

Regional Overview

North America



AVAILABILITY OF NEEDLE AND SYRINGE EXCHANGE PROGRAMMES AND OPIOID SUBSTITUTION THERAPY

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

HARM REDUCTION IN NORTH AMERICA

Country/territory with reported injecting drug use ^a	People who inject drugs	Adult HIV prevalence amongst people who inject drugs	Adult HCV prevalence amongst people who inject drugs ²	Harm reduction response			
				NSP	OST	SIF ^c	HIV and HCV programmes targeted towards people who inject drugs ^b
Canada	269,000 ²	2.9-23.8% ³	46-90%	✓	✓	✓	✓
United States	1,364,000 ⁴	14.5-47.9% ⁵	8-88.3%	✓	✓	x	✓

a There is no injecting drug use reported in Greenland. Mexico is included in the Latin American overview.

b These services include, among others, voluntary HIV testing and counselling; HIV prevention, treatment and care; hepatitis C testing and treatment; STI prevention and treatment; and information, education and communication.

c Safer Injecting Facility (SIF)

The United States (US) and Canada collectively are home to 332 million people. Both countries are among the wealthiest in the world and rank high on the human poverty index.⁶ Both countries have relatively strong economies and a high standard of living, although huge disparity exists, particularly in the US, between ethnic minority and white North American populations.

DRUGS IN THE REGION

Cultivation, production and transshipment

The US and Canada are primary consumer markets for illicit drugs. Some drugs, such as heroin and cocaine, are produced or cultivated elsewhere and smuggled into the region, primarily from Latin America, sometimes via the Caribbean. South-East and South-West Asian heroin also reaches North America, often via East or West Africa, or Europe.⁷ In the case of drugs such as cannabis and amphetamine-type stimulants (ATS), there is a significant domestic production capacity.

According to UNODC, the US and Canada are major producers of cannabis, and the US (along with Mexico) may be the largest cannabis herb producer globally. In the US, cannabis production is most widespread in the states of California, Kentucky, Tennessee, Hawaii and Washington. In Canada, production is concentrated in the provinces of British Columbia, Ontario and Quebec. UNODC notes that cannabis production in Canada 'remains significantly lower' than in the US.⁷

Both countries also have significant domestic production of ATS. North America is a main producer of methamphetamine internationally, although increased law enforcement activities, particularly in the US, have resulted in the movement of some of this production into Mexico. In recent years, ecstasy for consumption in the US and Canada is increasingly being produced locally, rather than imported from Europe.⁷

Drug use

In the US, the most commonly used drugs are alcohol, tobacco, cannabis and cocaine (including crack cocaine). In a 2006 national survey, it was estimated that 20.4 million people aged 12 years or older (8.3% of the population) had used an illicit drug during the previous month; a rate of use that has remained stable since 2003. The non-prescription use of pain relievers and tranquilisers is also common. Although heroin is not as commonly used as other illicit drugs in North America, it is one of the most commonly injected drugs in both countries. Heroin use is reported to have decreased in the US in recent years.⁷

In Canada, the most commonly used drugs are alcohol, tobacco, cannabis, hallucinogens and cocaine. There is evidence that crack cocaine use has increased, particularly among street-involved people who use drugs.⁸ Rates of illicit drug use vary substantially from one province to another, with figures for lifetime use of illicit drugs ranging from 36.9 to 52.7% and for past-year use varying from 10.7 to 17.5%. British Columbia, Quebec and Alberta have rates of use higher than the national average, while New Brunswick and Newfoundland exhibit rates of use below the national average.⁸ There are estimated to be between 25,000 and 50,000 people using heroin in the country, primarily in Vancouver, Toronto and Montreal.⁹

Alcohol

Per capita alcohol consumption in North America is relatively average by international standards: 8.51 litres of pure alcohol per capita in the US and 8.26 litres in Canada.¹⁰ However, the true patterns of drinking are more complex, with relatively high levels of self-reported 'last year abstainers' (33.9% of the population in the US and 22% of the population in Canada), and 'heavy episodic drinkers' (between one-fifth and one-quarter of the populations).¹¹

Just over half of people aged 12 years or older in the US in 2006 (50.9% or approximately 125 million persons) reported being current drinkers, a figure similar to that in 2005 (51.8%).¹² In Canada, a 2005 report found that 79.3% of people aged 15 years or older had consumed alcohol during the previous twelve months. This rate varied from a low of 70.2% in Prince Edward Island to 82.3% in Quebec. According to that survey, 22.6% of drinkers exceeded the 'low risk drinking guidelines', and 6.2% of drinkers were classified as 'heavy drinkers'.⁸

The US, with its high minimum age limit for legal alcohol consumption (21 years across all states), has relatively unique problems with underage drinking, particularly among college and university students with risky drinking patterns. Some US universities have applied a harm reduction approach to this problem by introducing 'medical amnesties', whereby intoxicated students can call emergency services when required without fear of reprimand despite being under the legal age to consume alcohol.¹³

Crack cocaine

It is estimated that in the US, in 2006, 1.5 million people (0.6% of the population) had used crack cocaine ('crack') within the previous year.¹² It is reported that, as of 2003, there has been a shift away from smoking to injecting crack in all major US cities.¹⁴ Studies have found crack smoking to be associated with sexual HIV transmission, with particularly increased risks among women who smoke crack.¹⁵

In Canada, there is evidence of increasing crack use since the 1990s, both via smoking and injecting. Data from many Canadian cities also show significant use of crack among people who inject drugs, although the rates of use vary between regions. For example, a 2004 Health Canada report noted that 52.2% of approximately 800 people who inject drugs surveyed in four cities (Toronto, Regina, Sudbury and Victoria) had smoked crack over the past six months. Rates of use ranged from 9.3% in Victoria to 63.3% in Toronto.¹⁶ A 2005 study of illicit opioid users in five cities found that over half (54.6%) had used crack in the past thirty days, 87.2% via smoking. Again rates of use varied, from 3.4% in Quebec City to 86.6% in Vancouver.¹⁷

Concerns about the potential transmission of HCV via shared crack pipes have prompted a number of US and Canadian cities to introduce harm reduction programmes specifically for people who smoke crack.

Methamphetamine

Treatment data indicated a large increase in methamphetamine use in the US between 1993 and 2003, and the number of seizures from illegal laboratories producing the drug increased between 2000 and 2005. However, methamphetamine use in the US remains lower than that of cannabis and cocaine (including crack).

Overall it was estimated in 2006 that 1.4 million people (0.6% of the population) had used methamphetamine in the US in the previous year. A study of young men (aged 15 to 22 years) who have sex with men between 1994 and 1998 found that 20% had used methamphetamine during the previous six months.¹⁸ Studies have found that methamphetamine use is associated with increased risk of sexual HIV transmission.



Map 6.2: Numbers of people who inject drugs in North America

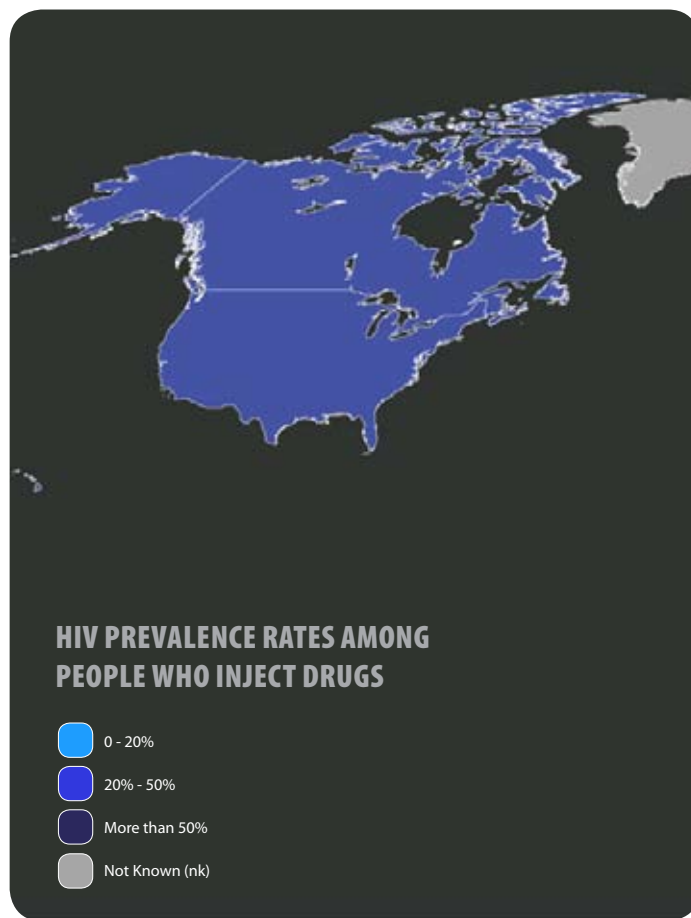
Injecting drug use

It is estimated that 1,364,000 people inject drugs in the US.⁴ The majority of people who inject drugs are male and living in urban areas, a large proportion in New York City.¹⁹ In 2002, the prevalence of injecting drug use per 100,000 in the general population was highest in Baltimore, Maryland (336); several cities in California, including Fresno (295), Stockton-Lodi (276), Bakersfield (240) and San Francisco (235); Tucson, Arizona (230) and Springfield, Massachusetts (224).²⁰

Overall prevalence of injecting drug use is reported to have declined in the US since the 1980s, with some variation by substance. People who inject drugs were recently described as ‘an aging population’, with decreasing rates of initiation of injecting among young drug users.²¹ The most commonly injected substances include heroin, cocaine (including crack) and methamphetamine.

In Canada, according to the Canadian Addiction Survey by Statistics Canada, 269,000 people reported having injected drugs in the past year, including steroids, in 2004.²² This represents an increase from 132,000 people in 1994 and estimates of 75,000 to 125,000 people in 1998. Injecting is reported in major cities including Vancouver, Toronto and Montreal and in small towns and rural

areas.²³ Commonly injected substances include heroin, cocaine (including crack), steroids, as well as controlled substances such as OxyContin, Talwin, Ritalin (in some areas) and Ketamine.²⁴



Map 6.3: HIV prevalence among people who inject drugs in North America

Drug-related harms

HIV and AIDS

In the US, there are an estimated 1.2 million people living with HIV,²⁵ and approximately 40,000 new HIV infections occur every year.²⁶ Almost three-quarters (74%) of HIV or AIDS diagnoses in 2005 were among men.²⁷

The black and Hispanic communities in the US are disproportionately affected by HIV. In 2005, black people, including African-Americans, accounted for almost half (49%) of the estimated number of HIV cases diagnosed, despite comprising only 13% of the US population. This situation is particularly evident among young people in the black community, as 61% of people under the age of 25 years living with HIV are African-American.²⁸ HIV-related illnesses are the leading cause of death among African-American women aged 25 to 34 years.²⁹

While sexual transmission remains the most common HIV transmission route, national HIV prevalence among people who inject drugs in the US is estimated to range between 14.5 and 47.9%.⁵ In 2007, the US Centers for Disease Control and Prevention (CDC) estimated that 18% of new HIV diagnoses are among people who inject drugs,³⁰ this figure rising to one in five new HIV diagnoses among women.²⁹ Among African-Americans, unsafe injecting

drug use is the second most common route of HIV transmission, accounting for about one-quarter of new HIV cases in 2005.²⁸

Certain sub-populations injecting drugs are reported to be more vulnerable to HIV, including new injectors, young people, street-involved people, people with a history of incarceration, transgender identified persons, gay men, African-Americans, Hispanic-Americans and Vietnam veterans.³¹ Those who inject ATS (such as methamphetamine) or cocaine may also be at increased risk of HIV transmission as these substances require more frequent injection to retain their effect.

There is considerable evidence of the link between non-injecting drug use and HIV, HCV and other STIs in the US through the sharing of paraphernalia and unprotected sex. For example, the use of crack cocaine has been linked to the transmission of HIV, particularly in circumstances where drugs are traded for sex, or when people engage in risky sexual behaviours while high on the drug.

A study of more than 2,000 young adults in three inner-city neighbourhoods found that crack smokers were three times more likely to be living with HIV than non-smokers.³² Researchers have also identified methamphetamine use as increasing the likelihood of risky sexual behaviours and the potential transmission of HIV and STIs.³³ The role of non-injecting drug use in HIV transmission is further explored in section 3 of this report.

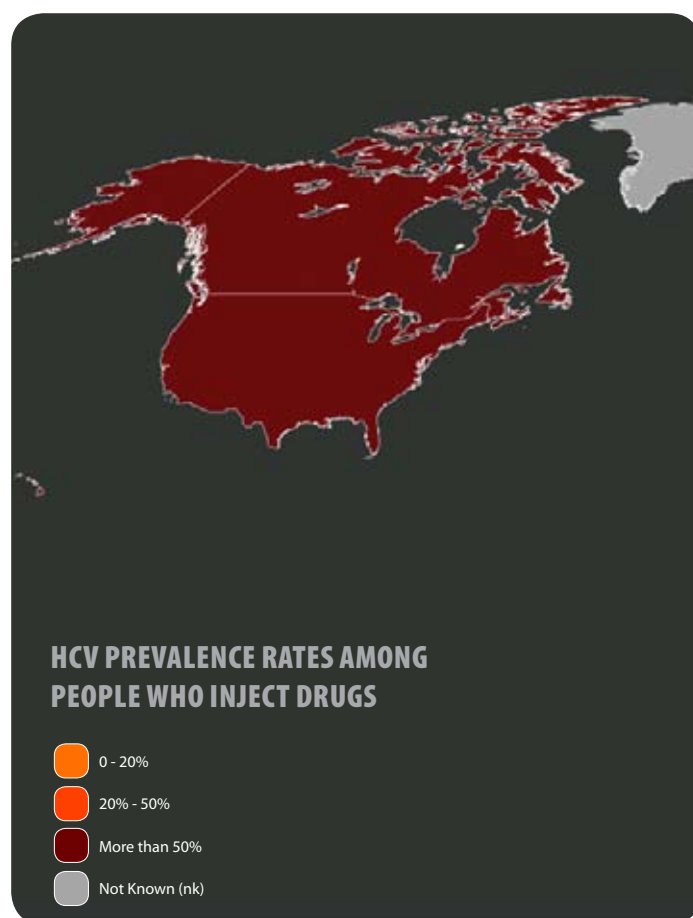
In Canada, there were estimated to be approximately 58,000 people living with HIV at the end of 2005. This represents a 16% increase from the estimated 50,000 people living with HIV at the end of 2002, which may be partly attributable to increasing numbers receiving life-prolonging antiretroviral treatment (ART). It is estimated that between 2,300 and 4,500 new infections occurred in 2005.

Over 95% of people known to be living with HIV in Canada reside in the provinces of Ontario, Quebec, British Columbia and Alberta, which together account for more than 85% of the total Canadian population.³ Aboriginal communities are significantly affected by HIV, and while Aboriginal people comprise 3.3% of the Canadian population they represent approximately 7.5% of people living with HIV.

HIV prevalence among people who inject drugs in Canada is estimated to be between 2.9 and 23.8%.³ In 2005, there were estimated to be 9,860 people who inject drugs living with HIV in Canada, comprising 17% of all people living with HIV in the country. Between 350 and 650 HIV diagnoses were attributable to injecting drug use that year, representing about 14% of all new diagnoses.³ HIV prevalence among people who inject drugs varies substantially across the country (Regina, Saskatchewan: 2.9%; Quebec City, Quebec: 7.1%; Ottawa, Ontario: 8%; Montreal, Quebec: 13.6%; Vancouver, British Columbia: 17%; Edmonton, Alberta: 23.8%).³

According to the Public Health Agency of Canada, 'national HIV estimates for 2005 show a slight decline in the number of new infections attributed to injecting drug use compared with 2002'.³ Women who inject drugs are disproportionately at risk of HIV infection, and since 1996 approximately 25 to 50% of positive HIV test results among Canadian women have been attributed to unsafe injecting drug use.³ More than half of all HIV diagnoses

among Aboriginal Canadians (53%) are the result of unsafe injecting drug use. This is much higher than that among non-Aboriginal Canadians (14%).³



Map 6.4: HCV prevalence among people who inject drugs in North America

Hepatitis C virus (HCV)

In the US, there are approximately 4 million people living with HCV, and there are estimated to be 30,000 new HCV cases each year. Unsafe injecting drug use is identified as the source of most new HCV diagnoses.³⁴ An estimated 60% of all new HCV infections annually in the US are related to unsafe injecting³⁵ and studies suggest that between 50 and 80% of people who inject drugs are living with HCV within five years of initiating injecting.³⁶

National HCV prevalence among people who inject drugs ranges between 8 and 88.3%. Across the US, this figure varies from 8% in Baltimore, to much higher levels in New York (61–71%) and Albuquerque (88%).¹ It is estimated that 50 to 90% of people living with HIV who inject drugs are also co-infected with HCV.³⁶

In Canada, there are between 250,000 and 300,000 people living with HCV (0.8 to 1% of the population). More than half of existing HCV cases, and three in four new infections, are related to unsafe injecting.³⁷ National HCV prevalence among people who inject drugs is estimated to be between 46 and 90% and studies in various Canadian cities have revealed HCV to be high among injectors in Vancouver (81.6%) and Montreal (70%).³⁷

A collaborative surveillance network involving multiple drug services in Ottawa, Ontario and in Quebec between 2003 and 2006

estimated HCV prevalence to be 62.2%.³ A study of illicit opioid users in five Canadian cities found that between 44.1 and 73.7% of people tested positive for HCV.³⁸ In Canada, it is estimated that between 5,000 and 10,000 people are living with both HIV and HCV.³⁷ In addition to unsafe injecting, there are concerns about HCV transmission via shared straws for snorting cocaine and shared pipes for smoking crack.³⁷

Drug use and its related harms in prisons

The US has the largest prison population and the highest incarceration rate in the world. Over 2 million people are behind bars in the US, a per capita incarceration rate of 714 persons per 100,000 in the general population.³⁹ Canada holds approximately 35,000 people in prison, and has an incarceration rate of 110 prisoners per 100,000.⁴⁰

In the US, harsh approaches to drug enforcement combined with mandatory minimum sentencing laws for drug offences at the state and federal levels have resulted in an exponential increase in the size of the prison population, and the number of non-violent offenders incarcerated for drug offences, over the past twenty-five years.

Drug enforcement has disproportionately affected the African-American community. While African-Americans comprise 14% of the overall drug-using population, they constitute 37% of those arrested for drug offences and 56% of those incarcerated in state prisons for drug offences.⁴¹

According to the US Bureau of Justice Statistics, 21% of state prisoners and 55% of federal prisoners in 2004 were incarcerated for violating drug laws.⁴² As a result, a significant proportion of people held in US prisons are current or former drug users, and it is estimated that 80% of prisoners have issues related to substance use.⁴³ In 2004, 56% of prisoners in state facilities and 50% of prisoners in federal facilities reported using illegal drugs in the month prior to their offence.⁴²

Similarly in Canada, various studies have found rates of injecting drug use among Canadian prison populations between 4.4 and 21%.⁴⁴ In 2008, the Canadian government announced that it would be introducing mandatory sentencing laws for drug offences.⁴⁵

Both countries have implemented drug treatment courts as one alternative to incarceration for people charged with low-level drug offences. In the US, the first drug court was established in Florida in 1989, and since that time over 1,600 have been established, with many hundreds more in development. In Canada, drug courts were established in Toronto (1998) and Vancouver (2001), and since that time have expanded to a small number of other cities, including Edmonton and Regina.⁴⁶

In the US, at the end of 2005, 20,888 people incarcerated in state prisons (1.8%) and 1,592 in federal prisons (1%) were known to be living with HIV. There is significant regional variation in HIV prevalence among US prisoners, from a low of 0.7% in the west to a high of 3.9% in the north-east. HIV prevalence is higher among women prisoners than among men, and higher among African-American and Hispanic American prisoners than among white prisoners.⁴⁷ HCV prevalence among US prisoners is estimated to be between 30 and 40%.⁴⁸

Estimates of HIV prevalence in Canadian federal and provincial prisons range from 2 to 8%, while studies of HIV prevalence in individual prisons report rates of between 1 and 11.94%. HCV prevalence among prisoners is between 19.2 and 39.8%.^{3,44} Several studies have found that HCV prevalence is elevated among female prisoners and prisoners who inject drugs.^{49,50}

THE RESPONSE

Harm reduction services

Needle and syringe exchange programmes (NSPs)

In the US, NSPs began in the mid- to late 1980s as unofficial, activist-based projects. However, over time, many states introduced legislation to allow NSPs to operate legally and to provide funding support for their implementation.⁵¹ As of November 2007, a total of 185 NSPs were operating in thirty-six states and the District of Columbia.

There has been an increase of funding at the state and local levels for NSPs in recent years, which has resulted in the number of programmes stabilising and their services expanding. For example, in 2006 the North American Syringe Exchange Network (NASEN) recorded 166 registered NSPs in the US, compared with 68 in 1994/1995, 101 in 1996, 113 in 1997, 131 in 1998, 154 in 2000, 148 in 2002 and 174 in 2004.⁵² However, despite this increased access, the Harm Reduction Coalition estimates that NSPs still reach less than 20% of people who inject drugs in the US.⁵³

The US government has placed a ban on federal funding for NSPs since 1988.⁵¹ The bulk of funding for these programmes (74 to 87%) therefore comes from city, county and state governments.⁵⁴ State support of NSPs is essential in enhancing service provision, and research has shown that the presence of government funding of NSPs in the US is associated with a larger number of syringes being exchanged and a greater variety of services being offered by the programmes, including increased likelihood of offering voluntary HIV counselling and testing (VCT).⁵⁵

According to the Harm Reduction Coalition, 'The federal funding ban also carries a significant symbolic weight in U.S. debates, rendering syringe exchange marginalized and controversial despite its long history and documented successes'.⁵¹ Indeed, research conducted across nearly 100 US cities concluded that need for an NSP is not a predictor of the presence of a programme.⁵⁶ A number of factors have been identified as limiting access to sterile injecting equipment in the US, including drug control and policing practices (i.e. by district attorneys, politicians or police) and syringe purchasing laws or laws criminalising the possession of drug paraphernalia.⁵⁷

In Canada, the first NSPs were opened unofficially in Toronto in 1987. The first official programme opened in Vancouver in 1989, followed soon after by projects in Toronto, Montreal and other major cities. As of 2007, the ministries of health in all ten provinces and two of three territories were providing support for NSPs.

Health Canada reported in 2001 that there were over 200 NSPs operating nationally, although the actual number of sites distributing sterile injecting equipment may be significantly higher.⁵⁸ For example, in 2007, the Toronto Department of Public Health listed over thirty needle exchange sites in that city alone.⁵⁹

However, only a small number of people who inject drugs have access to NSPs. It is estimated in Ontario that only fifty-three syringes are distributed per injector per year, about 5% of the number required. In Montreal, this figure is 6.6%.

A number of barriers have been identified by Canadian harm reduction advocates that limit the effectiveness of NSPs. According to research by the Canadian HIV/AIDS Legal Network, many regions of the country have little or no access to NSPs, particularly those outside of urban areas.⁵⁸ This may partly explain the findings of a survey done between 1995 and 2006 showing ‘significant differences ... between urban and semi-urban (small communities) participants with regard to needle sharing and borrowing’. The survey found that 27.8% of people living in urban settings who inject drugs had lent used syringes to another person during the previous six months, while the figure for those living in rural areas was 36.2%. Similar differences were also found in the number of persons who had borrowed used syringes from another person during the previous six months (urban 32.9%, rural 41%).³

In rural areas, this gap in access is often exacerbated by restricted opening hours of those NSPs that do exist.⁶⁰ Other barriers that have been identified include policies at some NSPs that require a strict one-for-one exchange or that in other ways limit the number of syringes distributed to service users per visit. In each case, such policies can result in fewer syringes being provided than is necessary for the number of injections.

Pharmacy sales of syringes vary significantly between the US and Canada. In the US, there are numerous laws, regulations and pharmacy practices that severely limit the ability of people who inject drugs to purchase syringes legally from pharmacies. For example, in 2002, forty-seven states and the District of Columbia had enacted drug paraphernalia laws under which the distribution and possession of any item used to consume illegal drugs, including syringes, is prohibited. In addition, eight states also require prescriptions in order to purchase syringes legally.⁶¹ Pharmacy regulations or guidelines in twenty-three states also have the effect of restricting the sale of syringes to people who inject drugs.⁶²

In Canada, the sale of syringes through pharmacies is legal,^{*} and pharmacists are encouraged by Health Canada and the relevant regulatory bodies to sell syringes openly as a strategy to prevent HIV transmission. However, in practice the decision on how and to whom syringes are sold is left to the discretion of individual pharmacists. According to the Canadian HIV/AIDS Legal Network, ‘There are reports from across Canada of pharmacists refusing to sell syringes to people who use drugs’.⁵⁸ This reluctance is reported to affect people in rural areas disproportionately as, in the absence of NSPs, pharmacies may be their only source for accessing sterile syringes.⁶³

Safer injecting facility

Canada has North America’s first and only legal safer injecting facility (SIF), called Insite, which is reported to receive an average of over 600 daily visits.⁶⁴ It was opened in September 2003 in the downtown eastside of Vancouver, and is operated by the Vancouver Coastal Health Authority. The Canadian government originally granted the facility a three-year ministerial exemption under Section 56 of the Controlled Drugs and Substances Act, allowing the site to operate without either the service users or

the staff risking criminal prosecution for the offence of possessing illegal substances on the premises. The initial pilot phase was co-funded by Health Canada and the British Columbia Ministry of Health.⁶⁵

Scientific evaluations of the SIF project have identified significant positive outcomes, including a reduction in the sharing of injecting equipment both among service users and the community as a whole, as well as a reduction in the number of people injecting in public.^{66,64}

Despite the positive evaluations, Insite has come under political attack from Canada’s Conservative government, which came into office during the course of the original three-year pilot phase.⁶⁷ The failure of the government to commit to renewing the exemption to the drugs laws allowing Insite to operate without risk of criminal prosecution were met with significant advocacy by harm reduction and HIV/AIDS advocates, drug user organisations and others, and attracted intense criticism during the 2006 International AIDS Conference hosted in Toronto. The result was a series of short extensions to Insite’s exemption, the most recent of which is due to expire in June 2008.⁶⁵

The failure of the government to grant a permanent exemption has been severely criticised by harm reduction advocates. The Canadian HIV/AIDS Legal Network, for example, called it ‘an irresponsible policy decision that’s based on ideology rather than on evidence ... that is simply not in the public interest’.⁶⁸ Although the International Narcotics Control Board (INCB)⁶⁹ and the US government⁷⁰ have criticised Canada for allowing Insite to operate, other Canadian cities including Toronto, Montreal and Victoria have indicated their interest in initiating SIFs.^{71,64}

Safer crack kits

In response to the risk of HCV transmission and other health problems associated with the smoking of crack cocaine and, in particular, the sharing of pipes and other equipment, a number of US and Canadian cities have introduced harm reduction programmes targeted at people who smoke crack.

In Canada, ‘safer crack kits’ were initially distributed in Toronto in the late 1990s by the Safer Crack Use Coalition as both an outreach tool and an HIV/HCV prevention intervention. In addition to health information, the kits typically include supplies such as glass pipe stems, rubber mouthpieces and metal screens to help prevent mouth injuries such as burns and cuts and to reduce the sharing of these items. The kits also often include condoms, lip balm and alcohol swabs.

As with the Vancouver SIF, Canada was criticised by the INCB for this health programme.⁶⁹ However, despite such criticism, safer crack kit programmes have expanded from Toronto to several major cities including Winnipeg, Ottawa, Vancouver, Halifax, Gatineau (Hull sector), Montreal and Guelph.⁷²

Safer crack kits also form part of the harm reduction response in the US. In 2006, the Beth Israel Medical Center Survey of US Needle and Syringe Exchange found that out of 150 responding programmes, 51 programmes (34%) stated that they had distributed safer crack use kits that year. Safer crack use kits are available from programmes in a number of US cities including New York City, Bridgeport, Hartford, Providence, Marin County, San Francisco, Seattle, Chicago, Los Angeles, Minneapolis and Albuquerque.³¹

* Canada also has a drug paraphernalia law (Criminal Code, Section 462.2) but the definition of ‘instruments for illicit drug use’ explicitly excludes ‘devices’ as defined under the Food and Drugs Act (Section 2), which is what exempts devices like syringes from being captured by the definition of drug paraphernalia, and hence permits pharmacists to sell them.

Treatment for drug dependence

Methadone maintenance was pioneered in the US in the mid-1960s, and has a long history of use for opioid substitution therapy (OST) in the country. In October 2002, buprenorphine was also approved for use by the Food and Drug Administration.⁷³ Despite this early leadership in OST, access in the US remains inconsistent, and is marked by geographical inconsistencies in service provision.

Historically, expansion of methadone programmes in the US has been hindered by restrictive licensing and control; misinformation about the nature of the treatment among local communities, health care providers and the public; and fears that methadone clinics would create centres for crime and drug trafficking.⁷⁴ Harm reduction advocates and service providers also identify stigma, lack of financial resources, lack of health insurance and a mistrust of the treatment system among service users as creating further barriers to optimum access.³¹ It was estimated in 2000 that only 20% of US heroin users were receiving methadone.⁷⁴

In Canada, methadone is legally approved for use by Health Canada's Therapeutic Products Directorate and is available in all provinces. Buprenorphine was approved in May 2007, and became available in December of that year.⁷⁵ Although the number of persons accessing OST has increased since licensing was transferred from federal to provincial control in the 1990s, the number of opiate-dependent persons accessing methadone remains low, and is estimated to be 25%.⁷⁶

A number of barriers have been identified to optimal access to OST in the country. Tight regulation of methadone and under-funding of methadone programmes have been identified as limiting the number of physicians and pharmacies providing OST; and the number of physicians licensed to prescribe OST varies widely from province to province.⁷⁷ For example, it was reported in 2005 that there was only one physician in Newfoundland prescribing methadone, and the provincial health ministry was experiencing difficulty in recruiting physicians to staff a newly opened methadone clinic.⁷⁸ In New Brunswick in 2007 there were more people on the waiting list for methadone (628) than there were on the province's methadone programme (624), forcing people to travel to the neighbouring province of Nova Scotia to access treatment.⁷⁹

Restrictive rules and assessment procedures for patients, such as mandatory daily visits for dispensing, and abstinence as a condition of treatment (enforced through random urine testing), have also been identified as creating barriers to people accessing or remaining in OST programmes.⁷⁷

Both the US and Canada have non-OST drug dependence treatment available, including detoxification, inpatient and outpatient rehabilitation, psychosocial support (group and/or individual, professional, self-help, twelve step) and supportive housing, among others. However, in both countries, services are insufficient to meet the need.

Commenting in 2002 on the provision of drug treatment services in the US, the CDC noted that, 'A gulf exists between the number of people who want or could benefit from substance abuse treatment and the number of people who actually receive services'.⁸⁰ A recent study of people who inject drugs in 94 major cities across the US found that the percentage of people accessing treatment varied from 1.1 to 39.3%, with only nine cities reaching a coverage rate greater than 20%.⁸¹

Targeted HIV prevention, treatment and care

Although HIV prevention, treatment and care services are available in the US and Canada, stigma and discrimination against people who use drugs create barriers to access for this population in both countries. According to the Harm Reduction Coalition in New York, 'Pervasive stigma towards drug use among health care providers results in unequal treatment for people with a history of drug injection, leading to sub-optimal care. HIV-positive people who inject drugs face high barriers to medical care and antiretroviral treatment, and increased mortality from AIDS-related illnesses and other causes, including liver disease and overdose'.⁸²

VCT is available throughout North America, including anonymous HIV testing in many (but not all) US states and Canadian provinces. Research in the US has shown, however, that uptake of VCT is very low among people who inject.⁸³ Current barriers to increasing access for people who inject drugs include stigma and discrimination and the legal framework regarding illicit drugs.

In Canada, for example, it has been noted that people who use drugs often hesitate to use health services, including HIV testing, for fear that their drug use will be discovered and that they will face prosecution. Some also fear jeopardising their custody of their children if they are identified as people who use drugs.⁸⁴

Community-based outreach in HIV prevention programmes specifically targeting people who use drugs exist in both countries, including programmes run by and for people who use drugs. A number of US and Canadian cities have developed mobile harm reduction units that provide syringe exchange, condoms, VCT and other health-related services to street-involved populations of sex workers and people who use drugs. However, significant gaps still exist. Harm reduction advocates identify the need for interventions to address issues such as race, ethnicity, culture, gender, sexual orientation, age and socio-economic status in order to increase accessibility.

ART is available throughout North America, and approximately 268,000 people in the US and 21,000 people in Canada are receiving treatment.⁸⁵ A recent study of HIV prevalence among people who inject drugs in large metropolitan areas in the US, from 1992 to 2002, concluded that some HIV prevalence increases were at least in part due to increased access to life-prolonging ART.²⁰

However, in both the US and Canada, studies have shown that people who inject drugs are less likely to be receiving ART than people who do not use drugs.^{86,87} Although there are no explicit policies that exclude people who inject drugs from accessing ART, misconceptions and uncertainties among health care workers often manifest in a reluctance to prescribe to this group.

In Canada, the largest and most active group of people who use drugs is the Vancouver Area Network of Drug Users (VANDU), formed in 1997. In 2003, VANDU received funding from the Canadian government to assist drug users in local communities across the country to build capacity to form organisations. At present, groups of people who use drugs have been formed in Montreal and in Kingston, Ontario. There is also impetus to establish groups in the cities of Edmonton and Calgary.

In recent years, drug user representatives have been invited to participate in policy consultations at the local, provincial and national levels, including those leading the national action plan on HIV and AIDS. However, according to the Canadian HIV/AIDS Legal Network, 'meaningful participation of people who use drugs remains limited in shaping Canada's response to drugs and to HIV and HCV'.⁸⁸

In the US, extreme and punitive law enforcement policies and practices have made public drug user organising more difficult. However, advocacy still takes place in various locations and in various forms. Advocacy groups of people who use drugs have been organised at various times in New York, Oakland, Philadelphia and Denver. For example, in 2005, Voices of Community Advocates and Leaders (VOCAL) was founded in New York City as a membership-led body of 'drug users, those who identify with drug users and allies', which 'organizes as a movement for the education, prevention and treatment of HIV/AIDS and Hepatitis C (HCV) and sound public policies affecting drug users'.

Many more groups work less openly in order to avoid repression, or are active under the umbrella of local harm reduction programmes and services. Indeed, much of the activism around needle exchange provision in the US has involved significant participation and leadership from people who use drugs.⁸⁹

There was an effort made in the late-1990s to create an umbrella group of drug user advocates in both the US and Canada, called the North American Users Union, however that initiative is no longer active.

Targeted HCV prevention, treatment and care

In the US, it has been reported that an increasing number of health care settings are integrating HCV care into their programmes and services. These include primary health-care providers, methadone and drug treatment programmes and infectious disease clinics. In 2002, the National Institutes of Health updated its HCV treatment guidelines to include people actively injecting drugs, as well as methadone patients, as potential candidates for treatment.⁹⁰

People who inject drugs constitute the largest proportion of those living with HCV in the US, and yet research has shown that 'a disproportionately low number of people who inject drugs have actually received antiviral therapy for HCV'. This poor access to treatment exists despite the fact that a large proportion of people who inject drugs are interested in entering HCV treatment.⁹¹ A number of barriers have been identified in this regard, including a

lack of access to general health services among this population as well as a lack of funds or medical insurance.⁹²

In Canada, efforts to reach people who inject drugs with HCV services have largely been integrated into existing HIV and STI programmes. Despite this, 'most Canadian communities have no access to HCV-related services'.⁹³ HCV treatment access guidelines have been described as 'restrictive'. In 2005, it was reported that only 20% of all people living with HCV are indicated for treatment, with only 8% actually receiving it.⁹³ Although people who use drugs are not considered ineligible for treatment, treatment barriers similar to those described in the US have been reported.

Harm reduction in prisons

Neither the US nor Canada has implemented a comprehensive harm reduction response to address the issues of HIV, HCV and injecting drug use in prisons, as neither country has implemented NSPs in prisons. However, many more harm reduction components have been implemented in Canadian than in US prisons.

All fourteen Canadian jurisdictions provide voluntary HIV testing, and a small number also offer anonymous HIV testing.⁹⁴ Most prison systems provide condoms. Ten jurisdictions provide methadone maintenance, at least to those people who were on treatment before being incarcerated. Federal prisons, as well as provincial prisons in British Columbia, Ontario, Prince Edward Island and Saskatchewan, will also initiate OST. Three jurisdictions provide bleach for cleaning injecting equipment.⁹⁵

Few US prison systems have implemented harm reduction measures. Although several large, urban jails, including the Los Angeles and San Francisco County Jails, and one state prison system make condoms available, less than 1% of all US prisons do so.⁹⁶ Methadone provision is rare in US prisons. A small number of states (Rhode Island and Maryland) provide methadone in some prisons, as do a handful of county jails in states such as New York, Florida, California, New Mexico, Washington and Pennsylvania. Buprenorphine is currently being piloted in Rikers Island prison in New York.⁹⁷

Policies for harm reduction

In October 2007, the US's extension of its national strategy on HIV prevention contained the objective to 'increase the proportion of people who inject drugs who abstain from drug use or, for those who do not abstain, use harm reduction strategies to reduce risk for HIV acquisition or transmission'.⁹⁸ In addition, the 2001 National Hepatitis C Prevention Strategy supports harm reduction. According to the plan, achieving the goal of reducing HCV incidence 'requires: 1) harm reduction programs directed at persons at increased risk for infection to reduce the incidence of new HCV infections'.⁹⁹ However, the US National Drug Control Strategy does not support harm reduction.

In Canada, the Federal Initiative to Address HIV/AIDS in Canada is supportive of harm reduction.¹⁰⁰ In addition, a national framework developed through a multi-year, multi-stakeholder process explicitly includes measures such as NSPs, OST, SIFs and the greater involvement of people who use drugs.¹⁰¹

Canada's previous national drug strategy included harm reduction as one of its four pillars. However, the current Conservative government has shown hostility to harm reduction programmes¹⁰² and the new National Anti-Drug Strategy does not include it.¹⁰³

The new policy marks a shift away from harm reduction towards more enforcement and punishment. For example, the government has recently tabled legislation to introduce mandatory minimum sentences for drug offences, a punitive approach which the Canadian HIV/AIDS Legal Network has described as a 'proven failure'.¹⁰⁴

Several Canadian provinces support harm reduction in policy, including British Columbia, Ontario and Nova Scotia, and most other provinces and territories fund and have guidelines on specific harm reduction interventions such as NSPs and OST.⁹⁵

A number of North American civil society organisations advocate nationally (and in some cases internationally) for harm reduction approaches. These include the Canadian HIV/AIDS Legal Network and the Canadian Harm Reduction Network in Canada, as well as the Harm Reduction Coalition and the Harm Reduction Project in the US. In addition, the North American Syringe Exchange Network (NASEN) focuses specifically on supporting the existence and scale up of NSPs in the region.

There are also several organisations advocating for greater access to quality Hepatitis C prevention, testing and treatment for people who use drugs in North America.

The US government provides financial and technical support for HIV prevention, treatment and care through the President's Emergency Plan for AIDS Relief (PEPFAR) to levels exceeding any other national government. However, PEPFAR funds are not permitted to be used for NSPs and although OST programmes can be supported by these funds, PEPFAR guidelines only allow OST to be provided to people living with HIV.¹⁰⁵

The US government has continually opposed harm reduction in international forums such as the Commission on Narcotic Drugs (CND). This was reiterated at the CND 51st Session in March 2008, where the US delegation expressed its opposition to harm reduction, claiming that it encouraged drug use.¹⁰⁶

The Canadian International Development Agency supports harm reduction initiatives such as HIV prevention, treatment and care for people who use drugs, as well as drug treatment services in countries such as Georgia, Russia, Ukraine and Vietnam.

Multilateral support for harm reduction

There are no multilateral organisations currently providing technical or financial support for programmes focusing on HIV and AIDS in the US or Canada.

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