2012

THE GLOBAL STATE OF HARM REDUCTION

TOWARDS AN INTEGRATED RESPONSE

HARM REDUCTION
INTERNATIONAL

CONTENTS

The Global State of Harm Reduction 2012
Towards an integrated response

Edited by Claudia Stoicescu

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Abbreviations and acronyms

AHRN	Asian Harm Reduction Network
AIVL	Australian Injecting and Illicit Drug Users' League
AIDS	Acquired immunodeficiency syndrome
ANPUD	Asian Network of People who use Drugs
ART	Antiretroviral therapy
ATS	Amphetamine-type stimulants
BMT	Buprenorphine maintenance treatment
CARICOM	Caribbean Community
CHRC	Caribbean Harm Reduction Coalition
CND	Commission on Narcotic Drugs
CPR	Cardiopulmonary resuscitation
CPT	Co-trimoxazole preventive treatment
CSO	Civil society organisation
DCR	Drug consumption room
DFID	Department for International Development (UK)
DOTS	Directly Observed Treatment Short-Course
ECOSOC	Economic and Social Council (UN)
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EMRO WHO	Eastern Mediterranean Regional Office
EC	European Commission
EU	European Union
EuroHRN	European Harm Reduction Network
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GP	General practitioner
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HAT	Heroin assisted treatment
HBV	Hepatitis B virus
HBsAG	Marker in the blood indicating active HBV infection
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HLS	High Level Segment
IDU	Injecting drug use
IHRA	International Harm Reduction Association
INCB	International Narcotics Control Board
INPUD	International Network of People who Use Drugs
MENA	Middle East and North Africa
MENAHRA	Middle East and North African Harm Reduction Network
MDT	Mandatory drug testing
MMT	Methadone maintenance treatment
MSM	Men who have sex with men
NASA	National AIDS Spending assessment
NGO	Non-governmental organisation
NIDU	Non-injecting drug use
NSP	Needle and syringe exchange programme
OST	Opioid substitution therapy
PAHO	Pan American Health Organization (WHO)
PEPFAR	President's Emergency Plan for AIDS Relief
PICTs	Pacific Island Countries and Territories
PNEP	Prison needle and syringe exchange programme
SAHRN	Sub-Saharan African Harm Reduction Network
SAMHSA	US Substance Abuse and Mental Health Services Administration
SIF	Supervised or safer injecting facility
STI	Sexually transmitted infection
SPC	Secretariat of the Pacific Community
TB	Tuberculosis
UAE	United Arab Emirates
UK	United Kingdom of Great Britain and Northern Ireland
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Economic, Social and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
MENARO UNODC	Middle East and North Africa Regional Office
US	United States of America
VCT	Voluntary HIV counselling and testing
WFP	World Food Programme (UN)
WHO	World Health Organization

Introductory comments from Michel Sidibé

Executive Director, UNAIDS

The third edition of the Global State of Harm Reduction report comes at a pivotal time in the HIV epidemic.

Thirty per cent of HIV infections outside sub-Saharan Africa, representing approximately 3 million people, are attributed to injecting drug use. New infections among people who use drugs account for an increasing share of global HIV incidence. In Eastern Europe and Central Asia, injecting drug use accounts for up to 80% of HIV infections, with the annual rate of new HIV infections in the region having increased by more than 250% between 2001 and 2010.[a] In several countries in sub-Saharan Africa including Kenya, Tanzania and South Africa a new wave of infections due to drug injecting has emerged in recent years.

This reality serves as an urgent reminder of the commitment made by all United Nations Member States in the 2011 Political Declaration on HIV/AIDS to reduce transmission of HIV among people who inject drugs by 50% by 2015. Achieving this target demands a cohesive response to HIV from UN agencies, states, civil society and affected communities alike based on the strongest available public health evidence and human rights principles.

UNAIDS is unequivocal in its message to Member States about what works to reduce HIV transmission among people who inject drugs. The evidence is clear and decisive: sufficient provision and coverage of needle and syringe programmes, opioid substitution therapy and antiretroviral therapy as part of the nine key interventions outlined in the WHO, UNODC, UNAIDS technical guide work to effectively reduce HIV transmission among people who inject drugs, as well as providing other measurable benefits to individuals' health and their communities.

Despite the existence of these evidence-based and cost-effective harm reduction interventions, their coverage remains shockingly low. As this report highlights, fewer than two clean needles per month are distributed globally per person who injects drugs, under 13% of people who use drugs are enrolled in opioid substitution therapy, and only 4% of people who inject drugs living with HIV are on antiretroviral treatment. [b]

Most alarming is that a significant number of countries with reported injecting drug use continue to restrict access to these services. Punitive laws and policies, whether via prohibiting the provision of sterile injecting equipment and opioid substitution therapy, criminalising drug use, possession of injecting paraphernalia, or denying HIV treatment to people who use drugs, violate people's right to health and harm the community. Such punitive policies not only fail to reduce HIV transmission but create unintended harms – for instance, by driving people who inject drugs away from prevention and care and resulting in prison overcrowding. Responses to HIV should transcend ideology and be based on scientific evidence and sound human rights principles; they should support, not punish, those affected.

UN Secretary-General Ban Ki-Moon stated that "No one should be stigmatised or discriminated against because of their dependence on drugs" and called on UN Member States to ensure that people who use drugs have equal access to health and social services. An important function of UNAIDS is to highlight the adverse human rights and public health impacts of restrictive laws and policies, and "to create protective social and legal environment that enable access to HIV programmes."[c] Further, in its 2011–2015 Strategy, Getting to Zero, UNAIDS is explicit about reducing by half the number of "countries with punitive laws and practices around HIV transmission, drug use or homosexuality that block effective responses".

The need for legal reform aligned with HIV prevention and treatment, complemented by the meaningful involvement of people who use drugs in service and policy formulation and implementation, has never been more imperative than it is now for achieving the goal of universal access.

On behalf of the UNAIDS Secretariat and our co-sponsors, I am proud to say that UNAIDS is committed to playing the leading role in a coordinated, unambiguous and bold UN response to HIV among people who inject drugs. In an increasingly hostile policy climate, we must replace dangerous complacency with decisive action when it comes to HIV-related harm reduction. Without firm global leadership, evidence and human rights-based national policies, bold resource replenishment for harm reduction and urgent scale-up of harm reduction interventions, there will be no "getting to zero".

The original Global State of Harm Reduction report, published in 2008, provided the first global snapshot of harm reduction service availability and coverage, reflecting the contributions of civil society organisations, multilateral agencies and researchers in the drug-related HIV response. Since then, the biennial reports have become an indispensable reference tool and authoritative resource for a wide range of agencies and individuals engaging in advocacy for harm reduction worldwide. The latest edition

a UNAIDS (2010) *Global Report. UNAIDS Report on the Global AIDS Epidemic.* Geneva: UNAIDS.

b Mathers BM et al. for the UN Reference Group on IDU (2010) The global epidemiology of injecting drug use and HIV among people who inject drugs: A systematic review, *Lancet*, 372 (9651): 1733–1745.

c UNAIDS (2010) *Strategy 2011–2015: Getting to Zero.* Geneva: UNAIDS

of the report includes important data on viral hepatitis, and a timely focus on intersections between drug use, HIV and harm reduction services among other key affected populations, including women, children and men who have sex with men. These sub-populations of people who inject drugs are often the most marginalised in the global AIDS response, requiring immediate services and a proportionate allocation of HIV prevention resources. The promotion of harm reduction as part of a bolder, more united and more comprehensive global effort will be essential to halving HIV infections among people who inject drugs by 2015.

Michel Sidibé
Executive Director, UNAIDS

Introductory comments from Michel Kazatchkine

Member of the Global Commission on Drug Policy

People who inject drugs remain a key population in global health, accounting for around 3 million HIV infections and 10 million hepatitis C infections. This is in addition to the numerous financial, social and public health burdens associated with overdose and drug dependence. But if you are reading this report, you probably know this all too well.

However, these issues – and the proven harm reduction interventions that can address them – are more important now than ever before. In a global economic downturn the burden of drug use is likely to increase, while the finances to deal with these problems become ever more limited. In 2011, United Nations Member States committed to reducing HIV transmission among people who inject drugs by 50% in the next four years, and yet we now face a major crossroads in the response. It is essential that people who use drugs are not forgotten or overlooked.

The Global State of Harm Reduction reports have fast become an integral tool in the ongoing advocacy for people who inject drugs. These biennial documents are helping us to track the progress that has been made. Grassroots projects to protect people who inject drugs in the 1980s have been developed, scaled up and integrated into mainstream healthcare in many diverse countries around the world. The evidence base has also grown, allowing harm reduction to become standard jargon for the key international bodies: including the United Nations General Assembly, the Office of the United Nations High Commissioner for Human Rights, the World Health Organization, the Joint United Nations Programme on HIV/AIDS, and the United Nations Office on Drugs and Crime.

I will always be proud to say that the Global Fund to Fight AIDS, Tuberculosis and Malaria explicitly supports harm reduction and is the leading international donor for this approach.[d] The Global Fund faces its own challenges in the current financial climate but remains committed to funding essential services including those for people who inject drugs. This report is a timely reminder of the urgent need for continued and reliable financing for harm reduction.

This report also highlights huge anomalies in the international response. In 2009, at the International Harm Reduction Conference in Bangkok, I stated that some countries "seem determined to swim against the tide with their wilful blindness to the evidence". This remains the case. For example, there are 120 countries that report HIV transmission among people who inject drugs, yet only 86 countries implement official needle and syringe programmes to some degree in order to prevent this transmission. In a majority of settings, coverage of such programmes is far below the level needed to have an impact. Too often we have seen inexpensive and cost-effective harm reduction approaches being overlooked, overshadowed or undermined by expensive and often ineffectual approaches with a 'war on drugs' rhetoric. The compulsory detention, forced treatment, execution, torture and corporal punishment of people who use drugs simply have to stop. They are violations of human rights and international law.

This is the third edition of this flagship publication, which provides the latest data on harm reduction, expanded regional updates and key thematic chapters. I would like to thank Harm Reduction International for giving me the opportunity to provide these introductory comments, and I wish you all the best in using this valuable resource to promote harm reduction in your own settings.

Professor Michel Kazatchkine
Former Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria
Member of the Global Commission on Drug Policy

d Bridge J et al. (2012) Global Fund Investments in Harm Reduction from 2002 to 2009, *International Journal of Drug Policy* (23): 279–285.

Introductory comments by Eliot Ross Albers

Executive Director, International Network of People who Use Drugs (INPUD)

On behalf of the International Network of People Who Use Drugs (INPUD), I welcome this third edition of the Global State of Harm Reduction, and thank Harm Reduction International for giving me the chance to add these opening remarks to what has become an essential tool used by INPUD and our members in their advocacy for the provision of essential harm reduction services for our community.

The evidence base for the efficacy of harm reduction programmes is irrefutable and widely supported by international agencies including UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Health Organization (WHO) and the Office of the United Nations High Commissioner for Human Rights.

Despite the overwhelming evidence in favour of harm reduction programmes, this report shows that there remains a significant discrepancy between what we know should be provided[e] and what actually is.

The publication of this report is especially timely, as not only are we in the grip of a global recession, but we are also seeing a political retreat from harm reduction on the domestic front by several states that have historically been strong supporters (e.g. the Netherlands and the United Kingdom); on the other hand, their international support for harm reduction remains strong. In many countries in Eastern Europe where the HIV and viral hepatitis epidemics are especially acute among people who inject drugs and largely driven by the sharing of syringes, harm reduction is scorned. For example, Russia, which has a population of 2 million injecting opiate users, of whom 37.2% are estimated to be living with HIV (in some regions prevalence reaches up to 75%),[f] refuses to provide needle and syringe exchange and prohibits the provision of methadone. The USA has also reinstated its ban on spending federal funds on needle and syringe programmes. This is a highly retrogressive step, as it applies not just to the USA but to all programmes, no matter where they are based, that receive federal funds.

Far from being provided with the services that we need, people who inject drugs remain criminalised, marginalised, repressed and discriminated against. We face human rights abuses including torture and corporal punishment, execution, arbitrary violence and abuse, compulsory detention and forced treatment in facilities that provide no medical services but that do subject their inmates to forced labour and often cruel and inhuman treatment.[g] [h] In spite of a recent call for their immediate closure sponsored by 12 UN bodies,[i] these facilities remain open and are often applauded, or simply ignored, by the guardians of the international system of punitive prohibition.

The Global State of Harm Reduction 2012 shows that where progress has taken place, it has often been at an insufficiently low level to have an impact on viral hepatitis and HIV epidemics among people who inject drugs, and the new programmes that have been implemented are generally small-scale pilots. The universal provision of harm reduction services is just the first step in righting the systematic human rights abuses to which people who use drugs are subjected. INPUD will continue to advocate and organise to make the voices of the illegal-drug-using community heard.

The Global State of Harm Reduction is an invaluable tool in INPUD's advocacy work and a strident wake-up call to anyone who believes that the work of harm reduction is done. We have known for more than 20 years what measures need to be taken to prevent HIV transmission among people who inject drugs, but we are facing a barrier of intransigent ignorance, prejudice and a refusal on the part of many governments around the world to accept the science. This is unacceptable and should be called what it is – wilful neglect and a breach of basic human rights, not least of all, the inalienable right to the highest standard of health to which all people, whether they use illegal drugs or not, are entitled.

Eliot Ross Albers
Executive Director, INPUD

e WHO, UNODC, UNAIDS (2009) *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users.* Geneva: World Health Organization.

f Federal Service on Customers' Rights and Human Well-being Surveillance of the Russian Federation (2010) *Country Progress Report on the progress of implementing the Declaration of Commitment on HIV/AIDS adopted at the 26th United Nations General Assembly Special Session on HIV/AIDS. Reporting period: January 2008 – December 2009.* Moscow: Federal Service on Customers' Rights and Human Well-being Surveillance of the Russian Federation.

g Stevens A (2012) The ethics and effectiveness of coerced treatment of people who use drugs, *Human Rights and Drugs*, 2(1) 7–16.

h Hall W et al. (2012) Compulsory detention, forced detoxification and enforced labour are not ethically acceptable or effective ways to treat addiction, *Addiction*, pp. 1-3. doi:10.1111/j.1360-0443.2012.03888.x, http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2012.03888.x/pdf Accessed 9 July 2012.

i United Nations (2012) Joint Statement: Compulsory drug detention and rehabilitation centres. New York: UN, http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/JC2310_Joint%20Statement6March12FINAL_en.pdf Accessed 20 May 2012.

Introduction

About the Global State of Harm Reduction 2012

In 2008 Harm Reduction International (HRI) released the *Global State of Harm Reduction,* a report that mapped responses to drug-related HIV and hepatitis C epidemics around the world for the first time.[j] The information gathered for the report provided a critical baseline against which progress could be measured in terms of the international, regional and national recognition of harm reduction in policy and practice. The second edition, *Global State of Harm Reduction 2010: Key Issues for Broadening the Response*, documented major developments in harm reduction policy adoption and programme implementation that had occurred since 2008, enabling some assessment of global progress. It also explored several key issues for harm reduction, such as the response to amphetamine-related harms; harm reduction in prisons; the reduction of various drug-related health harms including bacterial infections, tuberculosis, viral hepatitis and overdose; and the extent to which financial resources for harm reduction are available.[k]

The *Global State of Harm Reduction 2012* presents the major developments in harm reduction policy adoption and programme implementation that have occurred since 2010. It also explores several major topics for developing an integrated harm reduction response, such as effective harm reduction services for women who inject drugs; access to harm reduction services by young people; drug use among men who have sex with men and implications for harm reduction; global progress toward building an enabling policy environment for harm reduction implementation through drug decriminalisation and regulation; case studies on sustainability and scale-up of services; and promotion of harm reduction approaches in challenging environments.

This report, and other *Global State of Harm Reduction* resources[l] are designed to provide advocacy and reference tools for a wide range of audiences, such as international donor organisations, multilateral and bilateral agencies, civil society and non-governmental organisations (NGOs), including organisations of people who use drugs, as well as researchers and the media.

Methodology

The information in Sections 1 and 2 of this report was gathered using existing data sources, including research papers and reports from multilateral agencies, international NGOs, civil society and harm reduction networks, as well as expert opinion from organisations of people who use drugs and those working in the harm reduction field. Within each region, HRI enlisted support from regional harm reduction networks and researchers to gather qualitative information on key developments[m] and to review population size estimates, data on the epidemiology of HIV and viral hepatitis among people who inject drugs, and the extent of provision of needle and syringe exchange programmes (NSPs) and opioid substitution therapy (OST).

Quantitative data for the tables at the beginning of each regional update in Section 2 were obtained from a variety of sources. These data seek to reflect the most recent available estimates within each country at the time of the data collection exercise (January–April 2012). Sources used include global systematic reviews conducted by the Reference Group to the United Nations on HIV/ AIDS and Injecting Drug Use (UN Reference Group) on the epidemiology of injecting drug use and HIV and the coverage of key harm reduction interventions in 2008[n] and 2010,[o] updated reports since then by the UN Reference Group (including forthcoming articles),[p] national Global AIDS Progress reports submitted to UNAIDS in March 2012 and national surveillance studies conducted since 2010.[q] Where none of these sources were available, the data were unpublished or their reliability was questioned by civil society, researchers or other experts, expert opinion was sought to identify additional sources of information and verify their reliability. Unless HRI was able to identify newer data, prevalence estimates for viral hepatitis were sourced from the review of reviews published by Nelson and colleagues in the *Lancet* in 2011. Data for Western Europe and several countries in Eastern Europe were sourced from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2012 statistical bulletin, unless otherwise stated in the text.[r] Sources are provided for all of the estimates reported, and any discrepancies in data are noted in footnotes within the tables or in the text.

j Cook C and Kanaef N (2008) *Global State of Harm Reduction 2008: Mapping the Response to Drug-Related HIV and Hepatitis C Epidemics*. London: Harm Reduction International.

k Cook C (2010) *The Global State of Harm Reduction: Key Issues for Broadening the Response*. London: International Harm Reduction Association.

l See www.ihra.net for more details.

m A copy of the information collection questionnaire for the *Global State of Harm Reduction 2012* can be obtained by contacting info@ihra.net.

n Mathers B et al. (2008). The global epidemiology of injecting drug use and HIV among people who inject drugs: A systematic review, *Lancet*, 372 (9651): 1733-1745.

o Mathers B et al. (2010). HIV prevention, treatment, and care services for people who inject drugs: A systematic review of global, regional, and national coverage, *Lancet*, 375, DOI:10.1016/S0140-6736(10)60232-2.

p Petersen Z, Pluddemann A, van Hout MC, Dada S, Parry C & Myers B on behalf of the Secretariat to the United Nations Reference Group on Injecting Drug Use and HIV (2012) *The prevalence of HIV among people who inject drugs and availability of prevention and treatment services: findings from 21 countries. A brief report*. Parow: South African Medical Research Council.

q Nelson PK, Mathers BM, Cowie B, Hagan H, Des Jarlais D, Horyniak D & Degenhardt L (2011) Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews, *Lancet*, 378(9791): 571–583.

r See http://www.emcdda.europa.eu/stats12 for more details.

Figures published through international reporting systems, such as those undertaken by the World Health Organization and UNAIDS, may differ from those collated here due the different scope of monitoring surveys, varying reliability criteria and focus on regions that may include different country classifications.

Regions were largely identified using the coverage of the regional harm reduction networks. Therefore, this report examines the regions of Oceania, Asia, Eurasia (Central and Eastern Europe and Central Asia), Western Europe, Sub-Saharan Africa, Middle East and North Africa, Latin America, the Caribbean and North America.

Where possible, the regional updates were peer reviewed by the regional harm reduction networks and other experts in the field (see Acknowledgements).

This report also contains chapters on major topics for the harm reduction response, which were identified through feedback on the second report and consultation with HRI's Scientific Review Committee and key partners of the organisation. These chapters have been prepared by representatives from civil society, research and multilateral agencies with specific expertise in the area, and reviewed by peers in the field. Although some of the issues covered are fairly new areas with relatively little research to report on, these chapters aim to present what is currently known and raise issues for the international harm reduction community to consider.

Data quality

For global population size estimates of people who inject drugs and HIV epidemiology, this report draws heavily on global systematic reviews conducted by the UN Reference Group. These reviews present only data that fits with reliability criteria established by the UN Reference Group, resulting in data gaps for many countries with HIV epidemics among people who inject drugs.

Given that this remains the most reliable assessment of the state of the epidemic, HRI has presented the UN Reference Group data where these data were the most recent available estimates, and provided data from other sources for those countries and territories for which other reliable sources were available. These included bio-behavioural surveillance reports, academic studies and, for information on the most recent number of NSP and OST sites, expert opinion was also consulted. The data collection process involved regional harm reduction networks and other regional experts reviewing the regional data gathered, including the figures reported in the tables. The data tables were additionally shared for review with researchers and members of the UN Reference Group from around the world. Where the accuracy of data was questioned but no alternate, reliable figures were provided, this is noted in footnotes or within the text.

Although population size estimates for people who inject drugs have become available at the national level for several countries since 2008 (for instance, through UNAIDS Global AIDS Progress reports), a systematic calculation of global population size estimates was not conducted in the context of this report.

The significant data gaps are an important reminder of the need for improved monitoring systems and data reporting on HIV and drug use around the world.

In reporting on the existence and coverage of harm reduction, this report sought input from harm reduction networks, researchers and other experts in the field. Where no updates were available, 2010 data was reported.

The data presented here on epidemiology and coverage represent the most recent, verifiable estimates currently available; however, lack of uniformity in measures, data collection methodologies and definitions for the estimates provided renders cross-national and regional comparisons challenging.

Limitations

This report attempts to provide a global snapshot of harm reduction policies and programmes and, as such, has several limitations. It does not provide an extensive evaluation of the services or policies in place. It must be recognised that the existence of a service does not necessarily denote adequate quality and coverage to have an impact on drug-related harms.

While this report aims to cover some important areas for harm reduction, it focuses largely on the public health aspects of the response and does not document the full spectrum of social and legal harms faced by people who use drugs. Neither does it cover the full spectrum of health harms related to substance use, including, for example, those related to alcohol and tobacco use.

A significant gap in the current edition of the report is the omission of a thematic focus on the intersection between sex work and drug use. HRI is presently in the process of developing a separate publication and web resources addressing drug use among sex workers and broader implications for harm reduction.

Report structure

Section 1 provides a global overview of harm reduction policy and programming.

Section 2 contains nine brief regional updates – Asia, Eurasia, Western Europe, the Caribbean, Latin America, North America, Oceania, Middle East and North Africa, and Sub-Saharan Africa – that examine the developments for harm reduction since 2010.

Section 3 comprises six chapters that explore themes relevant to developing an integrated harm reduction response, including specific barriers to service access faced by women and young people who inject drugs, drug use among men who have sex with men and implications for harm reduction, 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.