1.1 | Harm Reduction
A Global Update

Harm Reduction: A Global Update

Harm reduction is increasing in recognition around the world. This is demonstrated by several significant developments in policy, implementation and research in the last two years. Among these are increases in the number of countries addressing harm reduction in national policies and strategic plans, as well as those gathering epidemiology and coverage monitoring data among people who inject drugs (PWID) and implementing harm reduction programmes. However, the availability and coverage of harm reduction programmes remains uneven among and within regions, and is particularly limited in low- and middle- income countries. In many parts of the world, harm reduction programmes face widespread challenges in the context of economic and donor uncertainty (see below for more details).

Injecting drug use (IDU) has been documented in at least 158 countries and territories globally.[1] The latest available global population size estimates indicate that 15.9 million (range 11–21 million) people inject drugs around the world.[2] The most significant numbers of PWID reside in China, the USA and Russia. Reports of HIV among PWID are documented in 120 countries.[3] In 2010, nearly half (47%) of people who inject drugs living with HIV in low- and middle-income countries came from five nations – China, Vietnam, Malaysia, Russia and Ukraine.[32] Specific sub-populations of PWID, including young people and women who inject drugs, experience elevated barriers to service access (see Sections 2 and 3 for more details).

PWID also face elevated rates of viral hepatitis and tuberculosis. Recent estimates indicate that approximately 10 million PWID worldwide may have hepatitis C, a figure that surpasses HIV infection among this population.[3] China is home to more than half (1.6 million, range 1.1–2.2 million) of PWID living with hepatitis C worldwide, followed by the USA (1.5 million) and Russia (1.3 million).[3] Asia has the largest populations of PWID with active hepatitis B (HbsAg)[a] (300,000, range 100,000–700,000). People living with HIV who also inject drugs have a two- to six-fold increased risk of developing TB compared to non-injectors, and commonly have co-infection with hepatitis B (HBV) and C (HCV) viral infection.[4] This risk is on average twenty-three times higher in prisons than in the general population[5] (see Section 2 for more details).

a HbsAg indicates active (either acute or chronic) infection. Approximately 95% of adults with acute HBV infection clear the virus and develop anti-HBc and hepatitis B surface antibodies (anti-HBs). People who inject drugs may have lower clearance rates for HBV than the general population because more PWID may become chronically infected. For more information, see Nelson PK et al (2011) Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews, *Lancet*, 378(9791): 571–583.

The global harm reduction response

International policy developments for harm reduction

In the past two years since 2010, several developments in international policy have occurred, with important implications for harm reduction:

» On 16 December 2011 the US Congress reinstated the ban on federal funding for needle and syringe exchange programmes (NSPs).[6] The decision comes just two years after the 21-year-old ban was repealed and signed into law by President Barack Obama in December 2009, thereby allowing states and local public health officials to use federal funds for sterile syringe access. The decision includes reinstatements of bans on both domestic and international use of US federal funds for NSPs as part of the 2012 omnibus spending bill.

» At the UN High Level Meeting on AIDS in June 2011, states adopted a new declaration with revised targets for measuring progress in the global response, the *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS*.[7] The text of the final outcome document reflects ongoing tensions between evidence and human rights-based approaches, and relativist stances by some states, which emphasise 'local circumstances, ethics and cultural values' at the expense of public health-based strategies.[8] However, the document also reflected negotiation successes, including the explicit mention of the WHO/UNAIDS/UNODC comprehensive harm reduction package, a pledge to reduce HIV among PWID by 50% by 2015 and concrete, time-bound coverage and funding targets.

» Countries submitted their first reports to monitor progress against commitments in the 2011 Political Declaration on HIV/AIDS to UNAIDS in March 2012, which will form the basis of an end-of-year report on the state of the global HIV epidemic. The core indicators for country progress reporting have been revised to reflect the new targets set out in the 2011 Political Declaration, and represent one of the most comprehensive tools to date for monitoring the epidemiology of HIV and service coverage among PWID by multilateral agencies.[9]

» In March 2012, twelve UN agencies called on states to close compulsory drug detention and rehabilitation centres and implement voluntary, evidence-informed and rights-based health and social services in the community.[10] This is a particularly relevant development for countries in Asia, where the continued commitment to compulsory detention by some countries remains a serious human rights concern.[11-12] During a meeting with civil society at the 55th Session of the Commission on Narcotic Drugs (CND), however, the International Narcotics Control Board (INCB) refused to denounce such

centres, or 'any atrocity' committed in the name of drug control.[13] The INCB President also refused to refrain from referring to people who use drugs (PWUD) as 'abusers' and 'drug abusing offenders' when asked to do so by the International Network of People who Use Drugs (INPUD), who explained the terms were seen as stigmatising and offensive.

» The role of naloxone in addressing opioid overdose was recognised for the first time in a high-level international resolution in March 2012. Members at the 55th CND unanimously endorsed a resolution promoting evidence-based strategies to address opioid overdose.[14] Introduced by the Czech Republic and co-sponsored by Israel and Denmark (the latter on behalf of the European Union), the resolution calls on UNODC, WHO and other international organisations to work with member states to address the global overdose epidemic.

» Also at the 54th session of the CND in March 2011, a resolution was adopted, co-sponsored by the USA, entitled 'Achieving zero new infections of HIV among injecting and other drug users.'[15] Following tense debates, with Russia in particular being resistant to the resolution, member states finally endorsed the WHO, UNAIDS, UNODC comprehensive package on HIV and IDU – a first at the CND.

» The emerging issue of new psychoactive substances, commonly known as 'legal highs', and the need to explore considered, evidence-informed approaches other than criminal justice, was recognised in a progressive resolution adopted at the 55th CND.[16] Originally proposed by Australia, the resolution did not call for 'legal highs' to be banned or criminalised, but rather urged countries 'to consider a wide variety of evidence-based control measures to tackle the emergence of new psychoactive substances, including the use of consumer protection, legislation regarding medicine and legislation regarding hazardous substances.' Advocates welcomed the resolution, noting that an acknowledgement of alternative means of regulating illicit substances is an important step forward for member states at the CND.[17]

» The World Health Organization (WHO) has developed new guidance[b] on prevention strategies for viral hepatitis B and C in PWID planned for release at the 19th International AIDS Conference Washington, DC, in July 2012. Recommendations will comprise three distinct but interlinked areas: surveillance, screening and antiretroviral therapy (ART) management in people with HIV and viral Hepatitis B and C co-infections. Recommendations include strengthening hepatitis monitoring systems through standardising case definitions of viral hepatitis, integrating hepatitis with HIV, TB and STI surveillance, and considering sentinel surveillance for acute hepatitis among key populations at higher risk, including PWID.

» Since 2010 the leadership of the UN Office on Drugs and Crime (UNODC) on HIV-related harm reduction has deteriorated. As UNODC is the lead UNAIDS co-sponsor with responsibility for HIV and IDU, this is a considerable concern. Since taking the office of Executive Director, Mr Yury Fedotov has failed to endorse basic HIV prevention measures related to IDU and has questioned whether his agency has a harm reduction mandate[18] or an official position on OST.[19] HIV/AIDS organisations took the occasion of World AIDS Day in 2011 to write to Mr Fedotov to seek clarification on these issues. They received no reply from Mr Fedotov, rather an ambiguous reply from another senior member of staff.

» During the 55th session of the CND, the UNODC Executive Director's report to member states on HIV and IDU reworded the agreed WHO, UNAIDS, UNODC comprehensive package to give prominence to abstinence-based drug treatment and to downplay opioid substitution therapy (OST).[20] Throughout the report, HIV prevention was seen as a subset of drug treatment, while the phrases 'opioid substitution therapy' and 'needle and syringe programmes' were avoided. Following an intervention by the European Union, UNODC had to correct the actual wording of the comprehensive package at the plenary of the Commission. To date the document remains unchanged.

» Within the European Union, Sweden and Italy continued to play negative roles on harm reduction. As a group, the European Union has weakened in its harm reduction position. This was evident at the High Level Meeting on HIV at the UN, and despite some important progress, also at the 55th CND. This is due in part to harm reduction being seen as a less important diplomatic issue for countries that previously adopted leadership roles internationally, including the United Kingdom and the Netherlands. This is despite strong, ongoing harm reduction programming nationally and funding for harm reduction internationally from those same countries.

An enabling environment for harm reduction

In 2012 there are 97 countries and territories that support a harm reduction approach, four more[c] than reported in 2010 (see Table 1.1.1).[21d] This support is explicit either in national policy documents (eighty-three countries – four more than in 2010), and/or through the implementation or tolerance of harm reduction interventions such as NSPs (eighty-six countries – four more than in 2010)[e] or OST (seventy-seven countries – seven more than in 2010).[f]

b The new guidance can be downloaded from http://www.who.int/hiv/pub/guidelines/hepatitis/en/.

c Macau, Jordan, Syria, Tunisia.
d Inclusion in this list refers both to countries or territories that have newly supported a harm reduction approach in policy and/or practice since 2010, and to countries or territories for which 'not known' was reported in 2010 (i.e. Macau).
e South Africa, Tanzania, Macau and Laos PDR.
f Cambodia, Bangladesh, Tajikistan, Kenya, Tanzania, Macau and Kosovo.

There is a trend towards less punitive responses toward PWID in some countries and regions, with between 25 and 30 countries adopting some form of decriminalisation of possession of drugs for personal use.[g] Although significant variations in such reforms and how they are implemented and evaluated makes generalisations difficult, emerging evidence indicates that decriminalisation provides an enabling environment supporting implementation and take-up of harm reduction programmes proven to reduce HIV and viral hepatitis transmission.

Table 1.1.1: Countries or territories employing a harm reduction approach in policy or practice[h]

Country or territory	Explicit supportive reference to harm reduction in national policy documents	Needle exchange programmes operational	Opioid substitution programmes operational	Drug consumption room(s)
ASIA				
Afghanistan	✓	✓	✓	x
Bangladesh	✓	✓	✓	x
Cambodia	✓	✓	x	x
China	✓	✓	✓	x
Hong Kong	✓	x	✓	x
India	✓	✓	✓	x
Indonesia	✓	✓	✓	x
Macau	✓	✓	✓	x
Malaysia	✓	✓	✓	x
Maldives	x	x	✓	x
Mongolia	x	✓	x	x
Myanmar	✓	✓	✓	x
Nepal	✓	✓	✓	x
Pakistan	✓	✓	x	x
PDR Laos	✓	x	x	x
Philippines	✓	✓	x	x
Taiwan	✓	✓	✓	x
Thailand	✓	✓	✓	x
Vietnam	✓	✓	✓	x
CARIBBEAN				
Puerto Rico	x	✓	✓	x
Trinidad and Tobago	✓	x	x	x
EURASIA				
Albania	✓	✓	✓	x
Armenia	✓	✓	✓	x
Azerbaijan	x	✓	✓	x
Belarus	✓	✓	✓	x
Bosnia & Herzegovina	✓	✓	✓	x
Bulgaria	✓	✓	✓	x
Croatia	✓	✓	✓	x
Czech Republic	✓	✓	✓	x
Estonia	✓	✓	✓	x
Georgia	✓	✓	✓	x
Hungary	✓	✓	✓	x
Kazakhstan	✓	✓	✓	x
Kosovo	✓	✓	✓	x
Kyrgyzstan	✓	✓	✓	x
Latvia	✓	✓	✓	x
Lithuania	✓	✓	✓	x
Macedonia	✓	✓	✓	x
Moldova	✓	✓	✓	x
Montenegro	✓	✓	✓	x
Poland	✓	✓	✓	x
Romania	✓	✓	✓	x
Russia	x	✓	x	x
Serbia	✓	✓	✓	x
Slovakia	✓	✓	✓	x
Slovenia	✓	✓	✓	x
Tajikistan	✓	✓	✓	x
Turkmenistan	x	✓	x	x
Ukraine	✓	✓	✓	x
Uzbekistan	✓	✓	x	x
LATIN AMERICA				
Argentina	✓	✓	x	x
Brazil	✓	✓	x	x
Colombia	✓	x	✓	x
Mexico	✓	✓	✓	x
Paraguay	✓	✓	x	x
Uruguay	✓	✓	x	x
MIDDLE EAST and NORTH AFRICA				
Egypt	x	✓	x	x
Iran	✓	✓	✓	x
Israel	✓	✓	✓	x
Jordan	✓	x	x	x
Lebanon	✓	✓	✓	x
Morocco	✓	✓	x	x
Oman	x	✓	x	x
Palestine	x	✓	x	x
Syria	✓	x	x	x
Tunisia	✓	✓	x	x
NORTH AMERICA				
Canada	✓	✓	✓	✓
United States	✓	✓	✓	x
OCEANIA				
Australia	✓	✓	✓	✓
New Zealand	✓	✓	✓	x
SUB-SAHARAN AFRICA				
Kenya	✓	x	✓	x
Mauritius	✓	✓	✓	x
Senegal	x	x	✓	x
Seychelles	x	x	x	x
South Africa	x	✓	✓	x

g See Chapter 3.4 of this publication for a global summary of drug decriminalisation policies.

h This includes countries that have harm reduction in their national policies or strategy documents on HIV, viral hepatitis and/or drug use. In many countries, harm reduction may appear in one or more of such policies, but not all. Inclusion in this table of NSP, OST and DCRs indicates only the availability of these interventions, rather than their scope or coverage.

Country or territory	Explicit supportive reference to harm reduction in national policy documents	Needle exchange programmes operational	Opioid substitution programmes operational	Drug consumption room(s)
Tanzania	✓	✓	✓	x
Zanzibar	✓	x	x	x
WESTERN EUROPE				
Austria	✓	✓	✓	x
Belgium	✓	✓	✓	x
Cyprus	✓	✓	✓	x
Denmark	✓	✓	✓	x
Finland	✓	✓	✓	x
France	✓	✓	✓	x
Germany	✓	✓	✓	✓
Greece	✓	✓	✓	x
Iceland	nk	x	✓	x
Ireland	✓	✓	✓	x
Italy	✓	✓	✓	x
Luxembourg	✓	✓	✓	✓
Malta	✓	✓	✓	x
Netherlands	✓	✓	✓	✓
Norway	✓	✓	✓	✓
Portugal	✓	✓	✓	x
Spain	✓	✓	✓	✓
Sweden	✓	✓	✓	x
Switzerland	✓	✓	✓	✓
United Kingdom	✓	✓	✓	x

Civil society and networks

Harm reduction networks continue to operate in every region of the world, and are making important contributions at national, regional and international levels. Regional networks include the AHRN Federation, Caribbean Harm Reduction Coalition (CHRC), Eurasian Harm Reduction Network (EHRN), European Harm Reduction Network (EuroHRN), Middle East and North Africa Harm Reduction Association (MENAHRA), Intercambios Asociación Civil (Latin America) and a nascent Sub-Saharan Africa Network. There are also numerous national and local level networks that continue to advocate for harm reduction at these levels.

In recent years, there have been a number of notable developments among regional harm reduction networks. These include the expansion of EuroHRN, which was formed in 2009. The major outputs of the network have been the publication of the first civil society audit in Europe and a report detailing a mapping of drug user organisations throughout the region.[22] The research into drug user organisations was particularly significant as it led to the formation of the first pan-European network of PWUD. EuroHRN held its first European Harm Reduction Meeting in Marseille in 2011.

The Asian Harm Reduction Network has gone through significant modifications including a name change to the AHRN Federation. It has undergone organisational restructuring to develop a federation model, which aims to allow national harm reduction organisations and networks to have a key role in determining the future and priorities of the network. The federation consists of national and sub-national harm reduction networks, as well as key focal organisations, and focuses its efforts in India, Indonesia, Thailand, Cambodia, Myanmar, China, Malaysia and Nepal.

MENAHRA has been a significant catalyst for increasing attention to harm reduction in the MENA region since its founding in 2007.[23] In January 2012, MENAHRA began implementation of its round 10 Global Fund grant to expand harm reduction in twelve countries[i] across the region through capacity building, training, advocacy and networking activities. The overall aim of this project is to create a conducive environment for the scale-up and implementation of HIV and harm reduction programmes across the region.

Global networks that include harm reduction as a key component of their work continue to operate at the international level. These include YouthRISE, International Network of People Who Use Drugs (INPUD), International Nursing Harm Reduction Network (INHRN), International Doctors for Healthy Drug Policies (IDHDP), International Centre for Science in Drug Policy (ICSDP), Law Enforcement and HIV Network (LEAHN), Women's Harm Reduction Network (WHRIN) and the International Drug Policy Consortium (IDPC).

IDPC has developed a strong membership base and produced several publications since 2010, including the Second Edition of the IDPC Drug Policy Guide and over twenty drug policy briefings. IDPC facilitates strong civil society involvement and engagement with policy makers at regional and international forums, particularly at the CND, and works at national and international levels to promote open dialogue around a human rights and public health approach to drug policy.

There has been some progress in the engagement of civil society in international policy-making. During the 54th CND session, a resolution was adopted on improving civil society engagement at the Commission. During informal negotiations it was one of the most contested resolutions, reflecting many member states' ongoing discomfort with civil society engagement. The following year, however, the first official civil society hearing was held at the CND: an important and positive development. Despite this improvement, the 2012 session of the CND was marred by the secretariat's censorship of civil society statements. Two oral statements – one criticising the UNODC's Executive Director for a lack of leadership on HIV, and the other on human rights concerns about the International Narcotics Control Board's annual report – were not permitted and had to be amended.

i Iran, Pakistan, Libya, Lebanon, Syria, Jordan, Bahrain, Morocco, Egypt, Afghanistan, Oman and Palestine.

Civil society launched a number of significant declarations that sought to mobilise international support for key international forums in 2010 and 2011. The Vienna Declaration,[24] a global initiative supported by the Open Society Foundations, was launched at the 18th International AIDS conference in July 2010. Calling for drug policy to be based on scientific evidence, the Declaration received over 17,000 endorsements in less than three months. Notable signatories include three former Latin American presidents, as well as cities, Nobel laureates, scientists, lawyers, academics, researchers, and activists from around the world.

In advance of the UN High Level Meeting (HLM) on AIDS held in June 2011, Harm Reduction International (HRI) launched the Beirut Declaration on HIV and Injecting Drug Use: A Global Call for Action, an initiative aimed at increasing support for harm reduction and related drug policy reform within the proceedings and outputs of the HLM, and raising awareness of the limited international support for harm reduction and the drug policy reforms necessary for its optimal implementation. The Declaration was endorsed by over 200 organisations in the broader HIV/AIDS and development fields[j] and was featured in prominent forums. For example, the 9 April 2011 edition of the scientific journal the *Lancet* featured the Beirut Declaration in its editorial, calling for increased attention to harm reduction, IDU and drug policy reform within the proceedings of the HLM.[25]

The visibility of regional networks of PWUD has also increased in recent years; new networks have been established in Eurasia, Europe and the MENA regions. The Eurasian[k] and MENA networks were established in 2010, and the European[l] network in 2011.

INPUD has undergone significant changes since 2010 with the selection of a new executive director, a full-time staff team and a newly elected board. INPUD's increased capacity has allowed its staff and members to engage actively in international forums such as the CND and the UNAIDS Programme Coordinating Board (PCB), and at the community level in Afghanistan, Kenya, Tanzania, Eastern Europe, and Central Asia through the delivery of capacity-building workshops and technical assistance. Since 2010, INPUD has become an increasingly important partner representing the perspective of drug using and injecting populations to civil society and multilateral agencies.

The harm reduction 'network of networks' continues to work collectively and share information. It is made up of regional and global networks as well as national harm reduction networks, which include the Canadian Harm Reduction Network (CHRN), Colectivo por Una Politicia Integral Hacia las Drogues (CUPIHD, based in Mexico) and the Harm Reduction Coalition (HRC, based in the USA).

Community Action on Harm Reduction

Community Action on Harm Reduction (CAHR) is a new and ambitious five-year project led by the International HIV/AIDS Alliance and made possible by a grant from the Dutch Ministry of Internal Affairs (BUZA). It aims to significantly improve HIV and harm reduction services for people who inject drugs, their partners and children, in China, India, Indonesia, Kenya and Malaysia. The project works to introduce essential harm reduction interventions in Kenya, improve access to community-based support services in China, increase the quality of behavioural change programming in India and Malaysia, and expand quality harm reduction services to new communities within PWID populations in Indonesia. Overall, it aims to reach more than 180,000 people who inject drugs, their partners and children. There is a strong focus on building the capacity of community-based organisations as well as the meaningful engagement of people who use drugs in the development, implementation and evaluation of services within each country.

Global coverage of harm reduction services

The lack of reliable population size estimates for PWID in several countries, and inconsistencies in the quality of available data, make accurate assessments of progress since 2010 challenging. Generally, where data is available, harm reduction service provision has increased in countries where it was already being implemented. Several countries in sub-Saharan Africa, Asia and parts of Eastern Europe and Central Asia have NSPs and/or OST. Despite these improvements, expansion of programmes has been slow and many new programmes are small-scale pilots. The last two years have also witnessed significant scale-down of services in countries with some of the highest HIV burdens among PWID. In most low- and middle-income countries, coverage remains insufficient to stabilise and reverse HIV and viral hepatitis epidemics among PWID.

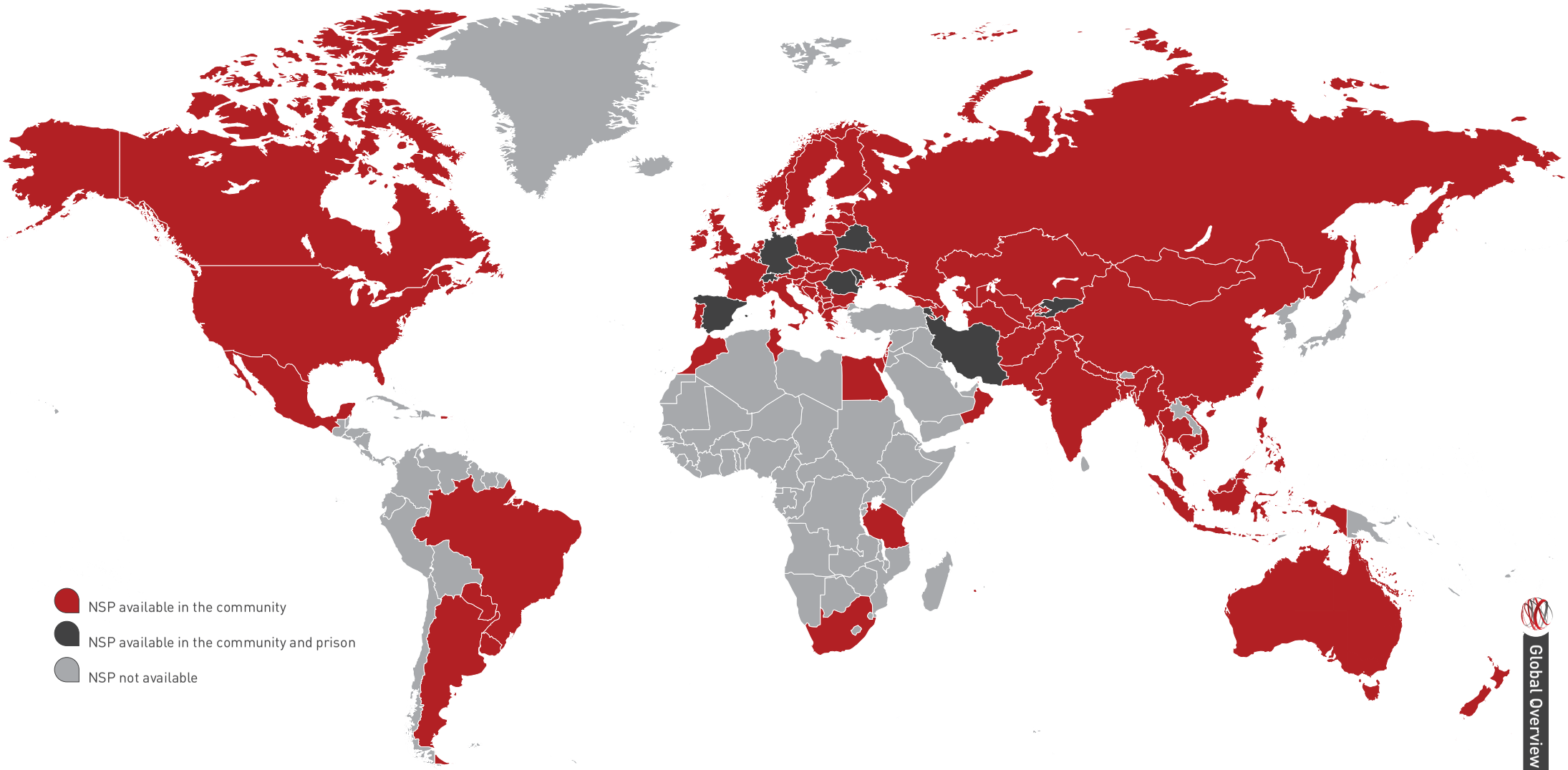
Needle and syringe exchange programmes

In 2012 there are eighty-six countries and territories that implement NSPs to varying degrees. Models of provision include fixed and specialist NSP sites, community-based outreach, pharmacy provision and vending machines. Three countries have newly implemented NSPs since 2010 -- South Africa, Tanzania and Laos PDR.[m]

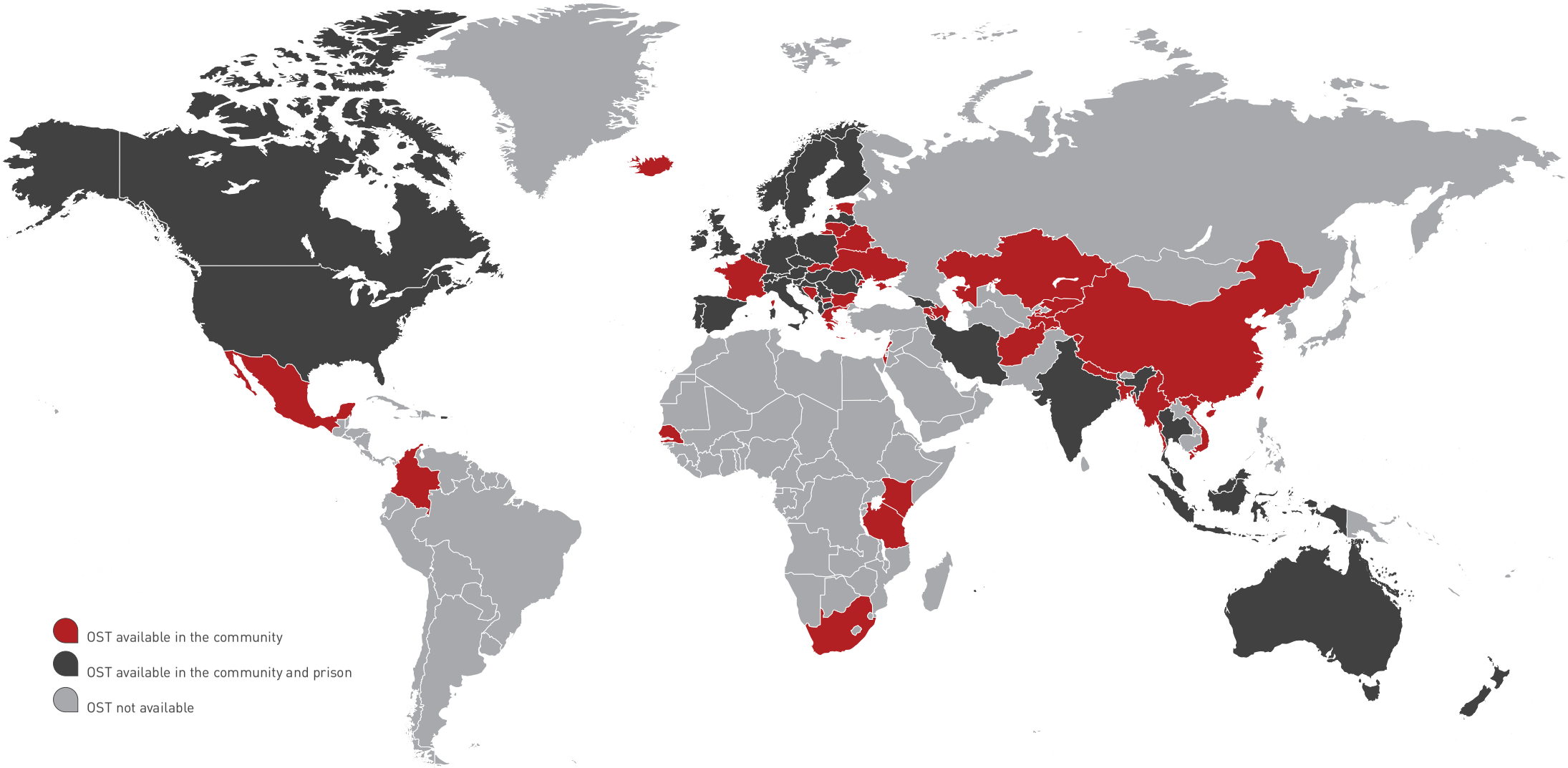
j For a complete list of endorsements visit www.ihra.net/endorsements.
k Refer to Chapter 2.2 of this publication for further information on the development of this network.
l Refer to Chapter 2.3 of this publication for further information of the development of this network.

m Macau is not included, although it is newly reported to provide NSP and OST in this report. Provision of harm reduction services in Macau started prior to 2010. However, in past reports, information on Macau was not known/not reported.

Map 1.1: Global availability of needle and syringe programmes in the community and in prisons



Map 1.2: Global availability of opioid substitution therapy in the community and in prisons



The number of operational NSP sites, and the coverage provided through existing services, varies widely among countries and regions. According to internationally recommended targets,[n] coverage is high in only a few countries such as Australia, several Western European countries, as well as in Bangladesh, where over 200 needle/syringes per PWID are reached per year.

Generally coverage is lower in low- and middle-income countries, with few changes in provision since 2010 in Latin America and the Caribbean, which distribute less than one needle per person per year.[26] An increasing number of sites provide sterile injecting equipment around the world, including in countries that have high HIV and viral hepatitis prevalence among PWID such as the Ukraine and several countries in Asia. Despite increases in provision, existing services in most low and middle-income countries do not reach coverage levels sufficient to stabilise and reverse HIV epidemics among this population. For instance, just an estimated 10% of PWID in Eastern Europe, and 36% in Central Asia, access NSPs.[27]

Since 2010, NSP provision was scaled back in several countries in Asia[o] and Eurasia.[p] Seventy-two countries and territories with reported IDU (thirty-eight of them with HIV reported among this population) remain without any NSP provision.

Drug consumption rooms

In 2012 there are fifty-eight cities around the world that operate at least one drug consumption room (DCR). DCRs form a vital part of harm reduction services in some parts of Western Europe, allowing PWUD to inject in a safe space and under medical supervision. They are eighty-six operational DCRs implemented across seven European countries (Denmark, Germany, Luxembourg, the Netherlands, Norway, Spain, and Switzerland), as well as one in Sydney, Australia and one in Vancouver, Canada. Denmark is the latest country to implement the intervention. In 2011, an NGO in Copenhagen began operating a mobile DCR without explicit permission or interference from authorities. Ten months later, in June 2012, the Danish parliament officially gave municipalities the legal mandate to operate DCRs, making Denmark the first country globally to implement legally regulated DCRs.[28]

Opioid substitution therapy

OST is provided in seventy-seven countries worldwide – seven more than reported in 2010.[q] Methadone and buprenorphine are the substances of choice for substitution, but in some countries other formulations are also provided, including slow-release morphine and codeine, and heroin-assisted treatment (HAT).

The number of sites providing OST and the proportion of people that receive substitution therapy, is substantially higher in high-income countries. For example, an estimated 61% of PWID are receiving OST in Western Europe.[26] Among low and middle-income countries, high coverage has also been reported in Iran, where 42.6% of PWID are receiving OST,[27] and in the Czech Republic, with 40% OST coverage.[30] Provision of OST has been scaled up in several countries in Asia, Eurasia and the Middle East and North Africa. Since 2010, OST provision has been newly introduced in Tajikistan, Kosovo, Kenya, Tanzania, Cambodia, and Bangladesh. However, the coverage of existing programmes remains substantially below minimum levels recommended by international guidance, and improvements in scale and quality are urgently needed to ensure that interventions achieve the greatest impact.[r]

The latest global estimates of OST coverage, from 2010, indicate that 6–12% of PWID are receiving OST, with wide variations among regions.[26] OST coverage remains very limited in parts of sub-Saharan Africa, Latin America and Asia. Available data suggest that less than 3% of PWID receive OST in countries such as Cambodia, Indonesia, Myanmar and Vietnam, where IDU has contributed significantly to HIV epidemics.[31]

OST remains unavailable in eighty-one countries with reported IDU (fifty of them with reports of HIV among PWID).

Integrated HIV, viral hepatitis and TB services for people who inject drugs

Data on the extent to which interventions other than NSP and OST, such as treatment for HIV, viral hepatitis and tuberculosis, reach PWID around the world is less available on a global basis. Comprehensive estimates of HIV, viral hepatitis and tuberculosis needs and access among PWID are not available. Existing research suggests that access to ART by people who inject drugs and live with HIV remains disproportionately low compared with other key populations at higher risk of HIV, particularly in low- and middle-income countries.[32-33] For example, PWID comprise 67% of cumulative HIV cases in China, Vietnam, Russia, Ukraine, Malaysia, but only 25% of ART recipients.[32]

Critical barriers affecting the delivery of and access to TB and HIV services for PWID include separate management of TB, HIV, viral hepatitis and drug use, high levels of stigma and discrimination and the criminalisation of drug use in many countries around the world.[4, 34] Increased research and surveillance efforts are also critical to better understand the true burden of HIV, viral hepatitis and TB among PWID in communities and prisons and the scale of services required.

n The 2009 WHO, UNAIDS, UNODC Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users categorises NSP coverage levels as follows: low (<100 needles/syringes per injector per year), medium (>100–<200 needles/syringes per injector per year) and high (≥200 needles/syringes per injector per year).

o For example, Pakistan, Nepal and Cambodia.

p For example, Belarus, Hungary, Kazakhstan, Lithuania and Russia.

q Cambodia, Bangladesh, Tajikistan, Kenya, Tanzania, Macau and Kosovo.

r The 2009 WHO, UNAIDS, UNODC Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users categorises OST coverage levels as follows: low: <20% of opioid dependent PWID on OST; medium: 20–40% of opioid dependent PWID on OST; and high: >40% of opioid dependent PWID on OST.

There is an urgent need for greater integration of ART provision with harm reduction services, including OST, as well as with TB and viral hepatitis treatment.[32, 35] The provision of coordinated and tailored service delivery models, along with peer involvement in treatment delivery, are key to achieving sufficient coverage of these interventions among PWID.[33]

Overdose

Overdose remains a leading cause of death globally among PWUD, particularly those who inject. Research from an increasing number of countries has examined overdose-related mortality among people who use opioids, including among PWID.[36] However, estimates on the occurrence of overdose mortality and non-fatal overdose outside of high-income countries remains very limited, and usually requires consultation of qualitative data sources and expert opinion.[37-38] A recent global meta-analysis of prospective studies on mortality associated with heroin and other opioid use found that Asia had the highest crude mortality rate (CMR) at 5.23 deaths per 100 person-years, and Australasia had the lowest (1.08), with overdose most commonly cited as the cause of death.[38] Research since 2010 has also shown that PWUD have a 74% greater risk of overdose if they are HIV-positive compared to their HIV-negative counterparts.[39] There is a clear need to conduct more research and to improve standardised reporting to obtain an accurate picture of overdose among this population in low and middle-income countries.

The urgent need to address overdose among PWUD was recognised in 2011 by the Global Fund to Fight AIDS, Tuberculosis and Malaria, which has encouraged grant applicants to include overdose services in national proposals since 2010.[40] The US President's Emergency Plan for AIDS Relief (PEPFAR) has also recently included naloxone provision as part of their revised guidance on PWID.[41]

Naloxone, an effective opioid antagonist used to reverse the effects of opiate overdose, remains limited for distribution by peers and family members of PWUD, especially in low- and middle-income countries. As of 2012, community-based naloxone distribution programmes are present to varying degrees in at least sixteen countries, including Afghanistan, Australia, Canada, China, Germany, Georgia, India, Kazakhstan, Kyrgyzstan, Tajikistan, Thailand, the UK, USA, Ukraine, Russia and Vietnam.

Harm reduction in prisons

The provision of harm reduction interventions including NSPs and OST in prisons and other closed settings, remains extremely limited compared with responses in the community. As of 2012, ten countries[s] around the world implement NSPs in prison, including Iran and countries in Eastern Europe, Central Asia and Western Europe. Forty-one countries[t] provide OST in prisons. Among these, sixteen are countries in Western Europe, twelve in Eurasia and four in Asia, in addition to Canada, the USA, Puerto Rico, Australia, New Zealand, Iran and Mauritius.

Considering the high rates of IDU and the complex interaction of HIV, viral hepatitis and tuberculosis in prison settings worldwide,[42-43] there is an urgent need to implement and expand the provision of harm reduction services in these settings. This is especially urgent for Eastern Europe and Central Asia where this interaction in prison settings is most marked.[4]

Resourcing the harm reduction response

The funding landscape has changed drastically since the first comprehensive analysis of harm reduction funding and resourcing gaps was published by HRI in 2010.[44] The international financial crisis, combined with a shift in aid priorities toward low-income countries and resource constraints at the Global Fund to Fight AIDS, Tuberculosis and Malaria, pose a major threat to the future and sustainability of harm reduction.

HRI previously estimated that approximately US$160 million (or US$0.03 per PWID per day) was invested in HIV-related harm reduction in low and middle-income countries in 2007, of which US$136 million (90%) was from international donors.[45] This amounted to 7% of the US$2.13 billion in 2009 and 5% of the US$3.29 billion in 2010 estimated by UNAIDS to meet the basic HIV prevention needs of PWID.[46]

In June 2011 a group of international experts, including from UNAIDS, the Global Fund, PEPFAR, WHO, the Bill and Melinda Gates Foundation, and the World Bank, launched a new framework for investment in the global HIV response, which has since been endorsed widely by multilateral agencies and researchers.[47] The investment framework argues for setting priorities based on country-specific epidemiology and calls for the scale-up of investments in evidence-based, high-impact interventions, including NSP and OST for PWID. Modelling of the framework's potential impact indicates that, to avert 12.2 million new infections and 7.4 million AIDS-related deaths between 2011 and 2020, annual resource needs must increase from US$16.6 billion in 2011 to US$22–24 billion in 2015.[48] To achieve the proposed reduction in transmission and AIDS-related deaths among PWID, US$2.3 billion is required by 2015 (falling to US$1.5 billion by 2020 through savings in treatment and economies of scale) compared to the US$0.5 billion estimated to be available in 2011.[47]

During the past decade, and particularly in recent years, the

s Armenia, Belarus, Kyrgyzstan, Moldova, Romania, Iran, Germany, Luxembourg, Spain and Switzerland.

t India, Indonesia, Malaysia, Thailand, Albania, Croatia, Czech Republic, Georgia, Hungary, Macedonia, Moldova, Montenegro, Poland, Romania, Serbia, Slovenia, Iran, Canada, USA, Puerto Rico, Australia, New Zealand, Mauritius, Austria, Belgium, Denmark, Finland, Germany, Ireland, Italy, Luxembourg, Malta, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, UK and Latvia.

Global Fund has emerged as the largest funder for harm reduction programmes targeting PWID. Between Round 1 in 2002 and Round 9 in 2009, an estimated US$430 million was approved for this population.[49] Two-thirds of the budgeted funds were allocated to the core package of harm reduction interventions as defined by WHO, UNODC and UNAIDS,[50] including needle and syringe distribution and OST. More than half of the funds (US$236 million) were granted to countries in Eastern Europe and Central Asia. Global Fund support for harm reduction has grown steadily since 2009, and has particularly risen in Round 10, when it introduced a funding reserve for grants targeting most-at-risk populations[51] and released the first harm reduction guidance note for applicants.[40] Subsequent analysis indicates that an additional estimated investment of US$152 million for PWID was committed in Round 10, taking the ten-year total to nearly US$580 million (see Table 1.1.2). Although the need for harm reduction services still far outweighs current provision, and hostile policy environments in some countries continue to prevent effective programmes from scaling up,[26] commitment to harm reduction improved significantly during this period, both in national level HIV and drug strategies and internationally.

Table 1.1.2: Approved Global Fund investments targeting people who inject drugs, Round 1 (2002) to Round 10 (2010)[52]

COUNTRY / TERRITORY	TOTAL (US$)	
ASIA	166,700,000	
Afghanistan	1,300,000	
Bangladesh	10,800,000	*
Bhutan	<100,000	
Cambodia	5,800,000	*
China	23,400,000	
India	20,800,000	*
Indonesia	14,000,000	*
Malaysia	6,100,000	*
Mongolia	100,000	
Maldives	500,000	
Myanmar	7,700,000	*
Nepal	7,600,000	*
Pakistan	13,800,000	*
Philippines	1,500,000	
Sri Lanka	200,000	*
Thailand	28,000,000	*
Timor Leste	<100,000	*
Viet Nam	25,100,000	*
EASTERN EUROPE AND CENTRAL ASIA	366,100,000	
Albania	1,400,000	
Armenia	3,100,000	*
Azerbaijan	6,000,000	*
Belarus	17,500,000	*
Bosnia & Herzegovina	9,800,000	*
Bulgaria	9,500,000	
Croatia	600,000	
Estonia	2,700,000	
Georgia	12,700,000	*
Kazakhstan	29,800,000	*
Kosovo	2,000,000	
Kyrgyzstan	25,800,000	*
Macedonia	15,600,000	*
Moldova	7,200,000	*
Montenegro	1,600,000	*
Romania	4,200,000	
Russian Federation	38,400,000	
Serbia	6,500,000	*
Tajikistan	15,600,000	
Ukraine	143,900,000	*
Uzbekistan	12,200,000	*
LATIN AMERICA	10,200,000	
Argentina	1,600,000	
Mexico	7,000,000	*
Paraguay	1,600,000	*
MIDDLE EAST AND NORTH AFRICA	24,000,000	
Algeria	500,000	
Egypt	800,000	
Iran	8,200,000	*
Jordan	300,000	
MENAHRA	6,200,000	* †
Morocco	4,600,000	*
Syrian Arab Republic	1,200,000	*
Tunisia	1,400,000	
West Bank and Gaza	800,000	
SUB-SAHARAN AFRICA	7,800,000	
Burundi	600,000	*
Cape Verde	700,000	*
Kenya	1,900,000	*
Madagascar	1,300,000	*
Mauritius	1,500,000	*
Nigeria	1,300,000	*
Zanzibar	500,000	‡
Western Europe	900,000	
Turkey	900,000	
Total (all regions)	575,900,000	

Notes
Figures are rounded. Data are correct as of March 2012. Data are based on detailed grant budgets submitted to the Global Fund and may not reflect actual expenditures.
* Figure includes projections for future years of grants that have not yet been formally committed.
† The Middle East and North Africa Harm Reduction Association (MENAHRA) received a multi-country grant that covers Afghanistan, Bahrain, Egypt, Iran, Jordan, Lebanon, Libya, Morocco, Oman, Pakistan, Syrian Arab Republic, Tunisia, and the West Bank and Gaza.
‡ Zanzibar, a semi-autonomous part of Tanzania, receives separate grants from the Global Fund.

In November 2011, however, the Global Fund announced the cancellation of its next funding round (Round 11) along with

the imposition of additional cost-cutting measures. These structural changes at the Global Fund have severe short and long-term implications for harm reduction programme start-up, sustainability and expansion.[u] The Transitional Funding Mechanism (TFM) was established by the Global Fund to support the continuation of existing, essential[v] programmes, but does not allow for further scale-up or start-up of services. This affected several countries in Asia, Eastern Europe and Central Asia with significant HIV and IDU burdens or emerging epidemics among PWID.[27] In addition, several countries that may have planned to submit grant proposals in 2012 and 2013 cannot now do so until 2014.

In November 2011, the Global Fund board also passed the '55% rule', requiring that total funding approved for grant renewals for low-income countries be no less than 55% of any annual funding window.[53] As an interim measure, it placed a 75% ceiling on grant renewals funding for lower-middle income countries, further limiting available funds. The new rules, based solely on income status, affected many states with prominent injecting-driven epidemics such as Indonesia, Thailand and Malaysia. In response to concerns voiced by several delegations, the Global Fund Board passed a decision at its 26th Board meeting in May 2012 to freeze the implementation of the '55% rule.'[53] A critical component informing this decision was the mobilisation of civil society organisations to document evidence of the short-term effects brought on by the '55% rule' at country level, and to bring this evidence into high-level discussions.[27, 54] At the time of writing, it is unclear how financing for harm reduction will be prioritised as part of the new Global Fund funding model that is being developed.

The limited donor landscape for harm reduction approaches is further undermined by a shift in bilateral aid priorities and a narrowing of international aid budgets in some countries. Between them, the main bilateral donors for harm reduction – the UK, Australia and the Netherlands – accounted for US$67.4 million in 2007.[45] Recently however, these donors too have shifted their priorities away from middle-income countries, and in some cases have noticeably reduced spending on HIV/AIDS. For example, the UK Department for International Development's (DFID) bilateral HIV programmes will be cut by 30% over the next three years, and remaining funds will largely focus on low-income countries.[55] The President's Emergency Plan for AIDS Relief (PEPFAR) increased its investment in HIV programmes targeting PWID from US$18.1 million in 2009[56] to US$27.7 million in 2011.[57] However, PEPFAR's funding for harm reduction represents only 0.65% of this budget.[54] The recent re-instatement of a federal funding ban on needle exchange programmes, both domestically and abroad, places further constraints on global harm reduction resources.[6]

Few national governments have been willing or able to finance the implementation and scale-up of HIV and harm reduction interventions within their own borders, with a few notable exceptions (such as Malaysia and Taiwan).[44] For example, when Romania became ineligible for Global Fund resources in 2010, the government failed to support existing NGO-run harm reduction programmes. As a result, the percentage of PWID reached by harm reduction programmes decreased from 76% in 2009 to 49% in 2010. In 2011, the number of newly reported HIV infections among PWID was higher than in previous years, and cases attributed to IDU increased as a proportion of new infections.[27] Numerous countries with IDU-driven epidemics are likely to experience a lack of government support following the exodus of international donor funds. Some private donors including the Gates Foundation and Open Society Foundations (OSF) have stepped in to support harm reduction approaches in the absence of national, bilateral and Global Fund support in certain settings. However, this support remains insufficient to maintain and allow sufficient scale-up to halt and reverse existing and emerging epidemics among PWID in the long-term.

Although there is no accurate estimation of the total spend on harm reduction globally, nor the shortfall in 2012, it is clear that recent developments significantly limit potential progress toward international commitments, such as halving HIV transmission among PWID by 2015[58] and achieving universal access to HIV prevention, treatment, care and support for PWID.[59] There is an urgent need for civil society (including international and local NGOs, organisations of PWUD) as well as donors and national governments to mobilise as a matter of urgency in order to ensure the continuation and sustainability of programmes and avoid reversing gains[w] already made in preventing HIV and other blood-borne viruses among PWID.

The regional updates in **Section 2** of this report provide a more detailed documentation of the state of harm reduction in different parts of the world, particularly highlighting developments since 2010. **Section 3** explores key thematic areas for building an integrated harm reduction response, including specific barriers to access faced by women and young people who inject drugs, and drug use among men who have sex with men, and implications for harm reduction service provision. Additional chapters provide a global overview of drug decriminalisation policies around the world, and an exploration of sustaining and scaling up services in challenging social and political environments.

u For a more in-depth discussion of repercussions internationally see McLean S, Wong F & Konopka S (2012) *HIV, Drug Use and The Global Fund: Don't Stop Now*. Brighton: International HIV/AIDS Alliance. For a detailed discussion in relation to Eastern Europe and Central Asia, see Raminta S, Votyagov S and Pinkham S (2012) *Quitting While Not Ahead: The Global Fund's retrenchment and the looming crisis for harm reduction in Eastern Europe & Central Asia*. Vilnius: EHRN.

v According to official Global Fund guidance, the term 'essential' for the purposes of the Transitional Funding Mechanism includes programmes for PWID.

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w Please see Section 2.2 of this report for a discussion of the situation in Greece as an example of a setting where HIV can re-emerge in the absence of well-resourced responses.

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