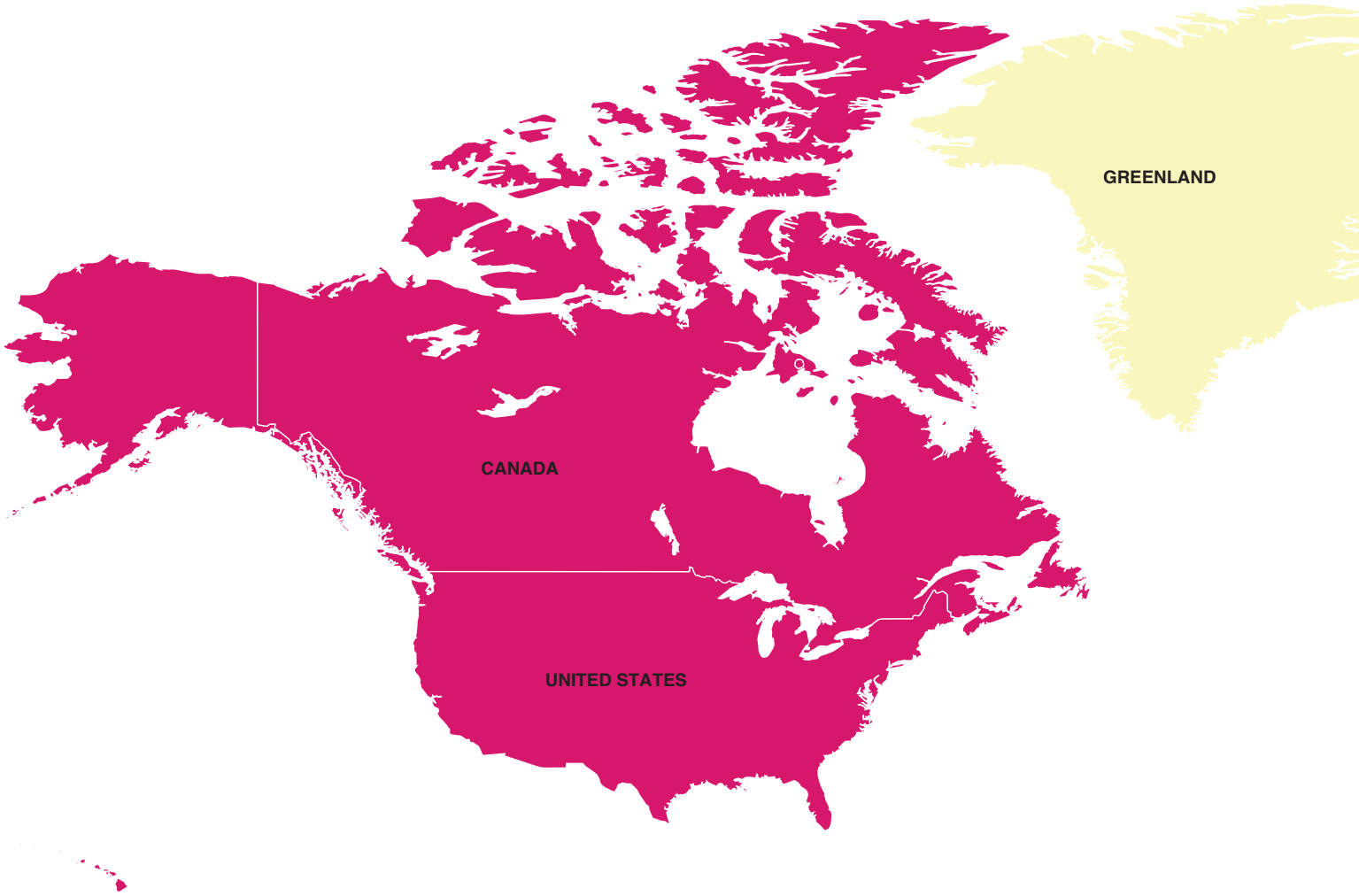
2.6 Regional Update: North America



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

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

Table 2.6.1: Harm reduction in North America

Country/territory with reported injecting drug use[a]	People who inject drugs[1]	Adult HIV prevalence amongst people who inject drugs[1]	Harm reduction response[2]		
			NSP[b]	OST[c]	DCR[d]
Canada	286,987	13.4%	✓(>775) (P) (SN)[e]	✓(B,M)	✓
United States	1,294,929	15.57%	✓(186) (P)	✓(1433) (B,M)	x

nk = not known

a There are no identified reports of injecting drug use in Greenland.
b The number in brackets represents the number of operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = needles and syringes reported to be available for purchase from pharmacies or other outlets. (SN) = sub-national data.
c The number in brackets represents the number of operational OST programmes, including publicly and privately funded clinics and pharmacy dispensing programmes. (M) = methadone and (B) = buprenorphine.
d Drug consumption room.
e This figure represents the number of sites in two Canadian provinces: British Columbia and Quebec. The number of sites in other provinces is not known.

Harm Reduction in North America

Canada and the United States are home to more than one-tenth of all people who inject drugs worldwide. UNAIDS recently stated that the role of injecting drug use in the North American HIV/AIDS epidemic had 'declined dramatically over the course of the epidemic'.[3] However, the US, after China and Russia, continues to have one of the highest estimated populations of people who inject drugs globally.[1] And, according to a 2008 systematic review for the Reference Group to the United Nations on HIV/AIDS and Injecting Drug Use, over 10% of people who inject drugs in the US and Canada are living with HIV.[1] In both countries, ethnic minorities and indigenous populations are particularly affected by drug-related harms such as HIV and hepatitis C, as well as by punitive drug law enforcement.

The US and Canada have key harm reduction programmes in place and support harm reduction in some aspects of national policy. However, service provision in both countries is inconsistent and influenced by local policies, many of which have historically favoured law enforcement and abstinence-only approaches to drugs. Coverage of needle and syringe programmes (NSPs) and opioid substitution therapy (OST) for people who inject drugs in North America is much lower than in Australasia and most Western European countries. Since 2008 NSP service provision has fallen in the US.[4] Harm reduction coverage in Canada remains difficult to ascertain due to a lack of national-level systematic data collection and surveillance mechanisms.[2]

Major positive developments at the policy level have taken place in the US, particularly the reversal in late 2009 of the long-standing ban on federal funding of syringe exchange. Although the US announced its policy support for syringe exchange domestically and internationally,[5] the impact of this on NSP service provision in the US and elsewhere is yet to be seen.

In Canada, a law enforcement approach to illicit drugs has predominated since 2008 at the expense of evidence-based health policy. Recent developments include the introduction of mandatory minimum sentencing for drug offences and continued legal challenges to Insite (the region's only safer injecting facility) by the Conservative federal government. In 2010 the British Colombia Court of Appeal dismissed an appeal by the federal government of a previous lower court decision supporting Insite, ultimately enabling the continued operation of the facility.

Developments in harm reduction implementation

Needle and syringe exchange programmes (NSPs)

A lack of national data collection on NSPs in Canada makes it difficult to establish whether service coverage has increased in recent years. According to the most recent available data from the Canadian HIV/AIDS Legal Network and the National Institute of Public Health, a total of 775 NSP sites operate in the provinces of British Columbia and Quebec.[6] [7]

Several barriers to NSP access have been reported, including strict drug and paraphernalia laws leading to a fear of arrest, distance from service, limited opening hours, limits on the injecting equipment provided per visit and concerns over confidentiality. It has also been reported that NSP staff are sometimes reluctant to provide young people (under eighteens) with injecting equipment.[8]

Civil society reports since 2008 indicate that as many as 10% of the NSPs in the US have closed or drastically reduced services as a result of state budget cuts.[4] In 2009 the North American Syringe Exchange Network was aware of 186 NSPs operating in the US.[9] The UN Reference Group estimate that there are only 0.1 NSP sites per 1,000 people who inject drugs in the US.[2] Although this does not provide a true measure of coverage, it is interesting to note that the only other country with such a low estimate of existing services is Thailand, where NSPs are NGO-led and have no government support. It is yet to be seen how the recent lifting of the federal funding ban on needle and syringe exchange in the US will affect NSP coverage.

NSP coverage across North America averages twenty-three syringes distributed per person injecting drugs per year, significantly lower than that of Western Europe (fifty-nine syringes) and Australasia (202 syringes).[2]

There is a need for culturally appropriate and accessible programmes for ethnic minorities who inject drugs. In the US, 40% of African-American men and 47% of African-American women living with HIV contracted the virus either through injecting or by having sex with someone who does.[10] Data derived from two prospective cohort studies in Vancouver, Canada comparing HIV incidence among Aboriginal and non-Aboriginal people who inject drugs indicated significantly elevated HIV prevalence and HIV incidence among Aboriginal people who inject.[11] Evidence-based and culturally sensitive harm reduction responses must be implemented proactively and in a timely manner to avert the likelihood of public health emergencies among injecting sub-populations at high risk.

The legal dispute over Insite

Since 2008 the legal status of Insite, North America's only safer injecting facility (SIF), has been challenged by the Canadian Conservative government with renewed vigour. In May 2008 a lower court in the province of British Columbia, where Insite is located, prevented the federal government from shutting the facility down.

Responding to this decision, the Canadian HIV/AIDS Legal Network stated on 29 May, 'In exempting Insite users from criminal prosecution for possessing drugs while at the facility, the court recognized that a simplistic approach of criminalizing people with drug addictions contributes to death and disease that could otherwise be prevented, and violates basic human rights protected by the [Canadian] *Charter [of Rights and Freedoms]*.'[12]

The Attorney General of Canada appealed the court's decision. On 15 January 2010 the British Colombia Court of Appeal dismissed this appeal, allowing Insite to continue operating and ruling a portion of Canada's Controlled Drugs and Substances Act unconstitutional in the process.

Safer crack use kit distribution

A significant increase in the use of crack cocaine, particularly among people who inject drugs, has been documented in Canada.[13] Research since 2008 has identified the smoking of crack cocaine as an independent risk factor for HIV infection among people who inject drugs, with female users at increased risk.[14] [15] According to recent epidemiological modelling of crack use trends in the Canadian setting, independent predictors of crack use initiation include frequent cocaine injection, crystal methamphetamine injection, residency in urban areas where drug use prevalence is high and involvement in sex work.[13] Given the multiplicity of factors that contribute to crack use among people who already inject, evidence-based and gender-sensitive interventions are urgently needed to address crack use and its associated harms.[16]

Some distribution of safer crack kits has continued in the US and Canada since 2008, albeit in limited areas and with continued opposition from the International Narcotics Control Board.[17] There is an urgent need to document and evaluate the kits' impact and to broaden support for these programmes.

Opioid substitution therapy (OST)

OST, including methadone and buprenorphine, is offered in 1,433 licensed facilities across the US to 253,475 clients.[2] Despite early leadership in OST provision, access in the US remains geographically inconsistent.[18] OST is available in Canada, but there are no available data on national service coverage. For both countries, developing national data collection systems in all areas of HIV surveillance, including injecting drug use and harm reduction service coverage, should be a public health priority.

A number of barriers remain to optimal OST access across the region. In the US, limited financial resources, a lack of health insurance and mistrust of the treatment system continue to prevent many people from accessing treatment.[4] In Canada, strict regulation of methadone and underfunding of maintenance programmes limits the number of physicians and pharmacies that can provide OST. As a result, OST accessibility varies broadly across provinces, with, for example, Newfoundland and New Brunswick facing large shortages of licensed physicians prescribing OST.[19]

In Canada, the North American Opiate Medication Initiative (NAOMI) published the findings in October 2008 of a three-year randomised controlled trial assessing whether the provision of diacetylmorphine (pharmaceutical heroin) under medical supervision would benefit people with chronic opiate dependencies for whom other treatment options have proved unsuccessful.[20] The study, conducted at two sites in Vancouver and Montreal and involving 251 participants, concluded that heroin assisted therapy (HAT) was significantly more effective than methadone for long-term opioid users for whom other treatments have not worked.[21] In addition, the study found that individuals on HAT were more likely to stay in treatment, decrease their use of illegal drugs and reduce their involvement in illegal activities than patients assigned to receive oral methadone.[21] These findings are consistent with the results of previous European studies[22] [23] [24] and solidify the evidence base for the provision of a range of treatments to opiate users, as well as for the decriminalisation of medically prescribed and regulated narcotic treatments.

Antiretroviral therapy (ART)

UNAIDS report that rates of new infections among people who inject drugs have generally fallen in the past few years in North America.[3] However, the disproportionate risk of death experienced by people who inject drugs due to the associated health risks, such as overdose and infection,[25] may also help to explain the documented decline in HIV prevalence.[3] While accounting for 20.9% of people with diagnosed HIV infection in New York City in 2007, people who inject drugs accounted for 38.1% of all deaths among HIV-diagnosed individuals.[26]

Furthermore, among people who inject drugs, minority populations remain disproportionately affected in terms of HIV prevalence and incidence. For instance, although African-Americans represent 12% of the US population, they accounted for 46% of HIV prevalence in 2008.[27]

The UN Reference Group estimate that 40,334 people who inject drugs in Canada and 308,208 people who inject drugs in the US were living with HIV in 2008.[2] However, there are currently no data on national coverage of ART provision for people who inject drugs in either country.[2]

Approximately 21% of people living with HIV in the US[27] and 27% in Canada[28] are unaware of their HIV status. The US Centers for Disease Control and Prevention estimate that up to 70% of new HIV infections in the US involve people who are unaware of their HIV-positive status.[29] The increased roll-out of harm reduction services, including NSPs and OST, in Canada and the US is essential if further progress in reducing HIV incidence and AIDS-related mortality is to be made. Integrated services that encourage early voluntary HIV counselling and testing for people who inject drugs and their sexual partners are also necessary measures.[3] Uptake of ART among people who inject drugs may be improved through targeted HIV testing and counselling initiatives that encourage the receipt of HIV test results and follow-up.[30]

Policy developments for harm reduction

Major positive developments at the policy level have taken place in the US in the past two years. The ban on federal funding of needle syringe exchange, dating back to 1988, was lifted by Congress in late 2009. In addition, the Office of National Drug Control Policy, under the Obama Administration, has signalled US support for syringe exchange domestically and internationally.

At the 2010 meeting of the UN Commission on Narcotic Drugs, the US's representative expressed government support for harm reduction interventions such as NSP and OST, but not the term itself.[5] Although the US government supports interventions that reduce both drug use and drug-related harm, it appears to exclude heroin prescription and supervised injection facilities. Nevertheless, as one of the countries that has traditionally opposed key harm reduction interventions in the past and as a major international donor to HIV programmes, the US's recent policy shift is an important development with potential positive implications for people who use drugs in the US and around the world.

Also in the US, overdose prevention issues have increasingly been taken up by federal agencies, particularly the Substance Abuse and Mental Health Services Administration (SAMHSA), through new policies, programmes and funding streams. However, policies or programming guidelines on overdose prevention have not yet been formally adopted at the federal level. Overdose prevention programmes dispensing naloxone have increased dramatically since 2008: over 100 such programmes now exist, ranging from small grass-roots projects to health department-supported initiatives (see Chapter 3.6 on overdose).[4]

Since 2006 Canada has experienced a political shift from public-health-oriented drug policies to prohibition-inspired criminal justice initiatives. Canada's 2007 Conservative federal budget contains the National Anti-Drug Strategy, Bill C-26, which introduces mandatory minimum prison sentences for cannabis offences.[31] Stephen Harper's Conservative government has continued the trend towards a law enforcement approach to illicit drugs, at the expense of evidence-based health policies. The legal challenges noted above against Insite during 2008 and 2009, despite numerous positive evaluations of the facility,[32] [33] illustrate this trend.

Civil society and advocacy developments for harm reduction

In the US, the harm reduction and syringe exchange communities, joined by HIV/AIDS advocacy groups, led the campaign to overturn the federal funding ban on syringe exchange, and remain mobilised to ensure appropriate and timely implementation.

The lifting of the ban paves the way for new and increased resources directed at syringe exchange programmes and other harm reduction activities based at these programmes, but no additional federal funding has yet materialised. This is a serious concern, given that the impact of the global financial crisis on state budgets is reported to have resulted in funding cuts to syringe exchange programmes in several US states, along with related harm reduction training and capacity-building activities.[4]

VOCAL-NY Users Union

Originally formed in 1992 as a hepatitis C 'consumer' advocacy committee at a syringe exchange programme in Manhattan, VOCAL-NY (Voices of Community Advocates and Leaders New York) has since partnered with the New York City AIDS Housing Network (NYCAHN) to expand its community organising and reach.

VOCAL-NY's tactics have included marches and rallies targeting the governor and legislature in Albany, lobbying, media outreach and participatory research around the impacts of current national and state laws on syringe sharing and re-use. Additional campaigns sought to lift the funding bans on syringe exchanges, to eliminate mandatory minimum sentences for people convicted of drug offences and to improve the rights of methadone patients.

VOCAL-NY has encountered numerous challenges to the continuation of its activities, including harassment by law enforcement officers, lack of government support for harm reduction programmes until very recently, poor access to health care (through lack of insurance and primary care physicians) and policy barriers to housing and income support.

In Canada, civil society organisations advocating for harm reduction have been heavily engaged in campaigns to ensure the continued operation of Insite, to oppose mandatory minimum sentencing for drug offences[34] [35] and to increase access to harm reduction interventions in prisons.[36] In 2010 leading Canadian non-governmental organisations working on HIV/AIDS, including the Canadian HIV/AIDS Legal Network and the Interagency Coalition on AIDS and Development, joined together in a call for improved government action to address the epidemic both nationally and around the world, highlighting the importance of an evidence-based approach.[37] In 2008, in a consultation commissioned by Health Canada, Canadian civil society organisations called for the government to use its bilateral and multilateral relations to champion the use of harm reduction strategies to address HIV and AIDS among people who use drugs.[38]

Multilaterals and donors: Developments for harm reduction

There are no multilateral programmes or international donors supporting harm reduction in North America.

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