reference by UN Treaty Bodies, UN Special Procedures, national courts, advocacy papers, amicus briefs and other litigation efforts around the world.

In line with increasing concern about drug control on human rights, multiple human rights bodies have scrutinised states' efforts to respect and promote the human rights of people who use drugs, including the right to essential harm reduction services. For example, the Human Rights Council, in its 41st Session, adopted a rare country-specific resolution expressing concern for human rights violations unfolding in the Philippines in the context of President Duterte's repressive anti-drug campaign, and requested the UN High Commissioner for Human Rights report on the situation.[118]

The High Commissioner also drew attention to the impact of punitive drug control on human rights. For example, in a 2019 report on violence, death and serious injury in situations of deprivation of liberty, the Commissioner denounced serious human rights violations endured by people who use drugs in detention settings, including torture and ill-treatment, intentional withholding of drug treatment as a form of punishment, and lack of adequate healthcare in detention.[119]

Similarly, the UN Committee on Economic, Social and Cultural Rights reiterated concerns for the criminalisation of drug use and drug possession, noting its negative impact on access to harm reduction services;[120,121] denounced the continued stigmatisation of people who use drugs and the limited access to harm reduction services in prisons;[122] and condemned regional disparities in availability and accessibility of harm reduction services.[123]
Finally, the UN Special Rapporteur on the right to health continued to clarify states' obligations vis-à-vis people

5. Technical guidance

who use drugs. For example, the Rapporteur denounced the impact of xenophobia and intolerance on access to harm reduction services,[124] and warned of the risks of purely biomedical approaches to drug use, explaining that they "can reflect parallel coercive practices, detention, stigmatisation and the lack of consent found in criminalised approaches." As a consequence, "without human rights safeguards, these practices can flourish and can often disproportionately affect individuals who face social, economic or racial marginalisation."[125]

This attention to the rights of people who use drugs was renewed in April 2020, when the Special Rapporteur, with the support of seven other UN Special Rapporteurs, published a statement on the protection of people who use drugs during the COVID-19 pandemic. After acknowledging the unique needs and risks faced by people who use drugs in this context, the UN expert provided detailed guidance on how to ensure fundamental rights are protected during the pandemic. Among others, states were urged to ensure access to harm reduction services and controlled medicines, safeguard gender-sensitive harm reduction services, protect people experiencing homelessness, address prison overcrowding, and safeguard the health of people in prison.[126]

As forcefully reiterated by the High Commissioner for Human Rights, Michelle Bachelet, in her keynote speech at the 2019 Harm Reduction International Conference in Porto (Portugal), it is now clearer than ever that "people do not lose their human rights because they use drugs", and that "government policies should not become a greater threat to their wellbeing than the drugs which they are using."[127]

- In January 2019, the International Network of People who Use Drugs and the Asian Network of People who Use Drugs published a language statement and reference guide under the title *Words Matter!*[129]
- In March 2019, the World Health Organization, the United Nations Development Programme, UNAIDS and the International Centre on Human Rights and Drug Policy published guidelines under the title *International Guidelines on Human Rights and Drug Policy*.[130]
- In April 2019, the World Health Organization published a policy brief titled *Access to hepatitis C testing and treatment for people who inject drugs and people in prisons – a global perspective*.[131]
- In August 2019, the United Nations Office on Drugs and Crime, World Health Organization and UNAIDS published a joint technical guide under the title *HIV prevention, treatment, care and support for people who use stimulant drugs*.[132]
- In September 2019, the European Monitoring Centre for Drugs and Drug Addiction published a technical report titled *Monitoring the elimination of viral hepatitis as a public health threat among people who inject drugs in Europe*.[133]
- In September 2019, the International Network of People who Use Drugs published a technical brief titled *What does Universal Health Coverage mean for People who Use Drugs*.[134]
- In October 2019, the Global Fund published a technical brief titled *Programming at scale with sex workers, men who have sex with men, transgender people, people who inject drugs, and people in prison and other closed settings*.[135]
- In March 2020, the Global Fund published a technical brief titled *Harm Reduction for People who Use Drugs*.[111]
- In April 2020, the United Nation Office on Drugs and Crime published recommendations on *COVID-19, HIV prevention, treatment, care and support for people who use drugs*.[136]
- In March 2020, the European Monitoring Centre for Drugs and Drug Addiction released an ad hoc publication under the title *EMCDDA update on the implications of COVID-19 for people who use drugs and drug service providers*.[137]
- In June 2020, PEPFAR, USAID, EpiC, UNAIDS and the Global HIV Prevention Coalition published a strategy titled *Strategic considerations for mitigating the impact of COVID-19 on key-population-focused HIV programs*[138]
- In August 2020, UNAIDS published a report *Rights in a pandemic – Lockdowns, rights and lessons from HIV in the early response to COVID-19*, which outlines 10 immediate areas for action for governments towards building effective, rights-based COVID-19 responses.[139]

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1.2 COVID-19

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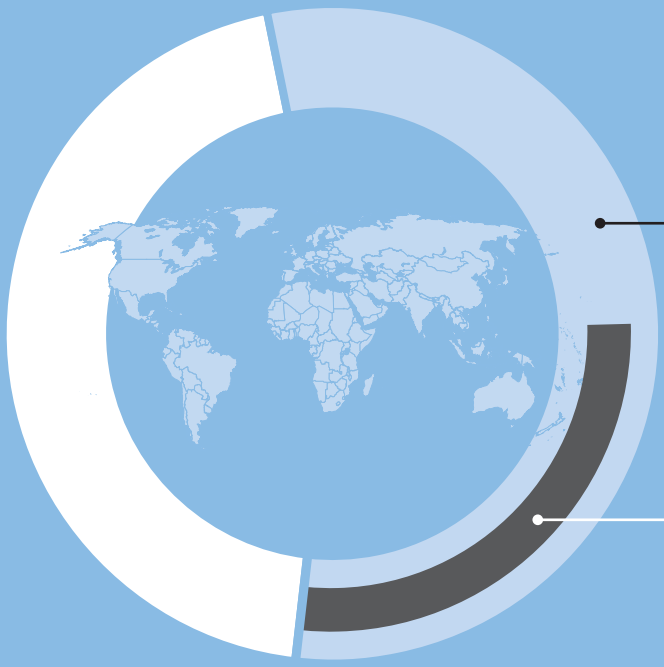
OPIOID AGONIST THERAPY (OAT)



84 COUNTRIES WORLDWIDE PROVIDE OAT

47 COUNTRIES (WITH AT LEAST ONE COUNTRY IN EVERY REGION) EXPANDED TAKE-HOME CAPACITIES PROVIDING FOR LONGER TAKE-HOME PERIODS

23 COUNTRIES MADE DISTRIBUTION MORE ACCESSIBLE WITH HOME DELIVERY OF OAT MEDICATION, OFFERING DOSING AT COMMUNITY PHARMACIES, OR DISTRIBUTING OAT IN OUTREACH SETTINGS

People who use drugs faced difficulties accessing services because of lockdown measures, while service providers had to reduce the number of working days or close entirely.

1. Overview

People who use drugs, especially people who smoke or inject drugs, face additional risks and vulnerabilities to COVID-19[1] infection compared to the general population.[2,3] Smoking or inhaling particularly increases COVID-related risks, as it is associated with pulmonary and respiratory problems.[4] People with a long history of opioid or stimulant use are more likely to have a compromised immune system,[3] and people who inject drugs can have underlying medical conditions that make them more vulnerable to certain infectious diseases. For example, HIV, tuberculosis (TB) and hepatitis C prevalence is higher in this population than in the general population.[5] [2] Therefore, maintaining services for this population is even more vital during a public health crisis such as the COVID-19 pandemic.

Harm reduction service delivery has been disrupted by the pandemic. In Asia, accessing services due to quarantine and travel restrictions was a challenge, including receiving opioid agonist therapy (OAT) medications and HIV-related services.[6][7] Access to OAT during the period of travel restrictions was also challenging in sub-Saharan Africa, where OAT is rarely available on a take-home basis. The closure of international borders caused disruptions to the supply of OAT medication in Eurasia and the COVID-19-related restructuring of government resources negatively impacted harm reduction programmes in countries in the region. Funding for harm reduction services in Latin America and the Caribbean was also negatively impacted,[8] with reports highlighting that outreach programmes were especially hindered by the limitation of movement and the introduction of physical distancing rules.[9] Harm reduction services in most countries in the Middle East and North Africa faced similar problems. People who use drugs faced difficulties accessing services because of lockdown measures, while service providers had to reduce the number of working days or close entirely. Although the pandemic seriously affected service delivery and the coverage of harm reduction services in North America, Oceania and Western Europe, the impact was less severe compared to other regions. For example, the majority of European Union countries reported a slight decrease or no change in availability of harm reduction services.[10]

The COVID-19 pandemic also resulted in some positive changes, with harm reduction services quickly adapting to the altered conditions. The most profound example of this was the change in OAT delivery across all regions. Out of the 84 countries worldwide where OAT is available, 47 countries (with at least one country in every region) expanded take-home capacities providing for longer take-home periods; 23 countries made distribution more accessible with home delivery of OAT medication, offering dosing at community pharmacies, or distributing OAT in outreach settings.[11] Innovative measures were introduced to compensate for decreased availability, for example, online consultations replaced some face-to-face meetings in the Middle East and North Africa; service providers set up online shops for injecting equipment in the United Kingdom and New Zealand; and service providers introduced home delivery of harm reduction equipment in Eurasia and Western Europe.

COVID-19 also resulted in some positive changes, with harm reduction services quickly adapting to altered conditions. The most profound example of this was the change in OAT delivery across all regions.

1 Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus. Most people infected with the COVID-19 virus will experience mild to moderate respiratory illness and recover without requiring special treatment. Older people, and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease and cancer, are more likely to develop serious illness.[1]

ASIA

Reports and correspondences in the region point to a number of adverse consequences of the COVID-19 pandemic. Firstly, people who use drugs have faced disproportionate risks of exposure and susceptibility to COVID-19, alongside barriers to care. This is particularly true of those who are in prison or detained.[12] In the Philippines, where jail overcrowding is a direct result of President Duterte's drug war and punitive drug laws, hundreds of COVID-19 cases have already been reported.[13] The prison-like conditions of compulsory drug detention and rehabilitation centres in the region has prompted UN agencies to call for their permanent closure in light of the pandemic.[14]

Secondly, people who use drugs have also been unable to access broader health care services and treatment, with closures of hospitals and medical centres, as well as quarantine and travel restrictions. In Thailand, individuals who regularly travel to receive OAT are unable to do so.[6] COVID-19 has also interrupted harm reduction services in Asia, [15–18] with a regional survey finding young key populations experiencing delays in accessing HIV and harm reduction services, and 70% reporting anxiety over COVID-19.[7]

Thirdly, civil society organisations have expressed concerns that the pandemic might affect donor priorities and lead to programmatic changes, with significant consequences for the health and rights of people who use drugs.[17,19]

Finally, the lack of civil society vigilance and media discourse have also deflected attention from the issues which affect people who use drugs. Independent media outlets face a variety of charges, indirectly affecting coverage of drug-related issues.[20]

Not all pandemic-related developments have been negative. In India, take-home buprenorphine and methadone have been approved as an emergency measure in some states, and the success of these measures is raising the prospects of the measure being sustained beyond the lockdown, offering greater flexibility for people who are prescribed OAT.[21]

Overall, however, the heightened vulnerability of people who use drugs and civil society organisations during the pandemic further underscores the need for drug policy reform in the region, including drug decriminalisation and strengthening of harm reduction initiatives.

EURASIA[2]

As in other regions, the COVID-19 crisis brought both positive and negative changes in the Eastern Europe and Central Asia region. Among positive developments, there is provision of online consultations and take-home OAT, home delivery of harm reduction materials, and introduction of new services such as substitution therapy for amphetamine-type stimulant (ATS) users in Czechia.

The pandemic also highlighted the vulnerability of harm reduction services. The closure of international borders led to disruptions in the supply of OAT medication in Moldova, and the lack of political support and reallocation of government resources to COVID-related activities put harm reduction programmes in Bulgaria and Montenegro at risk of closure. Despite international recommendations[22] and community and civil society advocacy efforts[23], there was no progress in lowering the prison population[24] and releasing people who were in prison for non-violent offences during the COVID-19 pandemic in the Eurasia region.

The opportunity to receive take-home OAT (both buprenorphine and methadone) for periods of five to 14 days became available to clients in many countries of the region except for Belarus and Kazakhstan. In Azerbaijan, this period was limited to two days and in Ukraine and Czechia, it was extended to up to one month. These changes affected only the clients that were already in the programme. In some countries, such as Lithuania and Latvia, no new clients were accepted during the quarantine.

In Kazakhstan and Ukraine, mobile outpatient units delivered OAT medications, often together with antiretroviral therapy (ART), to clients in remote locations. In Russia, harm reduction kits including masks, disinfectant and other hygiene materials were delivered directly to clients through courier services. Organisations also arranged online counselling for clients and, wherever possible, HIV testing through self-test kits (for example in Russia and Poland).

For many people who use drugs, quarantine measures and curfews restricted access to temporary accommodation and made it impossible for them to earn money. Responding to

2 All information provided in this section is based on interviews with EHRA members.

such basic needs, some organisations have re-programmed budgets (for example, in Czechia, Kazakhstan, Montenegro, and Slovakia) or organised crowdfunding campaigns to be able to feed those in need (for example in Bulgaria). In some countries, partnerships have been established to make it possible to provide shelter to people who use drugs and women survivors of violence, for example in Kyrgyzstan.[25] In Azerbaijan and Kazakhstan, harm reduction organisations have helped their clients receive specific COVID-19-related assistance for unemployed citizens.

In September 2020, AFEW International launched the regional COVID-19 Solidarity Program[26] in the Eastern Partnership countries to support community-based organisations respond to the immediate and longer-term impact of the COVID-19 pandemic.

LATIN AMERICA AND THE CARIBBEAN

The COVID-19 pandemic has had a major impact on the few harm reduction services operating in Latin America and the Caribbean. Physical distancing requirements have reduced the capacity of programmes to carry out their activities. For example, in the Dominican Republic, one NSP was partially suspended for the safety of its staff.[8]

The response to COVID-19 in Latin America has not been homogeneous. A majority of the states in the region are in some form of "lockdown" to increase self-isolation in order to flatten the infection curve and forestall health care system breakdown. Argentina, Chile, Colombia, Peru and many of the Central American nations were some of the first to implement such measures[38–41], with Brazil, Bolivia, Ecuador and Mexico implementing them later.[42,43] [44] In Venezuela, El Salvador, Guatemala and Honduras, the pandemic is happening against the backdrop of pre-existing humanitarian crises.[41]

Contact with harm reduction programmes or health care services during this time has been limited due to physical distancing and the already limited number of services available in most of the countries.[38,39,42,44–47] For example, coverage has decreased in NSPs in Mexico and Colombia. [39,42] Conversely in Uruguay, where no full lockdown has been implemented, services reported that their work was unaffected in comparison with other countries in the region.[48]

Outreach programmes have been particularly affected by limitations on movement, and physical distancing requirements have meant that services have fewer opportunities for close interaction with clients, limiting their ability to assess needs and collect feedback.[9] While extra funding has been given to health services, for example in the Dominican Republic, this has not been made available to civil society organisations, including those providing harm reduction services.[8] El Punto en la Montaña, an organisation operating an NSP in Puerto Rico, has sought funding to provide its staff and clients with personal protective equipment.[9]

In most countries, there are no specific state-led COVID-19 services for people who use drugs or other key populations. For this reason, harm reduction organisations including Intercambios in Argentina, RENFA (Anti-Prohibitionist Feminist Network) in Brazil and Verter in Mexico, are providing masks, sanitising gel and other protection equipment to people who use drugs.[43,46]
However, COVID-19 has also forced some positive changes. For example, OAT services in Colombia are now able to expand take-home capacities and provide take-home doses for longer periods. Such services have also been able to introduce home delivery of OAT.[11] However, such alterations to OAT practices have been rejected by health authorities in Argentina.[11]

The Latin American Network of People who Use Drugs released a series of recommendations and principles for governments, service providers and people who use drugs during the COVID-19 pandemic.[49] Among the recommendations for governments were calls to strengthen responses to withdrawal (which may increase in prevalence due to lockdown restrictions) and to prioritise key populations in the COVID-19 response, including people experiencing homelessness and people living with HIV. For people who use drugs, recommendations included cleaning surfaces with soap and water before using drugs, taking extra care around people who are immunosuppressed, and preparing the body and mind for a period of abstinence (due to lockdown restrictions and possible supply chain issues for some drugs).

Prisons and other custodial settings have higher risks of becoming epicentres for COVID-19, with populations vulnerable to higher levels of infection due to unavoidable close contact, poor ventilation, and low sanitation standards. Argentina, Bolivia, Brazil, Colombia, Costa Rica, Ecuador, Mexico, Peru, Uruguay and Venezuela have

already taken action, implementing different measures to reduce overcrowding and ensure health, safety and human dignity in prisons, according to international guidance.[22,40,50,51] With the exception of Costa Rica, most countries in the region have released people from prison through different modalities: home detention, pardons and amnesties. Visits have been suspended in many countries, which has psychosocial and economic consequences for those in prison. Measures taken have been insufficient to reduce the spread of infection in closed spaces. In addition, in Bolivia and Peru, incarceration has been used to enforce confinement measures, which is counterproductive to reducing overcrowding.[52] There is also specific guidance for women in prison.[53,54]

MIDDLE EAST AND NORTH AFRICA

Since the beginning of the COVID-19 pandemic, vulnerable populations have been impacted the most, and a multiplicity of issues have affected harm reduction services and the lives of people who use drugs and people living with HIV, mainly during the lockdown period. Voluntary counselling and treatment centres, drop in centres, dispensing units, outreach services and mobile units reduced the number of working days or closed entirely, while some services struggled to provide appropriate harm reduction workers, as the number of volunteers decreased due to fear of acquiring COVID-19. Furthermore, outreach services still operating found it difficult to reach people who use drugs to provide them with prevention or hygiene kits. On the other hand, people who use drugs found it difficult to access service centres (where they were open) due to lockdown policies and limited travel and movement, and large numbers of people experienced withdrawal syndrome due to unavailability of drugs or OAT in some countries. It was reported that some people who use drugs were reluctant to access services due to fear of getting COVID-19. Moreover, new needs such as food aid, housing support and financial aid emerged as a result of job losses. These were general issues faced in all countries in the region.[85–106]

Some governments have taken measures to support harm reduction services during COVID-19. For instance, in Algeria, Iran, Morocco, and Syria, the governments supported the distribution of personal protective equipment and hygiene materials for community and health workers working in harm reduction or for people who use drugs and people living with HIV.[86,92,97] In Lebanon, the Ministry of Public Health extended the prescription validity of OAT and patients could receive up to two-week doses; this was also the case in Morocco, Palestine and Iran where the government issued more flexible OAT protocols.[86–89,91,92,103] In Palestine and Morocco, outreach workers were provided with permits for travel movements.[91,97]

Organisations working in harm reduction have been creative in adapting the service delivery to the context of COVID-19 and have introduced many interventions to ensure the continuity of services. In almost every country, face-to-face consultations, follow-ups and support groups have been switched to online services. Even coordination and monitoring meetings were held on online platforms. Virtual trainings on COVID-19 and preventive measures to be taken were also conducted for the intervention teams. Home delivery of methadone was provided in Palestine and Morocco, while take-home doses of OAT were permitted in Iran and Morocco.[85–88,92,93,102,105,107] In Algeria, Bahrain, Iran, Morocco and Palestine, a larger supply of syringes was sometimes ensured.[85–88,92,93,102,105,107] Peer support and peer distribution of injection kits was reactivated and enforced. In Algeria and Morocco, centres extended their working hours to minimise crowding and be able to receive people while complying with the preventive measures.[86,97,102] Iran expanded mobile units and outreach work.[87]

Organisations are trying their best to adapt to the situation with available funds. Minimal governmental funding to support services during COVID-19 was reported from partners in countries who participated in the drafting of this chapter. Organisations are mobilising funds internally or from partners to purchase prevention tools, ensure uninterrupted service delivery and respond to the new emerging needs of their targeted population. One organisation in Algeria established a mask manufacturing unit managed and staffed by women living with HIV. Masks manufactured are distributed to key populations including people living with HIV and people who inject drugs.[85] In March 2020, an NGO in Iran created a COVID-19 prevention and control working group, bringing together a diverse range of representatives, including NGO managers and project coordinators, peer support workers, social workers, psychologists, clinicians, health policymakers, and academic researchers. The aim of this working group was to enable greater collaboration between government and non-government sectors and develop an equitable COVID-19 response among people who use drugs.[87,106]

NORTH AMERICA

As in all other areas of life, the COVID-19 pandemic has had a major effect on harm reduction services in North America. The need to obey physical distancing regulations and to protect medically vulnerable people has led to significant changes in the way harm reduction services operate.

Among the most widespread issues is the need for services to reduce capacity and opening hours, close temporarily or permanently, or operate on an appointment-only basis.[55,56] This has reportedly affected the vast majority of harm reduction services in Canada at least temporarily, including NSPs (and the promised expansion of prison NSPs), drug checking and DCRs.[55,56] In the medium to long term, civil society actors in Canada do not rule out the possibility of private foundations scaling down their commitments to harm reduction as a result of the pandemic, which is likely to result in the permanent closure of some harm reduction programmes.[56] In light of this, local fundraising will take on greater importance.[56]

In some cases, the pandemic has forced positive innovations in the implementation of harm reduction services. To facilitate self-isolation and physical distancing in Canada, an exemption to the Controlled Drug and Substances Act increased the role of pharmacists in the prescription of OAT and made take-home OAT considerably more available.[55–57] In British Columbia, detailed guidelines were published to address the twin crises of overdose deaths and COVID-19, which later fed into national level guidance.[58,59] These guidelines facilitate take-home OAT, including hydromorphone, as well as the prescription of methylphenidate and dexamphetamine for people who use stimulants.[58] They also recommended that people continue to avoid using drugs alone due to the risk of overdose.[58] The COVID-19-related exemption to federal drug laws was initially due to expire on 30th September 2020, but was extended to 30th September 2021 in August 2020.[57]

In the United States, federal restrictions on OAT have been loosened in order to increase access while also reducing risk of COVID-19 exposure.[60] Opioid Treatment Programmes were given flexibility to provide up to 28-day take-home doses and to waive urine drug testing requirements during that time, and there has been expanded use of online consultations (though these are not permitted to replace medical evaluation for new methadone clients). Despite these new guidelines, challenges still remain, namely that some state guidelines remain more restrictive than the federal guidelines and individual programmes may choose to continue more restrictive dispensing practices that still require frequent programme attendance.[61,62]

Preliminary evidence from Canada and the United States also indicates that overdose deaths have increased over the course of the pandemic.[62,63] According to the American Medical Association, 35 states had reported an increase in opioid-related mortality by July 2020.[64] Posited explanations for the variation include disruptions to global drug supplies which may have changed the composition of available drugs, increased likelihood of using alone under physical distancing restrictions, and the way in which COVID-19 has overwhelmed health and emergency services.[62] Increased overdose deaths may also be associated with the release of individuals from jails and prisons during the pandemic.[65]

A particular concern in the United States is the impact of the pandemic in jails and prisons. Correctional settings, particularly those as heavily populated as in the United States, face serious challenges with physical distancing, patient quarantine and health service capacity.[66–68] Several jails and prisons have experienced large outbreaks of COVID-19, including Rikers Island in New York, Cook County jail in Illinois, and San Quentin in California.[65,67,68] As of July 2020, more than 26,000 people had been released from jails and prisons across the United States to relieve this pressure.[68,69] While these early releases are welcome, they also pose new challenges which must be addressed, including increased risk of overdose and homelessness.[68] Given the racialised nature of drug law enforcement in the United States, COVID-19 in correctional settings has disproportionately impacted Black and Hispanic individuals.[65]

In many states across the United States that implemented lockdown restrictions, NSPs were deemed "essential services" so that they could continue to operate and provide services. Two rapid response research studies on NSP access in the US found that most NSPs had to restrict their days and hours of operation, but that they tried to pre-package supplies and provide extra syringes, equipment, and naloxone for distribution.[70,71] Some services have also shifted to mobile delivery or mail order models in order to ensure people have access during the pandemic.[65] Testing for HIV and hepatitis C has been reduced in many settings and concerns remain that there may be outbreaks if people experience shortages and are forced to reuse or share supplies.[70,71] Harm reduction providers are also educating participants to stay safe when using or buying drugs during

COVID-19, including using sanitiser, washing hands, and maintaining distance when using drugs with others.[62,72–74]

OCEANIA

Compared to the general population, people who use drugs in Oceania are more exposed to the risks of COVID-19 infection, as they are more likely to have poor health conditions, and to experience stigma, social and economic disadvantage, homelessness and imprisonment.[75] Recognising the vulnerability of people who use drugs, Australian experts summarised the challenges in maintaining treatment services during the COVID-19 pandemic, and concluded that OAT should be considered an essential treatment and called for scaling up of long-lasting buprenorphine provision, increased take-home doses of OAT with the rapid expansion of take-home naloxone programmes, and also suggested that NSPs should provide bulk numbers of injecting equipment to ensure availability.[75]

A survey among people who inject drugs in Melbourne, Australia, examined the effect of the pandemic in April 2020, and most participants reported that there had been little impact of COVID-19 restrictions on their drug purchase and use patterns at that early stage.[76] The impact on harm reduction service delivery, on the other hand, was profound. Some services closed operations, ceased accepting new clients or moved to electronic systems of service provision.[77] To minimise disruptions in service delivery, such as access to general practitioners and pharmacists, OAT policies were relaxed: more unsupervised dosing, longer take-home periods and third party collection of OAT medications became available.[77–79] However, policy changes in OAT delivery differed between Australian jurisdictions.[77] Peer organisations released guidance to people who are on OAT to get accurate information from the service provider, and prepare for larger take-home doses.[80] To accompany the increased availability of take-home OAT, naloxone was made widely available, though the initiative had unintended consequences: a major shortage of naloxone supply in the country.[77] Altogether, COVID-19-related changes in service delivery brought positive changes. In July 2020, Australian organisations working in the field of alcohol and other drugs called on federal, state and territory governments to make permanent or expand on reforms introduced during the pandemic to better support people who use drugs.[81]

In New Zealand, NSPs were included among essential health services available during the most strict lockdown measures and the government provided personal protective equipment to NSPs.[82,83] However, service delivery was modified to comply with physical distancing rules, which resulted in restrictions on the number of clients on the premises at one time and, in some cases, restricted opening hours due to staff capacity.[82] To compensate for the decrease in access and reduce the need for in-person visits, the New Zealand Needle Exchange Programme developed an online shop for clients unable or unwilling to access services.[82,84] There were concerns that people who inject drugs could be at greater risk of overdose during the lockdown period, which created an opportunity for government-funded access to naloxone kits at NSPs.

SUB-SAHARAN AFRICA

Disruption in harm reduction service availability due to the pandemic could cause long term consequences beyond those from COVID-19 itself,[108] with people who use drugs having to deal with interruptions in their treatment, counselling services or rehabilitation.[109] Where OAT services exist, access to OAT has been hampered by the COVID-19 pandemic. Most countries in sub-Saharan Africa still use directly observed therapy to deliver OAT, which meant that services were suspended in some countries during COVID-19 as the ability to travel to health facilities was restricted. The impact of these restrictions is as yet unclear. However, civil society actors in many places expect to see an increase in the use of illegal opioids and an increase in people experiencing opioid withdrawal as a result of COVID-19-related measures. The only countries where OAT is not exclusively provided through directly observed therapy are South Africa and Tanzania.[110] In Senegal, the drop-in clinic CEPIAD has increased the prescription period for OAT for some patients and set up a delivery service for specific cases. Staff also delivered sterile injection equipment and picked up used equipment from specific locations to cater to communities of people who inject drugs to minimise the risk of transmission. [111]

The prevailing unfavourable legal environment still exposes people who use and inject drugs to arrests, including for minor infractions. COVID-19 confinement measures and the enforcement of those measures by police exacerbate this punitive environment. Men who have sex with men, people who use drugs and people who inject drugs experiencing homelessness have been subject to arrests and detention in Uganda, with physical abuse and longer detention periods due to the lack of access to legal services

during the first phase of the lockdown. [112–114] The Human Rights Awareness and Promotion Forum, a civil society organisation that offers access to justice and legal aid services, reached detainees both virtually and physically. The Forum was able to access clients in detention by help of travel waivers, and contacted judges and attended court sessions virtually. As a result of COVID-19, people who use drugs reported food insecurity and a lack of access to ART and other harm reduction services. To respond to meeting the needs of the community, the Forum brought together organisations working with key populations, including people who inject drugs, to discuss the needs of the community. Consequently, a consolidated proposal of needs was developed and a reallocation of funds was approved by the Global Fund to Fight AIDS, Tuberculosis and Malaria.[115]

Despite this disruption, harm reduction organisations have made some strides in ensuring that the needs of people who use and inject drugs are addressed. The West Africa Drug Policy Network is a budding coalition of more than 600 civil society organisations from 17 countries which support drug policy reform. The coalition has been able to facilitate the continuity of harm reduction services, to design and disseminate user-friendly messages on COVID-19 prevention for people who inject drugs, and to supply food to people who inject drugs who are unemployed or experiencing homelessness.[116]

The West Africa Drug Policy Network released an emergency response to COVID-19 prevention and control among people who use drugs, focusing on the additional risks and challenges faced during the pandemic. The response emphasised the particular vulnerability of people who use drugs to COVID-19 due to underlying health conditions associated with their drug use, stigma, social marginalisation and higher economic and social vulnerabilities, including a lack of access to housing and health care. It also highlighted the difficulty for people who use drugs, particularly those with dependence and experiencing homelessness, to protect themselves from COVID-19 with the current protective measures in place, including physical distancing and periodic lockdowns.[109]

WESTERN EUROPE

The COVID-19 crisis catalysed the establishment of regular consulting or monitoring networks of professionals working in the fields of drug policy and harm reduction, and strengthened cooperation between organisations in many countries (e.g. Italy, Ireland, Netherlands, Norway, Portugal, United Kingdom).[27–32] In the United Kingdom, for example, a national network monitoring group with biweekly online meetings has been established to monitor the drugs market and harm reduction during the crisis, involving a wide range of stakeholders from service providers, networks of people who use drugs, law enforcement, advocacy groups and researchers.[29]

The availability and coverage of harm reduction services decreased after the COVID-19 measures were introduced in the region, but the majority of EU countries (14 out of 25) reported only a slight decrease and six countries reported no change in availability.[10] Reports to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) showed that the services were affected differently - NSPs and OAT programmes experienced serious decreases or closure in less than half of the countries, while drop-in-centres were seriously disrupted in almost 80% of EU countries.[10]

Most of the drug consumption rooms (DCRs) in the region have remained open during the crisis. Norway was the only country where DCRs were closed following the recommendations of the country's health authority.[10,33,34] DCRs in the region had to change service delivery modes to comply with the physical distancing rules. The number of clients using the facilities was limited, and many introduced additional preventive measures like fever checks for clients entering the DCR, mandatory hand washing and masks. To compensate for the decrease in capacity, temporary DCRs were opened in Barcelona, another mobile DCR was implemented in Lisbon, and DCR opening hours were increased in Germany. The DCR in Zurich have set up tents to ensure physical distancing can be observed.[10,33,35]

To compensate for the decreased access and coverage, harm reduction services adjusted their service delivery to the lockdown environment. Across Western Europe, NSPs increased the number of syringes one client could receive,[10] allowing secondary syringe exchange and safe injection practices during the lockdown period. Outreach was used to maintain the coverage of NSPs and take-home naloxone programmes in Italy;[28] and innovative ways of service delivery were introduced, for example click and collect schemes for harm reduction equipment in the United Kingdom, the mail delivery of syringes and other commodities in France. [10,29] Peer involvement became

more pronounced in many countries; peer networks provided secondary syringe exchange and outreach services, and disseminated information on lockdown measures and COVID-19.[32,36] OAT practices were reformed in many countries, for example, distribution of OAT medications and naloxone in low-threshold outreach settings in Luxembourg, Spain and Portugal,[10,32] and less restrictive prescribing practices across the region (longer take-home periods and significantly shorter initiation time).[10,27–30,37]

As a result of the pandemic and subsequent lockdown restrictions, the income of certain subpopulations of people who use drugs decreased substantially, for example sex workers and people who are homeless.[29,33,35,37] In response to this, a temporary OAT service was installed in Hamburg, Germany, where anyone could initiate OAT and access OAT medication without any costs, regardless of health insurance status.[35]

Photo by Voices of Community Action and Leadership, Kenya (VOCAL-KE)

Recommendations

HARM REDUCTION SERVICES ARE ESSENTIAL PUBLIC HEALTH INTERVENTIONS, PIVOTAL IN REACHING KEY POPULATIONS.

The pandemic showed that many harm reduction services are innovative and quick to adapt, and can maintain the best possible coverage, linking otherwise hidden key populations to other social and health care services. Harm reduction should thus be included in public health policies accordingly, and appropriate funding should be provided to ensure service delivery.

COVID-19 ADAPTATIONS IN OAT, NSP AND TREATMENT DELIVERY CAN INCREASE ACCESS TO SERVICES AND SHOULD REMAIN IN PLACE.

Long-awaited changes in harm reduction service delivery took place during the pandemic. Longer take-home periods for OAT and less restrictive initiation procedures were set up in many countries, providing evidence that these are feasible and beneficial. Greater emphasis should be given to low threshold community settings in the distribution of harm reduction commodities, as well as testing and treatment for HIV, viral hepatitis and TB.

GREATER COMMUNITY INVOLVEMENT IS CRUCIAL TO INCREASE COVERAGE AND ACCESSIBILITY OF SERVICES.

Networks of people who use drugs played an important role during the pandemic, contributing to service delivery with secondary syringe exchange, while providing input for professionals working in harm reduction, and disseminating crucial information among the drug user community. Peer involvement should be extended to provide more accessible services tailored for the needs of the community.

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1.3 HEPATITIS C

1.3 Hepatitis C

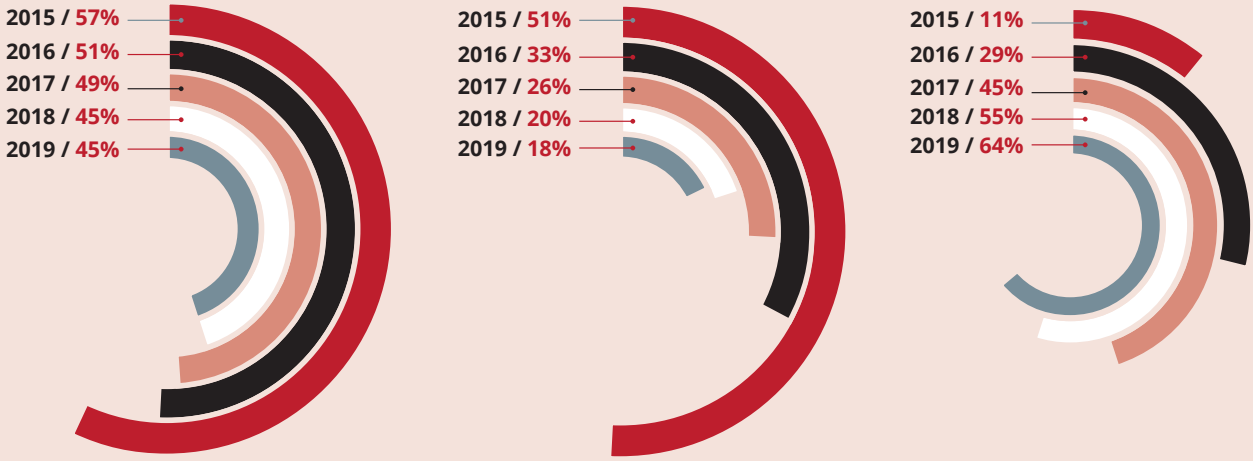
PEOPLE WHO INJECT DRUGS

1/2

MORE THAN HALF OF ALL PEOPLE WHO INJECT DRUGS ARE ESTIMATED TO **CARRY HEPATITIS C ANTIBODIES**, MEANING THAT THEY HAVE BEEN INFECTED WITH THE HEPATITIS C VIRUS AT SOME POINT IN THEIR LIFETIMES.

People who use drugs are explicitly excluded from treatment despite unequivocal evidence that treatment is equally effective for people actively using drugs.

HEPATITIS C-RELATED TRENDS AMONG AUSTRALIAN NSP SURVEY RESPONDENTS 2015-2019[80]



HEPATITIS C PREVALENCE[3] **ACTIVE HEPATITIS C INFECTION[4]** **LIFETIME HEPATITIS C TREATMENT[5]**

3 Hepatitis C antibody prevalence, for further details see p. 37 Table 1.3.1 in Heard, S; Iversen J; Geddes L & Maher, L. (2020). Australian NSP survey: Prevalence of HIV, HCV and injecting and sexual behaviour among NSP attendees, 25-year National Data Report 1995-2019. Sydney: The Kirby Institute, UNSW Sydney.

4 Hepatitis C RNA prevalence, for further details see ibid., p. 40 Table 1.4.1

5 Among people who tested HCV antibody positive and did not report spontaneous clearance, for further details see ibid., p. 32 Table 1.1.7

1. Overview

Globally, more than half of all people who inject drugs are estimated to carry hepatitis C antibodies, meaning that they have been infected with the hepatitis C virus at some point in their lifetimes.[1] People who use drugs but do not inject drugs, such as those who smoke opioids or stimulants, are also at greater risk than the general population.[2,3] For example, sharing pipes and engaging in higher-risk sexual practices among people who use stimulants are both associated with hepatitis C infection.[4–6] In the global effort to eliminate hepatitis B and C by 2030,[7] it is essential that people who use drugs are deemed a priority population for prevention, testing and treatment.

Harm reduction interventions are crucial to the prevention of hepatitis C among people who use drugs. Needle and syringe programmes (NSPs) and the distribution of safer smoking equipment are both means of reducing the sharing of equipment which can lead to viral hepatitis transmission.[8,9] Opioid agonist therapy (OAT) and drug consumption rooms (DCRs) reduce higher risk injection practices associated with viral hepatitis.[8,10] These harm reduction interventions also have a crucial role in linkage to care for people who use drugs, and can be a key means of engaging people in hepatitis C testing and treatment.[8,10]

The World Health Organization (WHO) recommends hepatitis C testing and treatment for all people who inject drugs.[11,12] Direct-acting antiviral treatments for hepatitis C are capable of achieving either sustained virological response or cure in more than 95% of cases, without the negative side effects associated with previous interferon-based treatments.[13] The advent of these treatments since 2011 has made the elimination of hepatitis C an achievable goal. However, for this to be achieved, it is essential that treatments are available and accessible to all those who need them, including people who use drugs. Currently, the cost of treatment in many contexts is prohibitively high for most clients and, in some cases, people who use drugs are explicitly excluded from treatment despite unequivocal evidence that treatment is equally effective for people actively using drugs.[14] Widespread treatment must also be accompanied by testing programmes to identify cases for treatment.

This section provides a regional overview of the hepatitis C situation and response as it relates to people who use drugs. National data on hepatitis B and C prevalence among people who inject drugs is available in each regional chapter.

ASIA

There are 1.8 million people with recent injecting drug use living with hepatitis C antibodies in Asia. This accounts for 30% of the global prevalence.[15] Barriers to care which have contributed to the high number of viral hepatitis cases and deaths among people who inject drugs include over-criminalisation and a lack of testing and harm reduction services,[16] while regulatory approval is the main barrier to treatment with direct-acting antivirals.[17,18] Even in high-income countries, costs are prohibitive. In Japan, for instance, a full treatment costs around USD 18,000.[19]
Despite the historic lack of attention to viral hepatitis in the region, particularly in relation to injecting drug use, significant progress has been made in the past few years, with an increasing number of countries sustaining, initiating, or committing to initiate hepatitis programmes. In Japan, the government has continued to subsidise treatment costs on top of free testing for all citizens between 40 and 70 years of age.[19] In Mongolia, 6,500 people had been treated within 20 months of the public-private Arkhangai project initiated in 2016,[20] and a 2019 report stated that officials hope to expand it to other sites in the country.[21] Similar treatment initiatives have been reported in China and Pakistan,[20] as well as in Bangladesh, where a study found that hepatitis C treatment can be feasibly provided within existing harm reduction services.[22]

In 2019, India announced a national action plan on viral hepatitis that recognises people who inject drugs as a key population.[23] Similarly, Malaysia - where direct-acting antivirals have been available since 2017 - included steps related to people who inject drugs in its 'National Strategic Plan for Hepatitis B and C'. This includes the goal of scaling up harm reduction services and "differentiated service delivery for people who inject drugs through engagement with non-governmental organisations."[24] Taiwan included similar provisions for people who inject drugs in its plan to eliminate hepatitis C by 2025.[25]

Civil society groups and communities of people who use drugs have also mobilised to enable access to hepatitis C treatment. One notable example is the 'Pengobatan Hepatitis C' in Indonesia, a 'buyer's club' that has been facilitating access to affordable direct-acting antivirals since 2015.[26]

EURASIA

The prevalence of hepatitis C among people using drugs is very high in Eurasia, varying between 15% and 94%. Hepatitis C prevalence among people who inject drugs is above 50% in 18 countries in Eurasia, up from 16 in 2018 (see regional table, p.82). Russia is one of the four main contributors to the hepatitis C burden among people who use drugs in the world.[27] The main barriers in the region to reaching the goal of eliminating hepatitis C by 2030[28] are poor coverage of harm reduction services, restrictive drug policies, criminalisation of drug use, poor access to cost-efficient harm reduction services, low hepatitis C testing, poor linkage to care and treatment, restrictions for accessing direct-acting antiviral therapy and the lack of national strategies and government investment to support elimination goals.[27, 29]

Over the past few years Armenia, Belarus, Georgia, Kazakhstan, Moldova and Ukraine have adopted national programmes to treat hepatitis C. Kazakhstan has become a notable example of cooperation between civil society and the Ministry of Health, having developed a national roadmap and a national hepatitis C treatment programme which are now among the most progressive in the post-Soviet region.

While the available data shows that the burden of hepatitis C among people who inject drugs is high, there are still significant gaps in data in many countries. For example, there is currently no systematic collection of data on the hepatitis C cascade of care (the transitions between testing, treatment and cure). National treatment guidelines require abstinence from drug use for between six months and a year in order to enrol into treatment in Bulgaria, Croatia, Hungary and Slovakia. In Romania, a negative drug test is required before starting treatment for hepatitis C patients co-infected with HIV. In Poland, people who are actively 'dependent' on drugs are excluded from treatment.[30] Slovenia has an integrated national network approach to treatment of hepatitis C among people who use drugs which is implemented with strong coordination between the five clinical centres for viral hepatitis treatment and the 18 drug treatment centres in the country.[30]

Funding for testing and treatment of hepatitis in most cases comes from national budgets. Consequently, availability of testing and treatment depends on whether it is prioritised by the state (as was done in Belarus, Kazakhstan, Moldova, Slovenia and Ukraine) or not (as in Azerbaijan, Kyrgyzstan and Uzbekistan). There are no global international donors that support hepatitis C treatment although, after extensive advocacy efforts, the Global Fund to Fight AIDS, Tuberculosis and Malaria started to allow for the inclusion of viral hepatitis within HIV response grants (for example in Ukraine). In Georgia, the launch of the programme in 2015 was sponsored by Gilead and the government contributed to its infrastructure.

LATIN AMERICA AND THE CARIBBEAN

In line with WHO recommendations, the integration of viral hepatitis services with HIV services is common in Latin America.[52–56] However, their integration with harm reduction services is sporadic. Such integration is only present in northern Mexican cities and those cities in Colombia where injecting drug use is more prevalent.[57,58] Some harm reduction services in Brazil for people who use crack cocaine also integrate those services.[58,59] E de Lei in Brazil provides hepatitis C, hepatitis B and HIV prevention in its harm reduction services.[53] In Buenos Aires, Argentina, the Casa Masantonio project continues integrating hepatitis C treatment into harm reduction services for people who use cocaine paste.[60]

Even though there are national responses implemented in the region to control viral hepatitis outbreaks, the coverage is insufficient because of lack of funding, the cost of rapid tests and the prevalence of late diagnosis.[54] For people who use drugs, stigma and discrimination are another barrier to accessing diagnosis and treatment.[57,59,61,62]

In March 2020, hepatitis C treatment with direct-acting antivirals was added to the Puerto Rico Medicaid programme, meaning it is now available for free. Treatment is not conditional on abstinence from illegal drug or alcohol use nor on the extent of liver damage. However, clients are asked to disclose previous drug use and can be directed to drug treatment on entry to hepatitis C treatment.[63] As a result, stigma and discrimination still act as a barrier to accessing treatment.[61] A further barrier is that prescription of hepatitis C treatment is restricted to certain liver and infectious disease specialists.[64]

MIDDLE EAST AND NORTH AFRICA

The WHO Eastern Mediterranean region has one of the highest rates of hepatitis C infection at 62.5 per 100,000 population compared to the global rate of 23.7 per 100,000, with injecting drug use and unsafe health care procedures being the leading modes of transmission.[55] In the Middle East and North Africa, the mean prevalence of hepatitis C in people who inject drugs is estimated at 49.3% ranging from 21.7% in Tunisia to 94.2% in Libya.[88] In a recent study, estimates about prevalence of chronically infected people who inject drugs were made and recommendations highlighted the need to expand harm reduction services and adopt innovative strategies to ensure accessibility and availability of hepatitis C testing and treatment.[88]

The majority of countries in the region have national viral hepatitis programmes or policies. In Morocco, a national strategy was prepared in 2016, however the government is yet to implement it. Currently, civil society organisations organise national campaigns for hepatitis C testing as part of their advocacy plans.[89] In Tunisia, national campaigns for community testing for HIV are organised by civil society organisations using a multiplex diagnostic platform for HIV and hepatitis B and C.[90] Although national policies and strategies exist in some countries, the coverage and availability of screening and treatment remains insufficient. Bahrain, Iran, Jordan, Lebanon, Qatar, Syria, and Tunisia do have dedicated units in their ministries of public health working on hepatitis C. However, the ministries do not always fund testing and treatment, and availability of services is limited to nationals and not foreign nationals.[90–97]

Tailored approaches for people who inject drugs or integrated services with infectious diseases or OAT are not always available. Tunisia reported integrated HIV and hepatitis C services for people who use drugs, however people need to pay for their initial laboratory tests (viral loads and others) which poses a huge barrier to access.[90] Stigma and discrimination are among the main barriers to testing. People who inject drugs report avoiding visiting centres for testing, recounting many instances of mistreatment. Another barrier to accessing treatment was the cost of additional tests required prior to the initiation of treatment.[90] The lack of availability of local and regional data and the lack of awareness and advocacy among local communities and people who inject drugs remain a challenge to political commitment and domestic funding of hepatitis C programmes.

NORTH AMERICA

In both Canada and the United States, hepatitis C causes more years of life lost than any other infectious disease, due in large part to its contribution to liver cancer.[14,65] Liver cancer is the only cancer with increasing mortality in Canada, and is the fastest growing cancer by number of cases in the United States.[14,65]

From 2009 to 2018, the number of acute hepatitis C cases in the United States population quadrupled, from 0.3 to 1.2 cases per 100,000 people.[66] Of the people living with hepatitis C in the country, 61% knew they had the infection.[67] Among people who inject drugs, a national study found that 44.1% had ever been diagnosed with hepatitis C, and that more than 20% had never been tested.[67] Millennials (those born between 1980 and 1995) account for more than half of people living with chronic hepatitis C in the United States.[68]

In Canada, 85% of new hepatitis C infections are among people who inject drugs and 40% of people living with hepatitis C have not been diagnosed.[65] Nationwide, hepatitis C incidence has increased in recent years, including from 30.5 to 31.7 cases per 100,000 people from 2015 to 2017.[69] Notably, hepatitis C incidence is five times higher among Indigenous people,[65] in part due to their overrepresentation in vulnerable populations such as people who inject drugs, people in detention and those with unstable housing.[70] As in the United States, hepatitis C infections in Canada increased among young people over recent years.[65]

In Canada, provincial and territorial governments fund viral hepatitis treatment.[71,72] However, stigma and discrimination towards people who use drugs, as well as unstable housing, poverty, criminalisation and incarceration, all act as barriers to people accessing viral hepatitis testing and treatment.[65,71,72] Hepatitis C services in Canada are often integrated into harm reduction services to increase accessibility for people who use drugs. However, this is not consistently implemented.[71] Examples of positive developments since 2018 include the scaling-up of Ontario's Hepatitis C Team Network, which conducts outreach for screening, treatment and prevention for people who inject drugs and people with unstable housing.[65]

There is no national policy in the United States defining access to hepatitis C treatment under Medicaid, the federal medical assistance programme.[73] As of 2020, three states

(Arkansas, South Dakota and Texas) continue to limit access to treatment under Medicaid to people with advanced (stage F3 or higher) liver damage (down from 12 in 2017).[64,74] A period of abstinence from illegal drugs and alcohol before treatment is still required by 16 states (down from 27 in 2017).[64,74,75] Only eight states now require patients to be abstinent from drugs and alcohol for six months or more.[74,75]

While this progress is positive, no state should impose these restrictions on access to potentially life-saving treatment. In fact, such limitations on access to treatment violate federal guidance that obliges states to only impose medically necessary restrictions.[14,76]

OCEANIA

Australia is among the few countries on track to reach the hepatitis C elimination goal by 2030.[31] Targets included in Australia's National Hepatitis C Strategy 2018–2022 are in line with the global elimination targets set by the WHO.[77,78] Since 2016, there has been universal access to hepatitis C direct-acting antiviral therapies, including for repeated direct-acting antiviral treatment due to reinfection.[79,80] According to the Australian NSP data collection, there have been significant improvements since these commitments were made. The prevalence of hepatitis C among people who inject drugs attending Australian NSPs has decreased significantly over the past few years, from 57% in 2015 to 45% in 2019, and lifetime hepatitis C treatment increased substantially from 11% in 2015 to 64% in 2019.[80] The proportion with active infection[3] also declined during this period, from 51% in 2015 to 18% in 2019. According to the most recent data available, illegal drug use was responsible for 75% of the acute hepatitis C burden in the country in 2015.[81]

Despite the considerable progress in Australia's hepatitis C situation, barriers still exist in access to hepatitis C treatment. Stigma and discrimination experienced by people who use drugs and people living with hepatitis C is the main issue,[78,79,82] as people who use drugs can be reluctant to engage with the healthcare system because of past bad experiences.[79] A study among people living with hepatitis C who inject drugs concluded that expanding the models of care on offer beyond hospital settings (outreach clinics, community-based programmes and peer-driven and other social support throughout the treatment journey) is necessary to ensure that people who inject drugs will come forward for hepatitis C treatment in sufficient numbers to drive elimination.[83] A study in an urban Aboriginal and Torres Strait Islander primary health care clinic also found that besides low rates of health literacy, feelings of shame and stigma are a barrier to treatment uptake. Connections within the community and family could provide support during the assessment and treatment process; stigma related to hepatitis C infection impacts the individual's desire to seek support and also limits the support available.[82]

While data on hepatitis C among people who inject drugs in New Zealand has not been updated since 2018, hepatitis C prevalence among people with lifetime prevalence of injecting drug use is estimated to be 58% according to the latest data available.[84] Currently, there are an estimated 45,000 people in New Zealand who have been infected with hepatitis C with a significant proportion, approximately 40-50%, being unaware of their status.[85,86] A significant development is that direct-acting antiviral treatment became publicly funded in February 2019, and is now available at no cost.[85,87] The public funding of direct-acting antivirals improved access to hepatitis C treatment for people who inject drugs as they are in the focus of testing and treatment measures,[85] for example hepatitis C service providers are required to work with local organisations including NSPs, community alcohol and drug services, and prisons,[86] while the New Zealand Needle Exchange Programme (NZNEP) is strongly committed to providing treatment for its clients.[85] However, there are multiple barriers to accessing hepatitis C treatment. Testing is insufficient in the country, especially onsite at NSPs, with only three having a permanent clinical service onsite.[85] Client pathways are underdeveloped and also hinder access to treatment. There is no formal plan within the NZNEP to network between NSP services and secondary or primary care and to link NSP clients with appropriate services.[85]

SUB-SAHARAN AFRICA

In sub-Saharan Africa, mortality and morbidity due to hepatitis C infection is on the rise and injecting drug use contributes considerably to the hepatitis C incidence rates with an estimated 10.2 million people in the region living with chronic hepatitis C.[54]

3 Hepatitis prevalence rates are based on hepatitis C antibody tests (determining whether the people tested were infected with the virus in the past), while active infection rates can be measured with hepatitis C RNA tests (determining whether the virus itself is present in the tested sample).

Although in many parts of Francophone Africa, detailed and reliable data on viral hepatitis is scarce, available estimates indicate a substantial burden: national prevalence of hepatitis C ranges from 0.7% (in Cameroon) to 3.1% (in Mali) and the prevalence of hepatitis B from 4.4% (Cameroon) to 8.5% (Mali). [98,99] To establish the extent of viral hepatitis among people who use drugs, systematic population-based prevalence studies should be conducted when developing models of national programmes for the control of hepatitis C.

Policy shifts and discussions are taking shape across the region. Testing for hepatitis B and C is offered in Kenya, Mauritius, Seychelles and Tanzania and is generally affordable. However, the current estimated costs of treatment of chronic hepatitis C are prohibitive in most settings in sub-Saharan Africa.[100] The International Network on Hepatitis in Substance Users held its conference in Cape Town, South Africa, in February 2020 - the first time the conference had been held in the region. The conference strongly emphasised the need to invest in the fight against hepatitis C among people who use drugs. It reinforced the African Union's 2019 Cairo Declaration on Viral Hepatitis in Africa which commits ministers to provide government leadership; implement hepatitis programmes; develop budgeted national plans; integrate hepatitis C care into existing services; raise awareness; ensure access to hepatitis prevention and treatment for key populations; and accelerate access to new diagnostics and medicines. Despite these developments, most of the governments in sub-Saharan Africa have not yet incorporated the WHO hepatitis C targets into their health sector programmes. The only exceptions are South Africa and Mauritius where a hepatitis C policy exists and has been integrated into health sector programming.

WESTERN EUROPE

The prevalence of hepatitis C antibodies among people who inject drugs varies widely across Western Europe, ranging from 10% in Iceland to 76% in Ireland (as shown in Table 2.3.1). Seven countries in the region are on track to meet WHO hepatitis C elimination targets: France, Iceland, Italy, Netherlands, Spain, Switzerland and the United Kingdom.[31] The United Kingdom and Iceland have recently reported an encouraging decline in the prevalence of hepatitis C among people who inject drugs following the scale-up of direct-acting antiviral treatment.[32] Hepatitis strategies are now in place in 17 EU countries and Norway.[4][34] Switzerland also has national guidelines on viral hepatitis for people who inject drugs, developed by Infodrog on behalf of the Federal Office of Public Health.[35,36] Malta is updating the country's national strategy on hepatitis C and key populations, including people who inject drugs, will have access to testing and treatment.[37,38] However, one country in the region, Cyprus, continues to restrict access to hepatitis C treatment for people who inject drugs.[39] Although hepatitis C treatment is free in many countries in the region,[40–45] cost of treatment remains a barrier to those without health insurance in insurance-based health systems (such as in Austria, Germany, Luxembourg and Switzerland), which negatively impacts upon access for people who inject drugs who are refugees or migrants. [33,35,44,46]

While hepatitis C testing and counselling are offered by harm reduction services, treatment provision is an area where the region lags behind. A study found that treatment prescription is available in services for people who use drugs in Cyprus, Denmark, Germany, Luxembourg and England,[47] and several NSPs offering hepatitis C treatment in Sweden.[48] However, a wide range of best practices and innovative models of care in harm reduction services are present in the region. There are at least eight countries where hepatitis C treatment in low-threshold settings, peer support and community-based programmes, and multidisciplinary treatment provision integrated to OAT and NSP are present.[49]

According to reports, the availability of hepatitis C testing in the region is high, with Cyprus being the only country where testing is not offered in harm reduction services.[47] In the United Kingdom, hepatitis C testing has been scaled up significantly and has been made available in harm reduction services, drug treatment services, pharmacies, health clinics and general practitioners.[41] Despite the availability of rapid hepatitis C tests in harm reduction services in Italy, uptake of testing is very low, with less than a fifth of drug service clients being tested. Low testing is attributed to insufficient information on the availability of testing among the clients. [50] There is also insufficient test uptake in Switzerland. However, the overall coverage of harm reduction services is the main barrier to access. It is estimated that coverage of OAT services is about 70%, and 75% of people who inject drugs are in NSPs.[35]

4 Although Denmark does not have national hepatitis C treatment guidelines, it has a number of strong policy documents regarding hepatitis C care for people who inject drugs. Therefore, the European Monitoring Centre for Drugs and Drug Addiction counts Denmark as 'having a policy'.[33]

The placement of hepatitis testing in inappropriate settings is consistently reported as a barrier to testing and treatment. In Germany, for example, hepatitis C testing is mainly available in medical settings (doctor's offices, hospitals), which does not sufficiently meet the needs of people who inject drugs. In order to effectively increase hepatitis C testing,[46] targeted harm reduction measures are needed to reach vulnerable subpopulations of people who inject drugs.[51] In the Netherlands, a specialised outreach project was launched to provide hepatitis C testing at drop-in centres and homeless shelters to reach those who would not normally attend the municipal health services for testing.[43] Although there are some informal arrangements to provide community-based testing in Portugal, most testing and treatment is hospital-based; health services are not adapted to the needs of people who inject drugs, and stigma and discrimination are still an issue.[40] Civil society actors also identify the fear of stigmatisation and discrimination from medical professionals as a major barrier in being able to access hepatitis C care in Austria.[44]

Recommendations

VIRAL HEPATITIS SERVICES MUST BE AVAILABLE FOR FREE OR AT LOW COST TO ALL PEOPLE WHO NEED THEM WITH NO REQUIREMENT FOR ABSTINENCE FROM DRUG USE.

The elimination of hepatitis B and C will not be possible unless testing and treatment (including repeated treatment due to reinfection) is widely available and accessible. This requires eliminating barriers that prevent people from accessing services such as clinical restrictions on drug use or liver damage and upfront or out-of-pocket costs to the client.

VIRAL HEPATITIS TESTING AND TREATMENT MUST BE INTEGRATED WITH OTHER HARM REDUCTION SERVICES.

In order for harm reduction services to meet their potential as sites of linkage to care for viral hepatitis, they must be integrated with services providing viral hepatitis testing and treatment. This can also mitigate the impact of stigma and discrimination.

VIRAL HEPATITIS SERVICES FOR PEOPLE WHO USE DRUGS MUST BE NON-JUDGEMENTAL AND COMPASSIONATE TO LIMIT THE EFFECTS OF REAL AND PERCEIVED STIGMA.

Stigma and discrimination towards people who use drugs, who may also belong to other stigmatised groups, are consistently reported as a barrier to viral hepatitis services in every world region. Ways of addressing this include the employment of peers as service providers, the integration of harm reduction and viral hepatitis services, and increased community outreach.

STATES MUST INCREASE EFFORTS TO GATHER ROBUST DATA ON HEPATITIS C AMONG PEOPLE WHO USE DRUGS TO INFORM THE RESPONSE, INCLUDING BY INCREASING TESTING.

The significant number of people living with hepatitis C who are not aware of their condition represents a challenge for elimination efforts. It is essential that states expand efforts to understand the epidemic in their territories, and ensure that testing is available to all those who are at risk.

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1.4 TUBERCULOSIS

1. Overview

The 2019 World Health Organization (WHO) Global TB Report found an estimated 10 million people fell ill with tuberculosis (TB) in 2018.[1] People who use drugs have higher rates of TB and latent TB infection regardless of their HIV status.[2] The risk of developing active TB disease is estimated to be between 20 to 30 times more likely in people living with HIV.[3,4] People living with HIV who inject drugs are two to six times more likely to develop TB disease,[5–7] and TB is the leading cause of mortality among people who inject drugs and who are living with HIV.[8] Current evidence mainly relates to people who inject drugs, but it is now known that people who use drugs have increased rates of TB, even if they do not inject. Drug practices such as inhaling crack cocaine and other inhalants, and exhaling directly into another person's mouth, increase the risk of developing TB disease. Environmental factors such as cramped and poorly ventilated spaces can also contribute to the transmission of TB.[5]

The stigmatisation and criminalisation of people who use drugs also contribute to higher rates of TB, for example by creating challenges in accessing sterile injecting equipment. In prisons and other custodial settings, the risk of TB is 23-50 times that of the general population.[9] People in prison have a higher prevalence of HIV, viral hepatitis, and TB compared with the general population. A systematic review found the global prevalence of infection among people in prison was 4.8% for hepatitis B virus, 15.1% for hepatitis C virus, 3.8% for HIV, and 2.8% for active TB.[10] Continuity of care for those released from prisons also poses challenges within the prison system and the community. Higher TB rates in prisons are linked to higher rates of TB and drug-resistant TB in the community. Studies show that one in 11 TB cases in the general population in high-income countries, and one in 16 cases in low- and middle-income countries, are estimated to be attributable to TB within the prison system.[11] Data also shows that there is a twofold increased risk of multidrug resistance among people in prison compared with the general population.[9] These concentrated rates of TB infection among people in prison must be met with interventions that prevent and treat those at risk.

Among people with TB who also use drugs, at least one in three have HIV, and two in three will have hepatitis C antibodies.[12] Low access to testing and treatment services, outdated treatment approaches that are not person-centered,[13] lack of follow-through on medical examinations and referrals, and insufficient treatment adherence are some of the issues with regard to TB services.[12] TB services rarely include harm reduction interventions such as opioid agonist therapy (OAT). Further, a lack of integration of TB, HIV and harm reduction services adds to the health disparities that the community faces.

ASIA

TB remains one of the leading causes of morbidity and mortality in the region, which accounts for more than half of the cases and deaths worldwide.[1] In India, TB kills over 400,000 people every year, underscoring the magnitude of the illness. Eleven countries in the region are on the WHO list of 30 high TB burden countries: Bangladesh, Cambodia, China, India, Indonesia, Myanmar, North Korea, Pakistan, the Philippines, Thailand and Vietnam, and WHO cites drug resistance (i.e. drug-resistant TB) as compounding efforts to eradicate the disease in the region.[1]

Studies that directly explore the relationships between TB and drug use are limited, but some key points can nonetheless be inferred from existing data, recognising TB, HIV, and drug use as a "syndemic."[14] For instance, China, India, Indonesia, Myanmar and Thailand are among the world's high HIV/TB burden countries. They also have HIV prevalence of more than 15% among people who inject drugs (with the exception of China), which suggests that the TB burden impacts many people who use drugs in the aforementioned countries.[1] People incarcerated for drug-related offences are particularly vulnerable, given the high rates of TB in prisons and jails.[15] In the Philippines, two out of three people awaiting their sentences in jails are charged with drug-related offences.[16] Over 5,000 people died in one prison alone, with a hospital director citing an inability to contain TB outbreaks as a major factor.[17]

Notwithstanding this dire situation, there has been a lack of inclusion of drug use in country-level TB programmes in the region. In India, despite public health officials' experiential knowledge about the high proportion of TB among people who use drugs, and the particular barriers they face such as stigma, there is no differentiated service delivery strategy for how to diagnose and treat people who inject drugs.[18]

EURASIA

About 83% of the estimated TB cases in the WHO Europe region occur in 18 countries, 17 of which are in Eurasia (Armenia, Azerbaijan, Belarus, Bulgaria, Estonia, Georgia,

Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Romania, Russia, Tajikistan, Turkmenistan, Ukraine and Uzbekistan). Together, these 18 countries accounted for over 87% of TB mortality in the WHO Europe region with the highest in Turkmenistan (10.4 deaths per 100,000), followed by Azerbaijan (10.1) and Ukraine (8.4). In addition, an estimated 20% to 25% of TB cases in Eurasia go undetected.[19]

The largest proportion of new and relapse cases (78,258, or 34.4%) come from Russia. The countries with the absolute highest number of TB cases over 10,000 are Russia (78,258), Ukraine (36,000), Uzbekistan (23,000), Romania (13,000) and Kazakhstan (12,000). There were an estimated 30,000 HIV-positive TB cases, with Russia (53%) and Ukraine (27%) contributing to the highest burden of coinfection. The TB notification rate exceeds 1,000 cases per 100,000 prison detainees in Azerbaijan, Kazakhstan, Kyrgyzstan, Moldova, Russia and Ukraine. The highest TB-related risks in prison are calculated to be in Slovakia (40.7), followed by Czechia (24.9), Ukraine (23.8), Russia (23.5) and Azerbaijan (22.1). Russia accounted for almost half of the deaths in the WHO EU Region in absolute numbers. Although few countries report TB in people who inject drugs, higher rates of notification (new cases) among this group supports evidence that people who use drugs are at higher risk of TB.[20]

OAT and drug treatment, even if available in the country, are largely unavailable in TB treatment facilities (for example Kazakhstan, Russia, Ukraine) and facilities are often restricted from prescribing controlled substances.[21] Consequently, people who use drugs often come into contact with the health system at late stages of the disease and are forced to interrupt treatment which, in turn, leads to high prevalence of multidrug-resistant TB.[1] A study conducted in Ukraine showed that only 57% of people who use drugs expressed willingness to immediately seek medical care upon finding symptoms of TB.[22] There are treatment initiation lists with new less harmful drugs, however, due to the high cost of these, treatment priority is given to patients not living with drug dependence.

A programme to actively find people with TB among at risk groups, such as people who use drugs in Ukraine, has been implemented since 2014 in 27 regions of the country by the Alliance for Public Health with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). Programme implementation coverage of at risk groups with screening interviews increased six to seven times in the last five years, which increased the TB detection rate by 46% compared to 2014. Out of those detected, 93% initiated treatment.[23] These successes are at risk, however, as countries that transition out of the Global Fund tend to focus on maintaining drug procurement instead of programme continuation.

LATIN AMERICA AND THE CARIBBEAN

TB incidence in Latin America is generally high, with a rate of 46.2 per 100,000 inhabitants and 25.9 in Central America and Mexico. Data from 2018 shows that Brazil, Mexico and Peru have the largest number of TB cases in the region.[24] Although data on TB rates among key populations is lacking, research suggests higher prevalence among people who inject drugs, people in prison, and people experiencing homelessness than in the general population.[1,25,26] In the Caribbean, TB cases fell by 45% from 2010 to 2017. The greatest reduction was in Haiti, where cases fell by more than 50%. However, over the same period, cases increased in Cuba and the Dominican Republic.[27] Dominica also saw an unexplained spike in cases in early 2020.[28]

TB testing and treatment is generally available across the region. In Argentina, Brazil, Bolivia, Colombia, Mexico, Peru and Uruguay, it is offered free of charge or on state insurance.[29–35] In response to the high concentration of TB in large cities in Latin America, the Pan-American Health Organization and World Health Organization Global Tuberculosis Program launched the Large Cities Tuberculosis Control Initiative in 2016. The initiative supports countries to strengthen TB control programmes and address social determinants of health through collaboration with sectors other than health.[36] However, there are geographical, economic and social barriers to accessing these TB services. Targeted TB services for people who use drugs are generally lacking, and diagnosis and treatment is not integrated into HIV or harm reduction programmes in the region.[29,31,35]

As with viral hepatitis, cocaine paste and crack cocaine use is associated with higher TB prevalence. The Casa Masantonio project in Buenos Aires, Argentina, and some services in Brazil integrate TB in their work with people who use cocaine paste.[37,38]

The number of TB cases occurring each year in Latin America can be reduced by providing preventive treatment

to people with latent TB infection, and taking multi-sectoral action on broader determinants of TB infection and disease such as poverty, malnutrition, housing quality and lack of safer water in vulnerable communities.[1]

MIDDLE EAST AND NORTH AFRICA

The estimated incidence of TB in the Eastern Mediterranean region is 704,000 cases with a rate of 115 cases per 10,000 population compared to the global average of 132 cases per 100,000 population.[1] Although the region is considered a low or intermediate incidence rate, there are multiple factors hindering progress towards the elimination of TB, namely a high level of refugee movement, unstable political environment, wars, and high numbers of foreign national workers.[39] Data remains unavailable for incidence of TB among people who inject drugs. People living with HIV are considered at high risk of developing active TB disease. Many countries in the region have thus mainstreamed TB responses within national HIV or harm reduction plans. Other countries have a specific programme for TB within their ministry of public health. The majority of countries in the region declared having easily accessible TB services, non-mandatory and free of charge to all TB patients, including people who inject drugs.[40–57]

NORTH AMERICA

More than 70% of cases of TB in North America occur among foreign-born populations.[58,59] Tuberculosis incidence in the United States was at the lowest level on record in 2019, with 2.7 cases per 100,000 people.[60] An estimated 4.9% of people diagnosed with tuberculosis were also living with HIV.[60] In 2018, 6.8% of cases were among people who reported non-injected drug use and 1.3% of cases were among people who reported injected drug use.[58] This is disproportionate to the population of people who use drugs in the country.

According to the latest available data in Canada, cases of active tuberculosis increased by 2.6% from 2016 to 2017. TB incidence was highest among Indigenous people at 21.5 cases per 100,000, and alarmingly high among those identifying as Inuit at 205.8 cases per 100,000.[58] No data is available on prevalence among people who use or inject drugs.

OCEANIA

TB prevalence and incidence is very low in most of the countries in the region, with the exception of Papua New Guinea which is classified as a high TB burden country.[1] According to the latest estimates, the TB incidence rate is very low in the region when compared to the global incidence of 132 per 100,000 population; Australia (6.6), Fiji (54), New Zealand (7.3), Samoa (6.4),Tonga (10) and Vanuatu (46).[1] The Oceania region has achieved TB treatment coverage levels above 75%.[1] Although data availability has increased in the region (Kiribati, Micronesia, Tonga and Tuvalu had quality-approved surveillance data for anti-TB drug resistance for the first time, and Timor-Leste implemented its first nationwide TB survey in 2018-2019),[1] data for TB incidence or prevalence among people who inject drugs is unavailable. Though treatment and diagnostics are available in Australia and New Zealand, TB is not a significant problem in these countries.[61,62]

SUB-SAHARAN AFRICA

According to latest available data, 34% of people living with HIV in Africa in 2016 were infected with TB. Sub-Saharan Africa bears the brunt of the dual TB and HIV epidemics, accounting for approximately 84% of all deaths from HIV-associated TB in 2018. TB prevalence is reported to be higher among people who inject drugs and people in prison than the general population, and is particularly acute among those who inject drugs in prison.[8]

Across the region, it is reported that TB testing and treatment services are available. However, there is evidence of limited accessibility for people who use drugs. The region adopted the preventive TB guidelines for all people living with HIV but treatment success rates are reported to be very poor. Currently, Burkina Faso, Côte d'Ivoire, Kenya, Mali, Mauritania, Niger, Senegal, Sierra Leone, South Africa and Tanzania offer TB treatment which is accessible to people who inject drugs. TB testing and treatment is integrated within the harm reduction package offered to people who inject drugs in Senegal and Sierra Leone.[63–69] In Uganda, people who inject drugs have not yet been reached with TB outreach services.

In 2016, WHO provided technical support to help countries adapt and implement the End TB Strategy while promoting the Sustainable Development Goals on TB and Universal Health Coverage. WHO collaborated on the Implementation

through Partnership project of the Global Fund, supporting countries in 11 French-speaking countries of West and Central Africa (Benin, Burkina Faso, Cameroon, Chad, Côte d'Ivoire, the Democratic Republic of the Congo, Guinea, Mali, Niger, Senegal and Togo).[70] The project supports countries encountering problems implementing grants.

WESTERN EUROPE

The WHO Europe region saw the fastest decline of TB prevalence among all WHO regions in recent years, but this is still not enough to achieve the WHO End TB Strategy targets.[71] The incidence of TB in Western Europe is generally low, ranging from 4.5 cases per 100,000 in Iceland and Greece to 17 per 100,000 in Turkey and 20 per 100,000 in Portugal.[71] TB diagnosis and treatment is generally available for people who inject drugs, but there are barriers to accessing services, including the fear of stigmatisation and discrimination, and the lack of health insurance, which disproportionately affects refugees and migrants.[72,73] The level of integration of TB into harm reduction and HIV programmes varies, with good integration reported in Belgium, Iceland, the Netherlands and the United Kingdom, to little integration in Germany.[72,72,74–77] Though TB diagnosis is accessible for people who inject drugs in Portugal, and there are partnerships between harm reduction services and TB diagnostic centres, further integration is needed.[78]

> *People who use drugs represent a disproportionate number of tuberculosis (TB) cases and are at greater risk of the infection progressing to more serious TB disease. The Global Plan to End TB 2016-2020 calls for 90% of all people who have TB to be reached and treated including 90% of key and vulnerable populations, which includes people who use drugs. If we are to achieve these targets, TB testing and treatment must be available without restriction to people who use drugs.*

1.4
Tuberculosis (TB)

1 IN 3

PEOPLE WITH TB WHO ALSO USE DRUGS HAVE HIV.

THE RISK OF DEVELOPING ACTIVE TB DISEASE IS ESTIMATED TO BE BETWEEN

20 TO 30 TIMES

MORE LIKELY IN PEOPLE LIVING WITH HIV.

TB is the leading cause of mortality among people who inject drugs and who are living with HIV.

Recommendations

TB DIAGNOSIS AND TREATMENT MUST BE MADE WIDELY AVAILABLE AND ACCESSIBLE TO ALL PEOPLE WITH SPECIFIC INTERVENTIONS.

TB must be integrated into harm reduction services and vice versa. Mechanisms for integrated delivery of services for people who use drugs will help reduce the burden of TB on them. This includes providing TB services in prisons through harmonisation of interventions found outside prisons and linkages to services in the community for people released from prison.[79]

PROGRAMMES AND REGIONAL AND INTERNATIONAL ORGANISATIONS MUST COLLECT ROBUST DATA ON TB AMONG PEOPLE WHO USE DRUGS.

People who use drugs face high risks of acquiring latent TB and TB disease. Accurate data will help to develop effective programmes and mitigate this burden. The data will also provide an accurate picture of the level of investment that is required to prevent unnecessary TB morbidity and mortality in people who use drugs.

PROGRAMMES MUST IMPLEMENT ACTIONS THAT ACTIVELY SEEK TO PREVENT, DIAGNOSE AND TREAT TB AMONG PEOPLE WHO USE DRUGS.

Active intensified TB case finding, together with appropriate diagnosis and treatment, has the potential to significantly reduce TB incidence.[80] Active case finding includes going outside the health facility and into communities to provide services where people are located. Due to criminalisation, and high rates of stigma and discrimination, community outreach for people who use drugs must be central to any TB prevention and treatment programme.

Conclusion

One of the biggest gaps in understanding the issues affecting people who use drugs and have TB found in this report is the lack of data at global, regional and national levels. This has resulted in harm reduction programmes not including TB in services and the absence of specific outreach and activities for people who use drugs in TB programmes. International agencies such as the WHO Global TB Programme, for example, do not collect this data from countries leaving wide gaps in programme implementation and investment. Without data, there is no clear picture of the scale of need of people who use drugs who are at risk of or have TB, and minimal investment in providing TB services for people who use drugs will continue.

People who use drugs represent a disproportionate number of TB cases and are at greater risk of the infection progressing to more serious TB disease.[81] The Global Plan to End TB 2016-2020 calls for 90% of all people who have TB to be reached and treated including 90% of key and vulnerable populations, which includes people who use drugs.[82] If we are to achieve these targets, TB testing and treatment must be available without restriction to people who use drugs.

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2.1 ASIA

AFGHANISTAN
BANGLADESH
BHUTAN
BRUNEI
CAMBODIA
CHINA
HONG KONG
INDIA
INDONESIA
JAPAN
LAOS
MACAU
MALAYSIA
MALDIVES
MONGOLIA
MYANMAR
NEPAL
NORTH KOREA
PAKISTAN
PHILIPPINES
SINGAPORE
SOUTH KOREA
SRI LANKA
TAIWAN
THAILAND
VIETNAM

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[1]	OAT[2]	Peer distribution of naloxone	DCRs[3]
Afghanistan	139,000 (88,000-190,500)[1]	4.4-20.7[2]	31.2[2]	6.6[2]	✓24[3]	✓8[3]	✓[3]	x
Bangladesh	68,500 (63,500-74,000)[1]	18.1[4]	39.6 - 95[4]	7.0 (4.7-10)[5]	✓88[6]	✓7[7]	x	x
Bhutan	nk	nk	nk	nk	x	x	x	x
Brunei	nk	nk	nk	nk	x	x	x	x
Cambodia	4,136 (3,267-4,742)[8]	15.2[8]	30.4[8]	nk	✓5[6]	✓2[9]	x	x
China	1,930,000 (1,310,000-2,540,000)[10]	2.6[11]	29.8[11]	23.4[5]	✓814[6]	✓785[12]	x	x
Hong Kong	1,078[13]	1.1[14]	56[15]	nk[15]	x	✓20[16]	x	x
India	850,000[17]	6.3[10]	40 (33.9-46.1)[5]	4.7 (0.9-.8.5)[5]	✓266[6]	✓225[18]	✓[19]	x
Indonesia	33,492 (14,016-88,812)[20]	28.76-44.5[10][5]	63.5-89.2[10][5]	6.7[10]	✓215[6]	✓92[21]	x	x
Japan	nk	0.02[10]	40[10]	8.6[10]	x	x	x	x
Laos	1,600[10]	17.4 (7.8-31.4)[5]	nk	nk	x[23]	x[24]	x	x
Macau	189[10]	0[10]	67[10]	17[10]	✓1[25]	✓4[25]	x	x
Malaysia	75,000[26]	13.4[26]	67.1[10]	nk	✓501[26]	✓891[27]	x	x
Maldives	793[10]	0[10]	0.7[10]	0.8[10]	x	✓2[28]	x	x
Mongolia	nk	nk	nk	nk	x[29]	x	x	x
Myanmar	92,798 (49,455-123,731)[30]	34.9[30]	56[30]	7.7[30]	✓51[31]	✓55[32]	✓[31]	x
Nepal	35,000 (33,500-37,000)[1]	2.8-6.4[10]	13.1-38.1[10]	1.35[10]	✓60[6]	✓15[33]	x	x
North Korea	nk	nk	nk	nk	nk	nk	nk	x
Pakistan	113,422[36]	38.4 (37.9-38.9)[10]	36.5[10]	6.8 (6.0-7.5)[5]	✓34[6]	x[37]	nk	x
Philippines	25,500 (19,000-32,000)[6]	29[10]	35.2 (15.9-54.5)[5]	7.12[10]	x	x	x	x
Singapore	nk	0.5[10]	42.5 (39.1-45.9)[5]	8.5 (7.0-10.0)[5]	x	x	x	x
South Korea	nk	0[10]	48.4 (42.1-54.1)[5]	6.6 (4.1-9.9)[5]	x	x	x	x
Sri Lanka	2,672[38]	0[10]	6.2 (2.8-9.5)[10]	0.1[10]	x	x	x	x
Taiwan	60,000[39]	12.4 (8.1,16.8)[5]	91.3[39]	15.3[40]	✓1,254[41]	✓162[42]	x	x
Thailand	51,000 (16,000-87,000)[1]	24.5 (17.4-31.7)[5]	88.5 (82.6,92.9)[5]	30.5 (28.2-32.9)[5]	✓42[43]	✓140[43]	x[4]	x
Vietnam	161,000 (123,000-200,500)[1]	9.5[44]	58.3 (42.7-74.0)[5]	11.1[44]	✓56[45]	✓332[45]	✓	x

nk = not known

1 All operational needle and syringe programme (NSP) sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers.
2 Opioid agonist therapy (OAT), including methadone (M), buprenorphine (B) and any other form (O) such as morphine and codeine.
3 Drug consumption rooms, also known as supervised injecting sites.
4 There are reports on take-home naloxone programme in Thailand, but we could not verify peer distribution.

MAP 2.1.1:
Availability of harm reduction services

- Both NSP and OAT available
- OAT only
- NSP only
- Neither available
- Not known
- DCR available
- Peer-distribution of naloxone

2.1
Harm reduction in Asia

13%

PEOPLE WHO INJECT DRUGS ACCOUNTED FOR 13% OF NEW INFECTIONS IN ASIA IN 2018.

391
PEOPLE WERE KILLED IN EXTRAJUDICIAL KILLINGS IN BANGLADESH IN 2019 ALONE

Sri Lanka's former President Maithripala Sirisena sought to reinstate the death penalty for drug traffickers,and Indonesia continues to hand out death sentences for drug offences. In May 2020, at the height of the COVID-19 pandemic, a man convicted of drug charges was sentenced to death via a hearing on Zoom in Singapore.

1. Overview

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There are approximately 4.35 million people who inject drugs in Asia, which is significantly higher than the previous estimate of over 3.5 million people (See Table 2.1.1). Although the full picture remains incomplete and is likely outdated due to lack of country reporting and updates, recent data and analyses indicate a far higher number of people who inject drugs in several countries than previously reported. In both India and Indonesia, for instance, the current figures are five times more than those reported in the *Global State of Harm Reduction 2018*.

The *World Drug Report 2020* estimates that there are over 11 million people who use amphetamines in Asia[10], with growing methamphetamine use spurred by an unprecedented increase in supply and decrease in prices.[46] The use of other drugs has similarly registered an increase, including opioids and new psychoactive substances (NPS) like ketamine and the locally-grown kratom, a traditional stimulant from a tree native to the region (*Mitragyna speciosa*). According to the most recent national household survey from 2016, kratom is currently the most widely used drug in Thailand,[47] as well as a popular NPS in Malaysia and Southern Myanmar.[48]

The widespread use of methamphetamine in Asia has led to some pioneering harm reduction efforts aimed at stimulant use in the region (See Box 2). At the same time, methamphetamine use is raising the need for more harm reduction services tailored to those who use it, even as existing harm reduction services (NSP, OAT) remain extremely limited.

In part because of many governments' lack of prioritisation of and negative attitudes towards harm reduction initiatives and people who inject drugs, there continues to be a dearth of data on prevalence of injecting drug use and the risks associated with it. However, the limited information points to a significant burden of disease among people who use drugs in the region, with HIV and viral hepatitis among people who inject drugs either increasing or stabilising over the past decade - despite the overall decline of HIV in the region. Moreover, some countries in the region exceed the global prevalence of hepatitis C and tuberculosis, suggesting a high disease burden for people who inject and use drugs. The 'syndemic'[5] of HIV, TB, viral hepatitis, and drug-related harms such as overdose, lack of access to treatment, and physical violence, is especially evident in the region's prisons, many of which are grossly overcrowded as a result of punitive drug laws.[49]

Drug policy in Asia continues to aim for a 'drug-free world' espoused by governments in countries like Bangladesh, Indonesia, the Philippines, Singapore and Sri Lanka, as well as regional organisations like the Association of Southeast Asian Nations (ASEAN).[49] Ostensibly aimed at reducing drug supply, deadly 'drug wars' have disproportionately affected people living in urban poor communities, as well as drug-producing communities, small-scale dealers and people who use drugs. While international attention on the drug war in the Philippines has decreased significantly since it started in 2016, tens of thousands continue to be killed and many others are jailed, orphaned or widowed (See Box 1).

A similar paradigm has informed the policies of Bangladesh, Cambodia, Indonesia, Nepal and Sri Lanka, with grim consequences for people who use drugs, as well as women, children, and people from poor and marginalised communities, regardless of drug use.[49] However, there are examples of community mobilisation efforts in the region for women who use drugs. National fora for women who use drugs were established in Nepal and India, which could help advocacy for more inclusive policy reform, and foster the building of women-centered services.[180]
Despite political uncertainties, criminal justice reforms involving drugs have been enacted in Malaysia, which included the previous administration setting goals for the abolition of the death penalty and decriminalisation of drug possession, and Myanmar, where the drug policy more explicitly embraces harm reduction principles. Even in countries with punitive drug regimes, like the Philippines and Indonesia, some harm reduction efforts have been initiated or sustained. Significantly, pioneering programmes aimed at people who use methamphetamine have also been initiated in China, Indonesia, Myanmar and Thailand (see Box 2).

The ongoing COVID-19 pandemic has exposed some of the above-mentioned gaps and has further underscored the need for drug policy reform in the region. On top of challenges for people who use drugs such as inaccessibility of treatment and other services and greater risk of infection, women and people deprived of liberty are especially vulnerable.[50,51] For their part, civil society groups report restrictions in their activities due to COVID-19, uncertainty in funding and, in some settings, increased political and legal vulnerability.[31,52,53]

The pandemic and its aftermath, the continued rise of methamphetamine and NPS, as well as the perpetuation of punitive drug policy regimes will likely pose major challenges for harm reduction in the region in the coming years.

5 The aggregation of two or more concurrent or sequential epidemics or disease clusters in a population with biological interactions.

2. Developments in harm reduction implementation

2.1 NEEDLE AND SYRINGE PROGRAMMES (NSPs)

Fourteen out of 25 countries/territories in the region have existing NSPs, with Bangladesh, Cambodia, China and Myanmar distributing over 200 syringes per person per year. Some countries have registered changes in the number of sites. In Vietnam and Indonesia, for instance, the number of NSP sites increased from 53 to 56 and 194 to 215 respectively, while in Malaysia and Macau, the number of sites decreased from 692 to 501 and three to one respectively.

Meanwhile, in India, the number of NSP sites increased from 247 to 266. However, a 2019 population size estimate indicates a much higher estimated number of people who inject drugs, meaning that although there are more NSP sites, there is still a much lower per capita syringe distribution - 35.5, down from the 250 reported in the *Global State of Harm Reduction 2018*.

Although the 14 countries/territories with NSPs constitute a majority in the region, the presence of NSPs does not necessarily mean that the services are adequate and evenly distributed. In Bangladesh, for instance, the services have been concentrated in Dhaka[7], while in Myanmar, the rate of syringes distributed per person per year varies greatly from state to state - from 814 in Kachin to 50 in South Shan.[32] There is also uneven distribution of services among different subpopulations. For example, in Nepal, NSP coverage is high for men who inject drugs, but there are hardly any services for women who inject drugs despite HIV prevalence being the same for both groups (8.8%).[180]

Civil society organisations in some countries report that while NSPs are officially allowed in their countries, they receive little support outside of the non-governmental sector.[9][53][54] Even in China, where NSPs have been proven to be an effective intervention, the notion that such programmes encourage drug use continue to inform unfavourable attitudes[55] echoed elsewhere in the region.[56]

On the other hand, eleven countries in the region either prohibit or do not implement NSPs - a figure unchanged since the *Global State of Harm Reduction 2018*. In Laos, the only two NSPs in the country were terminated in 2017, after the completion of a project funded by the Asian Development Bank.[23]

In the Philippines, no new NSP has been initiated since the termination of an NSP in Cebu that operated from 2014 to 2015 as an academic research initiative due to political pressure. This is despite calls from some health officials to restore it[57] and the 2018 HIV/AIDS Law potentially clearing the way for similar programmes.[52]

In Hong Kong, a 2017 report by the Hong Kong Advisory Council on AIDS acknowledges the possibility that "drug injection is unavoidable", and calls for the provision of sterile syringes, proper disposal of unsterile syringes, and provision of safe disposal equipment (e.g. sharps boxes) in venues frequented by people who inject drugs. However, it stops short of recommending NSPs.[58]

TABLE 2.1.2

Overview of syringe distribution per person who injects drugs per year in selected countries

Country/territory with reported injecting drug use	Syringes per person
Afghanistan	52[59]
Bangladesh	300[7]
Cambodia	457[60]
China	204[61]
India	35.5[18]
Indonesia	3[62]
Malaysia	17.9[26]
Myanmar	377[31]
Nepal	84[63]
Pakistan	46[64]
Taiwan	58[42]
Thailand	14[43]
Vietnam	117[65]

2.2 OPIOID AGONIST THERAPY (OAT)

Most of the countries that provide NSPs also provide OAT, with the exception of Maldives and Hong Kong which have OAT but no NSPs. Pakistan has NSPs but has yet to adopt OAT despite an official plan to do so as part of its AIDS Strategy 2015-2020[36] and an official study in 2017 concluding that doing so will bring considerable cost savings.[66] There has been a dramatic increase in the number of OAT programmes in Malaysia, while modest increases or little change can be seen in other countries with OAT programmes. In May 2020, Vietnam announced a pilot programme to allow for take-home methadone as part of its 2020-2022 plan.[67]

As with NSPs, the presence of or increase in the number of these programmes may obscure geographical inconsistencies and barriers affecting certain groups, for example, access to OAT for women who inject drugs remains low in many countries. In India, a review of the scholarly literature on OAT programmes found that the lack of a conducive policy environment prevents a scale-up of such programmes.[68] The same report underscored the need for more research on specific populations (e.g. women, adolescents), given that much of the previous research had been on adult males. In both India and China, client retention and scaling up of OAT programmes were identified as challenges.[12][68] Moreover, even in countries that officially support OAT (for example, China and Vietnam) tensions with law enforcement have been reported.[12][69]

Meanwhile, research in the region has strengthened the case for the efficacy of OAT and has articulated future prospects and challenges. In Vietnam, for instance, methadone maintenance treatment was found to be effective even in mountainous settings, with the concurrent provision of mental health services seen as key to the programme's success.[70] In Malaysia, a study found that compulsory drug detention centre (CDDC) participants were significantly more likely to return to the illegal drug market post-release compared with community-based cure and care centre participants.[71]

The widespread use of methamphetamine in Asia has led to some pioneering harm reduction efforts aimed at stimulant use in the region. At the same time, methamphetamine use is raising the need for more harm reduction services tailored to those who use it, even as existing harm reduction services (NSP, OAT) remain extremely limited.

2.3 AMPHETAMINE-TYPE STIMULANTS (ATS) AND NEW PSYCHOACTIVE SUBSTANCES (NPS)

Maintaining a trend observed since the 2000s, the methamphetamine market has expanded in the region[72], accounting for the majority of treatment admissions, including forced rehabilitation and compulsory detention.[48] Tablets (e.g. yaba) and crystal methamphetamine (e.g. ice or shabu) remain the two common ATS products in the region, but the injecting use of methamphetamine appears to be increasing[73], as well its involvement in poly-drug use (use of methamphetamine in combination with other drugs, e.g. opioids).[74] There are also reports of widespread use of crystal methamphetamine in North Korea, where it is known as "pingdu".[35]

The evidence base for harm reduction efforts for ATS remains limited, partly because such initiatives have been led by non-governmental organisations with little or no support from governments.[75] These include promising pilot programmes in Indonesia, Myanmar and Thailand that focus on people who use methamphetamine and have the potential to pave the way for larger-scale programmes (see Box 2). In a notable exception that involves state recognition, Myanmar introduced treatment guidelines for ATS in 2017 that call for general harm reduction measures including education, access to condoms and syringes and expressing openness for more specific interventions.[76]

Mirroring the trend with ATS, both the number of new psychoactive substances (NPS) and the people who use them are growing, with 434 different NPS (31% of which are synthetic cannabinoids and 26% synthetic cathinones) reported in East and South-East Asia from 2008 to 2018, accounting for almost half of the global total.[48] There are no known NPS-specific harm reduction interventions, although in Thailand testBKK - an HIV testing campaign aimed at young gay men - has developed materials for safer chemsex parties that often include ATS and NPS like ecstasy (MDMA) and GHB, both of which are club drugs perceived to enhance energy and sexual arousal.[77][78]

While most of the NPS used in the region are synthetic, the rise of NPS of natural origin or plant-based NPS have also been growing in popularity in the region, particularly kratom (*Mitragyna speciosa*), a traditional stimulant that is currently the most widely used drug in Thailand, as well as a popular NPS in Malaysia and Southern Myanmar.[48] Kratom is a substance that is being referenced for its harm reduction use (i.e. as an opioid substitute), potential for related harms, and growing global popularity,[79][80] and thus merits attention from harm reduction advocates and scholars in the coming years.

2.4 OVERDOSE, OVERDOSE RESPONSE, AND DRUG CONSUMPTION ROOMS (DCRS)

Governments in the region use the medical harms associated with drugs to justify punitive drug policies,[81] but there remains little or no data on drug mortality and overdose. Despite the extensive evidence of the efficacy of naloxone to reverse opioid overdoses, it remains largely unavailable in Asia. Moreover, overdose management is hardly, if at all, included in official documents on drugs and HIV policies. In some settings, people who use drugs may not consider or articulate drug overdose as a risk, in part because of punitive drug regimes.[82]

Amid this restrictive environment, however, a number of overdose initiatives have taken root, largely initiated and driven by civil society organisations. In Afghanistan, for instance, overdose management services are available in 12 out of 34 provinces - including the distribution and administration of naloxone by trained peer workers in drop-in centres.[3] In India, peer distribution of naloxone has continued in Manipur despite tensions with the police.[19] The India HIV/AIDS Alliance and its partners have also worked to offer access to naloxone across the country.[83] Meanwhile, the Asian Harm Reduction Network in Myanmar also reports the availability of overdose response services at their sites, including the distribution of naloxone through trained outreach workers, peers, and staff of areas of concentrated drug use.[31] Similar programmes have been reported in Thailand[84] and Vietnam.[85]

There are no known government-authorised drug consumption rooms in the region.

2.5
HIV AND ANTIRETROVIRAL THERAPY (ART)

Overall, there has been a modest decline in HIV incidence in the region, with people who inject drugs accounting for 13% of new infections in 2018.[104] However, at the country level, a mixed picture can be seen. While some countries including Cambodia, Singapore, Thailand and Vietnam have registered significant declines in new infections, others including Afghanistan, Bangladesh, Pakistan and the Philippines are reporting disturbingly high increases.[104]

Access to testing, treatment and care is also uneven across countries in the region. Among people who inject drugs in Bangladesh, Malaysia, Myanmar, Pakistan, Philippines, Sri Lanka and Thailand, for instance, less than half knew their HIV status. Among people living with HIV in Afghanistan and Indonesia, just a third who know their status are on treatment.[104] Stigma and discrimination remain major barriers to the cascade of care, and yet only a few countries have mounted concerted efforts to address them as part of their national policies.[105]

The situation in the Philippines is especially worrisome, with a 203% increase in new infections from 2010 to 2018 - the world's fastest growing HIV epidemic.[106] People who use drugs are particularly affected, with over-incarceration stemming from the government's 'drug war' and the lack of HIV testing, and condom distribution. A leading government official indicated that as many as 'one to three in every jail cell' have HIV. An HIV Law was passed in 2018 providing for more services and less stigma, but its impact remains to be seen.[52]

Efforts to combine and streamline harm reduction services with HIV counselling, testing and treatment in "one-stop services" comprise some of the region's best practices, especially when they address a particular demographic. For instance, in Kapurthala, India, the India HIV/AIDS Alliance has collaborated with the Punjab Government to develop a 'one-stop' clinic for women, offering HIV alongside harm reduction services (NSP, OAT, naloxone) as well as other health and gender-sensitive programmes.[83] Similar "one-stop" approaches are being pursued in Vietnam[107], Cambodia[108], and Myanmar.[31]

2.6
HARM REDUCTION IN PRISONS

Punitive drug policies have resulted in over-criminalisation and over-crowding of jails in what regional scholars have called 'penal populism'.[109] Women are not spared from this punitive regime. Six of the ten countries worldwide with the highest female incarceration rates are in Asia.[110]

A project implemented by the International Drug Policy Consortium in collaboration with NoBox Transitions (Philippines), Ozone Foundation (Thailand) and LBH Masyarakat (Indonesia), gave an insight into the predicaments women held in detention or prison face. In Thailand, 17% of women interviewed reported that they were compelled to admit to crimes that they did not commit, and only a few - if any - are able to access legal, health, and harm reduction services in detention/prison.[110] A similar scenario was seen in Indonesia and the Philippines.[101,111]

There are over 400,000 people detained in forced rehabilitation and compulsory detention centres in Asia.[49] Despite growing evidence that voluntary and community-based programmes are more effective[112], compulsory detention continues to be the major treatment paradigm, with Singapore increasing the maximum detention period in drug rehabilitation centres from three to four years.[113]

Harm reduction services in prisons in the region are very limited. Despite the availability of illegal drugs in prisons in some countries, there are no known prison-based NSPs, and OAT is offered only in a limited number of sites in Afghanistan,[3] India,[114], Indonesia,[115] Malaysia[116] and Vietnam.[117] Reflecting negative attitudes towards homosexuality, condom provision in prisons is confined to Indonesia and Thailand.[118] In countries like the Philippines, condoms must be requested from health staff.[119]

3. Policy developments for harm reduction

Overall, the regional policy model remains drug-free and punitive. Despite countries' commitments to UN frameworks, highly restrictive interpretations are used. This is reflected in regional documents. Southeast Asian countries, for instance, continue to follow the 2016-2025 ASEAN Work Plan Against Drugs, which calls for a "drug-free ASEAN" and regard drugs as a security issue, not a multifactorial one that involves public health and socio-economic reforms.[49,120]

Cambodia's drug war, which the government initiated in January 2017, has been described as an 'unmitigated disaster' characterised by brutality and violence, police targeting and the undermining of health and harm reduction services.[121] In Bangladesh, 391 extrajudicial killings were reported in 2019,[122] and accounts of evidence planting and assertions of self-defence to justify police killings despite eyewitness accounts to the contrary eerily echo President Duterte's drug war in the Philippines.[123]

Despite the proven ineffectiveness of the death penalty as a deterrent to drug use or crimes, its use for drug offences has continued, at times accompanying the drug wars, with Bangladesh expanding the death penalty to cover the manufacture and trafficking of yaba.[124] Sri Lanka's former President Maithripala Sirisena sought to reinstate the death penalty for drug traffickers,[125] and Indonesia continues to hand out death sentences for drug offences.[124] In May 2020, at the height of the COVID-19 pandemic, a man convicted of drug charges was sentenced to death via a hearing on Zoom in Singapore.[126]

On the other hand, some countries have enacted policy reforms. In 2019, the previous Malaysian government committed to the abolition of the death penalty and decriminalisation of drug possession,[127] although it is unclear how the newly installed government will act on drug issues.[128] For its part, Myanmar enacted a national drug policy in 2018 with the stated aim of building "safe and healthy communities by minimising health, social and economic harm."[129]

Owing to the politicised nature of drugs in the region, some policies and programmes are 'harm reduction' in name but not in practice, while others are 'harm reduction' in practice but not in name. Paradoxically, both are seen in the Philippines, where the drug enforcement agency uses the term 'harm reduction' to describe its forced rehabilitation programmes[130] and the HIV Law skirts around it, merely mentioning the promotion of "other practices that reduce risk of HIV infection."[131] Even so, at least two bills explicitly calling for harm reduction approaches have been filed in Congress since Duterte took office in 2016,[132,133] and even the discursive use of 'harm reduction' can open a new avenue of accountability to harm reduction principles. The same avenue can be seen in Japan, where the drug policy strategy for the first time includes a reference to harm reduction.[134]

In another welcome development, pioneering programmes aimed at people who use methamphetamine have also been initiated or contemplated in China, Indonesia, Myanmar, Thailand and Vietnam (see Box 2). While still in their infancy and largely driven by non-governmental organisations, these initiatives may nonetheless prove consequential given the continued rise of methamphetamine supply and demand in the region.

In countries that have already seen successes with harm reduction programmes, governments have taken steps to further institutionalise them. Malaysia's 15-year HIV strategy, for instance, asserts that its harm reduction programme "remains a priority and will be further intensified."[135]

Whether or not countries support harm reduction officially or in practice, one barrier to its political and financial sustainability in the region is the persistence of negative attitudes surrounding it, amplified by government officials[136,137] and shared by political, religious, and civic leaders around the region.

4. Funding developments for harm reduction

The fact that much of the harm reduction work in the region is initiated and implemented by civil society and non-governmental organisations means that the work is politically and financially precarious, undermined by the retreat of international donors, the predominance of punitive responses to drugs in national drug policies and, correspondingly, poor political support for harm reduction.[147,148] Harm Reduction International's research in Asia found that the region is experiencing these pressures acutely, with only the Vietnamese government expressing 'moderate' investment in harm reduction (out of seven countries studied in the region).[147,149] According to a 2020 report by Harm Reduction International,[150] earlier findings of low prioritisation remain, and are corroborated by civil society who cite the discontinuation of harm reduction programmes as examples. In both Mongolia and Laos, the few NSPs in operation were discontinued after foreign funding ceased in 2015 and 2017 respectively.[23,29]

The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) remains the most significant and influential donor of harm reduction in the region. Although many projects will terminate in 2020, application is ongoing (as of the time of writing) for the 2020-2022 cycle, for which many of the countries in the region remain eligible (see Table 2.1.3). The country allocations (or envelopes) are determined by country income status, disease burden and a qualitative analysis process, and it is positive that many of the countries in the region reliant on the Global Fund for harm reduction funding have seen an increase in their HIV country envelope. However, community representation on Country Coordinating Mechanisms (CCMs) and strong civil society and community advocacy is crucial, as the increased envelopes will only translate into an increase in harm reduction funding if it is requested in the country application by the CCM. Significantly for harm reduction, "adaptive prevention programming for different risk scenarios" is identified as one of the priority areas, specifying preventive services for people who inject drugs.[151] The Global Fund has also announced flexibility in the application process in consideration of COVID-19 pandemic-related circumstances.[152] It must be noted, however, that the uptake of these funds towards harm reduction remains contingent on country rules and local decision making mechanisms.

Other significant funding sources reported by civil society organisations in correspondence or acknowledged on their websites include the United States Agency for International Development (USAID), the Open Society Foundations (OSF), and the Robert Carr Fund.

TABLE 2.1.3

Global Fund HIV funding envelopes for 2017-2019 and 2020-2022 allocation periods

Country/ territory	Allocated funding for HIV for 2020-2022 cycle (in USD) [153]	Allocated funding for HIV for 2017-2019 cycle (in USD) [154]
Afghanistan	10,474,755	9,109,250
Bangladesh	23,000,765	18,295,447
Bhutan	1,054,855	1,081,903
Cambodia	41,595,706	41,597,533
India	155,000,000	155,063,624
Indonesia	102,717,937	91,934,562
Laos	6,930,536	7,374,096
Malaysia	3,964,273	4,031,592
Mongolia	2,626,061	3,044,708
Myanmar	122,408,561	123,102,465
Nepal	26,926,654	21,964,144
Pakistan	71,687,227	34,956,107
Philippines	20,338,651	8,483,242
Sri Lanka	6,387,963	6,948,047
Thailand	40,573,017	24,569,150
Vietnam	54,996,342	56,638,006

The drug war in the Philippines

Four years after Rodrigo Duterte, President of the Philippines, announced a "war on drugs" this continues to be state policy. Duterte repeatedly vows to continue "Operation Tokhang", which has killed tens of thousands of people, despite acknowledgment from government officials, and Duterte himself, that the campaign has been a failure.[162]

With public attention shifting to other issues and with media outlets facing pressure from the administration, it has become increasingly difficult to estimate the number of people killed in what scholars have described as verging on 'genocide'.[163] The government reported 29,000 "deaths under investigation" as of 2019. Human rights groups fear that this number represents the real death toll, as opposed to the official death toll of 5,601 reported by the government.[164,165] Only one case, that of 17-year-old Kian Delos Santos, has led to a murder conviction. Analyses of victim-level data from media reports indicate that most of the people killed were from poor communities, particularly in urban areas.[166]

The "war on drugs" in the Philippines has impacted individuals, families and communities, with tens of thousands of people affected, including thousands who have been widowed or orphaned after family members were killed in extrajudicial killings. Women are particularly vulnerable, with reports of sex being demanded in exchange for the prison release or lesser charges for their partners or family members. Lacking financial or social protection, there are reports of some 'drug war widows' turning to sex work.[167]

Children in the Philippines have also suffered great physical and emotional harm including, in some cases, the profoundly traumatic experience of witnessing one's parents being killed. There have been reports of children relocating out of fear of further violence, dropping out of school due to lack of funds, and bullying in school because of the stigma resulting from their parents being associated with drugs.[168]

Overcriminalisation of drugs has also led to over-congestion of Philippine jails and prisons, precipitating a humanitarian crisis. Between 2016 and 2018, people deprived of liberty increased from 96,000 to 160,000; a 64% increase that has resulted in the country becoming one of the world's most overcrowded prison systems.[169] In one Metro Manila jail alone, it is estimated that 40 inmates die each month.[170] These circumstances have been exacerbated by COVID-19 (see Section 6) and, beyond mortality and morbidity statistics, harrowing accounts and photographs point to violations of human rights and human dignity.[171,172]

Viewed as part of the broader climate of authoritarianism, the drug war has also made it more difficult for civil society groups to operate, due to increased regulation and the risk of political trolling, and legal harassment. Although some scholars have also noted the 'protective effect' of outsider presence (e.g. researchers) in heavily policed communities in Metro Manila.[173] Moreover, civil society organisations see the increased attention to drug issues as an opportunity to plant the seeds of policy reform.[174]

Harm reduction for methamphetamine use

Harm reduction responses for methamphetamine use have not kept pace with the rise of its use in Asia in part because, as drug policy advocates in the region point out, the evidence base for specific harm reduction interventions is underdeveloped.[75] Moreover, as methamphetamine is often the main target of punitive measures and violence, it has been politically difficult to advocate for measures that approach the substance as anything other than a dangerous drug. Finally, people who use methamphetamine often belong to different communities than those who inject drugs and do not identify with programmes that cater to people who inject drugs - or have no relationships with organisations who offer those programmes.[175]

Nonetheless, the past few years have seen innovative attempts to establish harm reduction programmes in the region that cater specifically for people who use methamphetamine. In 2016, Karisma, a Jakarta-based non-governmental organisation, piloted a shabu outreach programme which included the distribution of safer smoking kits and plastic straws, accompanied by trust building, harm reduction education, and provision of health and legal services - including access to HIV, hepatitis C, tuberculosis (TB) and sexually transmitted infection testing and treatment. The programme reached 1,650 people in 2018.[176]

An analysis of Karisma's programme in 2019 concluded that developing a new harm reduction approach requires an understanding of and meaningful involvement by people who use methamphetamine; particular attention to trust building; operating a broader definition of harm reduction; and securing funding. It also identified the development of national guidelines as a key step to scaling up the programme.[175]

Since the inception of Karisma's programme, a second site offering harm reduction for shabu opened in Makassar, Indonesia, established by Persaudaraan Korban Napza Makassar (PKNM) with support from Mainline, and reached 750 people in 2018.[177]Additionally, a similar initiative is being explored in Vietnam to build the capacity of local civil society organisations to respond to the need for harm reduction for methamphetamine use.[178]

Meanwhile, a recent report noted the ways in which people who use methamphetamine practise self-regulation and user-driven harm reduction in Myanmar, Thailand and Southern China.[73] Similar practices have been reported in the Philippines by scholars and civil society groups who emphasize the need to provide practical information and a safe environment for people to access basic health, social, and legal services as an equally important form of harm reduction - and a requisite step for specific services.[158,174,179]

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2.2 EURASIA

ALBANIA
ARMENIA
AZERBAIJAN
BELARUS
BOSNIA AND HERZEGOVINA
BULGARIA
CROATIA
CZECHIA
ESTONIA
GEORGIA
HUNGARY
KOSOVO
KAZAKHSTAN
KYRGYZSTAN
LATVIA
LITHUANIA
MOLDOVA
MONTENEGRO
NORTH MACEDONIA
POLAND
ROMANIA
RUSSIA
SERBIA
SLOVAKIA
SLOVENIA
TAJIKISTAN
TURKMENISTAN
UKRAINE
UZBEKISTAN

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	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[1]	OAT[2]	Peer distribution of naloxone	DCRs[3]
Albania	5,132-6,182[1]	0.5[2]	28.8[2]	11.5[2]	✓2[3,4]	✓6[3,4] (M,B)	x	x
Armenia	9,000[5]	1.9[5]	66.1[5]	nk	✓12[3,4]	✓4[3,4] (M)	x	x
Azerbaijan	60,000[6]	6.9[6]	43.9[7]	7.3[7]	✓17[8]	✓2[3,4] (M)	x	x
Belarus	66,500[9]	30.8[10]	58.2[10]	2.4[10]	✓34[11]	✓19[4,11] (M)	x	x
Bosnia and Herzegovina	12,500[9]	0.0[9,12]4	30.8[12]	0.2-3.1[12]	✓5[13]	✓12[12] (M,O)	x	x
Bulgaria	18,500[14]	6[15]	76.8[15]	5.0[15]	x[15,16]	✓30[15] (M,B,O)	x	x
Croatia	6,300[17]	0.5[17]	38.2[17]	0.9[8]	✓144[18]	✓[17] (M,B,O)	x	x
Czechia	43,700[19]	0.1[19]	14.7[19]	15.1[8]	✓164[18]	✓[19] (M,B,BN)	x	x
Estonia	8,600[20]	51.4[21]	79.7[21]	5.7[21]	✓41[4,18]	✓8[20] (M,B,BN)	✓[20]5	x
Georgia	52,500[22]	2.3[23]	65-75.0[23]	7.2[8]	✓22[3]	✓18[3] (M,BN)	x	x
Hungary	6,707[24]	0.2[24]6	49.7[24]	2.2[8]	✓40[18]	✓15[3] (M,B)	x	x
Kazakhstan	94,600[25]	7.9[26]	64.2[27]	7.9[8]	✓144[28]	✓13[25,26] (M)	x	x
Kosovo	5,819[29]	0.0[29]7	23.8[29]	4.1[30]	✓[30]	✓4[31] (M)	x	x
Kyrgyzstan	26,700[32]	14.3[33]	60.9[33]	nk	✓40[34]	✓31[35]	x	x
Latvia	7,100[36]	7.7[36]	56.8[36]	3.6[36]	✓28[18]	✓10[3] (M,B,BN)	x	x
Lithuania	8,900[37]	12.5[37]	77[37]	10.5[37]	✓11[18]	✓[18] (M,B,BN)	x	x
Moldova	36,900[9]	13.9-29.1[40]	32.7-62.1[41]	1.0-5.4[41]	✓28[42]	✓22[43]8 (M)	x	x
Montenegro	1,300[44]	0.5[6]	53.0[45]	1.4[45]	✓13[3]	✓5[3]	x	x
North Macedonia	6,756[38]	0.0[38]9	72[38]	5.6[38]	✓16[39]	✓16[39] (M,B)	x	x
Poland	14,670[46]	14.0-21.2[46]	57.9[46]	4.9[8]	✓51[18]	✓[46] (M,B)	x	x
Romania	81,500[8]10	15.9[47]	83.8[4]	5.2[4]	✓63[18]	✓[47] (M)	x	x
Russia	1,881,000[8]	48.1-75.2[48]	83.4-94.4[48]11	32.7-79.9[48]10	✓20[8]	x	x	x
Serbia	20,500[49]	0.0[8]	25.9[8]	3.6[8]	✓2[50]	✓23[49] (M,B)	x	x
Slovakia	20,000[8]	0.0[51]	42.3[51]	3.7[51]	✓14[18]	✓[51] (M,B,BN)	x	x
Slovenia	4,900[52]	0.0[52]	42.6[52]	4.6[52]	✓12[18]	✓10[4] (M,B,BN,O)	x	x
Tajikistan	22,200[53]	12.1[6]	61.3[8]	nk	✓53[54]	✓12[54] (M)	x	x
Turkmenistan	nk	nk	Nk	nk	x	x	x	x
Ukraine	317,000[55]	22.6[56]	63.9[57]	13.8[57] 12	✓2,380[56]	✓215[58] (M,B)	✓	x
Uzbekistan	48,000[59]	5.1[59]	15.7[59]	nk	✓230[60]	x	x	x

nk = not known

1 All operational needle and syringe programme (NSP) sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers.
2 Opioid agonist therapy (OAT), including methadone (M), buprenorphine (B) and any other form (O) such as morphine and codeine.
3 Drug consumption rooms, also known as supervised injecting sites.
4 No people who inject drugs were infected with HIV based on the results of the Integrated Biological and Behavioural Survey 2016 in Bosnia and Herzegovina.
5 Naloxone can only be provided by medical personnel. In 2018, a nasal naloxone spray applicator was also made available.
6 Data from 2015; however, civil society report an increase in HIV diagnoses attributed to injecting drug use in 2019.
7 No people who inject drugs were infected with HIV based on the results of the Integrated Biological and Behavioural Survey 2011, 2014 and 2018 in Kosovo.
8 Of these services, 13 are based in prisons.
9 No people who inject drugs were infected with HIV based on the results of the Integrated Biological and Behavioural Survey 2017 in the Republic of Macedonia.
10 National estimates for the number of people who inject drugs in Romania vary widely among different international agencies. The figure cited represents the most recent from an independent study.
11 Data received based on self-report among people who inject drugs who have tested HCV and HBV positive during the last 12 months (IBBS 2017).
12 Data received based on self-report among people who inject drugs who have HBV now or have had it before (IBBS 2017).

MAP 2.2.1:
Availability of harm reduction services

2.2
Harm reduction in Eurasia[13]

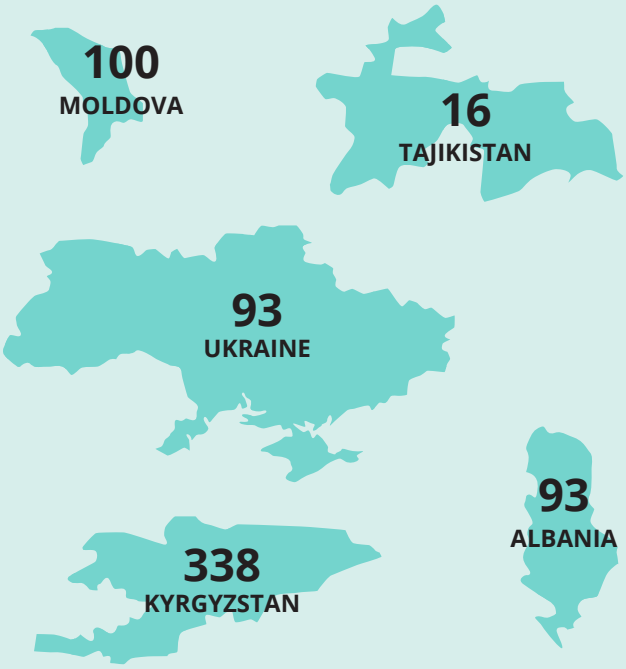
HIV AND ANTIRETROVIRAL THERAPY (ART)

77%

OF NEW HIV CASES IN EECA REGION WERE REGISTERED IN RUSSIA.

HARM REDUCTION IN PRISONS

THE NUMBER OF PEOPLE IN PRISON THAT RECEIVE OAT.



Drug checking is provided mostly through distribution of reagent test kits at festivals and nightlife settings in Czechia, Estonia, Georgia, Hungary, Lithuania, Slovenia, Poland and Ukraine but not as an official harm reduction intervention. There are still no official drug consumption rooms (DCRs) in the region; the first harm reduction site that allows drug use on its premises was opened in Sumy, Ukraine, in 2019.

SUMY, UKRAINE, 2019

1. Overview

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There are approximately three million people who use drugs in Eurasia (no data is available for Turkmenistan). Every country in the region reports injecting drug use although, according to national experts,[14] injection as the primary route of administration has reduced in recent years. Cannabis followed by opioids remain the most commonly used drugs[61] and, according to recent studies,[62] new psychoactive substances (NPS) are increasingly popular in the post-Soviet part of the region due to their low price and high availability.

Harm reduction, while not always in these exact words, is mentioned in national government policies in 25 of the 29 countries in the region. Needle and syringe programmes (NSPs) are available in 27 out of 29 countries (excluding Turkmenistan and Bulgaria), and opioid agonist therapy (OAT) in 26 countries (except Russia, Uzbekistan and Turkmenistan). However, the coverage of services in most of the countries doesn't reach the minimum 20% recommended by the World Health Organization (WHO)[4] and the quality of services remains low and not client-oriented. Consequently, nearly half of new HIV infections in 2019 in the post-Soviet part of the region were attributed to injecting drug use.[63]

Twenty-one countries provide OAT in prisons, and only five have needle and syringe programmes (NSPs).

Naloxone and overdose prevention education is explicitly stated as part of the harm reduction programme for people who use drugs in Georgia, Kyrgyzstan, Moldova, Tajiskistan and Uzbekistan.[9] Take-home naloxone is available at harm reduction sites in Estonia, Kazakhstan, Kyrgyzstan, Moldova and several cities in Russia, with support from international donors. In Ukraine, naloxone is available without a prescription in pharmacies. Nasal naloxone is available in Estonia and there are plans to introduce it in Lithuania in 2020.

Drug checking is provided mostly through distribution of reagent test kits at festivals and nightlife settings in Slovenia, Hungary, Estonia, Czechia, Lithuania, Ukraine, Georgia and Poland but not as an official harm reduction intervention. There are still no official drug consumption rooms (DCRs) in the region; the first harm reduction site that allows drug use on its premises was opened in Sumy, Ukraine, in 2019.

The COVID-19 crisis has brought some positive developments in the region, such as provision of take-home OAT, home delivery of harm reduction materials and provision of online consultations, but also led to the reduction of some services.

Since 2018, vending machines with harm reduction kits have been introduced in Georgia and substitution therapy for people who use amphetamine-type stimulants (ATS) in Czechia. There is still a lack of gender-sensitive services, particularly those aimed at sex workers, men who have sex with men, LGBTQI and young people who use drugs. Available harm reduction service packages are often limited to HIV prevention and lack psychosocial support such as housing, employment, legal assistance, protection from gender-based violence and psychotherapy.

Repressive drug policy and de facto criminalisation of people who use drugs lead to gross violations of human rights and are the main barriers to accessing services. In addition, Russia, Ukraine and Kazakhstan have recently moved to adopt legislative initiatives aimed at strengthening measures to combat drug-related advocacy (which the local governments refer to as "propaganda"), particularly on the internet, and increased the liability for the provision of such information. This raises concerns regarding the potential risks for social programmes focused on working with people who use drugs, and non-governmental organisations (NGOs) implementing those programmes.

According to an assessment of the costs of criminalisation conducted by the Eurasian Harm Reduction Association (EHRA) in 2018-2019, incarcerating people who use drugs in Eurasia costs two to six times more than providing health and social services such as OAT, NSP and social assistance.[64] However, in almost all the countries in the region, harm reduction and other health services are severely underfunded and depend on international donors, largely due to the criminalisation of people who use drugs. Withdrawal of international funding from the region has left gaps in service provision which governments are reluctant to fill. Civil society reports the closure of community organisations and a drop in the quality of services provided. The laws on 'foreign agents' and other restrictions on international financial support are exacerbating the situation in Russia and Belarus. The involvement of civil society and community organisations in service provision and decision making remains scarce but they continue to be important watchdogs. In addition, national advocacy organisations report to international human rights bodies and other protection mechanisms to improve the quality of life of people who use drugs in their countries.

14 While preparing this report, Eurasian Harm Reduction Association conducted 26 interviews with national and regional experts.

2. Developments in harm reduction implementation

2.1 NEEDLE AND SYRINGE PROGRAMMES (NSPs)

Harm reduction, while not always in these exact words, is mentioned in national government policies in 25 of the 29 countries in the region (except Turkmenistan, Russia, Azerbaijan, Armenia). The coverage,[15] in terms of number of syringes distributed per person who injects drugs per year,[4] and the quality of existing services throughout the region remain low in countries where data on NSP coverage is available (Armenia, Azerbaijan, Belarus, Bulgaria, Georgia, Hungary, Latvia, Lithuania, Romania, Slovakia, Slovenia, Ukraine). Uneven geographical coverage was also reported as an issue. In Slovakia, for example, services exist only in the western part of the country.

Harm reduction services in Albania, Bosnia and Herzegovina, Hungary, Romania[67] and Russia[66] are extremely limited and are mainly implemented by civil society on a volunteer basis. Since the *Global State of Harm Reduction 2018*, and after extensive advocacy efforts, Bulgaria reopened one NSP site for a year, but it closed again when funding stopped in July 2020.[16] Insufficient coverage of NSPs could lead to serious public health consequences. A study following up with former NSP clients after the closure of NSPs in Belgrade and Budapest found that equipment sharing was prevalent in both cities, and access to sterile injecting equipment declined significantly, while access to other social services, HIV and hepatitis C testing and counselling also decreased among the former clients of the NSPs.[68]

A number of countries in the region also have mobile NSPs (including Belarus, Estonia, Georgia, Latvia, Russia, Slovenia and Ukraine) or outreach programmes which deliver syringes alongside other injecting equipment and healthcare services or referrals. In Estonia, two mobile NSP units which combine HIV, hepatitis C, tuberculosis (TB) and sexual transmitted infection testing and treatment began operating in 2018. Syringes are accessible via vending machines in Czechia, Hungary and Georgia.

Some countries have NSP sites only in fixed locations, some rely exclusively on outreach work, as for example, in Armenia. In Kyrgyzstan, there is a requirement for outreach workers to have at least one year of experience, which prevents many peers from applying to this position. Civil society in Kazakhstan reports poor quality syringes distributed by government-funded programmes, leading to the potential for increased unsafe injecting. A number of countries don't have HIV or hepatitis C testing at harm reduction sites due to unavailability of oral test kits and the legal limitations for civil society to perform tests containing blood samples.

Restrictive opening hours, poor quality equipment and stigma remain barriers to access to NSPs in many countries of the region. Repressive drug policies that criminalise even the small amount of substance left in a syringe after use have effectively stopped the collection of used syringes in Ukraine. The same issue is reported in Georgia. Funding for harm reduction services is also severely lacking in the region.

The package of tools and services provided is slowly adapting to the changing drug use patterns, in terms of substance and method of administration. Over the last ten years, injecting as a main route of administration has steadily declined.[69] Czechia, Hungary, Latvia and Slovakia reported stimulants as the primary drug injected,[69] and it is estimated that in Czechia around 75% of people use methamphetamine.[70] As a result, Czechia has the most progressive harm reduction services in the region, providing harm reduction equipment not only for injections but also for smoking, snorting and oral administration.

Throughout the region, women who use drugs experience a high level of stigma, discrimination and violence, making it harder for them to reach NSPs and other harm reduction services.[71] Shelters for survivors of domestic violence often do not accept women who use drugs and/or those who are living with HIV. In Hungary, for example, there was only one female-only NSP programme which was closed in 2014. The Eurasian Women's Network on AIDS[16] and the Narcofeminism[17] movement and its activists are advocating for inclusive and female-oriented services for women who use drugs and/or who are living with HIV.

15 The World Health Organization's NSP indicator sets coverage levels as follows: low coverage – fewer than 100 needles per person who inject drugs per year, mid – 100 to 199, high – more than 200.[65]

16 See: http://www.ewna.org

17 See: https://harmreductioneurasia.org/narcofeminism/

2.2
OPIOID AGONIST THERAPY (OAT)

There have been no significant changes in OAT provision in the region since 2018, with 26 countries providing OAT for people who use opioids. OAT is prohibited in Russia, Turkmenistan and Uzbekistan, despite WHO's recommendation and overwhelming evidence supporting its efficacy. Methadone remains the most widely used form of OAT in the region. Buprenorphine is not subsidised in most cases and is only available as an out-of-pocket expense. In addition to methadone and buprenorphine, Slovenia and Bulgaria also have slow-release morphine. Heroin-assisted therapy (HAT) as a form of OAT remains unavailable. In 2020, buprenorphine was included on the pharmaceuticals procurement list of a Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) grant to support OAT for 350 clients in Belarus.

OAT coverage varies considerably in the region and is extremely low in some states: less than 5% of the estimated number of people who use opioids are undergoing such treatment in Azerbaijan, Belarus, Kazakhstan, Kosovo, Kyrgyzstan, Moldova, Tajikistan and Ukraine, and only seven countries (Bulgaria, Czechia, Georgia, Hungary, Lithuania, Macedonia and Serbia) have OAT coverage above 20% of those who need it. In Kazakhstan, the OAT programme has been implemented as a pilot programme since 2008. Ukraine has the largest OAT service in the region, providing treatment to 13,700[72] patients and is fully funded by the state. In a number of countries such as Czechia, Lithuania, and some regions of Ukraine, there are waiting lists to initiate treatment.

A repressive policy and legal environment, unequal coverage between rural and urban settings, stigmatisation of people who use drugs, and the requirement to abstain from illegal drugs all form barriers to access and adherence to OAT. Concurrent drug use could lead to expulsion from the programme in Azerbaijan, Belarus, Kazakhstan, Poland and Ukraine. The lack of take-home dosing in many countries (such as Azerbaijan, Belarus, Kazakhstan), the opposition of law enforcement officials, and a lack of trust between service providers and clients hinders access for people who inject drugs. Even in countries that have take-home OAT, its dispensing is highly restricted and only a small percentage of clients manages to meet the criteria. In Ukraine, for example, a person is required to be in the programme for at least half a year without any violations to be eligible for take-home OAT.

In some regions of Ukraine, people must be hospitalised for 21 days in order to enrol into OAT, to confirm the diagnoses and titration of the therapy. This poses a huge barrier, especially for women with children. In Azerbaijan, failed treatment attempts are still included in enrolment criteria, potential clients must have someone to vouch for them, and priority is given to people with double diagnoses (drug dependence and HIV, TB, hepatitis C). An assessment of client satisfaction with OAT programmes conducted in Kyiv and Kyiv Oblast in 2019 showed that although a formally designated range of services is provided, their content and quality are not satisfactory. Most services are aimed at monitoring the patient's behaviour, rather than providing patient-centred support, and many do not improve a person's quality of life.[73] In the last two years, OAT programmes have been at risk of closure in Kazakhstan and Bulgaria. In Kazakhstan, methadone registration ends in December 2020, after which methadone will not be available in the country.

Many governments fully fund OAT provision in the region, including Azerbaijan, Bulgaria, Croatia, Czechia, Estonia, Georgia, Hungary, Latvia, Lithuania, Moldova, Poland, Serbia, Slovakia, Slovenia and Ukraine. Others such as Belarus, Tajikistan and Kazakhstan only cover part of the services. In most of these cases, the medication itself is funded through the Global Fund.

An assessment conducted[74] in 2019-2020 in Tajikistan[75], Belarus[76] and Ukraine[77] showed that the most significant problems with regard to the sustainability of OAT programmes in the context of transition from donor support to domestic funding are the availability and coverage of the programme, and financial resources allocated to them. Many governments will only cover the cost of the facilities, medical personnel, and medicine. Additional services such as psychosocial support and training for personnel are the two areas that suffer the most during the transition to national funding.

2.3 AMPHETAMINE-TYPE STIMULANTS AND NEW PSYCHOACTIVE SUBSTANCES

A growing trend in the use of amphetamine-type stimulants (ATS), synthetic opioids and new psychoactive substances (NPS) has emerged in Eurasia over the past decade. The popularity of NPS is attributed to their low price and wide availability through the dark net.[62] Repressive policies in the region have led to the emergence of new ways of selling drugs. Most sellers do not hand off drugs anymore, but rather stash them in geotagged hiding spots to be picked up by online buyers. The Russian dark net marketplace Hydra has 2.5 million registered accounts and 400,000 regular customers, according to an analysis[78] published in 2019.

The use of NPS can increase the risk of HIV due to multiple injections and increased number of sexual contacts; there are also reports of mental health issues linked to some NPS use.[62,79][18] ATS are reported to be the most popular injectable substances in Czechia, Latvia and Hungary. A study on NPS use conducted by EHRA and the Swansea University School of Law in 2019-2020 in Moldova[80], Belarus[81], Kazakhstan[82], Kyrgyzstan[83], Serbia[84] and Georgia[85] showed a lack of capacity of existing harm reduction services and health professionals trained to deal with NPS use. The main issues are lack of psychological support, limited access to mental health counselling and no protocols for dealing with NPS overdose. Except Czechia, no country in the region distributes harm reduction kits for safer smoking, snorting or oral use of the substances on a regular basis. At the same time, the number of syringes allocated per person per year is not enough for people who inject NPS, who can require up to 30 injections per day.

The use of new psychoactive substances by marginalised and vulnerable populations also appears to have increased in some places. In addition, unregulated drug markets increase the opportunity for adulteration and contamination of new psychoactive substances and controlled drugs by a range of potentially dangerous and sometimes highly toxic substances. Studies consistently find that drug use is more commonly reported in nightlife settings than among the general population.[86] In Eurasia, drug checking, which could help to both reduce overdoses and engage people who use drugs with the medical system, is provided mostly through the distribution of reagent test kits at music festivals and in nightlife settings. It is provided by civil society and community-based organisations in

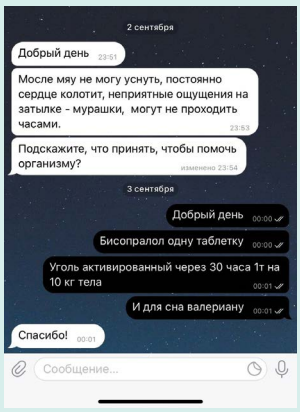
Harm reduction services in Albania, Bosnia and Herzegovina, Hungary, Romania and Russia are extremely limited and are mainly implemented by civil society on a volunteer basis.

Czechia, Estonia, Georgia, Hungary, Lithuania, Ukraine, Poland and Slovenia.

Stable drug checking services with adequate equipment exist only in Slovenia. In many cases, the requirement that service providers obtain licences to possess and work with scheduled substances prevents them from providing drug checking services and many countries do not accept drug checking as a valid reason to issue such licences.

18 Multiple injections are specific for Eurasia region, in other regions people predominantly smoke NPS.

Innovative harm reduction interventions in Eurasia



Photos by Artem Leshko.

ONLINE HARM REDUCTION IN SAINT PETERSBURG, RUSSIA

A Saint Petersburg organisation called Humanitarian Action launched an overdose bot in November 2019 in the messaging app Telegram[19] where people can get first aid in case of an overdose. Through this bot, one can also call an ambulance, both paid and free, and contact a peer consultant. Until recently, people could contact a peer consultant on NPS. This bot has around 2000 subscribers.

In addition, Humanitarian Action has an anonymous Telegram channel where it posts information about harm reduction and available services in Saint Petersburg and other regions. It also includes guidance for people who use drugs, statistics connected with harm reduction and examples of humane drug policies. There are already almost 2,300 subscribers, and the number is steadily growing. There are also closed chats for clients where they are added through outreach workers and case managers. The chat is a place where a person can get help if they need to be hospitalised, can be connected with the AIDS centre, or get an HIV self-test kit. Some people want to consult with a psychiatrist or discuss various issues related to drug use, so they write to the chat and other clients or professional consultants answer them.

Humanitarian Action also provides consultations on Hydra, a popular darknet marketplace. All these efforts raised the number of clients by 90% compared to the previous year.

SUBSTITUTION THERAPY FOR PEOPLE WHO USE ATS IN CZECHIA

Almost half of people, who use ATS, or around 15,000 - 20,000 people in Czechia inject methamphetamine every day. In 2020, pharmacologically-assisted treatment with methylphenidate was introduced for people who use methamphetamines. The commercial name of the drug is Ritalin, and it is used mainly for medication of attention deficit hyperactivity disorder (ADHD). This programme had existed unoffically for a while. However, the COVID-19 crisis, and the risk that crystal methamphetamine would not be available, propelled civil society to advocate for the release of official guidelines from the Society of Addictive Substances, which were certified by the Ministry of Health. Now the treatment can be provided by any facility that has a psychiatrist among its staff including drop-in centres. The main problem is capacity as the programme is only in its initial stage and there are thousands of people who need this kind of substitution treatment.

PINK HOUSE IN SOFIA, BULGARIA

Pink House - the last and only remaining drop-in centre for people who use drugs and are experiencing homelessness in Bulgaria - was at risk of closure at the end of April 2019 due to a lack of funding after the withdrawal of international donors. In order to prevent this from happening, the Centre for Humane Policy took over the administration of the House and launched an online crowdfunding campaign which gained extensive support. At the beginning of the campaign they managed to raise enough money to work for another three months and extend the working hours of the shelter from three hours three days per week to four hours every day including weekends. Later, two more smaller campaigns saw many people sign up for regular donations.

At the time of writing, Pink House has 200 registered clients, with 30-40 people coming every day. The permanent staff consists of only two people (a social worker and toxicologist), other members of the team work on a volunteer basis. At the House, clients can take a shower, wash their clothes, and receive food, clothes, assistance with documents, and legal support. Staff can also help connect people with medical services, and with hospitals to start HIV therapy.

A year after the crowdfunding campaign, Pink House still runs almost solely on private donations. The only two grants were from the Embassy of the Netherlands and a COVID-19-related grant from the Embassy of the United States.

19 Telegram is a messaging app, providing secure, encrypted communication.

MAP 2.2.1:
Access to naloxone in Eastern Europe and Central Asia (CEECA) region (community based survey)

Naloxone is accessible in the pharmacies without a perscription,[1] ambulance/ hospital has it and it's possible to get it in the harm reduction programmes.

Naloxone is not accessible in the pharmacies at all, or without a perscription, but ambulance/ hospital has it and it's possible to get naloxone in the harm reduction programmes.

Naloxone is not accessible in the pharmacies at all, or without a perscription, but ambulance/ hospital has it. It is not possible to get naloxone in the harm reduction programmes.

Naloxone is not accessible in the pharmacies at all, or without a perscription, ambulance/ hospital has no naloxone and harm reduction programmes do not provide it.[2]

No data

1 Naloxone is available in the pharmacies without a perscription at least in some cities.
2 In Albania, Montenegro and Russia some NGOs receive naloxone for a short - term distribution from private sources.

2.4 OVERDOSE, OVERDOSE RESPONSE AND DRUG CONSUMPTION ROOMS (DCRs)

A decreasing trend in the incidence of fatal drug overdoses can be observed in all Central Asian countries in the long run, albeit with signs of a recent increase in Kazakhstan. However, the number of drug overdoses varies significantly between the countries. While there were 238 reported fatal drug overdoses in Kazakhstan in 2017, there have been no registered fatal drug overdoses in Uzbekistan since 2016. [9] This reflects a decrease in the high-risk use of opiates. However, the proportion of deaths due to overdose is likely to be underestimated due to the limited ability of forensic medicine and forensic toxicology systems to detect overdoses on drugs other than opiates. Findings suggest that mortality risk for people engaging in high risk drug use[20] is three to seven times more when compared to peers of the same age and gender in the general population.[87] Factors associated with the increased mortality risk include regular injecting drug use over a long period of time, increased risk of acquiring blood-borne viruses, and other negative consequences like incarceration and a lack of housing.

Lithuania and Estonia are among the countries with the highest rates of drug-induced mortality among adults aged 15-64 years in Europe.[88] In Lithuania, opioids (mainly heroin, but also methadone, fentanyl and carfentanil) are involved in nine out of ten deaths with known toxicology results, and almost half of the fatalities occurred in the capital Vilnius. According to a bio-behavioural study of HIV prevalence and risk behaviour among vulnerable groups conducted in 2017 as part of a Global Fund grant in seven regions of the Russian Federation, 50% of people using drugs reported that they experienced an overdose at least once.[89] In 2019, in Saint Petersburg, Russia, 3916 people were hospitalised with overdoses - 10% more than in 2018. In Russia, Uzbekistan and Belarus, medical personnel have to notify the police about overdose cases.

In many countries in the region, naloxone is only available via prescription. Although emergency medical staff have access to the medication in all countries, for those most likely to witness an overdose, access is extremely limited. Naloxone is available at harm reduction sites in Estonia, Kazakhstan, Kyrgyzstan, Moldova and several cities in Russia, with support from international donors.[90] In Ukraine, naloxone has been available without prescription since 2019. Nasal naloxone is available in Estonia and it was introduced in Lithuania in 2020, where police in Vilnius carry nasal naloxone since October 2020. There are no specific overdose prevention measures for people who use NPS, despite the growing trend of NPS use and overdoses

20 According to the definition used in the mortality cohort studies in the referenced report, high risk drug use is injecting drug use or long-duration/ regular use of opioids, cocaine and/ or amphetamines.

attributed to it, especially in post-Soviet parts of the region.

There are still no drug consumption rooms (DCRs) in the region, although the first harm reduction site that allows drug use on its premises[21] was opened in Sumy, Ukraine, in 2019 with support from the local government. Civil society organisations continue to advocate for DCRs in Czechia, Estonia, Moldova, Poland and Slovenia.

2.5 HIV AND ANTIRETROVIRAL THERAPY (ART)

According to the 2020 UNAIDS report, 48% of all new HIV infections in Eurasia were attributed to injecting drug use, which is a 9% rise compared to 2018. However, transmission patterns vary from country to country.[91] Despite significant investments from external donors such as the Global Fund, 79% of the new cases in the WHO European Region were diagnosed in the East, which includes both Eastern Europe and Central Asia, and 77% of new cases in EECA region were registered in Russia.[92] HIV is concentrated among key populations, including men who have sex with men, people who use drugs, sex workers, and transgender people.[92] There are ten countries where HIV prevalence among people who inject drugs exceeds 10%: Moldova (29.1%), Poland (21.2%), Romania (15.6%), Lithuania (12.5%), Kyrgyzstan (14.2%), Estonia (51.4%), Ukraine (22.6%), Russia (up to 75.2%), Belarus (30.8%), Tajikistan (12.1%).[22]

In the majority of countries in the region, harm reduction services are part of the national HIV programme and mainly include services related to HIV prevention, access to HIV testing and referral to antiretroviral therapy (ART) for people who use drugs. ART is not included in harm reduction services even though the HIV prevention cascade[23] for people who use drugs is far from reaching the UNAIDS 90-90-90 targets.[93] Among the barriers to initiating treatment are centralised health systems, criminalisation of HIV transmission, and the lack of services responding to the specific needs of key population groups. In Russia, the country with the fastest growing HIV epidemic, one third of patients do not initiate treatment.[94]

In Eastern Europe and Central Asia in 2019, 70% of people living with HIV do not know their status, 44% of those who do know their status are on treatment and only 41% are virally suppressed. Aside from challenges to documenting the HIV care cascade in any population, there are several challenges specific to key populations. Due to the fear of discrimination and stigmatisation, people do not disclose same-sex practices, injecting drug use or sex work in the context of HIV care services, and healthcare workers commonly fail to ask about these behaviours.[95] A few countries that have data on HIV testing and status awareness among people who use drugs show quite good coverage: Albania 50.8%, Armenia 58.8%, Azerbaijan 18.6%, Belarus 59.7%, Bulgaria 100%, Czechia 55.1%, Estonia 72.6%, Kazakhstan 77%, Latvia 88.8%, North Macedonia 37.4%, Poland 97.2%, Romania 62%, Serbia 98.8%, Ukraine 43.1%.[96] HIV rapid testing at harm reduction sites performed by medical personnel or assisted by social workers is available in Estonia, Latvia, Lithuania, Poland, Russia and Ukraine. In Ukraine, assisted self-testing is included in harm reduction service packages for all clients twice a year. In Poland, there is an HIV helpline that assists with home self-testing, receiving two hundred calls per week.

Coverage of HIV prevention programmes among people who use drugs varies in the region: Albania 77.9%, Armenia 38.1%, Belarus 67.1%, Kyrgyzstan 40.4%, Moldova 39%, North Macedonia 67%, Tajikistan 67.2%.[96] ART coverage among people who use drugs also varies in the region: Belarus 40.5%, Bosnia 1.9%, Estonia 90.6%, Lithuania 21.8%, Poland 46.2%, Romania 32%, Tajikistan 57.7%, Ukraine 37.9%.[96]

According to HIV Justice Worldwide, Eastern Europe and Central Asia are the regions with the second highest number of laws criminalising HIV exposure, non-disclosure and transmission. Of the 19 countries where such laws have been adopted, 18 are in the Eurasia region. Russia and Belarus have the highest number of criminal cases related to HIV. In Uzbekistan, a person living with HIV can be prosecuted regardless of whether his/her partner wants to initiate a criminal case. In addition, every person in Uzbekistan is obliged to get an HIV test before marriage and, in the event of a positive result, their future spouse is notified.

In 2019, a punishment was introduced in Tajikistan

21 The programme works in a legal grey area, as it is not recognised officially as a DCR.

22 See regional table.

23 The HIV treatment cascade is a model that outlines the steps of care that people living with HIV go through from initial diagnosis to achieving viral suppression (a very low level of HIV in the body), and shows the proportion of individuals living with HIV who are engaged at each stage.

for those who refuse to receive HIV therapy. In 2018, Tajikistan became one of the few countries (and the only one in the region) to whom the Committee on Elimination of all Forms of Discrimination Against Women issued a recommendation to decriminalise the transmission of HIV, and repeal government decrees that prohibit women living with HIV from obtaining a medical degree, adopting a child, or being a legal guardian.

During the COVID-19 pandemic, the Eurasian Women's Network on AIDS supported by the UN Population Fund started a project, ARThelp, to ensure access to ART for people who are stuck in other countries during quarantine. In less than two months, 82 people from 13 countries received help through this service. The project highlighted the issue of migrant workers living with HIV in the post-Soviet region and their access to health services.

To achieve the 90-90-90 target set by UNAIDS, urgent scaling up of the nine core harm reduction interventions as recommended by WHO is needed in the region.

2.6
HARM REDUCTION IN PRISONS

UNAIDS estimates that 56–90% of people who inject drugs globally will be incarcerated at some stage during their life,[97] while about one third of people in prisons worldwide are estimated to have used drugs at least once during incarceration.[61] Coverage of treatment interventions offered to people in prison in Eurasia varies considerably by country but can include detoxification, individual and group counselling, treatment in therapeutic communities and in special inpatient wards. Azerbaijan, Uzbekistan and Belarus have special prisons for people convicted of drug offences.

The scale of NSPs in prisons remains stable. As in 2018, NSPs operate in prisons in five of the 29 countries in the Eurasia region: Armenia, Kyrgyzstan, North Macedonia, Moldova, Tajikistan.

OAT in prisons is currently available in 21 countries: Albania, Armenia, Bosnia and Herzegovina, Bulgaria, Croatia, Czechia, Estonia, Georgia, Hungary, Kyrgyzstan, Latvia, Lithuania, North Macedonia, Moldova, Montenegro, Poland, Romania, Serbia, Slovenia, Tajikistan and Ukraine.[98] Although OAT is available in prisons, this doesn't mean that it is widely accessible. In many countries, the quality and accessibility of OAT in prisons remain low. In Ukraine, just 93 people in prison receive OAT, in Moldova 100, in Tajikistan 16, in Albania 93, in Bosnia and Herzegovina 50, and in Kyrgyzstan 338.

In Georgia and Hungary[99], OAT is available only for short detoxification but not for long term maintenance treatment.[100] There is a plan to expand OAT provision from one to five prisons (one of which is for women) in Ukraine in 2020,[101] and there is a separate section on the availability of OAT in prisons and detention centres in the country's Drug Policy Action Plan for 2019-2020.[102] In Lithuania, OAT is available only in prisons and only for people who were already in the programme, and OAT is absent in detention centres leading to treatment interruptions.[103] In Albania, Latvia, Montenegro and Serbia OAT cannot be initiated within the prison, but is available as a continuation of medication. As reported in 2018, OAT is prohibited in Russia, Turkmenistan and Uzbekistan, both in prisons and in the community.

A recent review from the European Monitoring Centre for Drugs and Drug Addiction identified new psychoactive substance use in prisons in nine countries in the region, with synthetic cannabinoids identified as the most commonly used NPS.[104] In Latvia, the use of synthetic opioids in prison has been linked to increases in overdoses, as well as injecting and syringe sharing.[104] A 2018 survey indicated that almost half of the people in prison in Czechia had used an illicit drug in the 12 months prior to imprisonment, with methamphetamine reported as the most commonly used drug (30 %), followed by cannabis (28 %) and MDMA/ecstasy (12 %).[19]

People who inject opioids are also most vulnerable to overdose upon release from prison, yet post-release naloxone is reportedly unavailable in the region. In Estonia, everyone who has been incarcerated for a drug offence can receive naloxone training before being released but has to request it. People usually do not use the services due to the fear of being denied parole if they show any interest in using drugs (which is criminalised) upon release.

HIV, hepatitis C and active tuberculosis infection are disproportionally higher among prison populations, particularly among those who inject drugs in prison. A review of available studies found that people who inject drugs in

3. Policy developments for harm reduction

prison had six times the prevalence of HIV and more than eight times the prevalence of hepatitis C compared with the non-injecting prison population.[61] HIV testing and treatment is available in prisons in all countries in Eurasia. Hepatitis C testing, treatment and care in the region's prisons is scarce, which is also the case outside prisons. Only Slovakia and Slovenia offer hepatitis C treatment in all prisons; in Hungary and Ukraine, and to some extent in Bulgaria, Georgia, Romania and Serbia, it is in less than half.[105] Civil society reports that in most countries, condoms in prisons are not available or available to only a limited extent.

Between August and October 2019, the European Network of People Who Use Drugs and the European Prison Litigation Network documented 107 cases of rights violations in Ukraine, Russia, Moldova and Georgia against people in prison who use drugs. Among these were 33 cases of people experiencing abstinence syndrome during interrogation and 12 who, in addition to experiencing abstinence syndrome, had also not been provided with any legal support.[106]

Despite the implementation of harm reduction services in many countries in the region, for the vast majority of countries the policy environment is dominated by punitive drug policies.

Twenty-five of 29 countries in Eurasia have national HIV or drug policies that include references to harm reduction. At least four countries (Albania, Czechia, Estonia, Slovenia) have harm reduction as one of the four main pillars of their national Drugs Strategy. Despite the implementation of harm reduction services in many countries in the region, for the vast majority of countries the policy environment is dominated by punitive drug policies focused on supply reduction and criminalisation. Within this policy environment, hostility towards harm reduction is common. Russia, Ukraine and Kazakhstan have recently introduced legislative initiatives aimed at strengthening measures to combat drug-related information and advocacy, particularly on the internet, and have toughened the liability for such information.[107] This raises concerns related to the possible risks to social programmes focused on working with people who use drugs, and NGOs implementing those programmes. In Belarus, there are new cases of lack of confidentiality and sharing of personal data of OAT clients related to violations of parental rights due to drug dependence/OAT programme client status.[108]

National legislation on drugs in the former Soviet states sets low thresholds for possession offences, leading to prison sentences that are disproportionate in length to the associated drug arrest. In Kyrgyzstan, the so-called liberalisation of drug laws led to increased fines for drug possession (more than 1g of heroin) starting from USD 2577.[24][109] Similarly in Ukraine, a new law came into force in July 2020 with a minimum fine of USD 2000. In 2018, every seventh person convicted in Ukraine (10,144 of 73,659 people convicted of criminal offences) was convicted of drug crimes. Of those, 8,513 people (84%), were convicted of crimes of simple possession for personal use and, of those, 6,482 (76%) were convicted for possession of narcotics in miniscule amounts that ranged from 0.005g to 1g of heroin. People who use drugs and especially people who live with drug dependence are vulnerable to discrimination, arbitrary arrest and ill treatment by police. When people with drug dependence are criminally prosecuted for possession of small amounts of drugs for personal use, this amounts to detention solely on the basis of drug use or drug dependence.

In Estonia, changes to the Code of Misdemeanour and the Penal Code in 2015 created the possibility of terminating misdemeanour proceedings, or offering alternatives to coercive sanctions instead, if the person

24 Average wage in Kyrgyzstan is 233 USD.

subject to proceedings is willing to participate in a social support programme. Following these changes, the SÜTIK programme (short for Sõltlaste ühiskonnastamine tugiisikute kaasamisel in Estonian) was introduced. SÜTIK is a social support service that was developed for people who use or are dependent on drugs and who have been diverted by the police or have approached the service voluntarily. The SÜTIK programme is based on the Law Enforcement Assisted Diversion (LEAD) programme originally initiated in Seattle, USA, in 2011. It primarily enables police officers to refer people who use drugs who have committed a drug-related offence to a support person, as an alternative to punishment. The SÜTIK programme is funded by Estonia's National Institute for Health Development, and the service is generally delivered by non-governmental harm reduction organisations. The target group is people aged 18 or older who use drugs, and have been arrested for using or possessing a small amount of drugs and have been referred to the programme by the police, or who have turned to the service of their own volition. The majority of support workers are peers.[110] Another programme in Estonia which offers alternatives to coercive punishment to people who use cannabis is called VALIK (Estonian for "choice"). It consists of up to five or six sessions with a psychologist, who decides if the person needs additional services or treatment.

4. Funding developments for harm reduction

The Eurasia region faces ever increasing gaps in funding for rights-based, quality harm reduction services, exacerbated by the transition from international to domestic funding. This has been especially true for the majority of Eurasian countries previously classified as low-income that have been reclassified to middle-income countries due to recent economic growth (except Tajikistan).[111]

In this context, governments respond differently and implement several scenarios following the withdrawal or absence of international support:[25]

- In some cases, the government steps up and begins covering NSP and OAT programmes including the procurement of OAT medication, harm reduction supplies and psychosocial support (for example in Ukraine, Georgia, Moldova).
- In other cases, the state supports the purchase of equipment, the cost of facilities and key staff but does not support peer involvement and psychosocial help. In order to support the integrated harm reduction service including psychosocial support, organisations have to submit the same project for several ministries (for example in Slovakia, Slovenia, Czechia).
- And in some other cases, the government covers the cost of facilities and the key staff but the purchase of medication and harm reduction equipment are covered from external funds (for example Kazakhstan, Belarus).

In Belarus, Kyrgyzstan, Moldova and Ukraine, harm reduction and HIV-related services are gradually moving from donor to state funding, mostly using public tenders and social contracting mechanisms. Despite commitment by governments to continue HIV prevention among key groups, this transition has significantly weakened community systems and interrupted services. Lack of political support for harm reduction, not only as an HIV prevention measure but as a social service, is one of the main obstacles to sustainable and sufficient funding for quality programmes.

Southeastern Europe is a region where the withdrawal of the Global Fund has led to the collapse of services in countries including Albania, Bosnia and Herzegovina, Bulgaria, Romania and Serbia . In 2019, EHRA published a case study on sustainability bridge funding in Bosnia and Herzegovina, Montenegro and Serbia as a safety net mechanism to respond to gaps in funding and mitigate

25 Country examples are provided based on interviews with national experts.

adverse effects of donor funding withdrawal.[112] In 2016, the Global Fund adopted a Sustainability, Transition and Co-Financing Policy[113] which now allows countries to plan for their disease response after the withdrawal of donor support. According to this policy, a country's status as "transitioning" will be defined at an early stage, giving a country time to plan and prepare for taking over the funding of services. The Global Fund "bridges" the impact of funding withdrawal by providing investment into the health system as part of the national grant to help a country to establish sustainable programmes and through providing a "transition grant." Some donor and civil society stakeholders believe that a special mechanism - which could be called the Sustainability Bridge Fund (SBF) - should be introduced to ensure that countries have the required capacity to maintain and scale up their response to end HIV, TB and malaria after they are no longer eligible for international funding. Additionally, it could also help mitigate the damage of failed transitions if and when they arise. In 2017, the Civil Society Sustainability Network (CSSN) issued an Info Note[114] suggesting the areas such an SBF could target. According to CSSN, the SBF should be complementary to the existing donor transition efforts and could also work as a mechanism for coordination and communication among relevant donors during and after the transition.

In Estonia, all harm reduction services are covered by the state. In Poland, a government decision to allocate funding to harm reduction from money accumulated from gambling taxation has reportedly led to an increase for both harm reduction and drug treatment in the country.[115] In Bulgaria, after extensive advocacy efforts in July 2019, the Ministry of Health signed a contract with a number of NGOs to cover services for people who use drugs, men who have sex with men, and sex workers. A year later, however, the contract was not extended and NGOs have been forced to close all the services and, as of September 2020, there is no working NSP in the country.[16] In Hungary, funding for harm reduction was cut due to political reasons. The largest harm reduction programmes closed down in 2014 and coverage is still very low.[99]

Available packages and quality of harm reduction services while transitioning from international to domestic funding are decreasing even if services are supported. In Ukraine, for example, the unit cost of NSP programmes has decreased from USD 46.40[116] in 2012, to less than USD 20[117] in 2020 per client per year which covers only two HIV tests, two TB screenings, nine consultations, 120 syringes, 120 alcohol swabs, 20 condoms and two lubricants. The rest of the services included in the standard[118] are covered by international donors or municipal budgets.

Funding (domestic and international) for HIV responses in eastern Europe and central Asia (excluding the Russian Federation) peaked in 2017, before declining by 14% between 2017 and 2019, leaving the region at just 56% of its 2020 resource target.[119] HIV response funding from domestic sources increased by 24% from 2010 to 2019, while contributions from the Global Fund and all other international sources decreased by 10%.[119] Although the data shows an increase in government HIV spending in all countries in Eurasia, the incidence of HIV continues to increase[120] due to lack of support for specific services for key populations. Repressive enforcement of drug laws, including harsh criminal penalties and the registration of people who use drugs who are convicted, force people away from public health services into hidden environments, increasing their risk-taking behaviours and heightening the chance of acquiring or transmitting HIV.[119] To address these challenges, a multi-country three-year project - "Sustainability of services for key populations in the Eastern Europe and Central Asia region" (2019-2021)[121] - was financed by the Global Fund to the maximum extent possible: USD 13 million, with a focus on 14 countries and 25 cities in the region. In addition, the Elton John AIDS Foundation and Gilead Sciences have partnered together on the RADIAN[122] initiative. In 2019, they presented the 'Model Cities' and 'Unmet Need' funds.[26]

In order to help ensure the sustainable development of civil society organisations that provide harm reduction and other services for key population groups, EHRA gathered 20 case studies of alternatives to donor or government funding opportunities in 2019.[123]

26 The 'Model Cities' fund will provide funding for non-profit, academic and research organisations from 2020-2025, to deliver measurable impact in the fight against HIV/AIDS in key EECA cities and regions (Chelyabinsk Oblast, Irkutsk Oblast, Kemerovo Oblast, Krasnoyarsk Krai, Leningrad Oblast - not including City of St Petersburg, Novosibirsk Oblast, Orenburg Oblast, Perm Krai, Samara Oblast, Sverdlovsk Oblast, Tomsk Oblast, Tyumen Oblast). The 'Unmet Need' fund is supporting projects across Eastern Europe and Central Asia, focusing on HIV/AIDS-related prevention and care, education, community empowerment, and novel partnerships.[122]

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2.3 LATIN AMERICA & THE CARIBBEAN

ANTIGUA AND BARBUDA
THE BAHAMAS
BARBADOS
BELIZE
BERMUDA
CUBA
DOMINICA
DOMINICAN REPUBLIC
GRENADA
GUYANA
HAITI
JAMAICA
PUERTO RICO
SAINT KITTS AND NEVIS
SAINT LUCIA
SAINT VINCENT AND THE GRENADINES
SURINAME
TRINIDAD AND TOBAGO

ARGENTINA
BOLIVIA
BRAZIL
COLOMBIA
COSTA RICA
CHILE
ECUADOR
EL SALVADOR
GUATEMALA
HONDURAS
MEXICO
NICARAGUA
PANAMA
PARAGUAY
PERU
URUGUAY
VENEZUELA

TABLE 2.3.1:

Epidemiology of HIV and viral hepatitis, and harm reduction responses in the Latin America and the Caribbean

Country/ territory with reported injecting drug use[1]	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[2]	OAT[3]	Peer distribution of naloxone	DCRs[4]
Argentina	8,144[2]	3.5[3]	4.8[4]	1.6[4]	x	✓(M)[5]	x	x
The Bahamas	0[6]	nk	nk	nk	x	x	x	x
Bolivia	nk	nk	nk	nk	x	x	x	x
Brazil	nk [5]	9.9 [7]6	nk	nk	x	x	x	x
Chile	nk	nk	nk	nk	x	x	x	x
Colombia	14,893[8]	5.5[9]	31.6[9]	nk	✓[10,11]	✓(M)[10,11]	x	x
Costa Rica	nk[7]	nk	nk	nk	x	x	x	x
Dominican Republic	<1,359[13]8	3.2[13]9	22.8[14]10	nk	✓2[15]	x	x	x
Ecuador	nk	nk	nk	nk	x	x	x	x
El Salvador	nk	nk	nk	nk	x	x	x	x
Guatemala	nk	nk	nk	nk	x	x	x	x
Guyana	nk	nk	nk	nk	x	x	x	x
Haiti	nk	nk	nk	nk	x	x	x	x
Honduras	nk	nk	nk	nk	x	x	x	x
Jamaica	nk	nk	nk	nk	x	x	x	x
Mexico	164,157[18] 11	4.4[19] 12	96[20] 13	0.2[4]	✓[17]	✓(M)[21]	✓[21]	x[14]
Nicaragua	nk	nk	nk	nk	x	x	x	x
Panama	5,714[22]	nk	nk	nk	x	x	x	x
Paraguay	nk	nk	9.8[23]	nk	x	x	x	x
Peru	nk	nk	nk	nk	x	x	x	x
Puerto Rico	28,000[24]	11.3[25] 15	78.4 - 89[27,28] 16	nk	✓[29]	✓(M,B)[29]	✓[29]	x
Suriname	nk[30] 17	nk	nk	nk	x	x	x	x
Uruguay	nk	nk	nk	nk	x	x	x	x
Venezuela	nk	nk	nk	nk	x	x	x	x

nk = not known

1 Countries with reported injecting drug use according to Larney et al in 2017. The study found no reports of injecting drug use in Antigua and Barbuda, Barbados, Belize, Cuba, Dominica, Grenada, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines or Trinidad and Tobago.[1]

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

3 Opioid agonist therapy (OAT), including methadone (M), buprenorphine (B) and any other form (O) such as morphine and codeine.

4 Drug consumption rooms, also known as supervised injecting sites.

5 Unpublished data from a national household survey coordinated by Francisco Bastos found very little evidence of injecting drug use in Brazil.

6 Based on data collected in 2009 in eight Brazilian cities.

7 Civil society organisations indicate that injecting drug use is minimal in Costa Rica.[12]

8 There are an estimated 56,632 people who use illegal drugs in the Dominican Republic, less than 2.4% of whom are reported to be people who inject drugs.

9 Estimate from 2012 for people who use drugs.

10 Based on data from 2008.

11 Based on data from 2011 National Addiction Survey. There may be limitations to the representativeness of this data, as household surveys are known to exclude people living outside traditional households, such as people who are homeless or incarcerated.[16] Civil society organisations believe that this figure may be an overestimate, with the true number of people who inject drugs in the country being around 30,000.[17]

12 Based on data collected in 2006-2007.

13 Based on data collected in 2005.

14 Though one DCR operates in Mexicali, Mexico, this is not officially sanctioned by the state.[21]

15 Based on subnational data from 2015.

16 Based on subnational data from 2006-2015. Civil society organisations report that there is no effective system monitoring viral hepatitis infection among people who inject drugs in Puerto Rico.[26]

17 A 2008 government study estimated that 0.3% of Suriname's estimated 1,000 people who use drugs are people who inject drugs.

MAP 2.3.1:
Availability of harm reduction services

2.3
Harm reduction in Latin America and the Caribbean

NEEDLE AND SYRINGE PROGRAMMES (NSPs)

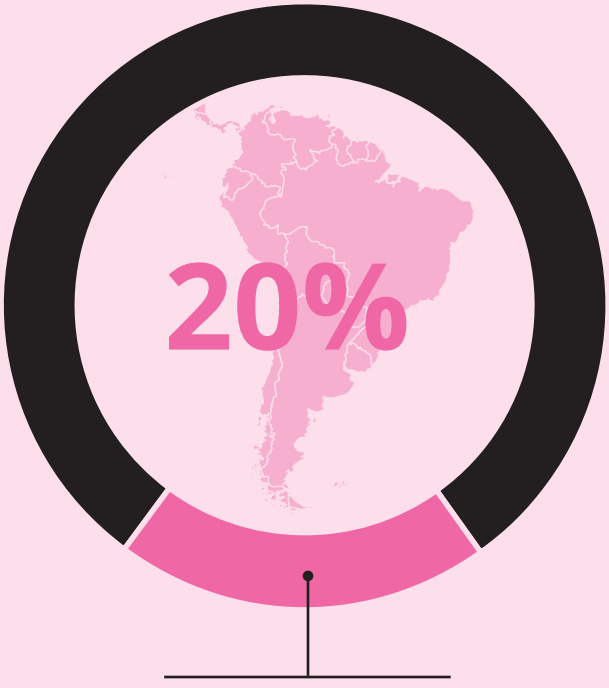
<5%

CIVIL SOCIETY ORGANISATIONS ESTIMATE THAT LESS THAN 5% OF THE PEOPLE WHO INJECT DRUGS IN MEXICO ACCESS NSPs.

Transition to domestic funding applies primarily to services for people who inject drugs, and there remain few funding opportunities for services for the majority of people who use drugs in the region who do not inject.

COCAINE

IN LATIN AMERICA APPROXIMATELY 40% OF PEOPLE IN CONTACT WITH THE CRIMINAL JUSTICE SYSTEM HAVE BEEN ARRESTED ON THE BASIS OF COCAINE-RELATED OFFENCES'



APPROXIMATELY 20% OF PEOPLE IN PRISON IN LATIN AMERICA ARE CHARGED WITH A DRUG OFFENCE.

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1. Overview

There are approximately 5.5 million people who use non-injected illegal drugs in Latin America and the number of people who inject drugs is very low compared with other regions.[31,32] This is largely due to the fact that, currently, injecting use is relatively rare outside Mexico and Colombia[33] and because the rate of use of cocaine and its derivatives (which are commonly not injected) in the region is among the highest in the world.[5,31,34]

The production and use of cocaine and coca derivatives is prevalent in South America, specifically Bolivia, Colombia and Peru, which are responsible for virtually all the world's coca leaf cultivation.[35,36] The smokable use of cocaine paste (an intermediate product in the production of cocaine also known as basuco, paco, base paste or oxi) is greater than that of opioids in Argentina, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru and Uruguay.[5,32,37–39] It is a cheaper alternative to cocaine in South America and people who use cocaine paste, as well as those who use crack cocaine, are usually from socially marginalised groups, are more stigmatised and face more barriers to access to health care and harm reduction programmes than other people.[5,11,12,34]

The rate of opioid use in Latin America and the Caribbean is lower than that of amphetamine-type substances (ATS) or other new psychoactive substances (NPS). However, opioid use is prevalent in Colombia, the Dominican Republic, Mexico and Puerto Rico.[11,15,21,29,31] NPS use is increasing in Argentina, Brazil, Colombia, Costa Rica, Mexico, Peru and Uruguay. MDMA is the most common substance among ATS, and NPS such as ketamine, synthetic cannabinoids and synthetic hallucinogens are also used in some countries.[11,12,21,32,37,39–41]

Harm reduction programmes for people who use non-injectable cocaine derivatives are in place in several countries in the region, with a particular focus on the use of the smokable forms of crack cocaine and cocaine paste. In some cases, there are community-based programmes that offer primary health services, food and hygiene services, legal advice and treatment to people who use non-injectable cocaine derivatives and other drugs.[5,42,43] Harm reduction programmes focused on people experiencing homelessness have been established in Argentina, Brazil, Chile, Colombia, Costa Rica and Uruguay.[12,44]

Harm reduction programmes for people who inject drugs, including opioid agonist therapy (OAT) and needle and syringe programmes (NSP), operate in Colombia, the Dominican Republic, Mexico and Puerto Rico.[11,15,21,29,45] In Mexico, primarily in the north close to the border with the USA, they also function as overdose prevention programmes, distributing naloxone and offering fentanyl strips. La Sala, a safe consumption space for women who use drugs, is the first drug consumption room (DCR) in the region, though it is not authorised by the Mexican government.[46]

Drug checking programmes (also known as substance analysis) have increased in the region since 2018, and are managed by civil society organisations, including in Colombia, Mexico, Peru and Uruguay.[11,39,44] There are other peer education projects in clubs and festivals that offer assistance, information and hydration points to reduce risk related to recreational drug use.[5,43]

There are several examples from recent years of regression towards more punitive drug policies in Latin America. For example, new governments in Brazil and Bolivia have explicitly rejected harm reduction as a response to illegal drug use and closed successful programmes, replacing them with abstinence-based, rehabilitation and law enforcement-led projects.[36] In several other countries such as Costa Rica, the Dominican Republic, El Salvador, Guatemala and Honduras, the response to drug use continues to be dominated by abstinence-centred programmes.[12,15]

With reductions in funding from international donors, the funding landscape for harm reduction in Latin America is becoming increasingly difficult. Due to the socio-economic crisis in the region caused by the COVID-19 pandemic, national government funding has also decreased. Many programmes are supported only by private contributions.

Based on the limited data available, prevalence rates of HIV, hepatitis C and tuberculosis (TB) are all higher among both people who inject drugs and non-injecting drug users than the general population. However, prevalence rates vary considerably across the region.

2. Developments in harm reduction implementation

2.1 NEEDLE AND SYRINGE PROGRAMMES (NSPs)

Latin America has one of the lowest rates of syringe distribution per person who injects drugs in the world.[31] Where injecting drug use has been identified, syringe distribution per person per year is lower than the World Health Organization recommendation for the elimination of hepatitis C of 300 syringes per person per year.[47] A relative absence of injecting drug use may make NSP implementation a lower priority in Bolivia, Costa Rica, Ecuador, Paraguay and Peru.[5,12,38,39] In Argentina, Brazil and Uruguay, cocaine injection is now minimal, so NSPs have redirected efforts towards harm reduction for non-injecting drug use.[3]

NSPs continue to operate in Colombia and Mexico, but a lack of funding and a regression towards more punitive drug policies in Latin America have caused a decrease in coverage of NSPs in both countries.[11,21,36] While services have recently been officially included in the HIV/TB response in Colombia, coverage has decreased since 2018 in Armenia, Bogotá, Cucuta and Bucaramanga[11] In Mexico, there were six active NSPs in 2018, including in the cities with the highest level of injected heroin use: Tijuana, Mexicali and Ciudad Juarez. However, civil society organisations estimate that less than 5% of the people who inject drugs in Mexico access NSPs.[21] In February 2019, the Mexican government ceased funding for citizen-led programmes, which forced some NSPs to reduce services.[48]

Even where NSPs are in operation, coverage is insufficient.[11,21] In Mexico, there is a shortage of syringes and people who inject drugs are reluctant to use those provided by the government because of concerns about quality and poor design.[21,49] There are geographical and organisational barriers to access in both Colombia and Mexico, and women and transgender people face additional barriers related to stigmatisation.[11,21] For example, in Mexicali, Verter reports that just one in ten of its NSP clients are women.[21]

Changes in NSP implementation in the Caribbean have been limited since 2018, and the Dominican Republic and Puerto Rico remain the only places where NSP services operate.[15,29] This is in large part due to the low recorded prevalence of injecting drug use in the region. For example, in the Bahamas and Saint Kitts and Nevis, governments report no injecting drug use and therefore no NSPs are in operation.[50,51] However, in several other Caribbean countries, no NSPs are in operation despite the acknowledged prevalence of small populations of people who inject drugs, for example in Dominica, Guyana and Jamaica.[52–55]

2.2 OPIOID AGONIST THERAPY (OAT)

No country in Latin America has newly implemented OAT since 2018. Despite OAT being available in Argentina, Colombia and Mexico, it is largely administered in an abstinence-focused manner rather than for harm reduction.[5,11,21]

OAT is available in Colombia in the form of methadone pills.[10,11] However, there are significant barriers to access for women, transgender people and people experiencing homelessness. Barriers include over-subscribed services; services that do not adjust to the needs of the most vulnerable groups; the fact that formal identification is necessary to access the state health insurance programme; long waiting times for appointments with specialists; and many medical practitioners and clients still considering methadone therapy to be a case of replacing one addiction with another.[10]

In Mexico, OAT is available only in private clinics and fee-charging government clinics, at high cost to the client. There are six centres in the three cities where injecting drug use is highest: Tijuana, Mexicali and Ciudad Juarez.[21] In Argentina, OAT is available in both public and private institutions in Buenos Aires.[5] In Costa Rica, Ecuador and Peru, prescription opioids are used for palliative care patients and for only a small number of people suffering from opioid withdrawal.[12,39]

Opioid use is relatively uncommon in the English-speaking Caribbean, with prevalence of 0.2% compared with 2% in the Americas as a whole.[56] However, both Puerto Rico and the Dominican Republic are home to significant populations of people who use opioids.[15,29] Puerto Rico remains the only place in the Caribbean where OAT is available, though civil society actors in Puerto Rico report that fewer programmes are operating in 2020 than in 2018 because of a lack of funding.[29]

In the Dominican Republic, no OAT services are available.[15] Law 50-88 (the primary drug control law in the country) specifically prohibits the use of methadone, but does not prohibit buprenorphine.[57] The National Drug Council is the state organ responsible for drug programmes, but only funds OAT for detoxification purposes with requirements for abstinence.[15] A long-awaited pilot OAT programme took place in 2019, providing services for 67 people. However, despite positive results, neither the government nor international donors were willing to fund a continuation of the programme.[15]

2.3 AMPHETAMINE-TYPE STIMULANTS (ATS) AND NEW PSYCHOACTIVE SUBSTANCES (NPS)

The use of ATS, including the non-medical use of amphetamine, methamphetamine and pharmaceutical stimulants, is lower in Latin America and the Caribbean than other regions. However, Central America[18] has higher rates of use than South America.[32] In South and Central America, the non-medical use of pharmaceutical stimulants is more common than the use of other amphetamines. The non-medical use of weight loss pills is reportedly more prevalent among women than among men, with pills such as sibutramine hydrochloride monohydrate (sold under the brand names Aderan and Ipomex) and phentermine (sold under the brand names Duromine and Suprenza), along with methylphenidate and amphetamine, reported to be the most commonly non-medically used pharmaceutical stimulants in those subregions.[31] Few harm reduction programmes addressing the use of ATS operate in the region.

Data on amphetamine-type stimulants is rarely collected systematically in the Caribbean.[58] According to the limited data available, prevalence of use appears to be low. For example, past-year prevalence of MDMA among secondary school students is estimated at 0.2% in the Dominican Republic and 0.3% in Barbados.[58]

Though the rates of NPS use in Latin America are lower than in other regions, NPS use has increased in the region among young people since 2018.[31,32] MDMA is the most common ATS in Argentina, Brazil, Colombia, Chile, Costa Rica, Mexico, Peru and Uruguay. NPS such as ketamine, synthetic cannabinoids and NBOMes (a group of synthetic hallucinogens commonly sold as LSD) are also used in some countries.[10,11,21,32,40,41,43,59]

Harm reduction programmes for ATS and NPS use in nightlife settings increased in the region. In Colombia, Peru and Uruguay there are drug checking programmes managed by civil society organisations, such as Echele Cabeza in Colombia, Imaginario 9 in Uruguay, and Latin America for a Sensible Drug Policy in Peru.[11,39,44] There are other peer education projects that offer assistance, information and hydration points to reduce risk related to recreational drug use such as Proyecto de Atención en Fiestas (PAF) in Argentina, Projeto Respire in Brazil and other similar services in Chile, Costa Rica and Ecuador.[5,12,43]

> *Drug checking programmes (also known as substance analysis) have increased in the region since 2018, and are managed by civil society organisations, including in Colombia, Mexico, Peru and Uruguay.*

18 This refers to: Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama.

The governments of Argentina, Chile, Colombia and Uruguay have established early warning systems on NPS at the national level.[59,60] In 2019, these systems were combined in the Early Warning System for the Americas, through which countries share information.[59,60] The early warning systems provide specific information on NPS including trend data, chemical details on individual substances and supporting documentation on laboratory analysis to public health institutions, including directly to frontline health workers in hospitals, to enable better responses to overdose. In many cases, including all alerts in Argentina, alerts are also made available to the public to inform people who use drugs and their families.[59] In Argentina, the system is operated by governmental agencies and does not source data or samples from organisations providing harm reduction services.[5] Barbados, Brazil, Costa Rica, Jamaica, Paraguay, Peru, and Trinidad and Tobago are developing national early warning systems in line with the recommendations of the Inter-American Drug Abuse Control Commission (CICAD).[59]

2.4
COCAINE AND ITS DERIVATIVES

Cocaine use in Central America (0.7% of the population) and South America (1.0%) is higher than the global average of 0.4% of the global population aged 15–64.[31,32] According to national estimates, between 4% and 6% of the general population have ever used powder cocaine in the English-speaking Caribbean[19] and less than 1% in the Dominican Republic, Haiti and Puerto Rico.[58] Prevalence of crack cocaine use is lower, but is still estimated at between 1% and 2% of people in the English-speaking Caribbean.[58] There is evidence that use of crack cocaine has increased over recent years across the Caribbean,[58] notably in Barbados, Belize and Dominica.[61–63]

With nearly 1.5 million past-year cocaine and crack cocaine users, Brazil is the largest cocaine market in South America.[31,43] Cocaine base paste, which was previously confined to countries where cocaine is manufactured (Bolivia, Colombia and Peru), is the most commonly used drug among many socio-economically deprived people who use drugs in Argentina, Colombia, Chile, Ecuador, Peru, Paraguay and Uruguay.[34,35] However, such use is difficult to estimate since people who use cocaine base paste are usually from socially marginalised groups that are not well captured by household surveys.[5,37,64]

Harm reduction programmes for people who use non-injectable cocaine derivatives are in place in Argentina, Brazil, Paraguay and Uruguay, with a particular focus on use of the smokable forms of crack cocaine and cocaine paste. Examples include the Casas de Atención y Acompañamiento Comunitario in Argentina, supported by the National Secretariat for Comprehensive Drug Policy (SEDRONAR) and implemented by civil society organisations, and the Centro de Convivencia E de Lei in Brazil, coordinated by a harm reduction organisation. Both are community-based programmes that offer primary health services, food and hygiene services, legal advice and treatment to people who use non-injectable cocaine derivatives and other legal and illegal drugs.[42,43] During the last two years, harm reduction programmes focusing on people experiencing homelessness have appeared in Argentina, Colombia, Costa Rica and Uruguay.[10,12,21,65]

In Puerto Rico, a few harm reduction programmes deliver safer smoking equipment to people who smoke crack cocaine, but these projects are small and do not have a steady source of funding.[29] Additionally, harm reduction organisations distribute fentanyl test strips to people who use cocaine as well as people who use opioids, as fentanyl is known to be present in both. This remains the only form of drug checking available on the island, mostly due to a lack of funding.[29]

Since 2018, many services to reduce and mitigate the consequences of crack cocaine and cocaine paste use have reduced their coverage due to lack of financial support and a regression towards more punitive drug policies in the region (see policy developments section). Conservative administrations in Argentina, Bolivia, Brazil, Chile, Colombia and Ecuador replaced funding for health programmes with funding for security measures focused on drug markets.[5,12,36,43,66] Some of them explored military responses to drug-related problems, for example Argentina, Brazil, Colombia, Mexico and Peru.[67] People who use cocaine paste are often subject to marginalisation, stigmatisation and violence.[34,64]

19 This refers to: Antigua and Barbuda, the Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines and Trinidad and Tobago.

Non-injected drug use and harm reduction

In much of Latin America and the Caribbean, injected drug use is uncommon, with smoking the preferred route of administration for crack cocaine and cocaine paste.[5,12,38,39] Non-injected drug use is less associated with blood-borne disease transmission, and in some cases can be an alternative to injection, which reduces the harms associated with injecting drug use, for example in 'pin-to-pipe' programmes.[68] However, there remain significant health risks associated with smokable cocaine. One harm reduction intervention that can address these risks is the provision of safer smoking equipment.

While the risk is lower than with sharing syringes, sharing smoking equipment remains a possible route of HIV and viral hepatitis transmission.[69,70] This risk is heightened where people have burns or cuts on their mouth or lips, often associated with the use of inappropriate or improvised smoking equipment.[34,68] Aside from infectious diseases, smoking drugs can also lead to pulmonary complications including chronic obstructive pulmonary disorder, emphysema and bronchitis.[34,71] As mentioned, this is frequently associated with improvised smoking equipment and the inhalation of toxic fumes, particularly where plastic or inked aluminium is heated at high temperatures.[34]

Distributing safer smoking kits can reduce sharing, reduce injuries to the mouth and lips, and lower the risk of damage to the lungs. Such kits may include glass stems and pipes, rubber mouth pieces and lip balm.[34] Some organisations also include condoms to prevent sexual transmission of diseases.[34] These kits must also be tailored to the needs of the local population. For example, one organisation in Colombia designed a pipe specifically for people who smoke cocaine paste, modelling the pipe on those already in use, but with safer materials and removable parts to facilitate cleaning and avoid sharing.[72]

2.5 OVERDOSE RESPONSE AND DRUG CONSUMPTION ROOMS (DCRs)

Since the last *Global State of Harm Reduction* report in 2018, the first official DCR in Latin America opened in Mexicali, Baja California, Mexico.[21] While the facility, under the name La Sala, briefly operated with the approval of the National Commission against Addiction (CONADIC), it has not been formally recognised by local or national government since 2018.[21] Verter, a harm reduction organisation that has operated since 2012, runs La Sala which serves women who inject drugs.[46] The DCR offers other harm reduction services such as reproductive and sexual health, legal support, peer counselling, drug checking, overdose response, HIV and hepatitis C prevention programmes and naloxone[20] distribution. However, with only one DCR operational in the country, the coverage is insufficient for more than 100,000 people who inject drugs. For this reason, civil society organisations established a peer distribution network of naloxone in those areas of northern Mexico where opioid use is prevalent.[21] However, the programme receives no government funding and these efforts remain unofficial.[73]

No data is available on the number of opioid overdose deaths that occur in Colombia, despite evidence suggesting that there are 15,000 people who use opioids in the country.[8,74] Civil society organisations highlight this lack of data as a key challenge when providing services and advocating for greater access to overdose prevention.[74] They also raise concerns that opioid overdose deaths are not formally recorded as such, but commonly referred to as death from cardiac arrest.[74] Naloxone remains highly limited in Colombia, where the primary barrier to distribution is restrictive legislation.[10,11]

A significant development in the response to opioid overdose has been improvements to the availability of naloxone in Puerto Rico. This is the result of a long advocacy campaign from civil society, as reported in the *Global State of Harm Reduction 2018*. Administrative Order 412 of the Department of Health permits non-governmental organisations to give out naloxone without a prescription, whereas previously harm reduction actors had been forced to act outside of the legal framework to ensure that people likely to witness an overdose had access to naloxone.[29] Accordingly, harm reduction outreach teams delivering sterile injecting equipment now distribute naloxone widely

20 Naloxone is a medication capable of reversing the effects of opioid overdose.

to people likely to witness an overdose, as well as providing overdose training and education.[29] However, civil society organisations report concern that as an administrative order with no accompanying legislation, this programme is subject to political changes and could be abruptly ended by a change of policy or government.[29]

The lower prevalence of opioid use in the region is one of the reasons for the absence of naloxone programmes in other countries.[5,12,32,38,39,44] For non-injecting users, emergency departments handle overdose and prevention is based on abstinence.[11,39]

2.6
HIV AND ANTIRETROVIRAL THERAPY (ART)

In Latin America there are approximately 1.9 million people living with HIV. In 2018, there were an estimated 100,000 new HIV infections in the region.[75] From 2010 to 2018, there was a 16% reduction in all new HIV cases in the Caribbean. Over the same period, only one country saw a rise in new infections (Belize) and in two countries the reduction was more than 20% (Cuba and the Bahamas).[76]

HIV testing is available in all countries in the region.[11,12,37,39,44,77] There are public programmes that provide HIV prevention services in several countries, such as Argentina, Brazil, the Dominican Republic, Mexico and Peru. In several countries, ART is available but very limited for people currently using drugs. Studies in the region show that stigma and discrimination towards people living with HIV persist in combination with stigma based on sexual orientation, gender identity, drug use or sex work, and remain prevalent in many settings.[78] Discrimination against people living with HIV in the Caribbean is particularly high. Up to two thirds of people in Jamaica and Haiti, and more than half of people in Antigua and Barbuda, the Dominican Republic, Grenada, Haiti and Guyana report negative attitudes towards people living with HIV.[76,79–81]

In the Dominican Republic, ART is available at no cost to people who use drugs and, since 2019, the national HIV agency CONAVIHSIDA has pledged to increase access to HIV care for vulnerable populations including people experiencing homelessness and/or use drugs.[15] However, civil society organisations report that, in practice, people who use drugs have not been prioritised in the response while other key populations have, and that they continue to face stigma and discrimination, as well as considerable out-of-pocket expenses when accessing services.[15,82] Similarly, in Puerto Rico, access to HIV treatment is covered by the territory's state insurance programme, La Reforma,[83] but only 62.5% of all people living with HIV are on ART, and 88.2% of those are virally suppressed.[84] Civil society organisations report that access to testing and treatment is particularly difficult for people who use drugs, as it requires physical attendance at a clinic which may be far from their place of residence and at which they may experience stigma and discrimination.[29]

Since the beginning of the HIV epidemic, the focus on HIV prevention, treatment and care among people who use drugs has concentrated on the needs of people who inject drugs, and mainly on those who inject opioids. In Latin America, data shows that use of stimulant drugs has also been associated with higher risk of HIV transmission through unsafe sexual behaviours.[85,86] Community-based programmes are an effective action to reduce the barriers to diagnosis and treatment for key populations such as people who use drugs, transgender people and people experiencing homelessness. However, not many countries in the region have these programmes. For example, in Brazil, the Consultorios de Rua (part of the Brazilian health system) in Salvador de Bahía and Rio de Janeiro offer access to rapid HIV tests and other harm reduction services to people experiencing homelessness. However, these services have reduced under the administration of President Jair Bolsonaro.[87] Casa Trans in Buenos Aires, Argentina, has provided the same services for transgender people since 2017.[5,43,88]

Addressing HIV among people who use drugs, including peer-to-peer work, the provision of ART to those living with HIV and the implementation of new prevention tools such as pre-exposure prophylaxis (PrEP), is still a challenge in the region.[37,75,78]

Migration, drug use and harm reduction

Migration is a significant phenomenon in Latin America and the Caribbean. In 2017, 37 million people in the region lived outside their country of birth, accounting for close to 15% of the worldwide number of international migrants.[89] Research suggests that migrant people who inject drugs have unique experiences of drug use and face barriers to harm reduction practices and services not faced by those without a history of migration.[90]

For people who use drugs, migration disrupts social networks for drug acquisition and use, as well as exposing migrants to different cultural practices, including those related to drug use.[83] This can put people at greater risk of infectious disease transmission (because of changes to drug use practices) or overdose (because of a lack of familiarity with the local drug supply).[83] For example, research on the Guatemala-Mexico border has found that recent migration is associated with higher-risk drug use practices.[91,92]

Undocumented migrants face particular challenges,[90] including barriers to accessing health care, based both on formal policies and social effects such as stigma, discrimination and fear of deportation.[93] Periods of detention due to migration status, most notably in the United States prior to deportation, are associated with initiation to injected drug use among both those who used non-injected drugs previously and those who did not use drugs before migrating.[90] Deportation from the United States is therefore associated with higher-risk drug use practices either learned or initiated in detention,[94]and higher prevalence of HIV and hepatitis C.[95]

Importantly, disruption to social networks can also affect the health and vulnerabilities of deported migrants, particularly those who have spent long periods of time outside their country of birth. Evidence suggests people deported from the United States to Tijuana, Mexico, face problems with social integration and financial hardship, which are associated with a lower likelihood of accessing HIV testing and other health services.[90] This emphasises the importance of recognising that migration is not a one-way street. Many migrants, whether by choice or through deportation, may travel numerous times between countries, and this has implications for approaches to harm reduction, such as prescribing medication, continuity of health care and trends in drug use practices.[83]

2.7 HARM REDUCTION IN PRISONS

There were approximately 1.6 million people incarcerated in Latin America and the Caribbean in 2018.[96] Approximately 20% of these people were charged with drug offences, either drug possession for personal use or drug trafficking.[97–99] Costa Rica, Chile and Ecuador have the highest rates of imprisoned people for drug offences in Latin America and the Caribbean.[100] Cannabis is the drug for which the most people are brought into contact with the criminal justice system in the world, but cocaine-related offences are particularly prevalent across the region (about 40% of cases).[99]

Punitive drug laws contribute to overcrowding in Latin American and Caribbean prisons.[97,101] The number of women incarcerated for drug offences has increased, and women are more likely than men in the region to be convicted of non-violent drug offences.[102] In Argentina, Brazil and Costa Rica, more than 60% of the female prison population is held for drug offences.[103] In the most extreme example, Brazil's female prison population increased by 342% between 2000 and 2016.[104] In Latin America, most women are arrested for first-time, non-violent, low-level but high-risk drug-related activities, such as small-scale drug selling or transporting drugs, or for simple drug use. They often engage in criminalised drug activities because of poverty, lack of opportunities and/or coercion. Most have suffered some form of sexual violence before and/or during their incarceration. Their incarceration can have severe and long-lasting consequences not only for themselves, but also for their families and communities.[104]

Prison populations are more vulnerable to infections such as HIV, hepatitis C and TB.[105] Prevalence rates are higher in prison populations compared with the general population, with higher risks of amplification and spread of infectious diseases within and beyond prisons.[106] Data on blood-borne diseases in prisons in the region is largely unavailable, though one study estimated that HIV prevalence in the Cuban prison system was 26%, more than 100 times higher than prevalence in the general population (0.2%).[107] The risk is even higher for incarcerated people who use drugs.[100] Condom distribution, HIV testing and ART are available in prisons in several countries in the region. Argentina, Paraguay, Peru and Uruguay have both viral hepatitis and TB programmes in prisons.[21,37–39,44,77] Since 2018, hepatitis C testing services have been introduced in prisons in Northern Mexico.[21] However, coverage is still insufficient across Latin

America and the Caribbean. HIV testing, ART and TB testing and treatment are available in Argentinian, Colombian, Mexican and Peruvian prisons. Specialised mental health services in Brazilian prisons closed and hepatitis C services were reduced in 2019 due to the withdrawal of government support.[43] In Paraguay, civil society organisation Enfoque Territorial implemented a pilot harm reduction programme in Asunción's prison, but it closed due to lack of funding.[38]

As reported in 2018, harm reduction services for people who use drugs are absent in prison settings across Latin America and the Caribbean. None of the countries where NSPs and/or OAT are available to the general population offer NSP or OAT in prisons.[11,15,21,29]

Drug court models have operated in the region since 2012, theoretically providing alternatives to incarceration and redirecting people charged with low-level drug offences to health services rather than prisons.[108] However, drug courts in Latin America exclusively provide abstinence-based treatment, limiting the harm reduction potential of these kind of programmes.[5,108] In Chile, Costa Rica, Puerto Rico and Mexico, the model is more established and is in a pilot phase in Argentina, Colombia, the Dominican Republic and Panama.[98] Ecuador and Peru are also considering the implementation of drug court programmes. Chile, Colombia and Mexico also have juvenile drug courts and other countries in the region have plans for their creation.

3. Policy developments for harm reduction

Drug policy development in Latin America is not homogeneous. Since the last *Global State of Harm Reduction* report in 2018, the differences have deepened. While drug policies in Brazil, Bolivia and Ecuador have become more punitive, Colombia is discussing cannabis and cocaine regulation.[11] Uruguay extended services and practices in favour of harm reduction and approved a new mental health law that includes a human rights perspective in drug treatment.[11,37,44,109] In Bolivia, the government has allowed farmers to grow a sufficient amount of coca for subsistence purposes since 2008, facilitating access to a national legal market for coca products, as well as improving access to safe water, education and other sources of income. A new unelected government has reduced these policies and imposed harsh drug control policies involving law enforcement and militarisation.[36,104]

New governments in Brazil, Bolivia, Colombia and Ecuador implemented drug strategies that explicitly reject the harm reduction approach.[36,37,109] The penalties for drug-related crimes, both possession and trafficking, have increased in Brazil and Ecuador. In 2018, the Technical Secretariat for Drugs in Ecuador was eliminated and its functions were divided between the Ministry of Security and the Ministry of Health. Recently, the Ecuadorian legislature approved a new law that penalises drug use in public spaces and gives more powers to the police force in drug-related offences.[110] In Brazil, changes in the Mental Health Law explicitly exclude harm reduction approaches and exclusively focus on abstinence-based treatment and government financial support to therapeutic communities. At a local level, several harm reduction services for people who use cocaine (primarily crack cocaine) in São Paulo closed and those in Salvador and Pernambuco reduced coverage due to decreased financial support.[43]

Of the 17 countries in the Caribbean region, Harm Reduction International has identified nine national drug policy plans and ten national HIV plans. Of the drug plans, only two contain any positive reference to harm reduction (the Bahamas[111] and the Dominican Republic[112]), though in both cases this has not been accompanied by practical application of government-supported harm reduction programmes. A further four drug policy plans contain references to the need to address HIV and the health of people who use drugs (Barbados,[113] Grenada,[114] Jamaica[115] and Suriname[116]), and three contain no reference to the health of people who use drugs (Antigua and Barbuda,[117] Guyana[118] and Trinidad and Tobago[119]). Among the HIV plans, eight refer to people who use drugs as a key population[21] but two contain no reference to people who use drugs (Grenada[128] and Saint Vincent and the Grenadines[129]).

The Caribbean has been a leading region in cannabis law reform, with several countries decriminalising cannabis for personal use including, since 2018, Antigua and Barbuda.[130] However, criminalisation remains in force in much of the region, and in the entire region for all drugs except cannabis. Some governments remain strongly opposed to any reform, for example the Cuban government has criticised other Caribbean governments for decriminalising or legalising cannabis,[131] and a report commissioned by the

21 These are: Antigua and Barbuda,[120] Belize,[121] Cuba,[122] the Dominican Republic,[13,123] Guyana,[124] Jamaica,[125] Saint Lucia[126] and Trinidad and Tobago[127].

government of the Bahamas recently failed to recommend any drug law reform.[132] Indeed, a recent government report in the Bahamas stated that increasing stigma towards people who use cannabis and alcohol to the levels experienced by people who use cocaine may be beneficial.[133]

Latin American drug control policies are still based on the general principles of eliminating the production, trade or use of any illegal psychoactive substance. The "war against drugs" in Latin America has not reduced drug trafficking, but it has led to more violence and human rights violations.[36,67,104]

Decree 1844 and civil society action in Colombia

Civil society advocacy in Colombia has had success in fighting back against President Iván Duque's increasingly punitive approach to drug policy.[73]

In 2018, Duque introduced Presidential Decree 1844, giving law enforcement officials additional powers to search and fine those in possession of small amounts of drugs. This is despite the fact that constitutional rulings in Colombia have decriminalised the possession of small amounts of cocaine and marijuana (known as the 'dosis minima') since the 1990s.[134]

Temblores, a civil society organisation, took the case to the constitutional court, highlighting disproportionate enforcement of the decree among racial and ethnic minorities and the targeting of people experiencing homelessness. In 2019, the court ruled the enforcement of the decree to be unconstitutional.[135–137]

Temblores, along with the José Alvear Lawyers Collective and member of the House of Representatives Katherina Miranda, then took the case to the Council of State, Colombia's supreme tribunal on administrative matters. On 19th July 2020, the Council of State officially nullified the effects of Decree 1844, preventing law enforcement from fining or arresting people in possession of drugs for personal use.[135–137]

4. Funding developments for harm reduction

As international donors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) withdraw from the region, the regional trend has been an increase in the proportion of harm reduction funding provided by national governments. However, domestic funding consistently falls short of what international donors have previously provided, leaving services without a sustainable source of finance and unable to provide continuous services to vulnerable populations.[5,11,21,43] Additionally, the transition to domestic funding applies primarily to services for people who inject drugs, and there remain few funding opportunities for services for the majority of people who use drugs in the region who do not inject.[87] Where the Global Fund continues to finance harm reduction, no country has community representation in their Country Coordinating Mechanism.[87]

In the Caribbean, the implementation of harm reduction is limited by a lack of funding as well as the absence of political will. No civil society organisations providing harm reduction interventions receive any state support for those services.[15,29] The withdrawal of the Global Fund from many low and middle income countries in the region has drastically affected the financial landscape for harm reduction.[138]

Barriers to accessing national public funding for harm reduction organisations increased during the period in each country due to the socio-economic crisis in the region and the regression towards more punitive drug policies. There is a clear, urgent and demonstrated need for declarations of political support for Latin American harm reduction programmes to be accompanied by financial support.

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2.4 MIDDLE EAST & NORTH AFRICA

ALGERIA
BAHRAIN
EGYPT
IRAN
IRAQ
ISRAEL
JORDAN
KUWAIT
LEBANON
LIBYA
MOROCCO
OMAN
PALESTINE
QATAR
SAUDI ARABIA
SYRIA
TUNISIA
UNITED ARAB EMIRATES
YEMEN

TABLE 2.4.1:

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[1]	OAT[2]	Peer distribution of naloxone	DCRs[3]
Algeria	nk	1.1	nk	nk	✓	x	x	x
Bahrain	nk	4.6	nk	nk	x	x	x	x
Egypt	nk	2.6	51.8	nk	✓	x	x	x
Iran	22,000	14	52	4.4	✓	✓	x	x
Iraq	nk	nk	nk	nk	x	x	x	x
Israel	nk	nk	nk	nk	✓	✓	x	x
Jordan	nk	nk	nk	nk	x	x	x	x
Kuwait	nk	nk	12.3	0.4	x	x	x	x
Lebanon	nk	0.0	23.4	1.2	✓	✓	x	x
Libya	2,000	89.6	94.2	nk	x	x	x	x
Morocco	3,000	9.6	46.2	nk	✓	✓	x	x
Oman	nk	11.8	48.1	nk	x	x	x	x
Palestine	nk	0.0	41.4	nk	x	✓	x	x
Qatar	nk	nk	69	nk	x	x	x	x
Saudi Arabia	nk	9.8	nk	nk	x	x	x	x
Syria	nk	0.0	40.8	nk	x	x	x	x
Tunisia	nk	3.5	21.7	nk	✓	x	x	x
United Arab Emirates	nk	nk	nk	nk	x	x	x	x
Yemen	nk	nk	nk	nk	x	x	x	x

nk = not known

1 All operational needle and syringe programme (NSP) sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers.
2 Opioid agonist therapy (OAT), including methadone (M), buprenorphine (B) and any other form (O) such as morphine and codeine.
3 Drug consumption rooms, also known as supervised injecting sites.

MAP 2.4.1:
Availability of harm reduction services

- Both NSP and OAT available
- OAT only
- NSP only
- Neither available
- Not known
- DCR available
- ⊗ Peer-distribution of naloxone

2.4
Harm reduction in the Middle East and North Africa

7
NEEDLE AND SYRINGE PROGRAMMES

5
OPIOID AGONIST THERAPY

0
DRUG CONSUMPTION ROOMS

0
PEER DISTRIBUTION OF NALOXONE

AN ESTIMATED

200,000

PEOPLE

WHO INJECT DRUGS LIVE WITH **CHRONIC HEPATITIS C** IN THE MENA REGION

HIV

ALTHOUGH THE MENA REGION IS ESTIMATED TO HAVE ONE OF THE LOWEST HIV PREVALENCE RATES IN THE WORLD (<0.1%), HIV/AIDS-RELATED DEATHS REMAIN HIGH.

<0.1%

HIV PREVALENCE RATES

8000

2020

AIDS-RELATED DEATHS

The COVID-19 pandemic has affected implementation of harm reduction programmes. The pandemic has drastically impacted the quality and delivery of harm reduction services, and stakeholders are struggling to ensure sustainable services during this period.

1. Overview

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Despite the well documented health and social impacts of substance use in general and injecting drug use specifically, harm reduction interventions remain very limited in the Middle East and North Africa (MENA) region. Only six countries implement needle and syringe programmes (NSPs) - Algeria, Egypt, Iran, Lebanon, Morocco, and Tunisia - and four provide opioid agonist therapy (OAT) services as part of harm reduction - Iran, Lebanon, Morocco and Palestine.[3–17] Even in countries where NSPs and OAT are provided, accessibility and coverage remain a challenge, due to lack of funding, legal issues, stigma and discrimination, criminalisation of drug use, lack of political commitment. Overdose response is minimal and limited to only two countries - Lebanon and Morocco.[4,18–20] No drug consumption rooms (DCRs) are currently available in the region nor programmes specific to the use of amphetamine-type stimulants (ATS).

People who inject drugs are identified as a vulnerable group to HIV and hepatitis C infection and remain underserved by social and health interventions.[21,22] Although the MENA region is estimated to have one of the lowest HIV prevalence rates in the world (<0.1%), HIV/AIDS-related deaths remain high (8000 in 2020) and only 38% of people living with HIV have access to antiretroviral therapy (ART).[23] When it comes to hepatitis C, estimates state that the MENA region has the highest prevalence of hepatitis C infection globally, with around 20% of the people living with hepatitis C infections residing in the MENA region.[2] In addition, in 2020, it was estimated that there are more than 200,000 people who inject drugs living with chronic hepatitis C with one third of these localised in Iran.[2]

Civil society organisations, with minimal input from governments, lead implementation of harm reduction programmes in the region, with the exception of Iran.[4–6,24,25] These organisations are mainly reliant on international funding and in the past few years have suffered from multiple budget cuts and termination of many programmes (for instance, all NSPs have been progressively closed in Palestine and Jordan since 2016).[8,9,16,26]

The past two years have seen a major expansion in harm reduction programmes in prisons in Egypt, Morocco and Tunisia, with the support of the United Nations Office on Drugs and Crime (UNODC) in an effort to tackle the high morbidity and mortality of HIV and limit its impact in closed settings.[13,27,28] ART is widely available to any person testing positive, however many barriers for HIV testing still exist and civil society organisations providing HIV services to people who inject drugs have also been affected by budget cuts which have led to significant decreases in services.[3,4,7,8,15,29,30] The MENA region is considered to have low or intermediate incidence of tuberculosis (TB), and TB services have been mainstreamed into public health services with acceptable accessibility and coverage.[31,32]

Multiple governments (Algeria, Iran, Lebanon, Palestine, and Morocco) have adopted new policies, leaning towards a less punitive approach to drug use, however it is still criminalised in many countries in the region.[3–7,9,33,34]

Many countries in the region have been scaling up their HIV and hepatitis C response, however the impact is still insufficient and challenged by multiple barriers. The COVID-19 pandemic has affected implementation of harm reduction programmes. The pandemic has drastically impacted the quality and delivery of harm reduction services, and stakeholders are struggling to ensure sustainable services during this period.

2. Developments in harm reduction implementation

2.1 NEEDLE AND SYRINGE PROGRAMMES (NSPs)

NSPs have been implemented in the region for the past twenty years. However, in the past couple of years many countries have ceased or decreased the number of sites delivering NSPs due to multiple challenges, mainly financial difficulties.

Algeria, Egypt and Morocco are the only countries reporting some improvements in the last two years. Reporting systems, advocacy, leadership, coverage of NSPs and acceptability were highlighted and improved.[3,4,24,30] No changes occurred with NSPs in the same period in Iran and Tunisia.[5,6,17,34] Lebanon reported a decrease in service delivery due to limited funding and resources;[7] in Palestine and Jordan NSP services stopped completely due to limited funding and lack of political commitment.[8,9] Only one civil society organisation, Soins Infirmiers et Développement Communautaires (SIDC), is currently providing an NSP in Lebanon through clinic and outreach work.[7] NSPs are still not available in Bahrain, Qatar, Syria and Yemen due to political and legal barriers.[11–13,25,35] People who inject drugs in most of these countries struggle to access sterile injecting equipment. In Bahrain, for instance, pharmacies refuse to sell sterile syringes to people who inject drugs and their only access to syringes is through hospital waste or through buying unsterile syringes from diabetic patients.[11]

The number of syringes distributed per year per person who inject drugs remains far below 300, which is the World Health Organization (WHO) target for the elimination of hepatitis C. Morocco and Iran report coverage to be less than 100 syringes per person per year, and represent the highest coverage in the region.[4,10,36] In Morocco, barriers to NSPs include the distribution of injecting equipment unsuited to the needs of older people who require different syringe sizes than the ones distributed; self-stigma of people who refuse to identify themselves as people who inject drugs; and the preference of users to alternate between injecting and sniffing which results in major variations in the total number of syringes distributed on a period of time.[4] Regional barriers to accessibility and coverage of NSPs are common across all countries. Structural challenges include legal barriers, criminalisation of drug use and possession, a lack of political commitment and a lack of social acceptability. Operational challenges include a lack of funding opportunities; limited capacities of service providers (mainly civil society organisations); a lack of unified reporting systems resulting in inconsistencies in reporting (e.g. duplications); and difficulties in issuing grants or contracts to the civil society organisations for the delivery of NSP services.[10,11,13,14,34]

2.2 OPIOID AGONIST THERAPY (OAT)

OAT as a harm reduction intervention is provided in Iran (using methadone, buprenorphine and tincture of opium), Lebanon (buprenorphine and buprenorphine-naloxone), Morocco (methadone), and Palestine (methadone and buprenorphine).[4–7,9,14–17,29] The Ministry of Health in Syria and civil society organisations in Yemen reported the availability of OAT only in detoxification units.[12,25]

A major development in the region is the development of a pilot OAT programme in Egypt. In 2019, the UNODC and WHO worked with the General Directorate of Mental Health and Addiction and National AIDS Programme of Egypt to review and update the OAT feasibility study conducted by UNODC in 2014, with the possibility of beginning a pilot programme.[10,13]

Other developments in the past two years have been seen in Iran, Lebanon and Morocco. Since 2018, Lebanon has been scaling up OAT services with two dispensing units (to provide buprenorphine or buprenorphine-naloxone) opened in Bekaa and Mount Lebanon, and two additional centres for multidisciplinary follow-up and prescriptions (Bekaa and Kesrouan areas) are also offering OAT. Fifty-eight psychiatrists are currently licensed to provide OAT in Lebanon, with three psychiatrists receiving their licence in the past two years. Psychiatrists have received authorisation to provide buprenorphine and buprenorphine-naloxone, which was introduced in addition to buprenorphine to limit injection practice among patients.[14] According to the Lebanese Ministry of Public Health, eligible patients for OAT need to be seen and diagnosed with opioid use disorder by an authorised psychiatrist and followed by a multidisciplinary team including the psychiatrist, a psychotherapist, a registered nurse and a social worker. Patients are also required to follow up weekly and have a regular negative urine test to be able to receive their medications, that they pay for out-of-pocket,[14,29] from

a dispensing unit in a government hospital. The current procedures (regular follow-up, urine tests, prescriptions) are an extremely high financial cost to patients. Civil society organisations are requesting that the Ministry of Public Health revise the frequency of these procedures and their relative cost.[7,14]

Three new OAT centres were opened in Morocco in an effort to improve coverage, geographical distribution of services and long waiting lists.[4] However, many cities in Morocco remain underserved. People who inject drugs are often forced to travel long distances to reach OAT services and in some instances they even relocate to be close to service centres.[4] The main challenges faced in Morocco with regards to OAT are long waiting lists and lack of qualified and trained staff (e.g. to prescribe and follow up) which hinders the quality of service offered.[4]

In Iran, where already close to one million people are receiving various OAT modalities,[17] the number of people on OAT has slightly increased since 2018. The government of Iran established an integrated national database for registration of all OAT patients which has improved monitoring of clinics and limited duplication of cases.[5] Insurance coverage for OAT was expanded. Initially, it was only available through government centres which offer a small proportion of OAT in Iran. From 2020, the Ministry of Health increased insurance coverage to selected private sector clinics where patients usually pay out-of-pocket.[6] The current barriers and challenges faced by OAT in Iran are mandatory registration, fear of breach of confidentiality, stigma and discrimination, daily dispensing of methadone in first months, limited accessibility in rural areas, and a lack of gender-specific services.[5,6]

Palestine is still offering OAT with methadone with minimal follow up and counselling.[9] Buprenorphine was recently introduced as an alternative.[16] Algeria, Bahrain and Jordan have not yet introduced OAT mainly due to legal barriers, technical barriers related to methadone import and storage and lack of resources.[3,4,8,10–13,30]

Only six countries implement needle and syringe programmes (NSPs) - Algeria, Egypt, Iran, Lebanon, Morocco, and Tunisia - and four provide opioid agonist therapy (OAT) services as part of harm reduction - Iran, Lebanon, Morocco and Palestine.

2.3 AMPHETAMINE-TYPE STIMULANTS (ATS) AND NEW PSYCHOACTIVE SUBSTANCES (NPS)

Amphetamine-type stimulants are the second most common type of illegal substances used globally and usually vary according to different regions and contexts. According to the World Drug Report 2019, the most used types of ATS in the MENA region were methamphetamine (crystal and tablet form), MDMA, stimulant NPS,[4] and cocaine.[38] The estimated last year prevalence of cocaine use among adults in the region was around 70,000 accounting for 0.02% of the population. Estimates of amphetamine and ecstasy use are not available.[38] Harm reduction services for ATS and NPS are still lacking. Civil society actors across the region reported that established harm reduction services are not tailored to the needs of people who use stimulants and NPS.[3,4,6,12,14,15,17,34]

Most of the global amphetamine trafficking remains concentrated in the MENA region with 51% of the global seizures happening in this region.[38] Most of the seized fenethylline (an amphetamine commonly known by the brand name Captagon) was produced in Lebanon and Syria.[39] In fact, since 2011, the unstable situation in Syria seems to have impacted the illicit drug trade; amphetamine production and trading have economically fuelled the war in Syria with huge economic gains.[40]

4 Stimulant NPS are drugs with similar effects to amphetamine, cocaine, and MDMA, which result in increased alertness, energy, confidence, and sociability, and suppression of appetite and fatigue (e.g. mephedrone, methylone, α-PVP)[37].

2.4
OVERDOSE, OVERDOSE RESPONSE AND DRUG CONSUMPTION ROOMS (DCRs)

Drug consumption rooms are still not available in the region due to legal, cultural and structural barriers. Drug use is still criminalised in most of the MENA countries and people who inject drugs often face high levels of stigma and discrimination. Public acceptance and funding challenges are also among the cited barriers for the implementation of DCRs.[3–14,16,17,25]

In the MENA region, naloxone is available in medical, emergency or treatment settings only and not in a take-home form, except in Iran where naloxone programmes are available and operational all over the country and take-home naloxone is easily available however not many people make use of the programme.[3–6,16,17,26]

When it comes to overdose, only two countries have seen developments since 2018: Morocco and Lebanon. Morocco conducted international consultations in their efforts to develop a National Overdose Framework.[4] Overdose prevention materials were also prepared and service providers were trained on overdose prevention and emergency interventions in 2019.[15] Lebanon highlighted the need to develop an overdose prevention framework in its Inter-Ministerial Substance Use Response Strategy 2016-2021.[18] Advocacy efforts by civil society organisations in Lebanon continued into 2020. An assessment conducted in 2018 by Skoun, a Lebanese civil society organisation, found that more than 60% of hospitals reported overdose cases to the police despite a statement issued by the Ministry of Public Health asking healthcare facilities not to report these types of cases.[19] Following the results of this assessment and consistent lobbying, the Ministry of Public Health issued a second statement in 2019 to reinforce the first statement and push hospitals and health professionals to refrain from reporting overdose cases. Consequently the Ministry of Interior Affairs also issued a statement asking law enforcement officers not to intervene in cases of overdose.[20] Small scale educational overdose programmes prepared by civil society organisations are also available in Lebanon but with minimal coverage.[7]

Reporting overdose cases to law enforcement was also mentioned as a main barrier to health seeking in Bahrain, where people who inject drugs or their friends would not seek emergency care because of fear of imprisonment.[11]

2.5
HIV AND ANTIRETROVIRAL THERAPY (ART)

In 2020, UNAIDS estimated that 240,000 persons are living with HIV in the MENA region, however, only 130,000 know their status.[23] Only 38% of people living with HIV are receiving ART and around 8000 individuals died of an AIDS-related disease in 2018.[23] Few countries have effective HIV surveillance systems and data is lacking in many of them. In 2018, the HIV prevalence among people who inject drugs was highest in Iran (9.3%), Morocco (7.1%) and Tunisia (6%), and lowest in Kuwait, Lebanon, Oman and Syria (around or below 1%).[23] Although all countries except Bahrain reported availability of HIV testing (including for people who use drugs), the number of persons not knowing their status remains high.[3–17,24,25,30,34,35] In addition, HIV prevention programmes are not usually tailored for people who use drugs, therefore coverage and accessibility to HIV testing for this population remains low.[10,17] Iran and Lebanon reported occasional shortages in rapid testing kits at civil society organisations targeting people who use drugs. In Bahrain, voluntary counselling and testing is not available, and testing (without counselling) is mandatory for people entering prisons or addiction treatment centres.[11] The main barriers for HIV testing among people who use drugs are related to the costs of testing including travel, missed work days, and programmes not geographically reaching people who use drugs.[4,9,10,12,15,17,34]

Antiretroviral therapy is still widely available and free of charge for anybody testing positive for HIV, including people who inject drugs across the region. However, data on numbers of people who inject drugs receiving ART remains scarce.[3,10,30,41] The main issues for non-adherence to ART for people who use drugs are stigmatisation and recurrent substance use relapse which results in missed doses and appointments, and in some countries ineligibility for ART.[7,15,17] Morocco was the only country in which civil society reported the integration of ART within OAT services. Once they test positive, people who use drugs receive priority to be included in the OAT programme before starting ART, in order to improve adherence. During the treatment, patients can receive multiple support interventions ranging from medical follow-up, transportation costs and individual accompaniment, if needed.[4]

2.6
HARM REDUCTION IN PRISONS

The availability of harm reduction services in prisons varies across countries, despite the fact that people who use drugs make up approximately one third of all people in prison in the MENA region.[27] The negative impact of the prison environment on morbidity and mortality of HIV is well evidenced, however the regional harm reduction response in prisons remains weak and fragmented.[27] Most of the MENA countries still criminalise drug possession and authorities are focusing on drug control and prohibition instead of the health and wellbeing of people in prisons.[28]

Even though some countries in the MENA region implement NSPs in the community, none provide NSPs in prisons. People who are on OAT prior to incarceration in Jordan, Lebanon, and Morocco can continue their treatment when in prisons. In Iran, OAT programmes in prisons are large and comprehensive, and methadone can be initiated inside the prison setting.[4,6,7]

In Egypt, UNODC launched the "Prison HIV Project" in collaboration with the Ministry of Interior in 2019. The project includes the expansion of the UNODC Prison Health Programme from three prisons to seven including, for the first time, a women's prison. The services included are voluntary counselling and testing; hepatitis B and C and TB prevention and treatment; and sexual and reproductive health services.[13] This project is also implemented in Morocco and Tunisia and addresses the gender gap and limited services delivered to women in prisons (see box, p.124). Since 2018, Morocco has also established OAT units in five prisons that are under this project. However, methadone is only available for people who had initiated OAT prior to being incarcerated.[4,15] All other interventions are available for everyone in all prisons in Morocco even if they were not initiated before incarceration (treatment of HIV, sexually transmitted infections and TB).[4,13] In addition to the methadone treatment programme in prisons for men and women, Iran provides HIV testing, ART, hepatitis C and TB services.[6] Other countries such as Algeria, Bahrain, Jordan, Lebanon, Syria and Yemen offer HIV and viral hepatitis testing and treatment inside prisons with variable coverage and accessibility.[3,7,8,11,12,25,29] For instance, in Bahrain, HIV and hepatitis C testing are mandatory upon incarceration, however no counselling is provided. Hepatitis C treatment is not available to people in prison in Bahrain, however ART is provided.[11]

3. Policy developments for harm reduction

Historically, countries in the MENA region have adopted conservative and punitive drug policies. Drug use and drug possession are criminalised in all of the countries in the region.[42] However, there have been policy developments in some countries towards a less punitive approach to drug use. A new Palestinian law was passed reframing drug use as a health issue rather than a criminal justice issue.[9] The same message was highlighted in the Inter-Ministerial Substance Use Response Strategy for Lebanon (2016-2021) and all five ministries launching this strategy agreed on including harm reduction as an essential theme under the services to be ensured within implementation.[18] In addition, a group of civil society organisations in Lebanon presented an amendment of the substance use law to the Lebanese parliament in an effort to reorient the national policy into a more humanitarian and public health approach.[7,14] In Algeria, the government issued the new National Strategic Plan for drug use (2020-2024) and included new harm reduction actions with people who inject drugs.[3] In 2017, the Iranian Parliament approved the addition of an amendment to the Drug Control Law for the purpose of converting the death penalty to imprisonment for some drug-related crimes.[5] Civil society in Morocco is advocating for changes of punitive laws regarding drug use.[4]

However, multiple discriminatory laws exist in the region and often hinder people who use drugs from accessing services. These discriminatory laws include compulsory parental consent for people under 18 who are accessing services, and other laws limiting people in the area of employment via criminal background checks.[3,7,9,30] In Iran, the police usually refer people who use drugs and experiencing homelessness to compulsory residential treatment facilities which contributes to further marginalisation of people who use drugs.[6] In Jordan, people who use heroin receive mandatory HIV testing, and drug tests are also conducted prior to being offered employment in the public sector.[8]

Iran and Lebanon reported using technology in the surveillance of the OAT service provision at the Ministry of Public Health (Iranian Drug Abuse Treatment Information System and OST Information System), with the aim of monitoring the OAT programmes and avoiding duplications.[6,14]

HIV, viral hepatitis and TB in prisons: From advocacy to policy reform and implementation[13]

In 2016 UNODC initiated HIV, viral hepatitis and TB prevention, treatment, voluntary confidential counselling and testing services, and sexual and reproductive health (SRH) projects in prison settings in three countries (Egypt, Morocco, and Tunisia).

Since 2018, UNODC has trained 470 professionals including 365 men and 105 women from the General Directorate of Prisons, Ministries of Health, and civil society organisations in Egypt, Morocco and Tunisia with 21 rounds of workshops. The participants included medical officers, nurses, social workers, and civil society organisation outreach teams working both at the community level and in closed settings. The workshops were facilitated by expert consultants and UNODC Global Prison and HIV Coordinators and covered a variety of subjects including:

- HIV testing and counselling;
- Delivering HIV prevention services to people who inject drugs, and people who use stimulants and a r e living in closed settings;
- Viral hepatitis among people who use drugs and living in closed settings;
- Tuberculosis;
- The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules);
- The United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (The Bangkok Rules);
- Occupational safety and health procedures related to HIV;
- Women's health in prisons.

During this period, almost 3,336 people in prison (male and female) received individual and group counselling sessions on safe injecting practices, HIV, hepatitis B and C, adverse consequences of drug use, symptoms of sexually transmitted infections, safe sex and condom use, HIV testing, TB and personal hygiene.

UNODC-trained medical professionals delivered HIV and viral hepatitis voluntary counselling and testing services to 15,000 people in prison, and 24,000 people in prison were screened for tuberculosis. A total of 800 male and female prison staff were vaccinated against hepatitis B.

EGYPT: Through established voluntary counselling and treatment centres, the project is covering 27,000 people in prison (male and female) at Fayoum, Wadi Al-Natroon, Borg Al-Arab, Gamasa, Merg, Minia, and Qanater regions.

MOROCCO: All prisoners have access to HIV testing and counselling services including 21,000 people in prison (male and female) in five major prisons of Morocco namely Oukacha, Tangier, Tetouan, Salé, and Nador, implemented through civil society organisations.

TUNISIA: Around 10,000 people in prison (male and female) and juvenile detainees in Mornaguia, Borj El Amri, La Manouba, Le Kef El Mourouj, and El Mghira centres are covered under this project with comprehensive HIV prevention, treatment, and care services. Civil society organisations will also work in partnership to provide training activities on prevention of HIV, sexually transmitted infections, TB and substance use to prison officers and inmates (Mornaguia, Borj El Amri, La Manouba and Le Kef) as well as in two juvenile rehabilitation centres (El Mourouj and El Mghira centres).

As a result of UNODC advocacy in the region, the provision of HIV prevention, treatment and care for people who use drugs and living in closed settings was added to the national HIV strategies of Egypt, Morocco, and Tunisia.

The UNODC Prison Health Project covers 7,000 females in prison in Egypt, 2,000 in Morocco and around 400 in Tunisia.

During the COVID-19 pandemic, UNODC organised virtual training for prison staff and contributed to the procurement of personal protective equipment for prisons and prison health staff in Egypt, Morocco and Tunisia. UNODC also worked on developing and translating education materials on COVID-19 and prevention methods for persons who use drugs and persons living in closed settings. The material is currently available in English, French and Arabic and distribution started in Algeria, Morocco, Egypt, Morocco, and Tunisia.

4. Funding developments for harm reduction

One of the main challenges faced by countries in the MENA region with regards to harm reduction is funding. Almost all countries, except Morocco, reported decreased funding since 2018. The main international donors reported by stakeholders supporting harm reduction are the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), and the Drosos Foundation. Funding is also channelled via the Middle East and North Africa Harm Reduction Association, UNODC, the UN Development Programme and UNAIDS.[3,4,6–10,24,25,29,30] Unfortunately, these funding sources have decreased their support in most countries.

In Yemen, the Global Fund had secured a budget to support harm reduction activities for 2016-2022, however this budget was reallocated for emergency support due to the unstable situation and conflicts in the country.[25] Similarly in Palestine, the Global Fund and UNODC have reshuffled their funding towards refugees and humanitarian aid. As a result, harm reduction interventions were cancelled except for OAT, which is funded by the Korea International Cooperation Agency.[9] Since 2018, the Drosos Foundation stopped funding harm reduction in Tunisia and the Global Fund stopped its harm reduction and HIV funding in Iran. However, advocacy efforts were quite successful in Iran, resulting in the inclusion of treatment interventions (including opioid agonist maintenance treatments with methadone, buprenorphine and opium tincture) in the health insurance package.[5,6,17] Government funding in Iran has increased since 2018, however the increase has not been proportionate to the inflation occurring in the country.[17] No funds are available in Bahrain due to major legal barriers which results in the near total absence of harm reduction services.[11]

In Algeria, the Ministry of Health has not secured a budget for harm reduction, however health services are offered for free in the public facilities for everyone including people who use drugs. The Global Fund is supporting civil society organisations to deliver integrated services for HIV and people who use drugs. The budget allocated for the year 2018-2019 was USD 430,000 and currently amounts to USD 114,000 for 2020-2022. It will be extremely difficult for civil society organisations to continue providing these services after 2022 as international funding is decreasing and domestic funding is not available.[3,33]

The case is the same in Lebanon, where multiple international donors have decreased or stopped their funding since 2018 and domestic funding is not available. The National Lebanese Drug Observatory fund was also stopped in 2019.[14,29]

In Morocco, funding is more sustainable. International donors are supporting civil society organisations working on harm reduction along with national funding mainly from the Mohammed V Foundation for Solidarity. This local foundation supported the construction of most addiction treatment centres along with their human resources, equipment, ART and TB treatment and others. No budget cuts are reported for the coming years.[4,15]
Competing priorities for government budgets have resulted in the deprioritisation of harm reduction as a crucial part of health services.

> *One of the main challenges faced by countries in the MENA region with regards to harm reduction is funding. Almost all countries reported decreased funding since 2018.*

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2.5 NORTH AMERICA

CANADA
UNITED STATES

TABLE 2.5.1:

Epidemiology of HIV and viral hepatitis, and harm reduction responses in North 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			
					NSP[1]	OAT[2]	Peer distribution of naloxone	DCRs[3]
Canada	130,000[1]	14.6[2]	70.6[3]	nk[3]	✓[4]	✓(M,B,BN,H,O)	✓	✓40[4]
United States	2,248,500[3]	8.7[3]	53.1[3]	4.8[3]	✓>418[5][5]	✓[6](M,B,TN)	✓	x

nk = not known

1 All operational needle and syringe programme (NSP) sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers.
2 Opioid agonist therapy (OAT), including methadone (M), buprenorphine (B) and any other form (O) such as morphine and codeine.
3 Drug consumption rooms, also known as supervised injecting sites.
4 No estimate is available for the total number of NSPs in Canada.
5 This is the number of NSPs registered with the North American Syringe Exchange Network and is therefore a minimum figure for the number of NSPs operating in the United States. These services operate in 44 of the 50 states.
6 OAT is available in every state.

MAP 2.5.1:
Availability of harm reduction services

2.5
Harm reduction in North America

GLOBAL POPULATION OF PEOPLE WHO INJECT DRUGS

16%

NORTH AMERICA IS HOME TO 16% OF THE GLOBAL POPULATION OF PEOPLE WHO INJECT DRUGS.

OVERDOSE, OVERDOSE RESPONSE AND DRUG CONSUMPTION ROOMS (DCRS)

FROM 1999 TO 2018, THERE WERE

769,935

DRUG OVERDOSE DEATHS

RECORDED IN THE UNITED STATES.

IN 2018, THERE WERE

67,367

OVERDOSE DEATHS,

70% OF WHICH INVOLVED AN OPIOID, MOST COMMONLY ILLICITLY MANUFACTURED FENTANYL OR ITS ANALOGUES.

DRUG CONSUMPTION ROOMS (DCRs)

40 OUT OF 130 DCRs IN THE WORLD ARE IN CANADA

> *People of colour, and most acutely Black people, are discriminated against at every stage of the judicial process in the United States: policing, pre-trial, sentencing, parole and post-incarceration.*

1. Overview

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North America is home to 16% of the global population of people who inject drugs.[6] Canada is among the most progressive countries in the world with regard to the implementation of harm reduction, though there remain significant issues in accessibility and service provision. The United States lags considerably behind Canada and other high-income countries in the implementation of almost all harm reduction services.

Needle and syringe programmes (NSPs)[7] and opioid agonist therapy (OAT) programmes[8] are in operation in both Canada and the United States. Since 2018, more jurisdictions have enabled access to NSPs. Methadone and buprenorphine are the most widely used medications for OAT across North America, and are the only medications available in the United States. In Canada, recent changes have led to the availability of heroin-assisted therapy (HAT) in the form of diacetylmorphine and hydromorphone in at least three provinces.

North America continues to experience a crisis of overdose deaths. In 2018, almost 70,000 overdose deaths were recorded in the United States alone.[7] In Canada, the number of federally regulated drug consumption rooms (DCRs) increased from 24 in 2018 to 40 in 2020. There remain no officially licensed DCRs in the United States, but there is at least one unsanctioned programme in an undisclosed location.[8,9] While regulations on access to naloxone have loosened in the United States since 2018, naloxone is still designated a prescription-only medication, creating barriers to access.

Despite the high prevalence of the use of stimulants in North America, the harm reduction response to stimulants remains limited compared with the response to opioids. Harm reduction programmes in some cities in Canada and the United States report the distribution of safer smoking and inhalation equipment.

In Canada, recent changes have led to the availability of heroin-assisted therapy (HAT) in the form of diacetylmorphine and hydromorphone in at least three provinces.

Drug checking is available in at least two provinces in Canada, and since 2019 has been available as an overdose prevention response often co-located with DCRs. In the United States, federal and state restrictions on drug checking are tighter and, as a result, access to drug checking is more limited.

In correctional settings, Canada is considerably more advanced in harm reduction implementation than the United States, with OAT available in all federal prisons and NSPs operational in 11 prisons. There is one operational prison DCR in Canada. However, civil society actors have expressed concern over its operation and the misconception among correctional staff that this may replace the need for an NSP. In the United States, no prison-based NSPs or DCRs are operational, and access to OAT in prisons is severely limited.

7 In the United States, these programmes are commonly called syringe service programmes (SSPs).
8 In the United States, these programmes are commonly called medications for opioid use disorder (MOUD).

2. Developments in harm reduction implementation

2.1 NEEDLE AND SYRINGE PROGRAMMES (NSPs)

As reported in 2018, NSPs are operational in both Canada and the United States. In both countries, individual states, provinces and territories are responsible for the legal status of NSPs. The overall trend in the region is for an increase in the availability of services.

NSPs are available in all Canadian provinces and territories except the Northwest Territories and Nunavut.[1] An estimated 50 million syringes were distributed in 2016, equivalent to 291 per person who injected drugs.[1] This is below the 300 syringes per person that the World Health Organization (WHO) recommends to achieve hepatitis C elimination by 2030.[10]

A United States government study found that 32.1% of people who inject drugs reported sharing syringes and 54.5% reported sharing any injecting equipment (including cookers and cotton wool).[11] Only 52.8% of people reported receiving syringes from NSPs, though this figure varied by city (from 93.1% in San Francisco to 0.9% in Houston).[11] Since 2018, in the United States, at least three states have taken steps to facilitate the establishment and operation of NSPs. New state legislation was passed in Idaho, Illinois and Florida to legalise or facilitate the establishment of NSPs.[12–15] At the federal level, in 2019 the Office of the Assistant Secretary of Health (OASH) launched an effort in collaboration with regional health administrators, the Centers for Disease Control and Prevention (CDC) and other federal, state and local stakeholders to promote the implementation of NSPs.[16] As of 2020, there are six states in which no legal NSPs operate: Alabama, Kansas, Mississippi, Nebraska, South Dakota and Wyoming.[9][5,12,17–19]

Civil society organisations in Canada and the United States report that the primary barrier to accessing NSPs is the lack of availability in certain jurisdictions, most acutely in rural areas (refer to rural communities box).[20–22] A lack of funding, a hostile political environment and municipal bylaws can all obstruct the establishment of services in these areas.[20,22] Even where NSP implementation is extensive, there is a lack of tailored and targeted programmes for marginalised subpopulations, such as women, young people and Indigenous communities.[20,21]

Stigma remains a significant barrier to accessing NSPs in Canada and the United States, as evidenced in pharmacies.[20,21,23,24] Only one state (Delaware) expressly prevents the sale of syringes in pharmacies, but many states allow for significant pharmacist discretion.[23] This frequently manifests in stigma and denial of service to people who inject drugs, as found in a 2019 study in Arizona.[23]

Law enforcement also has a negative impact on the accessibility of NSPs in North America. For example, state law in West Virginia permits the operation of NSPs but, in some cases, city ordinances prohibit the possession of drug paraphernalia including injecting equipment.[24] The result is that people who inject drugs do not access NSPs for fear of arrest.[24] In 2018, such contradictory local policies forced a West Virginia NSP to close as they could no longer operate in line with best practices.[25]

> *As of 2020, there are six states in which no legal NSPs operate: Alabama, Kansas, Mississippi, Nebraska, South Dakota and Wyoming.*

9 In some of these states it may be possible to purchase syringes from pharmacies, but no programmes distribute injecting equipment for free to people who inject drugs.

Rural communities

Almost 20% of people in Canada and the United States live in rural areas, as defined by their respective governments.[26] Rural communities have been affected by the ongoing crisis of overdose deaths. For example, the Appalachian region of the United States has experienced a disproportionate number of overdose deaths in recent years, and states in the region have the highest hepatitis C prevalence among people who use drugs in the country and have experienced a number of HIV outbreaks in communities that use drugs.[27–30] Rural populations in both the United States and Canada face unique challenges in accessing harm reduction services.

Civil society organisations report that rural areas are particularly underserved by harm reduction services, with facilities concentrated around urban centres.[20,21,31] In small communities, service providers find it difficult to maintain confidentiality, which creates a significant barrier to access due to anticipated stigma and discrimination.[20] Additionally, more than 60% of rural counties in the United States have no physician licensed to prescribe buprenorphine, and many people living in rural areas must travel long distances to Opioid Treatment Centres which are the only facilities that can prescribe methadone.[32,33]

To address these deficiencies, some harm reduction service providers have found innovative solutions. To increase the availability of naloxone to rural populations, providers in New Brunswick (Canada) have provided online training for clients, while in Alaska (United States) naloxone distribution sites have been asked to provide numerous naloxone kits at each visit.[31] In Saskatchewan (Canada), major efforts have been made to address hepatitis C among Indigenous and rural communities by implementing nurse-led treatment; for example collaboration with Indigenous leadership both on and off reserve to actively screen and treat Indigenous people living with hepatitis C.[34] Telemedicine for viral hepatitis treatment and OAT has been introduced in Alberta, British Columbia, Ontario and Quebec.[34] In rural areas of New York and California, an online mail order NSP is operational.[22,35] Finally, vending machines are now present in rural areas of British Columbia to enable access to harm reduction services there, with applications including providing sterile injecting equipment and naloxone, and potentially OAT medication, without the presence of a fixed-site harm reduction service.[36]

2.2 OPIOID AGONIST THERAPY (OAT)

OAT is available in both Canada and the United States. In Canada, provincial governments are responsible for OAT. In the United States, the federal government continues to maintain primary control of regulations and some states impose even greater restrictions. This results in more limited access and a more restricted range of medications available for OAT, currently limited to only methadone and buprenorphine.[10] [38] As reported in 2018, the expansion of buprenorphine prescribing in the United States to some nurses and physician assistants in 2016 was a crucial step to improving access to effective OAT. It resulted in an increase in the rate of buprenorphine prescribing from 1.97 prescriptions per 100,000 of the population in 2009 to 4.43 in 2018.[39] However, according to data from 2018, less than 4% of physicians in the United States are licensed to prescribe buprenorphine and in almost half of US counties, there is no physician licensed to prescribe it.[40] In addition, each prescriber is permitted to prescribe to a maximum of 30, 100 or 275 buprenorphine clients depending on their experience.[24,41] There is also evidence of racial disparity in access, with Black clients 77% less likely to be prescribed buprenorphine than white clients.[42]

In the United States, methadone is only accessible through federally certified Opioid Treatment Programmes and only in oral formulations.[43,44] Whilst these programmes exist in 49 states and the District of Columbia, none operate in Wyoming, meaning that methadone OAT (or any other full opioid agonist) is unavailable in the state.[43] Further federal and state restrictions limiting doses risk client safety by increasing the risk of overdose when using illicit opioids, and the predominant requirement for supervised doses requires clients to attend a clinic daily or near-daily.[44] Urine drug screening is common, and in some jurisdictions positive tests or missed doses can result in the termination of treatment or further reduction in dosage.[33] Further state-level restrictions are in place on the establishment of programmes: in Georgia, Indiana, Louisiana, Mississippi and West Virginia there is a limit on the total number of programmes (Ohio recently lifted an equivalent restriction), and in Indiana OAT programmes must demonstrate they have strong community support.[44,45] Some restrictions, such as on take-home doses and urine testing, have been waived during the COVID-19 pandemic (see COVID-19 chapter),

10 Naltrexone is also available for people who use opioids. However, community groups such as the International Network of People who Use Drugs have raised significant concerns over the use of naltrexone for OAT, arguing the opioid antagonist is coercive and based on ideals of abstinence rather than harm reduction.[1]

and civil society organisations and service providers hope that these changes will be made permanent.[22]

In Canada, the primary medications used for OAT are methadone and buprenorphine, with hydromorphone and diacetylmorphine[11] (also known as heroin-assisted therapy or HAT) increasingly available in some settings.[21] From May 2018, family physicians no longer require an exemption from the federal drug laws to prescribe methadone, enabling expanded access.[46] OAT is in some cases available in take-home form, and limitations on access to take-home OAT have in large part been loosened during the COVID-19 pandemic (see COVID-19 chapter).[20,21] In May 2019, the Canadian federal Department of Health announced changes to increase the accessibility of diacetylmorphine and hydromorphone.[20,21,46–48] However, only a small number of physicians in a limited number of locations are permitted to prescribe the medications.[48] Coverage is highest in Vancouver and in principal is available across British Columbia. At least one service operates in Ontario (in Ottawa) and at least two pilot sites operate in Alberta.[48]

Civil society actors in Canada have called for the removal of barriers to accessing hydromorphone and diacetylmorphine in the form of 'safe supply' programmes.[48] These programmes, according to the Canadian Association of People who Use Drugs, must provide access to a legal and regulated supply of drugs and must respect that people use drugs not just for maintenance, but also for the psychoactive effects. Accordingly, doses should be adjusted to client preference as this is likely to limit reliance on the illicit market.[49] In addition to existing safe supply programmes in British Columbia, some related initiatives began in 2019 in Alberta and Ontario, and new guidelines have been published in British Columbia.[20,21]

Overall, civil society actors deem the provision of OAT in Canada to be insufficient, with a lack of tailored services for women, Indigenous communities and young people.[20,21] Indigenous Services Canada provides OAT to Indigenous populations, but civil society actors report that these programmes often specifically target abstinence rather than harm reduction.[46]

2.3 AMPHETAMINE-TYPE STIMULANTS (ATS), COCAINE AND ITS DERIVATIVES, AND NEW PSYCHOACTIVE SUBSTANCES (NPS)

North America remains the world region with the highest past year prevalence of stimulant use at 2.1% compared to the global prevalence figure of 0.6%.[6] People who use stimulants in North America frequently report that they do not believe harm reduction services such as NSPs and DCRs are relevant to their needs.[50] Examples of this include limitations on the number of syringes that can be acquired at a time (stimulant use is associated with more frequent injection) and the exclusion of people who smoke or inhale drugs rather than inject from DCRs (stimulants are more likely to be smoked or inhaled than opioids).[50]

Civil society organisations in North America report the adulteration of ATS, cocaine and new psychoactive substances as a significant source of potential harm associated with stimulant use.[21] For example, in British Columbia, fentanyl was detected in three-quarters of cocaine- and methamphetamine-related deaths - a pattern which is repeated across the region and is also indicative of high levels of polysubstance use.[50] The risk is particularly high for opioid-naïve people who use stimulants.[50] Fentanyl testing strips are a significant and low-threshold innovation in the response to fentanyl adulteration. These strips allow people to determine if a sample contains fentanyl (though they cannot determine the quantity), and are commonly available at harm reduction services in Canada and the United States. In June 2019, the New York City Health Department launched a campaign distributing informational flyers and coasters to bars and nightclubs in the city, as well as naloxone and first aid equipment. The programme particularly targets people who use cocaine occasionally and might not be aware of the presence of fentanyl in the supply.[51]

Higher-threshold drug checking services can provide detailed information on the content of substances, including strength and adulterants. Such services have become more widespread in Canada since 2018, and are available in some areas of Alberta, British Columbia and Ontario, but remain largely focused on opioid use because of local harm reduction priorities.[20,21] This includes services based at DCRs (in all DCRs in Vancouver, in three DCRs in Toronto since October 2019), walk-in centres, festival drug checking, and services available by mail.[52–57] Get Your Drugs Tested is

11 Diacetylmorphine is a chemical name for heroin, and hydromorphone is an opioid agonist significantly more potent than methadone.

a service launched in 2019 with financial support from the Vancouver Dispensary Society which makes drug checking by mail available to people anywhere in Canada.[53]

Drug checking is considerably less widespread in the United States than in Canada, largely due to greater legal barriers to implementation and the categorisation of testing equipment as drug paraphernalia.[58] DrugsData.org provides services by mail,[59] while DanceSafe has 16 chapters nationwide and sells home testing kits to the public and provides onsite drug analysis where possible at electronic music events.[60] Recent changes include a law in 2018 in Maryland exempting drug checking kits and fentanyl testing strips from drug paraphernalia laws.[61] Though drug checking has high acceptability among people who use stimulants,[62] it continues to face considerable regulatory barriers in most US states, and services in Canada require formal exemption from federal and state drug laws in order to operate legally.[21,61]

Additionally, in practice, drug checking is unavailable to the most vulnerable people who use stimulants.[50,62] Studies have found the most marginalised people (including people experiencing homelessness and people from racial and ethnic minorities) are less likely to use available services, and may be unable to obtain drugs from alternative sources even if they know they are adulterated.[50,62]

No substances are widely approved in North America for use as medical supply for people who use stimulants. Though there is emerging evidence of the effectiveness of a variety of substances (including methylphenidate, dexamphetamine, extended release amphetamine, modafinil, bupropion and mazindol), the use of any of these for people who use stimulants is mostly considered 'off-label'.[50,63,64] In the context of the COVID-19 pandemic, the British Columbia Centre on Substance Use released interim clinical guidance recommending the prescription of dexamphetamine and methylphenidate to people who use stimulants.[65]

The distribution of inhalation equipment for safer use of stimulants can be effective in reducing health harms, notably reducing the risk of viral hepatitis transmission.[66] In the United States, 46% of people who use methamphetamine reported smoking it,[67] indicating that any harm reduction approach to the substance must address the needs of people who smoke as well as those who inject. Several projects exist in North America to provide safer smoking equipment to people who smoke stimulants and opioids. One such project, launched in 2020, is a collaboration between harm reduction services and the police department in New Haven, Connecticut.[68] Other programmes delivering harm reduction supplies to people who use drugs include those operating in nightclubs and other party settings. TRIP! and Pieces to Pathway are two such services in Toronto, distributing syringes, pipes, condoms, straws and chewing gum, and providing chill-out spaces for people who use drugs at parties.[21,69]

In the United States, many states have exempted syringes from their state paraphernalia laws. However, that is not the case for safer smoking and inhalation equipment, which in many states remains technically illegal to distribute.[22]

2.4 OVERDOSE, OVERDOSE RESPONSE AND DRUG CONSUMPTION ROOMS (DCRs)

From 1999 to 2018, there were 769,935 drug overdose deaths recorded in the United States.[7] In 2018, there were 67,367 overdose deaths, 70% of which involved an opioid, most commonly illicitly manufactured fentanyl or its analogues.[7] This is the second highest annual number of overdose deaths on record.[7] The highest rates of overdose death in 2018 were in Virginia (51.5 per 100,000 population) and Delaware (43.8).[7] In recent years, stimulant-involved overdoses have dramatically increased with the rate of cocaine-involved overdoses tripling between 2012 and 2018, and methamphetamine-involved overdoses increasing five-fold over the same period.[7] Additionally, 28% of people who inject drugs in the United States report having experienced a non-fatal overdose.[11]

In Canada, there were 15,393 opioid overdose deaths from January 2016 to December 2019, 77% of which involved fentanyl or analogues.[70] In 2019, the highest rates of overdose death were in British Columbia (20.7 per 100,000 population) and Alberta (14.7 per 100,000).[70]

DCRs[12] are a key harm reduction intervention to prevent overdose deaths, as well as reduce transmission of HIV and

12 Also known as safe consumption sites or supervised injection facilities.

viral hepatitis.[71] Canada now has more DCRs than any other country in the world, with an increase from 24 facilities in 2018 to 40 facilities in 2020.[4,20,21] The facilities operate in five provinces: Alberta (7), British Columbia (9), Ontario (20, Quebec (4) and Saskatchewan (1). There are ongoing applications or preparations for ten further sites at the time of writing, including in the provinces of Manitoba.[4] In addition, at least 20 overdose prevention sites have been opened and operated since 2017, many by people who use drugs and their allies.[72] These services are primarily volunteer-run and funded.[20]

Although DCRs are widespread in Canada, the number and accessibility of the facilities remain insufficient to meet need, particularly outside major cities (see rural communities box).[20,21] Organisations proposing DCRs must apply for an exemption to federal drug laws on a case-by-case basis.[20,73] Civil society organisations report that the application process is overly burdensome and contains irrelevant criteria, preventing harm reduction actors from responding to public health emergencies quickly and effectively.[20,74] Restrictions also obstruct the ability of DCRs to provide services catering to the specific needs of marginalised groups such as women, people with disabilities, Indigenous people and young people.[20,21,74] The only site until 2020 to provide a safe smoking space, in Lethbridge, Alberta, had its government funding revoked in July 2020 and is now expected to close.[4,20,75,76] A site in Saskatoon, Saskatchewan, opened in late 2020 with a safe smoking space.[76]

The election of conservative provincial governments in Ontario and Alberta led to reviews of DCR implementation.[20,21,77] In Alberta, the review has been strongly criticised for being politicised and biased by civil society organisations, researchers and health workers.[78] In Ontario, this has led to the introduction of a new model of DCR known as Consumption and Treatment Services. As part of this reformulation, the government seeks to place higher emphasis on referrals to addiction treatment, reduce funding, and cap the number of sites in Ontario at 21 (currently there are 20).[20,21,77] A demonstration of one potential impact of this change came in early 2020 when a DCR in Ottawa reduced its operating hours due to a shortfall in funding after the Ontario provincial government withdrew its support.[79]

Despite a clear need, no licensed DCRs operate in the United States.[13] Civil society and local political actors have

In recent years, stimulant-involved overdoses have dramatically increased in the United States, with the rate of cocaine-involved overdoses tripling between 2012 and 2018, and methamphetamine-involved overdoses increasing five-fold over the same period. Additionally, 28% of people who inject drugs in the United States report having experienced a non-fatal overdose.

13 Though at least one underground DCR operates in an undisclosed location.[2]

pushed for the introduction of facilities in cities across the country. In California, Colorado, Maine, Massachusetts, New York, New Jersey, Rhode Island and Vermont among others, DCRs have secured some degree of support from state legislators but were blocked during the legislative process.[81–86] In Philadelphia, Pennsylvania, where overdose deaths have risen by 200% since 2009, a federal judge ruled that plans to open the Safehouse DCR do not violate federal law after a legal challenge from the Trump administration.[87–89] However, in February 2020, progress was paused pending consultation with the local community.[87] In January 2020, the Mayor of Seattle, Washington, announced that the city would open the first DCR in the United States. The plan is likely to face similar legal obstacles to the project in Philadelphia.[90,91]

Naloxone[14] is increasingly available in Canada, no longer requiring a prescription and available to purchase or for free at pharmacies in take-home doses in injectable or nasal spray forms.[20,21,93] Models of distribution vary by province and territory, but in every jurisdiction naloxone and naloxone training are available for free to people likely to witness an overdose.[94–106] While naloxone is in theory highly available, civil society organisations have expressed concerns that programmes do not do enough to actively seek out marginalised subpopulations, and that stigma towards people who use drugs acts as a barrier to access.[21]

In the United States, naloxone remains officially designated as a prescription-only medication by the federal Food and Drug Administration (FDA), despite the organisation's own insistence that efforts should be made to widen access and the fact that naloxone meets the FDA's criteria for an over-the-counter medication.[44,107] The US Surgeon General, Jerome Adams, released a statement in 2018 explicitly encouraging anyone likely to witness or experience an overdose to carry naloxone and know how to use it.[108] As of 2020, all 50 states and the District of Columbia have passed laws to allow pharmacists to dispense or prescribe naloxone directly, although out-of-pocket costs remain a barrier in some states.[107,109–111]

Only 29 states have laws permitting secondary distribution of naloxone.[109]

In Canada, the federal Good Samaritan Drug Overdose Act was passed in 2017. It ensures that people calling emergency services and those present at the scene of an overdose cannot be charged for possession of controlled substances.[20,21,112] The US state of Maine passed a Good Samaritan law in late 2019[113] meaning that, at the time of writing, 47 US states have enacted such laws (all states except Kansas, Texas and Wyoming).[114] However, only 25 of these states include provisions in their law to protect people from arrest for possession of controlled substances when attended by emergency services, and only 18 provide immunity from arrest for possession of paraphernalia.[109] Even in these cases, some states (such as Washington) do not protect people from arrests related to outstanding warrants, probation or parole violations, or crimes other than drug possession (including drug manufacture and delivery).[22]

Drug checking (see p.134) has emerged in response to the presence of fentanyl[15] in the opioid supply in the region. Fentanyl testing strips, which can identify the presence of fentanyl in a sample though not the concentration, are used in DCRs in Canada.[4,115] In the United States, the absence of DCRs as a key means of contact between health services and people who use drugs means that fentanyl testing has been less systematically implemented.[116] However, projects operate in Oregon and Rhode Island,[116,117] and were legalised and implemented in Maryland in 2018.[61,118] In parts of the United States, heroin has been almost entirely supplanted by fentanyl, meaning that testing services provide little value.[33] One such city is Baltimore, where harm reduction messaging is instead focused on encouraging people who use fentanyl to 'go slow', using small doses initially to prevent overdose.[119]

Moving from injection to smoking opioids is associated with a lower risk of overdose.[120–122] To this end, the People's Harm Reduction Alliance in Seattle specifically designed a pipe for smoking heroin (as pipes for smoking meth and crack cocaine can block when used with heroin). From the end of June to November 2019, the programme had distributed over 40,000 pipes. Alongside the primary aim of reducing overdose incidence, the project also reduces the risk of infection from injection and sharing pipes, and enables greater inclusion of people who smoke opioids in harm reduction programmes.[123]

14 Naloxone is a medication that can reverse the effects of opioid overdose. The World Health Organization recommends that states take every step to ensure that anyone likely to witness an overdose has access to naloxone.[3]

15 Fentanyl is an opioid up to 100 times more potent than morphine.

2.5 ANTIRETROVIRAL THERAPY (ART)

According to the latest available data, 2018 was the fourth consecutive year of increasing new HIV infections in Canada, with an 8.2% increase from 2017 to 2018.[124] New HIV infections in the general population remained stable in the United States from 2013 to 2017.[125]

Of all new HIV diagnoses in 2018, 7% in the United States and 18% in Canada were among people who reported injecting drugs.[124,125] Among women in Canada, 28.4% of cases were in those who inject drugs.[124] A study in 23 cities in the United States in 2019 found that 6.4% of people who inject drugs were living with HIV, compared with the general population HIV prevalence of 0.04%.[11,126] The same study found that only 54.8% of those people who inject drugs had been tested for HIV in the last year, and only 69.6% of those living with HIV were receiving antiretroviral therapy.[11] Several HIV outbreaks (for example in Indiana, Massachusetts, Washington and West Virginia) have occurred in the United States since 2018, in part due to the lack of adequate harm reduction services.[22,80,127]

People living with HIV in Canada have access to publicly funded ART, with each province or territory managing services for its residents. In six provinces and territories,[16] antiretroviral therapy is universally available for free to people living with HIV. In the other seven jurisdictions, the client is liable for some out-of-pocket costs (however, these costs are commonly waived for those with low income).[128] In addition, there are federal programmes covering all costs for certain populations (such as Indigenous people, military veterans, people in prison and refugees).[128]

Key barriers to HIV testing and treatment for people who use drugs in North America include stigma based on HIV status and drug use, a lack of access to anonymous HIV testing, and the criminalisation of HIV non-disclosure.[20,129] A qualitative study in New York City in 2019 found that people who use opioids are more likely to access HIV care where it is integrated into services for people who use opioids, such as OAT.[129]

In both Canada and the United States, people who inject drugs are among eligible populations for pre-exposure prophylaxis (PrEP) prescriptions, however low awareness had led to limited uptake.[130–132] The integration of PrEP prescription[17] into existing harm reduction services, most importantly NSPs, represents a significant opportunity to reduce the transmission of HIV among people who use drugs.[133]

2.6 HARM REDUCTION IN PRISONS

The United States has both the highest prison population and highest rate of incarceration in the world.[134] In 2018, approximately 1.5 million people were imprisoned in the country (including 1% of the entire male population), a rate of 655 per 100,000 of the population.[134,135] The United States imprisons its people at six times the rate of Canada (where 107 of every 100,000 people are in prison).[134] At least 17 states have prison systems that operate above their capacity, meaning that facilities are overcrowded.[135] Among other health concerns, this has made jails and prisons in the United States particularly dangerous during the COVID-19 pandemic (see COVID-19 section, p 33).[22]

Drug use is criminalised in both the United States and Canada.[20,21] In state prisons in the United States, 14.4% of people in prison are detained for drug offences, while in federal prisons the figure is 47.1%.[135] The proportion is higher among women (25.4% in state prisons and 57.9% in federal prisons).[135]

Despite the large population of people who use drugs in prisons, there is still no NSP operating in any prison in the United States. Canada introduced prison NSPs in 2018, and at the time of writing there are 11 such services operating in federal prisons.[20] While this is a positive development, coverage remains low: federal prisons account for only 40% of prison capacity in Canada, and no NSPs operate in provincial or territorial prisons.[136–138] Only 25% of federal prisons are covered by the programmes in operation.[136–138]

Where NSPs do operate in Canadian prisons, civil society organisations and Canada's Correctional Investigator have raised concerns about significant barriers that make the services largely unavailable in practice.[20,21,139] Security staff

16 Alberta, British Columbia, New Brunswick, Northwest Territories, Nunavut and Prince Edward Island.
17 PrEP is a medication that can provide short-term protection from HIV infection.

act as gatekeepers to access and can veto requests to participate in NSPs.[20] Prison staff continue to carry out daily inspections of cells during which they can apply disciplinary measures if a person is found in possession of drugs, or if equipment acquired from the NSP is found to be damaged, altered or missing.[139] In addition, confidentiality is limited, syringes are only provided on a one-for-one exchange basis, little information is given to people in prison about the availability of the NSP, and there are long waiting lists and high rates of rejection from the programme.[20,21,139] As a result, many people in prison are not even aware of the existence of the programmes, and participation is limited to only a handful of people in each prison.[20,21,139] As a result of these deficiencies, in 2020, a former prisoner and four HIV organisations continued to pursue a constitutional challenge against the federal government over its failure to provide easy, confidential and effective access to NSPs in prisons.[140]

The Union of Canadian Correctional Officers officially opposes prison NSPs and has advocated replacing the services with onsite DCRs.[140,141] The world's first prison DCR opened in Drumheller, Alberta, in June 2019.[20] The site was accessed more than 300 times by 23 people in its first four months of operation.[141] While the introduction of DCRs in prison is commendable, it must not be considered a replacement for an effective NSP. Not providing NSPs violates people in prisons' right to the same standard of health care as in the community.[140]

In Canada, OAT is officially available in all 43 federal prisons, but there are ongoing barriers to access. It is available in some but not all provincial and territorial prisons. Barriers include long waiting lists and a lack of prescribers, and there is evidence that treatment has been denied or terminated based on unfounded fears of diversion.[20] In Canadian federal prisons, OAT can be both continued from the community and initiated in prison. In provincial prisons where OAT is available, some deny people in prison the right to initiate OAT by failing to establish links with prescribing physicians.[20] In these cases, OAT can only be provided where it is a continuation from the community.[20]

As reported in 2018, OAT is available in only a small number of United States correctional facilities. In July 2019, the National Sheriffs' Association said that OAT is available in 270 (9%) of 3,100 state prisons and jails.[142] Since 2018, state governments in California, Delaware, Maine, Virginia, Washington and Wisconsin have committed to expanding access to OAT in prisons.[142] Since 2018, the Bureau of Prisons has pressured state prison authorities to enable access to OAT, while simultaneously denying access to those resident in the federal prisons under its own jurisdiction.[143] In 2019, a female prisoner in Massachusetts became the first known person to receive OAT in a federal prison after successfully suing the Bureau of Prisons, citing Eighth Amendment rights to freedom from cruel and unusual punishment.[142] Implementing prison OAT can also have a significant impact on the wider prevalence of overdose deaths. One study in Rhode Island, United States, found that implementing OAT in jails and prisons and providing linkage to community care on release reduced the overall number of overdoses in the state by 12%.[144]

There is a significantly increased risk of death from drug overdose in the period immediately following release from prison.[145–147] As such, it is essential that people in and recently released from prison have access to naloxone. In Canada, overdose prevention training is limited in most prisons, and naloxone is available to some people on release from prison.[20] In all prisons, naloxone is unavailable to prisoners themselves, but health staff - and in some prisons security staff - have access.[20] An evaluation of an overdose education and naloxone distribution project in San Francisco found that very few of those trained had been trained previously outside prison, and that one third of those released with naloxone reported using it to reverse an overdose.[148] Similar programmes have been implemented in California, Illinois, Maryland, Michigan and New York among other states.[149]

Incarceration of people who inject drugs is associated with an increased risk of viral hepatitis, tuberculosis and HIV, and accordingly it is essential that people in prison have access to testing and treatment services.[150,151] In Canada, health services in federal and most provincial prisons are provided not by the federal or provincial department of health but by the federal or provincial public safety authorities, endangering the equivalence of care between prison and the community.[20] This is especially true with regard to drug use and harm reduction, with prison health services more likely to prioritise security over health.[20] As a result, HIV, viral hepatitis and tuberculosis testing and treatment is widely available in prisons, but stigma and a lack of confidentiality impede access.[20]

Race, incarceration and drug policy in the United States

The murder of George Floyd by a police officer in Minneapolis in May 2020 catalysed a global wave of protests and brought a renewed energy to questions about the structures of racial oppression and discrimination. The United States has a long history of using the language and policies of the 'war on drugs' to perpetuate the systemic racial discrimination of the Jim Crow era of enforced racial segregation and, ultimately, the legacy of slavery.[152] A powerful example of this entrenched rhetoric lies in the county coroner's report into the death of George Floyd, which suggested potential drug use as a contributing factor, and minimised the role of police brutality in his death.[153]

People of colour, and most acutely Black people, are discriminated against at every stage of the judicial process: policing, pre-trial, sentencing, parole and post-incarceration.[154] [18]

Black people are over three times more likely to experience arrest for drug offences by the age of 29 than white people.[155] Black drivers are more likely to be stopped without cause by police, and once stopped are three times more likely to be searched and twice as likely to be arrested compared with white drivers.[154,156,157] Research finds that these disparities cannot be accounted for by rates of drug use or drug offences, but are due to racial prejudice and discrimination by police officers and racial biases that are inherent in certain policing practices. [155,157,159]

At sentencing, racial disparities in mandatory minimum sentencing[19] for drug offences mean that people of colour are not only incarcerated more often, but also for longer sentences. Almost half of all mandatory minimum sentences for drug offences are given to Hispanic people, and almost one third are given to Black people. Possession thresholds in particular, result in significant racial disparities. For example, crack cocaine continues to be subject to much lower thresholds, than powder cocaine, with possession of just 28 grams sufficient to trigger a five-year minimum sentence (compared with 500 grams for powder cocaine). In 2016, 85% of people subject to mandatory minimum sentences related to crack cocaine were Black.[160]

As a result of racial disparities in policing and sentencing, Black men are incarcerated at five times the rate of white men.[135] More than one third of all federal prisoners are Black, meaning their representation is almost three times that in the general population (13% of Americans identify as Black).[135] In the state of Georgia, 3% of all Black men are in prison.[161] Almost half of Black people and 60% of Hispanic people in prison are incarcerated for drug offences.[135]

18 An example includes 'broken windows policing', a focus on low level public order offences that disproportionately targets Black and other minority communities.[4]

19 Mandatory minimum sentencing requires that offenders serve a predefined term for certain crimes, including some drug offences.

3. Policy developments in harm reduction

Civil society organisations report that housing policy is a key failure in the effort to ensure that people who use drugs can experience good health and access social services.[20,21] This is due to both a lack of affordable housing, and the effect of drug-related offences on a criminal record as a barrier to accessing social housing and other services.[20,21] Additionally, civil society actors report low rates of social assistance for people with disabilities, and the prevalence of stigma and discrimination against people who use drugs when accessing social services.[20,21]

At the international level, the Canadian government has been supportive of harm reduction in international forums, including statements in favour of harm reduction at all sessions of the UN Commission on Narcotic Drugs since 2018.[20,21]

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4. Funding developments for harm reduction

In Canada, harm reduction services are funded primarily by provincial governments.[21] In addition, the federal Harm Reduction Fund is providing a total of CAD 30 million (USD 23 million) from 2017-2022 to projects that help to reduce HIV and viral hepatitis among people who inject or inhale drugs.[20] The fund primarily finances peer outreach and capacity building programmes, and explicitly commits to the meaningful inclusion of people who use drugs, stigma reduction, gender-based analysis and mental health promotion.[162,163] Non-state funders in Canada include the Open Society Foundations, MAC AIDS Fund and the Levi Strauss Foundation, as well as other local foundations.[20,21]

The reliance on provincial governments for funding for harm reduction makes it sensitive to political changes at the provincial level. For example, the election of a conservative government in Ontario in 2018 led to a reduction in funding for harm reduction.[21] Overall, civil society organisations in Canada report that domestic funding is still well below the level needed to respond to the health issues faced by people who use drugs, and that prison harm reduction services are particularly underfunded. The lack of funding is also a barrier to the emergence of new networks in the harm reduction sector.[20]

Almost one third of the entire drug-related expenditure of the United States government for 2021 will be spent on domestic law enforcement (US$10 billion), without even accounting for the cost of incarceration.[164] A significant funding barrier in the United States is the ban on federal funding for NSPs, which means that such programmes are reliant on local, state or private sources of funding.[33] However, recent attention on the opioid overdose crisis has led to some federal funding for overdose response, notably naloxone, and can in some cases be used to fund support staff in needle and syringe programmes (though still cannot be used for the purchase of sterile paraphernalia).[22]

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2.6 OCEANIA

AUSTRALIA
FIJI
KIRIBATI
MARSHALL ISLANDS
MICRONESIA, FEDERATED STATES OF
NAURU
NEW ZEALAND
PALAU
PAPUA NEW GUINEA
SAMOA
SOLOMON ISLANDS
TIMOR LESTE
TONGA
TUVALU
VANUATU

TABLE 2.6.1:

Epidemiology of HIV and viral hepatitis, and harm reduction responses in Oceania

Country/ territory with reported injecting drug use[1]	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[2]	OAT[3]	Peer distribution of naloxone	DCRs[4]
Australia	75,178[5][2]	2.3[3]	45[4]	4.0[5]	✓(4,182)[6][2]	✓(2,940)[7] (B,M)[6]	✓[7,8]	✓2
Federated States of Micronesia	nk	nk	nk	nk	x	x	x	x
Fiji	nk	nk	nk	nk	x	x	x	x
Kiribati	nk	nk	nk	nk	x	x	x	x
Marshall Islands	nk	nk	nk	nk	x	x	x	x
New Zealand	18,000[8][10]	0.2[10]	58[9][10]	nk	✓(185)[10][11]	✓(B,M)[11,12]	✓[11][9]	x
Palau	nk	nk	nk	nk	x	x	x	x
Papua New Guinea	nk	nk	nk	nk	x	x	x	x
Samoa	nk	nk	nk	nk	x	x	x	x
Solomon Islands	nk	nk	nk	nk	x	x	x	x
Timor Leste	nk	nk	nk	nk	x	x	x	x
Tonga	nk	nk	nk	nk	x	x	x	x
Vanuatu	nk	nk	nk	nk	x	x	x	x

nk = not known

1 Countries with reported injecting drug use according to Larney et al 2017. The study found no reports of injecting drug use in Nauru or Tuvalu.
2 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.
3 Opioid agonist therapy (OAT), including methadone (M), buprenorphine (B) and any other form (O) such as morphine and codeine.
4 Drug consumption rooms, also known as supervised injecting sites.
5 Estimated for the 2018/19 years based on the method described by Kwon et al in 2019.[1]
6 2,836 pharmacies, 98 primary, 908 secondary sites and 340 syringe dispensing machines.
7 This refers to the number of dosing points in the country. 89% of opioid pharmacotherapy dosing points were pharmacies.
8 This number would be an upper limit, with recent analysis suggesting a figure close to 12,000.[9]
9 This figure is based on 2013 prevalence data and likely under-reports exposure, as the cohort most likely to have been exposed will have aged, with age being a proxy for length of injecting career, and the latter correlated with increased exposure as career lengthens.[11]
10 163 pharmacies and alternative outlets, and 22 peer-based NSPs (includes two mobile services).
11 Commenced May 2020. Available through some peer-based NEXs and drug treatment services.

MAP 2.6.1:
Availability of harm reduction services

- Both NSP and OAT available
- OAT only
- NSP only
- Neither available
- Not known
- DCR available
- ⊗ Peer-distribution of naloxone

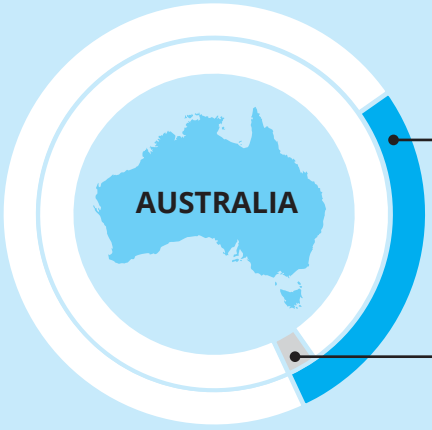
2.6
Harm reduction in Oceania

OVERDOSE, OVERDOSE RESPONSE AND DRUG CONSUMPTION ROOMS (DCRS)

119,000 VISITS
0 DEATHS
ONSITE

THE SECOND DCR OPENED IN 2018 IN MELBOURNE FOR A TWO-YEAR TRIAL PERIOD, ENDING IN 2020. AN INDEPENDENT EXPERT PANEL CONDUCTED A REVIEW OF THE PROGRAMME BASED ON THE FIRST 18 MONTHS OF OPERATION, AND FOUND THAT THE DCR HAD SUCCESSFULLY REDUCED HARMS FOR SERVICE USERS, WITH MORE THAN 119,000 VISITS IN THE FIRST 18 MONTHS, AND NO OVERDOSE DEATHS ONSITE.

HARM REDUCTION IN PRISONS



28%

IN AUSTRALIA, ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE REPRESENTED **28%** OF THE PRISONER POPULATION IN 2019

3.3%

ACCOUNTING FOR **3.3%** OF THE GENERAL POPULATION.

IN NEW ZEALAND IN 2019, **52%** OF THE PRISON POPULATION WAS MĀORI PEOPLE.

THEY REPRESENTED **16.5%** OF THE GENERAL POPULATION.

The proportion of NSP clients reporting an Aboriginal and/or Torres Strait Islander background in Australia increased significantly over the past five years, from 14% in 2015 to 22% in 2019.

1. Overview

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Harm Reduction International

There are significant numbers of people who inject drugs in Australia and New Zealand, but there appear to be few in the rest of the region, with no evidence of injecting drug use in Fiji, Marshall Islands, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga or Tuvalu.[13–20] While there are a wide range of harm reduction services available in Australia and New Zealand, there is no new evidence for any such services anywhere else in the region since the *Global State of Harm Reduction 2018*. The highly variable data, in terms of availability and quality, across the region remains a key limitation in collating an overall picture of the state of harm reduction in Oceania.

All Australian states and territories operate needle and syringe programmes (NSPs), with a small increase in the number of NSPs operating in the country since 2018.[2] Various NSP service models exist in Australia, including primary and secondary outlets, mobile and outreach services, syringe vending machines, and peer-led models.[21] New Zealand has a national state-sponsored peer-based NSP, which consists of 185 facilities.[11,22] Though New Zealand is among countries with high prevalence of injecting drug use, the prevalence of HIV among people who inject drugs is low,[23] which can be attributed to the early introduction of NSPs in the country.[24] The number of opioid agonist therapy (OAT) clients in Australia has remained stable since 2018, though there is a trend of an ageing cohort in OAT.[25] An important characteristic in OAT provision in Australia is the slow but continuous shift towards a higher proportion of dosing occurring at community pharmacies rather than specialist OAT facilities. There is an increasing trend in the number of people receiving OAT in New Zealand,[26] where initiation time has decreased in the past few years.[26] Unfair treatment and stigma and discrimination towards people who inject drugs or are attending OAT programmes are evident in both countries,[7,27] and further barriers to access exist for certain communities. In Australia, access to NSPs is suboptimal for young people and Indigenous people, and in New Zealand, people who inject performance and image-enhancing substances are underserved and the needs of Māori (Indigenous New Zealanders) are not appropriately met.[11]

A recent analysis of adolescent health behaviour in six Pacific Island countries and territories (Cook Islands, Kiribati, Samoa, Solomon Islands, Tonga and Tuvalu) found higher lifetime prevalence of amphetamine use than previous studies, though the prevalence rates varied greatly between countries.[28] The two most popular stimulants in Australia are cocaine and MDMA,[29] while cocaine is less prevalent in New Zealand than amphetamines and MDMA.[30]. An important harm reduction response to amphetamine-type stimulants (ATS) and new psychoactive substances (NPS) use in Australia and New Zealand is drug checking (also known as pill testing), which has been available in festival settings since 2014 in New Zealand,[31–33] and two pilot programmes have been implemented over the past two years in Australia.[7,34–36]

Australia is among the few countries on track globally to reach the hepatitis C elimination goal by 2030.[37] People have had universal access to hepatitis C direct-acting antivirals (DAAs) since 2016, with access to further DAA treatment if they become re-infected.[3,7] Prison-based access is a particular priority; the therapeutic cost of DAAs for people in prison is covered by the Australian government.[38] A study among hepatitis C-positive people who inject drugs recommended expanding community-based programmes and peer support to ensure that people who inject drugs take up hepatitis C treatment in sufficient numbers to drive elimination.[39] A significant development in New Zealand is that DAA treatment became publicly funded and it is now available at no cost to patients.[11,40] The public funding of DAA has improved access to hepatitis C treatment for people who inject drugs, as they are the focus of testing and treatment measures.[11] Low HIV prevalence is a historic characteristic in both countries. A recent analysis found that the prevalence rate among people who inject drugs was below 2.3% in all survey years between 1995-2019 in Australia.[3] A study examining new HIV cases between 1996-2018 in New Zealand found that on average two HIV diagnoses (less than 3%) per year could be attributed to injecting drug use over the study period.[24] The successful prevention of an HIV epidemic is attributed to the early implementation of NSPs and the sustained harm reduction response.[24,41]

Data availability in Oceania

A key limitation in assessing the state of harm reduction in Oceania, is the highly variable data across the region. The data collection systems in Australia are of high quality: regular systematic data collection and analysis are available on drug use in the general population,[29] among people who inject drugs;[42] NSP implementation[2] and national strategies[43] are monitored regularly; pilot programmes are evaluated;[36,44] analyses on long-term trends are published,[3] while the national drug user network also conducts studies complementing the government's and academics' perspectives.[27] At the same time estimates on injecting use or the prevalence of blood-borne viruses among people who inject drugs are not available in any Pacific Island countries and territories,[10] and drug use or harm reduction in general is hardly mentioned in reports to international agencies.[45] While data on drug use and harm reduction is widely available in Australia and New Zealand, which contain 73% of the population of the region,[10] the lack of information on the Pacific Island countries and territories constitutes a significant data gap in the global state of harm reduction.

To bridge the gap, international agencies could focus on countries in the region with relatively bigger populations: adding estimates on the number of people who use drugs in Fiji, Papua New Guinea and Solomon Island would increase UNODC data coverage to 96% of people in the region. Furthermore, it would be worth considering alternative methodologies to questionnaires sent to ministries, where governments' country reports based on available quantitative data are complemented by qualitative data involving civil society organisations, professionals and other stakeholders. Methodologies are available to create mixed method surveys that can fill the gap in quantitative information while providing timely, quality data.[46]

Data gaps can be identified in Australia and New Zealand, even though these countries have a great deal of research on drug use, prevalence of blood-borne diseases and coverage of services. Analysis on drug-related government expenditure is an area where evidence is lacking. The latest analysis available on government spending examined decade-old data in Australia, and eight-year-old data in New Zealand.[47,48] These countries implement evidence-based drug policy, include harm reduction in their national drug strategies, and also involve peers in government consultations. Adding government spending analysis to their toolkit would improve the evidence base and could inform decision makers and advocacy groups to better target public resources.

Estimates on injecting use or the prevalence of blood-borne viruses among people who inject drugs are not available in any Pacific Island countries and territories,[10] and drug use or harm reduction in general is hardly mentioned in reports to international agencies.[45]

1. Developments in harm reduction implementation

2.1 NEEDLE AND SYRINGE PROGRAMMES (NSPs)

According to national reports submitted by the respective ministries of health to the Joint United Nations Programme on HIV/AIDS (UNAIDS), there is no evidence of injecting drug use in Fiji, Marshall Islands, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga or Tuvalu.[13–20] However, Australia and New Zealand are home to a substantial number of people who inject drugs, and these are the two countries in the region with long running NSP services.

According to the Australian NSP survey, the most commonly injected drugs in the country are methamphetamine (49% reported injecting it in 2019, up from 36% in 2015), and heroin (27% reported injecting in 2019, decreased from 31% in 2015).[3,4,49] Over the last decade, there has been a continuous shift in the drug last injected; the proportion of people who injected heroin declined, while the prevalence of methamphetamine doubled over the period 2010 to 2019.[3] All Australian states and territories operate NSPs, with a total of 4,182 in operation in the country, a 15% increase since 2018.[2] The country's network services have different types of NSPs. The majority (two-thirds), is based in pharmacies, and there are 98 primary[12] and 908 secondary[13] NSPs.[2] The number of syringe dispensing machines (vending machines that dispense syringes for free or at a nominal cost) almost tripled from 118 in 2008 to 340 in 2019, with 17 new machines since the *Global State of Harm Reduction* last reported in 2018.[2] Outreach programmes and peer distribution are also part of the NSP services in Australia.[21,52] The majority of primary and pharmacy NSPs are located in major cities, while secondary NSPs and syringe dispensing machines are mainly located outside of major cities.[2] The number of distributed syringes steadily increased over the last decade, with 52.5 million syringes distributed in 2018/19. This translates to 698 syringes per person who injects drugs , reaching far beyond the World Health Organization (WHO) targets[14] on syringe distribution.[2,53,54] The main developments in NSP implementation since the last report are the increased integration of take-home naloxone programmes,[8] and the increased availability of hepatitis treatment at NSPs in Australia.[7]

New Zealand was the first country in the world to have a national state-sponsored needle and syringe programme (New Zealand Needle Exchange Programme, NZNEP), and a peer-based model has been a defining feature of the country-wide network, which consists of 163 pharmacies and alternative outlets, and 22 peer-based programmes (including two mobile services).[11,22] NSPs in New Zealand distributed 3.75 million syringes in 2018,[55] providing moderate coverage of a minimum of 200 syringes per person who injects drugs in a year.[11] Since 2018, access to hepatitis C testing in NSPs has been expanded and it is now available across the NSPs in New Zealand, not just at the three services with an on-site health clinic.[11] Furthermore, as a response to the COVID-19 pandemic, an online NSP store was launched in 2020; following the introduction of nationwide COVID-19 measures, the online shop helped to ensure access to sterile injecting equipment.[11]

Though NSPs are widely available both in Australia and in New Zealand, there are barriers to access. The Australian Injecting & Illicit Drug Users League (AIVL) reported unfair treatment and stigma and discrimination towards people who inject drugs when accessing injecting equipment in hospitals and pharmacies.[27] In New Zealand, the cost of injecting equipment could be a barrier as only a limited range of syringes is available for free under the one-for-one exchange scheme,[15] and all other harm reduction commodities have to be purchased.[11] Geographical barriers also exist in the country. The NZNEP operates only two mobile services, leaving a number of areas underserved by the programme.[11] Insufficient geographical coverage is a problem in Australia too: many locations are missing syringe dispensing machines, and the number and location of NSPs are also insufficient,[7] while coverage varies within capital cities.[56] Barriers to access exist for certain communities in both countries. In Australia, access to NSPs is suboptimal for young people and Aboriginal and Torres Strait Islander people because many feel uncomfortable about approaching the mainstream face-to-face NSPs, and limited targeted programmes are available in the country for these populations.[7] Two groups were identified in New Zealand where access to NSPs is insufficient: there is some anecdotal evidence that people who inject performance- and image-enhancing substances are underserved and have little exposure to harm reduction services, and the needs of Māori people are not appropriately met, though data is lacking in this area.[11]

12 Primary NSPs are integrated into broader health services – and offer broader support for people who inject drugs (PWID) e.g. referrals to other health and welfare services, nurses assisting with injecting-based injuries, vein care etc.[21,50]

13 According to the Australian NSP National Minimum Data Collection Data Dictionary, secondary NSP refers to NSPs operating within existing health or community services with staff that are not solely dedicated to the provision of services to PWID.[51]

14 According to the WHO indicator, NSP coverage is high if NSPs in a country distribute more than 200 syringes per person who injects drugs per year, though the WHO hepatitis strategy calls for 300 syringes per person who injects drugs per year by 2030.[53,54]

15 One-for-one exchange scheme means that sterile syringes are available free of charge in exchange for the return of used equipment on a one-for-one basis: one sterile syringe for one unsterile syringe.

Health inequalities among Indigenous peoples in Oceania

Indigenous peoples in Oceania, specifically Aboriginal and Torres Strait Islander people in Australia and the Māori population in New Zealand, are disproportionately affected by the harms of drug use, and consistently experience worse health outcomes than other ethnic groups in the region.[102–104] This inequality has persisted since the arrival of European settlers and the beginning of colonialism,[105] with newly imposed health care systems focusing primarily to serve those of European descent.[102]

Structural inequalities negatively impact the health of Indigenous people both in Australia and New Zealand. In New Zealand, such factors include social deprivation, poverty, the quality of housing and household crowding, which could contribute to inequalities in rates of most infectious diseases – COVID-19 included.[106] Furthermore, Māori people consistently experience barriers when accessing health services, from discriminatory behaviour and inadequate information provision to practical barriers like costs and travel challenges, resulting in Māori people disengaging or actively avoiding health services.[102] Factors contributing to worse health outcomes in Aboriginal and Torres Strait Islander people include higher prevalence of low household incomes, unemployment, food insecurity, poorer housing and lower level of education compared to the non-Indigenous population.[103,107] The lack of accessibility to culturally appropriate health services is also apparent.[107] Though there are government-funded Indigenous-specific primary health care services in Australia, the low rate in specialist service use reflects difficulties in accessing these services for many Aboriginal and Torres Strait Islander people.[108] It has been recognised in New Zealand that Māori people have specific health needs, and the Māori Health Strategy was adopted in 2014.[109] However, racism and discrimination across the health system was raised as a key issue when the Māori Health Action Plan 2020–2025 was developed.[110,111]

Inequalities are reflected in higher burden of drug-related infectious diseases, for example hepatitis C prevalence is higher among Aboriginal and Torres Strait Islander people who inject drugs compared to non-Indigenous people who inject drugs.[3,112] However, research in Australia found that factors associated with hepatitis C infection were the same for Indigenous and non-Indigenous people who inject drugs - imprisonment, sharing injecting equipment in prison - but the extent of exposure to these factors differed.[112] In particular, incarceration rates are higher for Indigenous people in both countries.[113,114] In Australia, Aboriginal and Torres Strait Islander people represented 28% of the prisoner population in 2019, while accounting for 3.3% of the general population.[113] In New Zealand in 2019, 52% of the prison population was Māori people, while they represented 16.5% of the general population.[114,115]

Social determinants of health have a demonstrable effect on the harms associated with drug use. Addressing structural inequalities and implementing harm reduction services tailored to Indigenous peoples' needs, practices and conceptualisations of health are pivotal to decrease the prevalence of blood-borne viruses and drug-related harms.

Prevalence of drug use in general is also higher among Indigenous peoples. In New Zealand, Māori people are more likely to have used cannabis and amphetamines in the past year than non-Māori people[26] and, in Australia, last year prevalence of cannabis is 1.9 times higher, while last year prevalence of amphetamines is 2.3 times higher among Aboriginal and Torres Strait Islander Australians than non-Indigenous Australians.[116] Also, the proportion of NSP clients reporting an Aboriginal and/or Torres Strait Islander background in Australia increased significantly over the past five years, from 14% in 2015 to 22% in 2019.[3]

Social determinants of health have a demonstrable effect on the harms associated with drug use. Addressing structural inequalities and implementing harm reduction services tailored to Indigenous peoples' needs, practices and conceptualisations of health are pivotal to decrease the prevalence of blood-borne viruses and drug-related harms.

2.2 OPIOID AGONIST THERAPY (OAT)

The number of OAT clients in Australia has remained stable since 2018. On a snapshot day in June 2019, 50,945 people in Australia were receiving OAT (a 2% increase from 49,762 in 2017), two-thirds of these were male and 10% identified as Aboriginal or Torres Strait Islander, and the majority (61%) of OAT clients received methadone (17% received buprenorphine and 23% received buprenorphine-naloxone).[25] A recent development is that depot buprenorphine (a slow release, long-acting version of buprenorphine) has been introduced in Australia and became available from April 2020.[7,57] There is a trend of an ageing cohort in OAT over the past decade in Australia, the proportion of clients aged 60 and over has increased, while the proportion of clients under 30 has declined since 2010.[25] Reports attribute aging in the OAT population to three factors: methadone being available in Australia for more than 40 years, OAT reducing the risk of premature death, and clients seeking OAT for the first time at an older age.[25] On the snapshot day in 2019, there were 3,395 authorised prescribers of OAT, a 33% increase since 2015.[25] Between 2015 and 2019, the ratio of clients per prescriber decreased to 16; though, nationally, prescribers working in correctional facilities had an average of 36 clients. An important characteristic in OAT provision in Australia is the slow but continuous shift towards a higher proportion of dosing occurring at community pharmacies rather than specialist OAT facilities.[7] Though OAT coverage is sufficient in Australia, costs remained a barrier to access as clients have to pay dispensing fees at pharmacies of up to AUD 75 (USD 54) per week.[7,34,58,59] Although access to take-home OAT has improved slightly with COVID-19 (see COVID-19 chapter p.33),[60,61] there is also a need for greater access to take-home OAT.[7,34] Furthermore, actual and perceived stigmatisation of OAT clients is still an issue in the country.[7,34]

Methadone, buprenorphine and slow-release morphine tablets are available for OAT in New Zealand, and are mostly consumed orally and daily.[62,63] There is an increasing trend in the number of people receiving OAT in New Zealand, 5,573 people were on OAT in 2018 compared to 5,158 in 2013.[26] OAT initiation time has decreased in the past few years, with 75% of new clients starting OAT within four weeks of initial consultation with a provider in 2019 compared to 50% in 2013.[26] A recent report found that stigma and discriminatory behaviour by healthcare workers are a common issue for OAT clients in New Zealand. Stigma could impact the quality and type of medical treatment for other health issues given to people who receive OAT, for example reluctance to prescribe pharmacological pain treatment because of suspicion about drug-seeking behaviour.[63] Stigma creates a serious barrier in access as it could prevent people who receive OAT from accessing treatment, and also dissuades general practitioners from prescribing OAT.[63]

2.3 AMPHETAMINE-TYPE STIMULANTS (ATS) AND NEW PSYCHOACTIVE SUBSTANCES (NPS)

A recent analysis of adolescent health behaviour in six Pacific Island countries and territories (Cook Islands, Kiribati, Samoa, Solomon Islands, Tonga and Tuvalu) found higher lifetime prevalence of amphetamine use than previous studies, though the prevalence rates varied greatly between countries, ranging from 2.7% in Cook Islands to 34.6% in Samoa.[16][28]

According to the latest general population survey in Australia, the two most popular stimulants in the country are cocaine and ecstasy.[29][17] Cocaine has become more popular in Australia since 2016, with both lifetime prevalence (11.2%) and last year prevalence (4.2%) of cocaine use having increased, while last year use increased across all age groups, and the frequency of use also increased among people who used cocaine.[29] Recent ecstasy use in the country increased between 2016 and 2019; in 2019 12.5% reported lifetime use, and 3% reported last year use of ecstasy.[29] People living in the wealthier areas in Australia continued to be more than twice as likely as those in the least wealthy areas to use ecstasy.[29] The declining trend in methamphetamine and amphetamine use has continued since 2018, and it is still driven mainly by a decline in use among people in their 20s; in 2019, 5.8% of adult population reported lifetime use of methamphetamine and amphetamine, and 1.3% reported last year use.[29] An estimated 50% of people who used methamphetamine and amphetamine used it mainly in crystal form, which is linked with more frequent use. Similarly, 47% of people who used crystal methamphetamine as their main form use it monthly or more often.[29]

16 Lifetime prevalence rate of amphetamine use in the remaining four countries: Kiribati 4.1%, Solomon Islands 14.9%, Tonga 6.2%, Tuvalu 3.6%

17 In the 2019 National Drug Strategy Household Survey questionnaire, "ecstasy" was the general term for substances containing MDMA as an active ingredient. See https://www.aihw.gov.au/getmedia/5dc5a9f9-a877-4637-9aa5-b1b066c2adce/aihw-phe-270-2019-NDSHS-questionnaire.pdf.aspx

The prevalence of last year amphetamine and methamphetamine use was 1% in 2018/19 in the adult population in New Zealand, an increase from 0.7% in 2017/18.[64] Though amphetamine and methamphetamine use is relatively low in the country, methamphetamine use is concentrated in some communities. Wastewater testing by the police showed four times higher methamphetamine use per capita in the northernmost part of New Zealand as compared to the southernmost part.[18][26,30] MDMA use is on the rise in the country; it was the second most commonly detected drug in wastewater testing, and seizures have increased in the past years.[26,30] Reports attributed the increased MDMA use to increased availability as the supply from overseas grew and ecstasy pills became more affordable, while dose and purity also increased over the past years.[26,30] According to the police, wastewater testing for cocaine is less prevalent in New Zealand than for amphetamines and MDMA.[30]

More than 70 deaths were connected to synthetic cannabinoids between 2017 and 2019.[26] However, death rates decreased at the end of 2019. Reports attribute this decline to steadily decreasing police and border seizures of synthetic substances, and the type of synthetic cannabinoids available in the market being less toxic.[26] At the beginning of 2020, New Zealand launched an early warning system to help identify drug-related risk situations by collecting information through a standardised analysis process including street national data sets, street sample testing, and information from civil society organisations working on the ground.[65,66] Some Australian jurisdictions have established informal information sharing groups as local early warning systems,[67] with a model for a national early warning system soon to be tested for feasibility.[68,69]

An important harm reduction response to ATS and NPS use in the region is drug checking (also known as pill testing). In New Zealand, KnowYourStuffNZ has operated a free pill testing service at music festivals since 2014 and, in 2019, the organisation in partnership with the New Zealand Drug Foundation implemented a fixed site pilot pill testing service in Wellington.[31–33] The organisation considered the pilot programme successful, and the number of clients and tested substances increased steadily over the six month pilot period.[32] Both at festivals and at the fixed site testing programme the majority of substances tested was MDMA, and most clients said that they would not take a substance if it turned out not to be what they expected.[31,32] In the festival scene, the trends showed an increase in the proportion of substances that were what they were expected to be: in 2016/17, only 68% of substances tested consistently with what they were supposed to be, compared to 87% in 2018/19. An increase of high-dose ecstasy pills was a concern in the year of reporting.[31]

All but one of Australia's nine state and territorial governments officially oppose drug checking.[7] However, there have been two trials of pill testing at music festivals in the Australian Capital Territory (Canberra) over the last two years[7,34–36] and, on 20 August 2020, the government of the Australian Capital Territory announced a plan to extend drug checking, and implement a weekly fixed site drug checking service in Canberra towards the end of 2020.[7,70] The evaluation of the pilot programmes concluded that the trials were successful, provided valuable information on drug availability in Canberra, and produced positive results in terms of participants' harm reduction knowledge and practices.[35,36] After the successful 2018 Canberra pilot, the policy debate significantly increased on drug checking, and an analysis of the debate in New South Wales concluded that despite the fact that advocates and the opponents shared the same goal (to save lives), a productive debate on the issue has to address underlying differences in values on drug use and agency of young people. While opponents viewed drugs as inherently bad and thought young people require protection from their poor choices, advocates viewed drug use as a reality and thought young people can make informed decisions based on the information drug checking could provide.[71]

2.4 OVERDOSE, OVERDOSE RESPONSE AND DRUG CONSUMPTION ROOMS (DCRs)

There are two drug consumption rooms (DCRs) in the region, both in Australia where they are known as medically supervised injection facilities. The DCR in Sydney has been operating since May 2001.[72] The second DCR opened in 2018 in Melbourne for a two-year trial period, ending in 2020. An independent expert panel conducted a review of the programme based on the first 18 months of operation,[44] and found that the DCR had successfully reduced harms for service clients, with more than 119,000

18 New Zealand has 12 police districts, nine in the North Island and three in the South Island. Northland district is the northernmost, Southern district is the southernmost.. See: https://www.police.govt.nz/about-us/structure/police-districts

visits in the first 18 months, and no overdose deaths onsite.[44] Furthermore, the DCR provided access to other health and support services to people who used the service, and the report concluded that the provision of complex services (NSPs, infectious disease testing, counselling of HIV and hepatitis C, and treatment of hepatitis C) at the DCR is beneficial, for example more than a third of people screened tested positive for hepatitis C and a quarter had begun treatment.[44] Following the recommendations of the review panel, in June 2020, the local government announced the extension of the trial for another three years, and the opening of Melbourne's second DCR.[34,44,73,74] Establishing a DCR is an ongoing issue in the Australian Capital Territory, where the government funded a feasibility study in 2020 to examine the possibility of implementing a DCR in the territory.[75] Establishing DCRs in New Zealand is not currently debated as the main barriers to implementation are the lack of political will and the costs of such facilities.[11]

Naloxone (including the intranasal form)[76] is available in all states and territories in Australia with a prescription or over the counter from a pharmacy, though people have to pay for it,[7,8] and cost is a barrier to access.[77] However, there is a movement towards community-based distribution of naloxone with a national government trial of take-home naloxone (THN) which began in 2019 and will run until 2021. Naloxone is available free of charge (and without a prescription) under the THN pilot in three states: New South Wales, South Australia and Western Australia.[7,34,78] During the pilot period, THN is available in community and hospital-based pharmacies, alcohol and other drug treatment centres, NSPs, custodial release programmes and at general practitioner clinics.[78] THN programmes are available through 66 NSPs in the country, and 40% of primary NSPs and 3% of secondary NSPs have programmes to facilitate access to THN.[2]

Naloxone kits are available at NSPs in New Zealand, though there has not been universal uptake of this approach, and it is not part of the New Zealand Needle Exchange Programme service provision.[11] However, during the COVID-19 pandemic the government funded access to naloxone kits at NSPs.

2.5 HIV AND ANTIRETROVIRAL THERAPY (ART)

HIV prevalence among people who inject drugs remains low in the region, estimated at 2.3% in Australia and 0.2% in New Zealand.[3,10,11] Low HIV prevalence is an historic characteristic in both countries. A recent analysis found that the HIV prevalence rate among people who inject drugs was below 2.3% in all survey years between 1995-2019 in Australia, and has been stable over the past five years.[3] A study examining new HIV cases between 1996-2018 in New Zealand found that new HIV diagnoses among people who inject drugs remained very low, on average two (less than 3%) per year could be attributed to injecting drug use over the study period.[24] The low prevalence rates among people who inject drugs in New Zealand is attributed to the early introduction of NSPs, the peer-led approach in NSP implementation, and the sustained harm reduction response in the country.[24,41]

Drug use is not the major mode of HIV transmission in these countries. In Australia, injecting drug use was reported for 3% of new HIV cases in the country,[5] and injecting drug use accounts for a small fraction of HIV transmission in New Zealand: in 2019 only one locally acquired case was attributed to injecting drug use in the country.[24,79] HIV prevalence has a similar pattern in Australia: injecting drug use is not the main mode of transmission, men who have sex with men have a much higher risk of acquiring HIV.[5] HIV prevalence was 32% in 2019 among the subpopulation of people who inject drugs and reported being men who have sex with men.[3] According to the national NSP survey data, the HIV prevalence rate among Aboriginal and Torres Strait Islander respondents was stable between 2014 to 2018. However, it was higher among this population compared to other respondents (3.6% and 1.1% respectively in 2018).[4] This difference could be attributed to several factors (inadequate implementation of prevention strategies such as treatment as prevention and pre-exposure prophylaxis; higher proportion of undiagnosed HIV cases in the population; higher HIV incidence in the Aboriginal and Torres Strait Islander population attributed to injecting drug use than in the non-Indigenous population),[5,80] though structural factors contributing to overall worse health outcomes among Indigenous populations also have to be considered (see Box 2 on p.152).

ART and pre-exposure and post-exposure prophylaxis[19] are widely available in both Australia and New Zealand.[81–84] Among the Australian NSP survey respondents who reported they were living with HIV, 88% reported they were on ART.[3]

2.6 HARM REDUCTION IN PRISONS

Prison is a high risk setting where harm reduction interventions are of key importance. In Australia, people in prison with a history of injecting drug use are a key population for hepatitis C elimination. Hepatitis C prevalence is high among prison entrants in both men (24%) and women (28%).[5] Furthermore, in 2019, half of NSP survey respondents reported a lifetime history of incarceration,[3] and hepatitis C prevalence was higher among respondents reporting recent imprisonment compared to those who did not.[4] NSP clients in New Zealand have similar characteristics; data derived from the most recent NZNEP client survey indicates that imprisonment is the most powerful predictor of hepatitis C serostatus, and that 43% of respondents had been imprisoned at some time in their lives.[11,85]

Despite NSPs being established services in Australia and New Zealand, with good coverage in community settings, NSPs are not available in any prison in the region.[7,11,34] Implementing NSPs in prisons was considered in the development of the National Hepatitis C Action Plan in New Zealand,[11] though the action plan has not yet been published.[86] Without appropriate access to sterile injecting equipment, injecting drug use in prison poses serious health risks; according to a study by AIVL, syringes in prison settings are reused an estimated 100 times.[27] This is a major concern, as 32% of recently imprisoned NSP clients reported injecting in prison in Australia.[3] These are consistent with the results of a recent longitudinal study of injecting risk behaviours in Australian prisons, where they found that, following entry into prison, the proportion of people who reported injecting drug use decreased, but among those who did inject drugs, syringe sharing increased.[87]

OAT is available in prisons in both Australia and New Zealand, however access is more limited than in the general population.[7,34,88] In New Zealand, OAT is only available to prisoners who had initiated OAT prior to incarceration (except in one prison where OAT can be initiated).[89] In Australia, OAT can and frequently is newly initiated within prison;[7] a total of 3,588 clients received OAT in prisons on a given day in 2019 (7% of all OAT clients in the country).[25] The availability of OAT can vary considerably between prisons in different states and territories. Out of the 101 OAT prescribers in correctional facilities in Australia, 48 were located in New South Wales, whereas just three were in Queensland.[25] Clients of OAT prescribers in correctional facilities in 2019 were younger than clients of public or private prescribers, and there were more males among them: nine out of ten OAT clients in correctional facilities were male, compared to twice as many males as females at public and private prescribers.[25]

In Australia, OAT can and frequently is newly initiated within prison; a total of 3,588 clients received OAT in prisons on a given day in 2019 (7% of all OAT clients in the country)

19 Pre-exposure prophylaxis is a course of medication that can reduce the chances of HIV infection before exposure to the virus. Post-exposure prophylaxis is a preventive medical treatment started after possible exposure to HIV in order to prevent the infection from occurring.

3. Policy developments for harm reduction

The Australian and New Zealand governments remain supportive of harm reduction interventions both within their countries and internationally, for example through support for harm reduction at the UN Commission on Narcotic Drugs.[7,90,91] Harm reduction forms one of the three pillars of Australia's National Drug Strategy 2017-2026 (alongside demand reduction and supply reduction), and is included in the most recent national drug strategy annual report as an approach that is integral to the national response to drug use.[92,93] New Zealand's National Drug Policy 2015-2020 also explicitly supports harm reduction and a people-centred system of interventions.[94] No evidence has been found of policy documents declaring explicit support for harm reduction in the region outside these two countries.

In November 2018, the Australian government publicly released five national blood-borne virus (BBV) and sexually transmissible infection (STI) strategies for 2018-2022.[7,95] While the National STI Strategy does not contain explicit reference to harm reduction, the National HIV Strategy, the National Hepatitis C Strategy, the National Hepatitis B Strategy and the National Aboriginal and Torres Strait Islander BBV and STI Strategy include harm reduction in the guiding principles, and increasing access to NSPs and facilitation of peer-based harm reduction initiatives are included among the priority areas of action.[95–99]

There were some changes in the legal environment in the region. Australia's National Drug Strategy annual report highlighted that the New South Wales Police Force has announced a trial of drug Criminal Infringement Notices[20] for minor possession offences at music festivals as part of a harm reduction approach.[92] In August 2019, New Zealand's drug laws were updated to emphasize a health-based approach to personal drug use. In the case of personal possession and use of drugs, police must determine whether a health-centred or therapeutic approach would be more beneficial to the public interest than prosecution.[26,100]

4. Funding developments for harm reduction

In both New Zealand and Australia, much investment in harm reduction services and advocacy comes from national and state governments.[7,11] In Australia, a commitment to harm reduction investment is included in the National Drug Strategy.[93] However, it is estimated that the majority of funding allocated in the strategy goes to law enforcement,[7] while THN and OAT are not fully funded, and funding for traditional harm reduction services and drug checking is insufficient.[21] The last analysis of drug-related expenditure in Australia was in 2009/10 and no such analysis has been made since then.[34,47] Although funding for harm reduction is stable in Australia, the level of funding is insufficient.[7,34] Harm reduction organisations are generally funded to provide services, but there is a lack of funding to engage in policy work and advocacy.[7] Funding also limits the expansion of NSPs,[7,34] for example AIVL recommendations include extended services for outer suburbs where there are no primary NSPs, outreach services in communities with dispersed populations, and greater funding flexibility in general to establish operating hours that align with community needs or provide a broader range of equipment that matches the community's pattern of usage.[27]

In New Zealand, harm reduction in general is closely aligned with the Ministry of Health, which provides the Secretariat for New Zealand's National Drug Policy, and the NZNEP.[11] As with all government-funded programmes in the country, service provision is limited by the allocation of resources, a problem not limited to harm reduction.[11] Since 2018, the government of New Zealand has on several occasions introduced extra funds to address emerging trends in drug use. To address the acute drug harms related to synthetic cannabinoid receptor agonists, the government announced a dedicated NZD 8.6 million (USD 5.7 million) acute drug harm discretionary fund at the end of 2018 to support community responses.[101] Furthermore, in 2020, a NZD 32 million (USD 21.3 million) investment was announced for District Health Boards to strengthen their existing alcohol and drug specialist services.[11]

20 Criminal Infringement Notices are 'on-the spot' fines[7,34] for certain minor offences.

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2.7 SUB-SAHARAN AFRICA

ANGOLA
BENIN
BOTSWANA
BURKINA FASO
BURUNDI
CABO VERDE
CAMEROON
CENTRAL AFRICAN REPUBLIC
CHAD
COMOROS
CONGO (DEMOCRATIC REPUBLIC OF)
CONGO (REPUBLIC OF)
CÔTE D'IVOIRE
DJIBOUTI
EQUATORIAL GUINEA
ERITREA
ESWATINI
ETHIOPIA
GABON
THE GAMBIA
GHANA
GUINEA
GUINEA-BISSAU
KENYA
LESOTHO
LIBERIA
MADAGASCAR
MALAWI
MALI
MAURITANIA
MAURITIUS
MOZAMBIQUE
NAMIBIA
NIGER
NIGERIA
RWANDA
SÃO TOMÉ AND PRÍNCIPE
SENEGAL
SEYCHELLES
SIERRA LEONE
SOMALIA
SOUTH AFRICA
SOUTH SUDAN
SUDAN
TANZANIA
TOGO
UGANDA
ZAMBIA
ZIMBABWE

TABLE 2.7.1:

Epidemiology of HIV and viral hepatitis, and harm reduction responses in sub-Saharan Africa

Country/territory with reported injecting drug use[1]	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[2]	OAT[3]	Peer distribution of naloxone	DCRs[4]
Angola	nk	nk	nk	nk	x	x	x	x
Benin	nk	2.2[1]	nk	nk	✓[2]	x	x	x
Burkina Faso	nk	nk	nk	nk	x	✓[3]	x	x
Burundi	nk	nk	nk	nk	x	x	x	x
Cameroon	nk	nk	nk	nk	x	x	x	x
Cabo Verde	nk	nk	nk	nk	x	x	x	x
Central African Republic	nk	nk	nk	nk	x	x	x	x
Chad	nk	nk	nk	nk	x	x	x	x
Congo (Democratic Republic of)	160,000[1]	13.3[4]	nk	nk	x	x	x	x
Côte d'Ivoire	500[4]5	3.4[1]	1.8[4]	10.5[4]	x	✓1[5]	x	x
Djibouti	nk	nk	nk	nk	x	x	x	x
Eswatini	nk	nk	nk	nk	x	x	x	x
Ethiopia	nk	nk	nk	nk	x	x	x	x
Gabon	nk	nk	nk	nk	x	x	x	x
Gambia	nk	nk	nk	nk	x	x	x	x
Ghana	6,314[6]	nk	40.1[4]	nk	x	x	x	x
Guinea	nk	nk	nk	nk	x	x	x	x
Kenya	30,500[4]	18[7]	16.4[4]	5.4[4]	✓19[8]	✓7[8,9]	x6	x
Lesotho	2,600[10]	nk	nk	nk	x	x	x	x
Liberia	457[11]7	3.9[12]8	nk	nk	x	x	x	x
Madagascar	15,500[4]	4.8[4]	5.5[4]	5[4]	x	x	x	x
Malawi	nk	nk	nk	nk	x	x	x	x
Mali	nk	5.1[13]9	nk	nk	✓[14]	x	x	x
Mauritius	11,667[15]	45.5[4]	97.1[4]	6.%[4]	✓46[16]10	✓42[16] (M,B)	x	x
Mozambique	29,000[4]	46.3[4]	67.1[4]	nk	✓1[17]	x	x	x
Niger	nk	nk	nk	nk	x	x	x[18]	x
Nigeria	44,515[13]	3.1[4]	2.3[19]	6.7[4]	✓3[20–22]	x	x	x
Rwanda	2,000[4]	nk	nk	nk	x	x	x	x
Senegal	1,324[23]11	9.4[4]	39.3[4]	nk	✓4[24,25]	✓1[24]	x	x
Seychelles	2,560[26]12	12.7[26]	76[26]	1[26]	x	✓13	x	x
Sierra Leone	1,500[4]	8.5[1,4]	nk	nk	✓[27]	x	x	x
Somalia	nk	nk	nk	nk	x	x	x	x
South Africa	76,000[4]	14.2[4]	54.7[28]14	5[29]	✓5[30]	✓<11[30] 15(M,B,B-N)	x16	x
Tanzania	30,000[31]17	15.5[7]	57[32]	1.1[4]	✓[4]	✓6[33]	x	x
Tanzania (Zanzibar)	3,000[34]	11.3[35]	25.4[35]	5.9[35]	x	✓[36]	x18	x
Togo	2,500[4]	nk	nk	nk	x	x	x	x
Uganda	3892[37]	17-20[38]19	nk	nk	x	x	x	x
Zambia	nk	nk	nk	nk	x	x	x	x
Zimbabwe	nk	nk	nk	nk	x	x	x	x

nk = not known

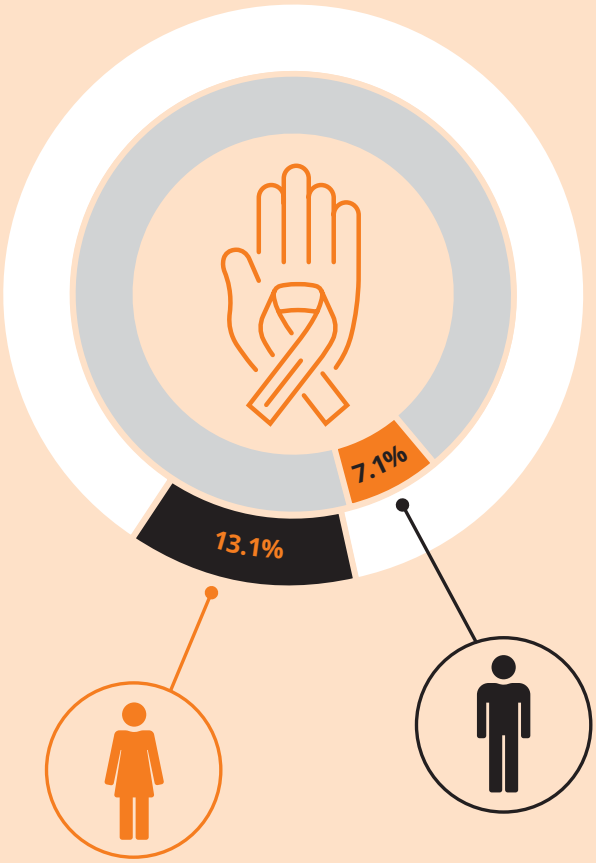
1 The countries included in this table are those with reported injecting drug use according to Larney et al., 2017. No evidence of injecting drug use was found in: Botswana, Central African Republic, Comoros, Equatorial Guinea, Eritrea, Guinea Bissau, Mauritania, Namibia, Congo (Republic of), São Tomé and Príncipe, or South Sudan.[1]
2 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.
3 Opioid agonist therapy (OAT), including methadone (M), buprenorphine (B) and any other form (O) such as morphine and codeine.
4 Drug consumption rooms, also known as supervised injecting sites.
5 For people who use drugs this number is believed to be between 6,000 to 10,000 people, with smoking rather than injecting more widely practised.
6 Naloxone is available at harm reduction sites in Kenya but can be administered only by trained healthcare personnel.
7 Based on sub-national data from six cities in three counties of Liberia.
8 Based on sub-national data from Grand Cape Mount, Grand Bassa, Grand Gedeh, Gbarpolu, Lofa, Montserrado, Margibi, Nimba and River Gee.
9 Based on sub-national data for Bamako only, with a sample size of 39.
10 35 sites managed by the Ministry of Health and Quality of Life (Government of Mauritius), 11 sites managed by the NGO Collectif Urgence Toxida.
11 Based on sub-population data from Dakar only.
12 Total number of people using heroin estimated to be 4,318, with 2,560 using injection as the chosen route of administration.
13 OAT offered by the Agency for the Prevention of Drug Abuse and Rehabilitation, believed to be an abstinence-oriented programme.
14 N=940 people who inject drugs in Cape Town, Durban and Pretoria. Data from 2017.
15 OAT is available in four cities: Cape Town, Durban, Johannesburg and Pretoria (eight sites in Pretoria).
16 Naloxone available for administration by first responders/emergency healthcare workers.
17 Figure is believed to be an underestimate nationally, but locally adequate in selected sites.
18 Naloxone available for administration by first responders/emergency healthcare workers.
19 Figure relates to people who use drugs, but women who inject drugs appear disproportionally affected by HIV with more than double the prevalence at 45%.

MAP 2.7.1:
Availability of harm reduction services

- Both NSP and OAT available
- OAT only
- NSP only
- Neither available
- Not known
- DCR available
- Peer-distribution of naloxone

2.7
Harm reduction in sub-Saharan Africa

HIV PREVALENCE IN PRISONS



IN WEST AND CENTRAL AFRICA, HIV PREVALENCE AMONG WOMEN IN PRISON IS ESTIMATED AT 13.1%, COMPARED WITH 7.1% AMONG MEN IN PRISON.

30% of people who inject drugs in the region are estimated to be living with HIV.

THE NUMBER OF PEOPLE WHO INJECT DRUGS IS ESTIMATED TO BE BETWEEN

560,000 AND **2.7 MILLION**

A RANGE THAT DEMONSTRATES THE PAUCITY OF DATA.

HIV IN THE REGION

51% ON ANTI-RETROVIRAL THERAPY

AS OF 2018, ONLY 51% OF ALL PEOPLE LIVING WITH HIV IN WEST AND CENTRAL AFRICA RECEIVED ART, WHICH MEANS THAT AROUND 2.5 MILLION PEOPLE LIVING WITH HIV IN THE REGION NEEDED TREATMENT BUT WERE NOT RECEIVING IT.

1. Overview

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Most countries in sub-Saharan Africa have poor collection and availability of data on drug use and the health of people who use drugs, and harm reduction services for people who inject drugs are limited. Injecting drug use is reported in 38 of 49 countries in sub-Saharan Africa, and the number of people who inject drugs is estimated to be between 560,000 and 2.7 million, a range that demonstrates the paucity of data.[39] Most people who report injecting drugs in sub-Saharan Africa are male, ranging from 66% in northern Nigeria to 93% in Nairobi, Kenya.[40]

The most commonly injected drugs in the region are opioids, followed by cocaine and tranquilizers.[41] Until now across the region, cocaine and heroin have been commonly used, with cocaine use highest in West, Central and Southern Africa, and heroin consumption concentrated along the East African coast (particularly in Kenya, Mauritius, Seychelles, South Africa and Tanzania).[41]

Drug use is criminalised in most sub-Saharan African countries, and people who use drugs are the target of law enforcement operations. Government policies on psychoactive drugs reflect a political preference for controlling drug supply. National and regional drug policies, influenced by the United States, UN conventions and other states' interests, often limit resources for harm reduction on the grounds that they condone drug use.[42] However, in West Africa in particular, there has recently been a movement towards more evidence-based and humane policy responses.[42]

Only a few countries in the region have implemented harm reduction programmes, particularly in the public sector. For example, needle and syringe programmes (NSPs) exist in ten countries in the region (Benin, Kenya, Mali, Mauritius, Mozambique, Nigeria, Tanzania, Senegal, Sierra Leone, South Africa and Tanzania), while opioid agonist therapy (OAT) is available in nine territories (Burkina Faso, Côte d'Ivoire, Kenya, Mauritius, Senegal, Seychelles, South Africa and Tanzania, as well as in Zanzibar). Although regional data is limited, country surveys among people who inject drugs suggest high HIV prevalence.[43]

Overall, just under a third (30%) of people who inject drugs in the region are estimated to be living with HIV and the same population is estimated to have accounted for 2% of new HIV infections in the region in 2019.[1,44] As noted above, data collection in the region is poor and therefore these estimates should be used with caution. Although there is progress with harm reduction programmes in the region, the overarching theme is one of implementation gaps and barriers, including limited programmes for women who use drugs, criminalisation of drug use, and limited legal and policy provisions to support programmes.

> *Needle and syringe programmes (NSPs) exist in ten countries in sub-Saharan Africa, while opioid agonist therapy (OAT) is available in nine territories.*

2. Developments in harm reduction implementation

2.1 NEEDLE AND SYRINGE PROGRAMMES (NSPs)

Since the *Global State of Harm Reduction 2018*, there has been some progress in initiating NSP programmes in sub-Saharan Africa, with NSPs now operational in Benin, Nigeria and Sierra Leone. However, the NSPs which commenced in 2018 in Uganda are no longer operational. In total, NSPs exist in sub-Saharan Africa across ten countries (Benin,[2] Kenya, Mali, Mauritius, Mozambique, Nigeria, Senegal, Sierra Leone, South Africa, and Tanzania), an increase of one since 2018.[45] In Benin, the NSP was initially implemented in certain communities with a high concentration of people who inject drugs, but since 2018 has been extended to the entire country through a programme supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). Currently, people who inject drugs enrolled in the programme receive ten syringes per month.[2] In Nigeria, three pilot sites are now operational with support from the federal government.[20–22] The Uganda Harm Reduction Network in 2018, with support from the Global Fund, piloted an NSP reporting distribution of 2,244 syringes to 120 people who inject drugs over a period of eight months from January to September 2018.[46] However, due to limited funding, the pilot programme was never scaled up, and the activity closed in 2019 at the end of the regional Global Fund grant.

Senegal remains a model example of successful implementation of harm reduction, showcasing positive collaboration between different state bodies and agencies, which resulted in the launch of West Africa's first harm reduction centre in 2014. The centre continues to operate outreach activities for NSPs within communities of people who inject drugs.[47] Since March 2019, the Sierra Leone Youth Development and Child Link (SLYDCL) has run the country's first NSP and plans to scale up its activities nationally and include people in prison once the results of the survey among people who inject drugs provides updated population size estimates. The National AIDS Secretariat in Sierra Leone advocates for the inclusion of harm reduction training into the mainstream police academy curriculum, with the aim of reducing police interference in NSP provision.[27]

Since the beginning of 2017, ARCAD Santé Plus in Mali has implemented a harm reduction programme focusing on injecting drug use in the districts of Bamako and Sikasso and financed by the Global Fund. Given the difficult context in Mali, an important component of the project is aimed at creating an enabling environment, including addressing political, legal, clinical and social barriers. The successful implementation to date has paved the way for harm reduction to be included in the funding request from Mali to the Global Fund for the 2021 to 2023 cycle.[20][14]

Despite these examples of achievements and the demonstrated effectiveness of NSP programmes in sub-Saharan Africa, coverage remains inadequate. Of the countries that have NSPs, the majority provide less than the World Health Organization (WHO) recommendation of 300 syringes per person who inject drugs per year.[48,49] The risk of acquiring HIV through sharing of injecting equipment is high among the people who inject drugs in sub-Saharan Africa. Many HIV prevention programmes in the region have deprioritised injection risks in their public awareness communications, perceiving injected drug use to be uncommon.[50] The reality is that a large proportion of people who inject drugs regularly share equipment, and research carried out in Nigeria revealed that only 25% of people who inject drugs know that sharing of syringes carries the risk of HIV transmission.[50]

In Nigeria, in 2019, the government committed to piloting needle and syringe programmes after advocacy from the health sector and civil society organisations.[51] Pilots have been implemented in three states in 2020, but the coverage and extent is unclear.[20, 21]

Criminalisation, legal restrictions on young people, and stigma and discrimination were reported as key barriers to effective NSPs. Additionally, people who inject drugs rely chiefly on civil society organisations for harm reduction services, which often operate in hostile environments. Funding for NSP programmes is insufficient, largely due to lack of political will and support. For example, in May 2018 in Durban, South Africa, the NSP was closed due to concerns of insufficient stakeholder consultation and the systems available for waste management of unsterile injecting equipment.[53] While this service was reinstated in late June 2020 and has seen a significant increase in the total number of clients, programme staff have struggled to locate the previous cohort of clients that had accessed the service before its closure.[20] The reform of obstructive laws and policies – along with greater funding and other

20 ARCAD Santé Plus (formerly a Global Fund sub-recipient) became the principal recipient for implementation.

support for community-based organisations – would greatly enhance HIV prevention among people who inject drugs in the region.[7]

NSP delivery in many countries across the region adopts a peer-led approach to distribute syringes and collect unsterile equipment. However, a challenge with the peer-led approach is that it is often supported by international donors, and once donor funding ends, national governments do not fill the funding gap.[53]

2.2 OPIOID AGONIST THERAPY (OAT)

In sub-Saharan Africa, OAT services are available in Burkina Faso, Côte d'Ivoire, Kenya, Mauritius, Senegal, Seychelles, South Africa and Tanzania (as well as in Zanzibar). Despite the unstable legal and policy environment in the region, there has been an incremental increase in countries or territories with OAT services from eight in 2018 to nine in 2020. The government has steadily expanded access to OAT in Kenya since 2014, although still only an estimated 10% of people who inject drugs are reached.[53]

The commonly used opioid agonist medications in the region are methadone, buprenorphine and buprenorphine-naloxone combinations. Where OAT exists, it is generally provided only through direct observation therapy in treatment settings, with the exception of South Africa and Tanzania where OAT is also provided in take-home doses (though only in a small-scale pilot in Tanzania). OAT services in sub-Saharan Africa are offered primarily in public general hospital settings, for example in Kenya and Tanzania, OAT is offered in public and national referral hospitals.[32,54] However, there remain some cases of private drug treatment centres in Kenya and South Africa.[32,54]

Since 2018, in Burkina Faso, methadone is listed as an essential medicine and delivered at the addictology unit at the Centre Hospitalier Universitaire Yalgado[3] in the capital city of Ouagadougou. In Dakar, Senegal, the drop-in clinic CEPIAD offers free OAT. In Uganda, the President's Emergency Plan for AIDS Relief (PEPFAR) pledged to support programmes for people who inject drugs.[46] Uganda now has plans in place for setting up its first ever OAT programme, likely to use both methadone and buprenorphine-naloxone combination.

OAT remains unavailable in Zimbabwe and Nigeria, despite significant populations of people who inject drugs and high HIV prevalence in both countries. However, the Nigerian government began processes in March 2019 to develop guidelines on the use of methadone for drug treatment and has also created a national task force on harm reduction.[55] In Mali, ARCAD Santé Plus is advocating for the introduction of OAT, backed up by data from a pilot project launched in 2017.[14] OAT is not yet available in Niger; however, the national pharmaceutical laws do provide a legal framework for the use of agonists such as methadone and naltrexone.[18] Sierra Leone aims to address drug use by using a holistic approach focusing on HIV prevention, including OAT implementation. However, while there is growing political support for harm reduction measures in Sierra Leone, there is no domestic funding for this work which is currently wholly supported by the Global Fund.[27]

Despite advances in OAT programming, relevant policy and OAT advocacy lag behind in South Africa. The South African Addiction Medicine Society has developed OAT guidelines, and new National Department of Health OAT guidelines are currently in development to be aligned with the new National Drug Master Plan.[20] OAT medications are still not included on the essential drug list for use at the primary care level. Even with the third five-year South African National Strategic Plan on HIV, Sexually Transmitted Infections and Tuberculosis (2017–2022), OAT is not included.[56]

2.3 AMPHETAMINE-TYPE STIMULANTS (ATS) AND NEW PSYCHOACTIVE SUBSTANCES (NPS)

While some African countries, notably Nigeria and South Africa, are the site of manufacture of ATS such as methamphetamine, these substances are largely manufactured for export.[57] Prevalence of amphetamine and methamphetamine use across Africa is less than 0.5% according to the United Nations Office on Drugs and Crime (UNODC), while cocaine use is even less prevalent (0.2%).[58] National-level data is completely absent for most countries. In Nigeria, the use of amphetamines and MDMA is prevalent

among young people, negligible among older people and less prevalent among women and girls.[13] Overall, the estimated prevalence of use of amphetamines is 0.2%.[59]
A significant proportion of people who inject drugs in South Africa use methamphetamine or cocaine, and use is especially high in Cape Town.[60,61] One three-city cross-sectional survey in the country found that 28% of people who inject drugs had injected methamphetamine or ATS in the last month, compared with 86% who had injected heroin.[60] Stimulant injection is associated with more frequent injection and therefore higher prevalence of risk behaviours (such as using equipment multiple times or for multiple people) and higher risk of HIV and hepatitis transmission.[62] NSPs are the primary harm reduction service for this population in South Africa. Since 2017, TB/HIV Care in Cape Town and Durban has offered Contemplation Groups as a part of their harm reduction programming. The sessions with these groups focus on providing room for reflection on drug use, and creating and strengthening identities separate from drug use among people who use drugs. Qualitative evaluation has found that the groups succeed in allowing participants an opportunity to manage their drug use, increase harm reduction practices and rebuild relationships according to their needs and experiences.[63]

The emergence of new psychoactive substances (NPS) and the counterfeit drug trade is also an issue in the region. WHO estimates that as many as 100,000 deaths per year in Africa could be due to counterfeit prescription medication not intended for recreational use. The total demand in West Africa for amphetamines, cocaine, opiates and prescription opioids is projected to more than double by 2050, from roughly 185 metric tons in 2018.[59]

2.4 OVERDOSE, OVERDOSE RESPONSE AND DRUG CONSUMPTION ROOMS (DCRs)

Overdose, overdose response and DCRs have remained the same as reported in the *Global State of Harm Reduction 2018*. Naloxone use in overdose management has been reported in some parts of sub-Saharan Africa, including South Africa and Kenya[45] and only in hospitals in Tanzania. In South Africa, projects have trained peers and staff in overdose and prevention management, but naloxone itself remains only accessible through prescription or medical first responders.[20] Civil society actors continue to advocate for the inclusion of naloxone in all public harm reduction programmes.[20] In the Democratic Republic of the Congo, Mauritius, Nigeria, Senegal, Seychelles, Uganda and Zimbabwe, naloxone is reportedly unavailable.[64]

2.5 HIV AND ANTIRETROVIRAL THERAPY (ART)

HIV prevalence among people who inject drugs in sub-Saharan Africa is approximately 56%, though up-to-date and robust data is scarce.[65] National prevalence estimates among people who inject drugs vary considerably, for example from 3.1% in Nigeria to 45.5% in Mauritius.[66] In 2017, it was estimated that roughly 6.5% of people who inject drugs in West and Central Africa are living with HIV.[67] This variation demonstrates the urgent need for accurate and representative data on HIV among people who use drugs in the region.

This geographic variation in HIV prevalence may be related to gender inequality within settings and the degree of overlap between injection drug use and sex work. There is a higher HIV prevalence among women who inject drugs, who are two to ten times more likely to be living with HIV than men who inject drugs in Nigeria, South Africa and Tanzania.[43,68]

As of 2018, only 51% of all people living with HIV in West and Central Africa received ART, which means that around 2.5 million people living with HIV in the region needed treatment but were not receiving it.[69] As of June 2020, Benin, Burkina Faso, Burundi, Cape Verde, Côte d'Ivoire, Chad, Guinea, Guinea-Bissau, Liberia, Mauritania, Mali, Niger, Sierra Leone and Togo had all introduced supportive policies relating to HIV testing and treatment.[1]

ART coverage in West and Central Africa is below that of East and Southern Africa, which has attained 67% coverage. The low coverage in the West and Central sub-regions is attributed to various factors, mainly conflict within the region, other epidemics such as Ebola, and the fact that a high proportion of people do not know their HIV status. This situation is further exacerbated by the lack of national and international political will, weak healthcare systems and lack of support for community-based and community-led

organisations.[70] As a result of low testing, low ART coverage and issues with treatment retention, in 2018, an estimated 39% of people living with HIV in West and Central Africa achieved viral suppression. However, as few people can access a viral load test, the real picture on viral suppression is uncertain.[69]

Where harm reduction services exist in sub-Saharan Africa, HIV services, including HIV testing and access to ART, have been integrated. OAT services have been used as sites for HIV testing and ART delivery for people who inject drugs. Additionally, ART services are provided in outreach settings for hard-to-reach populations, including people who inject drugs. Despite the efforts to make services available to people who inject drugs in the region, the performance of ART services has been affected by client loss to follow-up and poor adherence outcomes, especially for those who fall in and out of the OAT programme[71].

2.6 HARM REDUCTION IN PRISONS

Prisons are a high-risk environment for HIV transmission due to widespread drug use and a lack of availability of sterile injecting equipment, tattooing with homemade and unsterile equipment, and high-risk and non-consensual sex. UNAIDS estimates that people in prison worldwide are on average five times more likely to be living with HIV compared with adults who are not imprisoned, while WHO estimates the difference to be even higher.[72,73] A systematic review released in 2018 found that recent incarceration was associated with an 81% increase in HIV risk and 62% increase in hepatitis C risk.[74] Due to overcrowding, as well as stress, malnutrition, drug use, and violence, the immune system may be further weakened, rendering people living with HIV more exposed to other health complications.[74–76] Despite this, HIV prevention programmes are rarely made available within prison settings and many people in prison with HIV are unable to access ART.[75,77]

Reported HIV prevalence among people in prisons in sub-Saharan Africa ranges between 2.3% in Ghana and 27% in Zambia, though data among this population is likely to be largely unreliable.[77–79] Women in prison are more affected, experiencing HIV prevalence that is almost double that of men. For example in West and Central Africa, HIV prevalence among women in prison is estimated at 13.1%, compared with 7.1% among men in prison.[80]

In sub-Saharan Africa, the punitive response to drug use remains dominant, and people who use drugs continue to be harshly criminalised. Three countries in the region (Mauritius, Kenya and Seychelles) offer OAT services in prison settings. In Kenya, one magistrate in Mombasa County offers alternatives to prison for people convicted of minor offences. [81] This has legal basis through the Kenya Community Service Orders Act (1998), which established a diversion scheme that enables Kenya Probation and Aftercare Services (KPAS) to assess people convicted of a drug use offence. The initial assessment when a person is referred to KPAS also includes a comprehensive familial and social component. On the basis of that report, a magistrate has the flexibility to refer the person to a drug dependence treatment facility.

In Uganda, the Uganda Harm Reduction Network has an ad hoc arrangement with the police in Kampala to divert certain cases of drug use to them for alternative support rather than incarceration.[71] Evidence indicates that people who use drugs who have been incarcerated for non-injected drug use transition to injecting drug use during incarceration and continue to inject after release. Prisons in the country have limited ART and HIV testing services[82].

3. Policy developments for harm reduction

Ten countries across the region - Côte d'Ivoire, Kenya, Mali, Mauritius, Mozambique, Senegal, Seychelles, South Africa, Tanzania and Uganda - have incorporated harm reduction into their national HIV strategic plans. In addition to these ten countries, since 2018, the East African Community (EAC) with support from the Global Fund (through Principal Recipient Kenya AIDS NGO Consortium (KANCO) together with Sub-Recipients), has developed a regional policy for harm reduction. This led to the development of the EAC Regional Policy on Prevention, Management, and Control of Alcohol, Drugs and Other Substance Use.[83]

The African Union continues to demonstrate a strong commitment to addressing drug use in the region by facilitating the availability of a wide range of evidence-based treatment options, including OAT. For the first time, the new African Union Plan of Action on Drug Control and Crime Prevention for 2019-2023 calls for harm reduction services and alternatives to imprisonment to be made available. It includes a commitment to review and harmonise drug policies across the region and to the continuous support of international research and data collection processes.[84]

A national task force has been formulated in Nigeria to develop policies as the government has started to show some signs of embracing harm reduction. However, the majority of sub-Saharan African countries continue to focus on supply reduction and criminalisation of drug use.

In South Africa, the long-awaited National Drug Master Plan 2019-2025 began to be implemented at the national and regional level from July 2020. The part of the plan focused on the health sector includes commitment to harm reduction services under its strategic goals.[20,85]

4. Funding developments for harm reduction

While harm reduction measures are most often relatively inexpensive and demonstrably cost-effective, one of the most important barriers to harm reduction initiatives is nonetheless a lack of sustainable funding.[86] This forces programmes to reduce capacity or prevents them from opening at all. The Global Fund remains the driving force behind the introduction and financing of harm reduction programmes in West and Central Africa.[27,87]

In Sierra Leone, the Global Fund committed to continue their support for the implementation of harm reduction programmes focusing on NSP and the use of naloxone to combat overdoses for the 2020-2022 period.[27] In Senegal, the Global Fund finances the CNLS (Conseil National de Lutte contre le Sida) CEPIAD harm reduction centre.[87]
In some countries, domestic investment is increasing for HIV key population programming, which includes people who inject drugs. For example, in Kenya OAT is budgeted through the national domestic budget.[8,9]

Women who use drugs in East Africa

A persistent gap in harm reduction programming in East Africa is the lack of programmes designed to address the specific needs of women, taking into account the unique challenges they face. With the number of women who use drugs increasing across the region, they also face more serious consequences from co-infection with diseases such as HIV, hepatitis C and B and other sexually transmitted infections. In some cases, women who use drugs may also be members of other key populations. For example, an urban study in Kenya found that 48.7% of women who inject drugs in low-income urban settings engaged in sex work as their main source of income.[88] Despite these factors, women-led civil society organisations advocating for the rights of women who inject drugs are uncommon, the notable exceptions being the South African and Tanzanian networks of people who use drugs. Some services have emerged to meet the needs of women who use drugs. Community-based programmes for women who inject drugs exist in South Africa and Kenya. The Muslim Education and Welfare Association is a Kenyan civil society organisation that provides quality HIV prevention, treatment, care, support services, socio-economic rehabilitation, reintegration and human rights-based and gender-sensitive services for people who use drugs. To date, the services have been scaled up to include provision of shelter to homeless women who inject drugs and are experiencing homelessness and their children, as well as engaging women in health education and economic empowerment activities.

Despite these developments and growing research over the past decade on the structural factors that shape HIV among people who inject drugs, it is difficult to find sex-disaggregated data on drug use. Population-based studies of people who use drugs rarely include women, making it difficult to estimate prevalence of drug use among them. Special efforts are needed to systematically include women in studies on substance use, and gather comprehensive age and sex-disaggregated data. This is particularly true among women who use drugs in rural communities.[20]

In its plans to establish the country's first OAT site in a public mental health facility with support from PEPFAR, the Ugandan government supported the Uganda Harm Reduction Network to conduct an assessment of the perspectives of women who inject drugs. Focus group discussions and key informant interviews with women who use and inject drugs revealed that many women between 16 and 32 years old had first used drugs with the assistance of an intimate partner.[71] Many women also reported that they engaged in sex work. Women expressed a desire to engage with drug and health services, but noted that they were discouraged from doing so because of the stigma they experience as women who inject drugs.

During a 2016 study among people who use drugs in Uganda,[46] one respondent reported that women who inject drugs who are experiencing homelessness and those who are sex workers were particularly vulnerable to both violence and HIV transmission, and that programmes do not provide services that meet their unique needs, including night outreach and offering food and shelter. For example, women who inject drugs experiencing homelessness who have families and babies have no adequate services available to them.[46]

> *Women who inject drugs who are experiencing homelessness and those who are sex workers were particularly vulnerable to both violence and HIV transmission, and programmes do not provide services that meet their unique needs.*

Opportunities to end the War on Drugs in Africa

The Global Fund is the primary funder of harm reduction programmes in Africa, but implementation is limited by national policies. As a result, harm reduction policies and programmes are severely lacking in West and Central Africa. The main obstacle remains the 'war on drugs', the prohibitionist approach that governments promote over more humane, evidence-based policies.

An exception to this pattern is Senegal, where the CEPIAD centre has created an environment favourable to people who use drugs by providing free OAT and NSPs.[89] Integrating harm reduction into national health strategies, and treating drug use as a public health issue, has allowed Senegal to begin to implement more effective drug policies.

The African Union Plan of Action on Drugs and Crime for 2019-2023 offers a unique opportunity to African countries to incorporate harm reduction in national policy frameworks. For the first time, the words 'harm reduction' were explicitly included in the plan. The plan also covers 'alternatives to punishment'. The ground-breaking inclusion of harm reduction and harm reduction-based health centres for people who use drugs paves the way for governments and policy-makers to develop and implement harm reduction measures by including these in their respective national drug control masterplans.

The West Africa Commission on Drugs has developed a Model Drug Law for West Africa, a tool for policy makers to advocate for evidence-based drug laws in the region.[90] The Model Drug Law contains legislative provisions and commentary incorporating the obligations of the three UN drug control treaties. It also takes into account the outcomes and commitments from the 2016 United Nations General Assembly Special Session on the World Drug Problem and the ECOWAS Drug Action Plan to Address Illicit Drug Trafficking, Organized Crime and Drug Abuse in West Africa (2016-2020).[90,91] It seeks to promote the protection of public health as the overriding priority of drug policy, and includes recommendations for the implementation of needle and syringe programmes, opioid agonist therapy and the decriminalisation of drug possession where there is no intent to manufacture, traffic, sell or supply.[90]

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2.8 WESTERN EUROPE

ANDORRA
AUSTRIA
BELGIUM
CYPRUS
DENMARK
FINLAND
FRANCE
GERMANY
GREECE
ICELAND
ITALY
IRELAND
LIECHTENSTEIN
LUXEMBOURG
MALTA
MONACO
NETHERLANDS
NORWAY
PORTUGAL
SAN MARINO
SPAIN
SWEDEN
SWITZERLAND
TURKEY
UNITED KINGDOM

TABLE 2.8.1:

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] [1]	HIV prevalence among people who inject drugs (%) [1] [2]	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%) [1] [3]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%) [1] [4]	Harm reduction response			
					NSP[5] [1]	OAT[6] [1,2]	Peer distribution of naloxone	DCR[7]
Andorra	nk	nk	nk	nk	nk	nk	x	x
Austria	12,000-17,000 [3]	8.7	28.6	4.9[8]	✓41	✓(B,M,O)	x	x
Belgium[9]	23,828	10.5	22	5.6	✓98 (P=28)	✓(B,H,M)	x[4]	✓1[10] [8]
Cyprus	331[11]	3.3	48.8	5.9	✓7	✓(B,O) [9]	x	x
Denmark	nk	nk	nk	nk	✓5	✓(B,H,M)	✓[10]	✓5[11]
Finland	15,611[12]	1.2[13]	74[14]	nk	✓61	✓(B,M,O)	x	x
France	117,000[15]	4.7[16]	63.8[17]	0.81[18]	✓553	✓(B,M)	x[19] [12]	✓2[13]
Germany	nk	1.6-9.1[20]	62.6-73[21]	0.4-1.4[22]	✓[23]	✓(B,H,M,O)	x[15]	✓24[14,15]
Greece	3,339[24]	4.1	60.5	2.2	✓12	✓(B,M)	x	x
Iceland	700[25][16]	5[3][26]	10[16][27]	nk	✓[17,18]	✓[17]	x	x
Ireland[28]	1,151[29][19]	6	76[30][3]	0.5	✓120 (P=96)	✓(B,M)	x[20][31]	x
Italy	nk	30.5	60.1	2.4[19]	✓73 (P=28)	✓(B,M,O)	✓21	x
Liechtenstein	nk	nk	nk	nk	nk	nk	x	x
Luxembourg	1,467[32]	13.2[33]	62.9	nk	✓10	✓(B,M,O)	x	✓2[22]
Malta	703[19]	1.2	60.1	nk	✓8	✓(B,M,O)[23]	x	x
Monaco	nk	nk	nk	nk	nk	nk	x	x
Netherlands	840[34]	3.8[35]	59.3[24][36]	6.3[37]	✓175	✓(B,H,M,O)	x	✓24[25]
Norway	8682	1.3	38.8	0.9[38]	✓81	✓(B,H,M)	✓[26]	✓2[26]
Portugal	13,162[39]	13	83	1	✓2,137 (P=1691)	✓(B,M)	x	✓1[27]
San Marino	nk	nk	nk	nk	nk	nk	x	x
Spain[40]	13,136	0.8[41]	61.4[42]	7.7[43]	✓760 (P=575)	✓(B,M)	x	✓13[28]
Sweden	8,021[44]	7.4[45]	54.6[3][46]	0.4[3][47]	✓26[29]	✓(B,M)[30]	x	x
Switzerland	42,000[19][48]	10-12[31]	74.6[3][49]	nk	✓	✓(B,H,M,O)[32]	x	✓14[33]
Turkey	12,733 [34][50]	0.5	49.2	3.5	x	✓(B,M,O)[35]	x	x
United Kingdom	122,894[51]	1.2[52]	51-58[36,37][53]	0.2[54]	✓627 (P=461)[55]	✓(B,H,M,O)	✓[38,39][56]	x

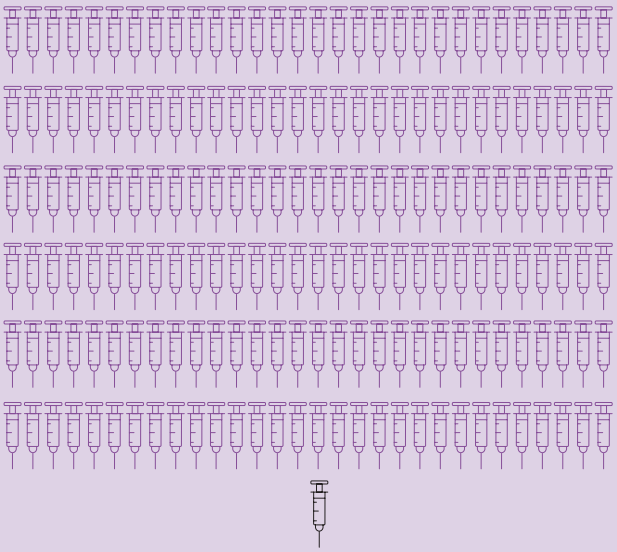
nk = not known

1 Unless otherwise stated, data is from 2016.
2 Unless otherwise stated, data is from 2018.
3 Unless otherwise stated, data is from 2018.
4 Unless otherwise stated, data is from 2018.
5 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.
6 Opioid agonist therapy (OAT), including methadone (M), buprenorphine (B), (H) medical heroin (diamorphine) and any other form (O) such as morphine and codeine. Figures for the number of sites are often not available in Western Europe due to a variety of service providers, which includes general practitioners.
7 Drug consumption rooms, also known as supervised injecting sites.
8 Based on subnational data.
9 People who inject drugs population estimate refers to lifetime injecting drug use and is based on national data from 2015. Infectious disease prevalence estimates based on subnational data from the Flemish community from 2016.
10 One drug consumption room operates in Liège with the approval of local government, though no national legislation permits such facilities.[5-7]
11 Year of estimate: 2018
12 Year of estimate: 2012.
13 Based on subnational data from 2014.
13 Year of estimate: 2014
14 Year of estimate: 2017.
16 Year of estimate: 2015.
17 Based on subnational data from 2011.
18 Based on subnational data from 2011.
19 While take-home naloxone is available in France, it can only be acquired with a personal prescription.
20 Based on subnational data from 2013-2014.
21 Based on subnational data from 2013-2014.
22 Based on subnational data from 2013-2014.
23 A total of 176[1] syringe dispensing machines operate in Germany, but the total number of NSPs is unavailable.[14,15]
24 Year of estimate: 2018.
25 Year of estimate: 2012
26 Data from 2017.
27 Data from 2020.
28 Year of estimates: 2010.
29 Year of estimate: 2015.
30 Year of estimate: 2014, definition of PWID: lifetime injecting
31 While take-home naloxone is available in Ireland, it can only be acquired with a personal prescription.
32 Year of estimate: 2015.
33 Data from 2016.
34 Year of estimate: 2015.
35 Based on subnational data from 2016.
36 Year of estimate: 2019
37 Based on subnational data from 2017.
38 Based on subnational data from 2015
39 Year of estimate: 2015.
40 Year of estimate: 2017.
41 Data from 2017.
42 Data from 2017.
43 Data from 2017
44 Years of estimate: 2008-2011.
45 Based on subnational data from 2013.
46 Data from 2015
47 Based on subnational data from 2015.
48 Year of estimate: 2015.
49 Year of estimate: 2016. definition of PWID: lifetime injecting (and to be or have been on opioid substitution)
50 Based on a subnational estimate and number of high-risk opioid users, including but not exclusively people who inject drugs.
51 Years of estimate: 2004-2011.
52 Based on data from England and Wales only.
53 Hepatitis C prevalence among people who inject drugs is 51% in England, Wales and Northern Ireland, and 58% in Scotland.
54 Based on data from England, Northern Ireland and Wales only. Data from 2017.
55 This figure does not include NSPs in England due to a lack of national data.
56 In the United Kingdom, peer distribution of naloxone is limited to a small number of projects.

MAP 2.8.1:
Availability of harm reduction services

2.8
Harm reduction in Western Europe

HARM REDUCTION IN PRISONS



GERMAN PRISONS

THERE IS A SYRINGE-DISPENSING MACHINE IN **ONE OUT OF ONLY 181 PRISONS** - A WOMEN'S PRISON WITH 200 INMATES.

FUNDING DEVELOPMENTS FOR HARM REDUCTION

26% DECREASE

OF FUNDING FOR DRUG SERVICES OVER THE LAST FIVE YEARS IN THE UNITED KINGDOM.

Needle and syringe programmes (NSPs)

Reports indicate there is lower coverage in rural areas in Austria, Belgium, Germany, the Netherlands and Portugal.

Heroin-assisted therapy (HAT)

Available in six countries: Denmark, Germany, Luxembourg, the Netherlands, Switzerland and the United Kingdom.

1. Overview

Author: Robert Csak
Harm Reduction International

Countries in Western Europe were among the first to adopt harm reduction services, and the region is one of the most advantaged in terms of available resources for harm reduction. Core harm reduction services, including needle and syringe programmes (NSPs) and opioid agonist therapy (OAT), are available in most Western European countries. Heroin-assisted treatment (HAT) is available in six countries, and drug consumption rooms (DCRs) are operational in ten, with more countries slated to open such facilities.

However, the coverage of harm reduction services is still below the World Health Organization (WHO) coverage targets in most countries,[40,41] and people who use drugs still face significant barriers to access harm reduction services in some countries in the region. One of the most prevalent barriers to accessing NSPs or OAT in Western Europe is uneven distribution of services within countries. There are many underserved regions, including rural areas which have low coverage in general.

In addition to the geographical gaps in coverage, there are sub-groups of people who use drugs that experience barriers in access. For example, NSP provision may be especially inadequate for people who inject stimulants. Stimulant injecting has recently been associated with localised HIV outbreaks in the region – highlighting the need for harm reduction interventions for people who inject stimulants.[42–44]

Increasing access and availability of HIV and hepatitis C testing, counselling and treatment in community settings and low threshold services[57] is an area where progress is needed. Implementing and scaling up of community-based interventions and peer-led services can help overcome geographical coverage issues. Community-based service delivery has the potential to increase HIV testing uptake among otherwise hard to reach communities, populations at higher risk and those with potentially poorer access to health care services.[46]

In recent years, advocacy for DCRs has been effective in the region. Portugal began implementing a mobile DCR in 2019 and, as of August 2020, the local government has allocated funds to open a pilot fixed site DCR in Porto.[47,48] There are also ongoing efforts to open a DCR in Ireland. Civil society and advocacy groups are pivotal in achieving these goals.[49,50] The regional response to the COVID-19 pandemic shows that harm reduction services can adapt quickly and effectively to changes in the environment. Harm reduction services in the region were able to adjust service delivery and integrate innovative methods to meet the needs of the communities they serve. Governments took action to decrease barriers in OAT provision in many countries during the pandemic. The crisis highlighted the important role of harm reduction services in reaching key populations, and providing a range of essential services beyond those aiming at reducing harms associated with substance use. Harm reduction and peer outreach workers were often the first to inform and educate their clients on COVID-19 preventive measures and lockdown rules.[51–55]

NSP provision may be especially inadequate for people who inject stimulants. Stimulant injecting has recently been associated with localised HIV outbreaks in the region – highlighting the need for harm reduction interventions for people who inject stimulants.

57 Low threshold services are services aiming to minimalise barriers in access, with no requirements on clients' drug use (e.g. abstinence), don't impose any requirements on clients (e.g. mandatory counselling), don't have any bureaucratic requirements (e.g. ID, health insurance etc). Low threshold services usually have a harm reduction focus, though harm reduction services are not necessarily low threshold services.[45]

2. Developments in harm reduction implementation

2.1 NEEDLE AND SYRINGE PROGRAMMES (NSPs)

The number of countries in Western Europe in which NSPs operate is unchanged since the *Global State of Harm Reduction 2018,* with services available in all countries except Turkey (and no data on Andorra, Liechtenstein, Monaco and San Marino). The provision of syringes has been stable since 2018 in most countries.[9,27,28,56–63] Belgium, Finland, Iceland, Ireland, Luxembourg and Sweden have all seen increases in the number of syringes distributed over recent years.[64–70] The number of syringes distributed through NSPs decreased in Greece and NSP coverage has remained below recommended benchmarks, despite a decrease over the last few years in the estimated number of people who inject drugs in the country.[71,72] Luxembourg, Spain and the Netherlands also reported declines in injecting drug use.[28,56,73,74]

Due to a decrease in funding over the past five years, there has been a reduction of specialist NSPs in the United Kingdom, with a shift to provision in pharmacies.[75] Pharmacies also play an important role in syringe distribution in Iceland, Spain and Portugal.[1,27,28,64,75–77] Pharmacies can increase the coverage and availability of syringes; they cannot provide the comprehensive harm reduction services available at a specialist harm reduction service with NSP, and more limited pharmacy opening hours can hinder access to sterile injecting equipment for people who inject drugs.[64,75]

In general, for people who use opioids in urban areas, the coverage of NSPs in Western Europe is sufficient and there are no major barriers in access. However, the uneven geographical distribution of NSPs within countries remains a barrier to access. For example, there is no stable NSP provision in the southern region of Italy,[57] and there are cities in the northern regions of Italy (e.g. Novara, Vicenza) where NSPs are not available.[57,78] Reports indicate there is lower coverage in rural areas in Austria, Belgium, Germany, the Netherlands and Portugal.[27,56,59,60,79] Analysis by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) found that Greece has the worst geographical coverage in the region, with NSPs available in only 4%[58] of the country.[22,80]

In addition to geographical gaps, there are groups of people who inject drugs that experience barriers to access. NSP provision for people who use stimulants is suboptimal, and stimulant injecting was associated with local HIV outbreaks in five countries[59] in the past few years.[42,43,81] There are reports of migrants who inject drugs facing barriers to accessing harm reduction services in Austria, Germany, Italy and the Netherlands.[59,60,82]

> *NSP provision for people who use stimulants is suboptimal, and stimulant injecting was associated with local HIV outbreaks in five countries in the past few years. There are reports of migrants who inject drugs facing barriers to accessing harm reduction services in Austria, Germany, Italy and the Netherlands.*

58 Measured in NUTS 3 level, a statistical territorial unit of the EU. See: https://ec.europa.eu/eurostat/web/nuts/background
59 Ireland, Germany, Luxembourg, and the United Kingdom. See HIV and antiretroviral therapy (ART) section.

Changing population of people who use drugs

There are several changes in drug use trends among people who use drugs in Western Europe. While traditional harm reduction responses like NSPs and OAT were tailored to the needs of an urban, heroin-injecting population, this community is decreasing. The prevalence of injecting drug use is in decline in much of Western Europe, the cohort of people in OAT treatment is ageing, and the decreasing demand makes it challenging to maintain the same level of harm reduction services.[28,56] At the same time there are populations where harm reduction responses are less established. People who use drugs and live in rural areas require more targeted service delivery, as geographical gaps in the coverage of harm reduction services is a common problem in the region see sections 2.1, 2.2, 2.7.

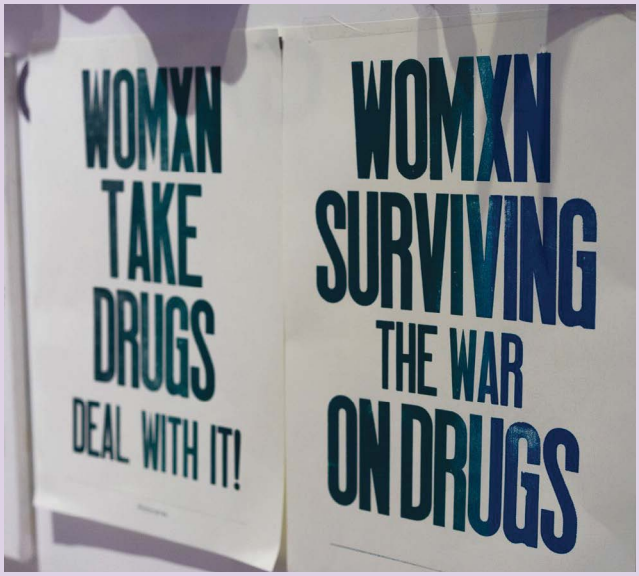
Despite the complex harms, stigmatisation and structural violence they face, women who use drugs are still frequently overlooked as a group with unique needs who need targeted interventions. Though interventions for women who use drugs exist in the region, a substantial increase in gender-sensitive services is needed to appropriately address their needs.

Injecting stimulants is associated with increased injecting frequency and substantial potential health risks,[43,120–122] yet appropriate harm reduction responses for stimulant use remain under-implemented.[138] Different NSP provision is needed for people who inject stimulants, and medical substitution therapy should also be considered.[139]

Non-injecting use is another area where harm reduction responses are not sufficient, though DCRs are increasing the spaces for smoking use. Using unsafe crack pipes has significant health risks,[140] but the provision of safer smoking equipment is scarce.[27,75] More widespread availability of drug checking services would be important in this area, both in terms of the number of countries and settings.

More specialised interventions can help to increase the coverage of harm reduction initiatives in communities where multiple needs have to be addressed. 'Housing First' programmes are well suited to serve people who use drugs who are experiencing homelessness,[141] by providing stable housing as a foundation for those who have complex needs. People who use drugs with migrant and refugee backgrounds also experience difficulties accessing harm reduction interventions. Language is often a barrier but, more significantly, the lack of health insurance negatively impacts access to harm reduction in the region.[58,59] Providing OAT and HIV and hepatitis C testing and treatment in low-threshold community settings could offer easier access to this group.

The community of men having sex with men is also inadequately served by existing or traditional harm reduction services. Though injecting use is prevalent in chemsex settings,[56,75,142] few NSPs are tailored to the needs of this population. Chemsex specific harm reduction interventions were developed and implemented in the Netherlands and Portugal.[27,56]



Photos: Nigel Brunsdon

2.2 OPIOID AGONIST THERAPY (OAT)

Though a significant proportion of the health and social costs of drug use in Europe can be attributed to opioid use, rates of injecting opioid use have fallen in the past decade. An ageing, vulnerable cohort of people who use opioids increasingly defines the treatment demands in the region. [83] In the European Union (EU)[60] and Norway, an estimated 662,000 people were on OAT in 2017, with a slight increase in 2016 after a decline between 2010 and 2015.[83] About half of the people who use opioids in the region are estimated to receive OAT, with overall coverage increasing from 2016 to 2017.[83] OAT coverage remained stable in Belgium, France, Italy, Luxembourg, Malta, the Netherlands, Norway, Portugal and Switzerland, [23,56–58,62,63,63,65,69] and increased in Austria, Iceland, Ireland, Sweden and Germany (the last is attributed to a slight increase of prison availability). [18,68,70,79,84] There is a declining trend in the number of clients on OAT in Spain due to a decline in the number of people who use heroin. [28] The coverage slightly decreased in Cyprus, though few clients receive OAT (209 in 2017).[9] According to data from the EMCDDA, nearly two-thirds of OAT clients in Europe are receiving methadone, and the use of buprenorphine in the pharmacological treatment of opioid dependence in Europe is steadily increasing.[22,83]

Although OAT is well established in Western Europe, there are still barriers to access such as initiation time and the availability of take-home OAT, though the COVID-19 pandemic has brought at least temporary positive changes in many countries in the region (see COVID-19 chapter for more details). Other typical barriers include access to OAT for specific subpopulations, for example, in Switzerland OAT is not available for young people who use drugs.[58] In Belgium and Germany people who inject drugs living in rural areas also have difficulties accessing OAT.[59,65,79]

HAT is available in six countries: Denmark, Germany, Luxembourg, the Netherlands, Switzerland and the United Kingdom. HAT has been available in Switzerland since 1994,[85] and a recent survey among HAT clients reflects an ageing population. The proportion of HAT clients older than 35 years increased from 22% to 85% between 1994-2017. [32] HAT was recently introduced in Glasgow, Scotland - a significant development in harm reduction in the United Kingdom,[86] though it was suspended due to the COVID-19 pandemic.[87] Norway could be the seventh country in the region to implement HAT, with plans to start treatment for 400 people in 2020.[88,89] A 12 month HAT clinical trial in Belgium and follow-up study found that treatment benefits included a reduction in illicit heroin use, and improved physical and mental health. However, the Belgian government has not moved to make HAT available outside of the clinical trial.[90,91]

2.3 AMPHETAMINE-TYPE STIMULANTS (ATS) AND NEW PSYCHOACTIVE SUBSTANCES (NPS)

The most frequently used stimulants in Europe are cocaine, amphetamine, methamphetamine and MDMA.[83] The cocaine market is the second largest drug market in the European Union (after cannabis).[83,92] In 2019, more than 2.5% of people aged 15 to 34 years old reported using cocaine in the past year in six countries: Denmark, Ireland, Spain, France, the Netherlands and the United Kingdom.[83] Cocaine use increased in France (3%), Netherlands (4.5%) and the United Kingdom (4.7%) and decreased in Spain (2.8%).[83,93,94] The prevalence of MDMA use among young people in the EU was 1.7% in 2019, ranging from 0.2% in Portugal to 7.4% in the Netherlands.[83] Prevalence of amphetamine use among young adults in the EU is 1%, and downward trends were observed in Denmark, Spain and the United Kingdom, with surveys suggesting an increase in the Netherlands.[83] Amphetamines and MDMA tend to be associated with recreational use and nightlife settings in Germany, the Netherlands, Switzerland and the United Kingdom.[58,59,75]

The prevalence of the use of NPS is much lower than ATS and cocaine. NPS are disproportionately used by marginalised populations in the region.[95–97] Synthetic cannabinoid (e.g. "spice") use has been reported among prison populations and people experiencing homelessness, while synthetic cathinones (e.g. "bath salts") are frequently used by people who inject drugs, and have been associated with an increased risk of hepatitis C infection.[75,79,83,94,95,98–100]

Methamphetamine use is very low in Western Europe,[83] Norway being the only country where wastewater analysis suggests relatively high prevalence.[63] Methamphetamine use was reported amongst men who have sex with men in the Netherlands and the United Kingdom,[56,75] while in

60 The United Kingdom is included in EU data as it was in the EU at the time of data collection.

Austria and Germany methamphetamine use is limited to specific regions.[79,84]

Though NSPs and DCRs can be accessed by people who inject stimulants, reports show that existing harm reduction services are not always adequate for their needs. Difficulties in reaching people who use ATS in low threshold settings were reported from Belgium;[65] crack cocaine smoking kit distribution is the only stimulant-specific response in Portugal;[27] and very few ATS specific harm reduction responses are implemented in the United Kingdom.[75]

Drug checking services enable people to get the contents of their drugs analysed - an important harm reduction initiative for people who use stimulants. Drug checking services have been implemented in at least nine countries: Austria, France, Italy, Luxembourg, the Netherlands, Portugal, Spain, Switzerland and the United Kingdom. However, implementation faces legal barriers in many countries. In Germany, while drug checking is explicitly included in policy documents, the majority of states consider it illegal.[79,101] Based on a concept developed by three civil society organisations, drug checking for NPS is now being offered by an organisation in Berlin with state funding for implementation and evaluation in the 2020/2021 budget.[79,101,102] While drug checking in Portugal is well established in nightlife settings, it is not available in other settings because samples have to be received on site; sending in samples by mail or through other harm reduction services is not available.[27]

2.4 OVERDOSE, OVERDOSE RESPONSE AND DRUG CONSUMPTION ROOMS (DCRs)

The number of countries with DCRs has increased since 2018, with Portugal opening a mobile DCR in 2019.[27,103] In the summer of 2020, there were 88 DCRs in 10 countries: Belgium, Denmark, France, Germany, Luxembourg, Netherlands, Norway, Portugal, Spain, Switzerland,[27,58,65,66,104] and further increases are expected. In Iceland and Ireland, efforts to open DCRs have the support of their national governments,[64,105,106] while in Finland and the UK subnational governments are supportive but legal challenges at the national level have prevented implementation.[75,86,107,108]

In Portugal, the latest country to introduce a DCR in the region, two civil society organisations, Grupo de Ativistas em Tratamentos (GAT) and Médicos do Mundo, run a mobile DCR. The Lisbon City Council provides funding for the two-year pilot project, after which financing is expected to come from the National Drugs Agency.[27] Furthermore, Porto also commenced a mobile programme in 2019, and as of August 2020, the local government has allocated the budget to open a pilot fixed-site DCR in Porto,[47,48] and there are plans to open two fixed-site DCRs in Lisbon in 2021.[22,27] Countries with established DCR services have also opened new sites since 2018. In Germany, two states opened their first DCR, Berlin opened a third, and the number of mobile DCRs increased.[59] In Luxembourg, a second facility was established in Esch-sur-Alzette,[22] and, in Switzerland, a pilot mobile DCR program began in Zurich.[58]

DCRs increasingly include supervised inhalation alongside injecting. With a decrease in injecting and an increase in access to OAT, service providers are adapting to the needs of people who smoke drugs.[104] This is a strong trend in Germany where DCRs continuously add new slots for inhalation because of increasing demand,[59] and most DCRs in the Netherlands have areas for smoking.[109] A decline in the number of people who inject drugs has resulted in closure of some DCRs in Switzerland and Spain.[56,104] In the Netherlands, the number of DCRs decreased from 37 in 2010 to 24 in 2018, however these numbers do not include in-house DCRs in sheltered housing facilities.[56,110]

New psychoactive substances (NPS)

The phenomenon of new psychoactive substances emerged around a decade ago in Western Europe, and is now an established market. The EMCDDA is monitoring more than 730 new psychoactive substances.[83] The peak of the new substances identified was in 2014-15, with around 200 NPS identified during that period. Post 2015, this number decreased and stabilised at levels similar to the beginning of the decade.[83] After the initial difficulties in designing health-based responses to NPS, there is now EMCDDA guidance,[143] and general principles of harm reduction remain relevant.[143] The term NPS is an umbrella term covering vastly different substance groups. Different types of NPS have become associated with different user groups and settings. NPS can be associated with serious health and social harms,[83,144] thus appropriate harm reduction responses are crucial.

Novel psychoactive substances are disproportionately used by marginalised populations in the region. Synthetic cannabinoid (e.g. "spice") use has been reported among prison populations and people experiencing homelessness, while synthetic cathinones (e.g. "bath salts") are frequently used by people who inject drugs, and have been associated with an increased risk of hepatitis C infection.

SYNTHETIC CANNABINOID RECEPTOR AGONISTS

The substances in this category are functionally similar to THC1, the active compound of cannabis, and are usually smoked in herbal mixtures. They are frequently associated with prison settings and people experiencing homelessness. Relevant harm reduction interventions are outreach programmes, drop-in centres, and counselling and education in prison settings.[99,141,145]

SYNTHETIC CATHINONES

These substances are stimulants related to cathinone, one of the psychoactive components of the khat plant, and are usually found in powder form. Synthetic cathinones are mostly used in nightlife and recreational settings in Western Europe, though recently they have been mostly associated with men who have sex with men who are engaging in chemsex. NSPs, injection and snorting kit distribution could be beneficial harm reduction interventions for people who use synthetic cathinones.

NEW PSYCHEDELIC SUBSTANCES

These are NPS with hallucinogenic effects which are mostly associated with nightlife settings and recreational use, with less treatment demand. Harm reduction services in nightlife or party settings (e.g. drug information, education, help with psychedelic emergencies or 'bad trips', chill out spaces, water, snacks) remain relevant, particularly drug checking services.

SYNTHETIC OPIOIDS

Synthetic opioids, most notably fentanyl, are associated with the current overdose crisis in North America. Though these substances are uncommon in Western Europe, reports suggest increased concern due to growing availability in the European Union, and growing presence of these substances in overdose cases.[83,92] Overdose prevention measures are appropriate harm reduction responses to the risks of overdose from potent synthetic opioids, including DCRs, naloxone and drug checking.

67 Tetrahydrocannabinol (THC) is the main psychoactive component of cannabis.

Take-home naloxone programmes[61] are available in 10 countries.[29,60,83,92] There was no change in the number of countries with naloxone peer distribution programmes which currently operate in Denmark, Italy, Norway and the United Kingdom.[62] Take-home naloxone programmes are available in a further six countries - Germany, France, Ireland and Spain with two new additions, Austria and Sweden, introducing take-home naloxone since the *Global State of Harm Reduction 2018*.[29,60,92] There is also a plan to develop take-home naloxone in Belgium.[65] Take-home naloxone is available in one city in Austria (Graz), and 50 people have received training and naloxone kits since it began.[60] Sweden implemented a take-home naloxone programme in two regions in 2018, and take-home naloxone became available in most regions in 2019.[29] Peer-led naloxone distribution programmes expanded in the United Kingdom where 14 local authorities reported implementing, or having concrete plans to implement, the initiative in 2019.[116] EuroNPUD implemented a Naloxone Access and Advocacy Project in the United Kingdom, which peer audited take-home naloxone in three locations and ran local advocacy events, and developed guidelines for implementing and advocating for naloxone peer distribution programmes.[113,114] In Portugal injectable naloxone became available in the context of the implementation of the DCR and, in 2020, nasal naloxone became available to harm reduction service providers.[27] Misconceptions about naloxone (e.g. naloxone encourages risky behaviours, or people who use drugs are not competent enough), a lack of widespread access even in countries where take-home naloxone is available,[57,59,117,118] and legal barriers (e.g. medical background required to administer naloxone in an emergency) are hindering the introduction and scaling up of such programmes.[65,79,118]

2.5 HIV AND ANTI-RETROVIRAL THERAPY (ART)

The number of new cases of HIV in Western Europe attributed to drug injecting each year has decreased by around 45% since 2010.[81] In 2018, there were 996 new HIV diagnoses attributable to injecting drug use in the EU, representing 4.6% of all HIV diagnoses.[63] This proportion exceeded 10% only in Greece.[43] More than half of new HIV diagnoses among people who inject drugs in the European Union in 2018 were diagnosed late,[81,83] which suggests that increased access to testing and scaling-up of opportunities for earlier intervention are needed. Among those countries in Western Europe where data is available on the UNAIDS continuum of care targets[64] for people who inject drugs, four reached the first target (90% of people who inject drugs living with HIV who know their status): Finland, France, Germany, Portugal.[119] Six countries reached the target of 90% being on ART: Austria, France, Malta, Switzerland, Sweden and the United Kingdom (Luxembourg at 88% is close to reaching the target,[119] while the proportion is just 55% in Germany).[59] Seven countries reached the target on the viral suppression rate: Belgium, France, Luxembourg, Germany, Sweden, Switzerland and the United Kingdom.[119]

Despite the decline in diagnosed HIV infections among people who inject drugs, localised HIV outbreaks have been documented in the past five years in Ireland, Germany, Luxembourg, and the United Kingdom.[43,83] All four outbreaks have been associated with marginalised populations of people who inject drugs and people who inject stimulants (cocaine injecting in Luxembourg and the United Kingdom, and NPS injecting in Ireland and Germany). As stimulants are commonly injected more frequently than opioids, an increase in stimulant injecting can lead to a shortage in sterile injecting equipment.[43,83,120–122] These outbreaks occurred in countries with good availability of NSPs, OST and ART, which highlights the importance of adapting traditional models of care to the needs of local communities. In Germany, for example, community-based testing has been expanded and testing is also now being offered in low-threshold drug services.[119] In Portugal, HIV testing is also available in community-based organisations across the country, targeting key populations including

61 Take-home naloxone programmes are decreasing overdose-related mortality by combining training on overdose risk and management with the distribution of naloxone to potential bystanders, aiming to make naloxone more readily available in places where overdoses might occur.[111,112] Naloxone peer distribution programmes are take-home naloxone programmes where a training programme is delivered by a peer trainer, and approved peer workers are authorised to distribute naloxone on an outreach basis without the direct participation of an approved prescriber.[113,114]

62 In Norway, this refers to a multi-site pilot programme.[115]

63 All HIV diagnoses for which the route of transmission is known.

64 UNAIDS 90-90-90 targets are: By 2020, 90% of all people living with HIV will know their HIV status. By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression. https://www.unaids.org/en/resources/documents/2017/90-90-90

people who inject drugs. This network plays an important role in overcoming barriers like fear of stigmatisation and discrimination, lack of knowledge about the healthcare system, and poor health literacy.[27]

Though HIV testing and treatment is generally available in the region, there are significant barriers to access and only one country (France) has met all three UNAIDS targets. Organisations in the region saw similar problems in HIV testing and treatment as for hepatitis C testing and treatment. Though ART is available and free, a lack of health insurance is an issue in accessing HIV treatment in insurance-based health systems such as in Austria, Germany, Luxembourg and Switzerland.[58,59,79] The unequal geographic distribution of service providers within countries is also a barrier for people who inject drugs living in underserved regions. Stigma and discrimination towards people who inject drugs is still a serious barrier in many countries. The latter was reported in connection with health services in Portugal and Germany.[27,79]

2.6 HARM REDUCTION IN PRISONS

People in prison report higher lifetime rates of drug use and injection than the general population in EU countries[83] and, in the absence of adequate services for people who inject drugs, the risk of unsafe drug use and the transmission of blood-borne diseases in prisons is high.[119] Recent studies strengthened the evidence base; a study among people who use drugs in Germany found that previous imprisonment is associated with increased likelihood of hepatitis C infection, regardless of gender.[82] A study in Irish prisons showed high prevalence of hepatitis C and risk factors including a history of injecting drug use, prison tattooing, community tattooing, and sharing injecting equipment among men in prison.[123]

OAT in prison is available in all countries in the region except Turkey, but only four countries provide NSPs in prisons. These are: Spain (all prisons), Switzerland (15 out of 106 facilities, accounting for 21% of the prison population), Luxembourg (one of two prisons) and Germany (one syringe-dispensing machine in one out of 181 prisons - a women's prison with capacity of 200).[28,58,59,69,79,124] Though harm reduction equipment such as syringes, foil and condoms is in principle available in all Spanish prisons, the number of facilities with active NSPs has decreased to 47 in recent years following a decrease in people who inject drugs and demand.[28]

Access to OAT in prisons varies significantly between and within countries in the region. In Germany for example, one person reported receiving OAT in Saxony, while 1068 people reported receiving OAT in Berlin.[125] Major regional differences were also reported in Switzerland.[58] Although OAT can be initiated in prisons in every country except Cyprus,[126] reports suggest direct and indirect barriers hinder access. OAT initiation is available in only four prisons in Portugal, while in Belgium initiation depends on local policies in each prison.[27,65] Other countries have more indirect barriers. Prison doctors can be hard to reach and sometimes offer minimal medical care in the Netherlands.[56] Being in treatment prior to imprisonment was identified as an advantage to access in Austria, and negative attitudes towards people who use drugs in prisons is an issue in Germany and Italy.[57,59,60,79] People who are released from prison are particularly vulnerable to opioid overdose.[116] However, people who are newly released from prison are only seen as a target population for take-home naloxone programmes in France, Italy and the United Kingdom.[118] A study found that take-home naloxone and training was delivered in 51% of prisons to only 12% of people released from prison with opioid use history in the United Kingdom.[75,116] Overdose training (without naloxone) is available in some prisons in Belgium,[65] and in one prison in Germany.[59,79]

HIV and hepatitis C testing and treatment in prisons are available in every country but data on coverage in prison settings is not available.[126] Different barriers affect accessibility of treatment in prisons: long bureaucratic processes make it difficult to continue treatment in prisons in Italy;[57] the lack of health insurance and unclear financing of treatment is a barrier in Switzerland;[58] there are financial barriers to hepatitis C treatment uptake in Belgium (difficult to initiate treatment, because it is reimbursed by the prison);[65] and it is not clear how regular screenings are in Portugal and the Netherlands.[27,56]

3. Policy developments for harm reduction

There were no major changes in the region since the last *Global State of Harm Reduction* report regarding the inclusion of harm reduction in national drug or addiction strategies. At least 17 of the 25 countries[65] in Western Europe have adopted strategies that express some form of support for harm reduction. In at least five of these countries (Cyprus, Germany, the Netherlands, Portugal and Switzerland), harm reduction forms a pillar of national drug policy separate from treatment and rehabilitation.[9,73,79,124,127]

A new national drug strategy was adopted in France in 2018, and although harm reduction is not a separate pillar, it is explicitly included as a priority area and among the five priorities for research.[62,128] A new alcohol and drug strategy was adopted in Scotland at the end of 2018 in which harm reduction is also not a separate pillar but the document expresses the importance of improving access to harm reduction services in general and in prison settings specifically.[86,129] More countries will develop new national strategies in 2020, including Finland, Greece, Luxembourg, Norway, and Sweden. The EU drugs strategy will also expire in 2020, and development of the new strategy will be a key policy development.[83,130]

The EU Agenda and Action Plan on Drugs 2021-2025 was published in July 2020. Increasing the efficiency of harm reduction interventions is one of the priority areas of the action plan, with integrated service delivery and services tailored to the characteristics of key populations also included.[131] Civil society organisations and community networks working in the region raised concerns regarding the lack of meaningful involvement of civil society during the process for development of the action plan, as well as with the substance of it.[132] They criticised the document for losing a balanced approach, as over half of the action plan's eight priority areas concern security and supply control interventions, with the rest distributed between prisons, prevention, treatment and harm reduction.[132] According to their analysis, the current action plan is deprioritising human rights and public health, deprioritising scientific evidence and dropping support for key international documents.[132]

In Italy, harm reduction interventions were included in the package of basic health services but implementation lags behind with only a few regions introducing them in their regional guidelines since 2018.[57] Another notable development in Italy is the adaptation of the legal framework for drug checking, and public health services began to deliver drug checking in some regions.[57] Ireland introduced a less punitive approach to possession of drugs in 2019, with diversion to health services as an alternative to criminal prosecution for the possession of drugs for personal use.[105] A new drug policy is under development in Norway with an important shift towards a public health-centred approach. According to the proposal, use and possession of drugs will no longer be a criminal offence, and people who use drugs will be diverted to counselling instead of the criminal justice system.[133,134]

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65 Austria,[84] Belgium,[66] Cyprus,[9] Denmark,[61] Finland,[67] France,[62] Germany,[124] Greece,[71] Ireland,[68] Luxembourg,[69] Malta,[23] the Netherlands,[73] Norway,[63] Portugal,[77] Spain,[28] Switzerland,[127] and the United Kingdom.[76]

4. Funding developments for harm reduction

Western Europe invests more than other regions in harm reduction. However, the scale of funding remains an issue.[118,135] National, regional and local budgets are the main sources of funding for harm reduction in Western Europe. Although EU funds are available, they support small-scale pilots, short-term projects, training and research, and are thus not a sustainable source of harm reduction funding.[136]

A recent analysis by the Correlation European Harm Reduction Network found that the lack of funding for harm reduction was the most mentioned barrier to implementation in EU countries, especially for viral hepatitis interventions.[118] The level of funding is usually connected with the levels of political support and recognition of harm reduction measures. A lack of funding, support and recognition were mentioned by civil society organisations in Germany, France, Ireland and the United Kingdom.[118] Funding for drug services decreased by 26% over the last five years in the United Kingdom,[75] and a civil society organisation in the Netherlands reported reduced national funding since 2018.[56] Harm reduction is heavily underfunded in Italy, where the main concern is the decreasing national resources for public health services overall.[57] Sustainability is also a problem in Portugal, where project level funding is available in the short term, but new programmes are hardly funded as national level funding has not changed in recent years.[27]

Specific harm reduction services have been underfunded in other countries. For example, while harm reduction in general is sufficiently funded in Iceland, NSPs are underfunded.[64] In Austria, OAT provision is hindered by the low financial reimbursement per client.[60] In Germany, harm reduction is financed by the states not the federal government, thus the level of funding varies by region and has to be negotiated annually. Some states have increased funding for harm reduction since 2018, for example Berlin which allowed the extension of DCR services.[59,79]

International donors no longer support harm reduction in Western Europe. There are examples of multinational pharmaceutical companies funding harm reduction programmes in the region, for example in Italy. Such companies supported campaigns and single actions in the field of take-home naloxone and hepatitis C testing,[57] and support from pharmaceutical companies also helped to implement the take-home naloxone programme in Austria.[60] Over the last few years, with the rise of chemsex, pharmaceutical companies in the Netherlands have invested more in harm reduction initiatives to promote pre-exposure prophylaxis and direct-acting antiviral (DAA) medications.[56]

A recent analysis found that the lack of funding for harm reduction was the most mentioned barrier to implementation in EU countries, especially for viral hepatitis interventions.

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