2.5 | Regional Update
Latin America

Table 2.5.1: Epidemiology of HIV and Viral Hepatitis, and Harm Reduction Responses in Latin America[a]

Country/territory with reported injecting drug use	People who inject drugs[b]	HIV prevalence among people who inject drugs (%)[b]	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[f]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[f]	Harm reduction response[c]	
					NSP[d]	OST[e]
Argentina	65,829 (64,500–67,158)	49.7 (35.4–64)	54.6	8.6	✔ (25)	✖
Bolivia	nk	nk	nk	nk	✖	✖
Brazil	540,500	48 (18–78)	63.9	2.3	✔ (150–450)	✖
Chile	42,176	nk	nk	nk	✖	✖
Colombia	nk	1[f]	nk	nk	✖	✔ (4)
Costa Rica	nk	nk	nk	nk	✖	✖
Ecuador	nk	nk	nk	nk	✖	✖
El Salvador	nk	nk	nk	nk	✖	✖
Guatemala	nk	nk	nk	nk	✖	✖
Honduras	nk	nk	nk	nk	✖	✖
Mexico	nk	3 (1.9–4.1)	97.4 (96–98.7)	nk	✔ (19)	✔ (21–25)(M)
Nicaragua	nk	6	nk	nk	✖	✖
Panama	nk	nk	nk	nk	✖	✖
Paraguay	nk	9.35 (3.7–15)	9.8	nk	✔ (3)	✖
Peru	nk	13[g]	nk	nk	✖	✖
Uruguay	nk	nk	21.9	4.5	✔	✖
Venezuela	nk	nk	nk	nk	✖	✖

nk= not known

a Latin American civil society respondents reviewing the data above expressed concern that many of the estimates were outdated and did not accurately represent the current national situation in relation to the number of PWID and HIV among PWID. Where more recent alternative estimates were available, these are included in the text of this chapter. Similar concern was expressed regarding the number of NSP and OST within countries, but in most cases up-to-date figures were not available.

b Unless otherwise stated, data are sourced from Mathers B et al. for the Reference Group to the UN on HIV and Injecting Drug Use (2008) Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review, Lancet, 372(9651):1733–1745.

c Unless otherwise stated, data on NSP and OST coverage are sourced from Mathers B et al. for the Reference Group to the United Nations on HIV and Injecting Drug Use (2010) HIV prevention, treatment and care for people who inject drugs: A systematic review of global, regional and country level coverage, Lancet, 375(9719):1014–28.

d 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, and (NP) = needles and syringes not available for purchase.

e The number in brackets represents the number of operational OST programmes, including publicly and privately funded clinics and pharmacy dispensing programmes. (M) = methadone, (B) = buprenorphine, (O) = any other form (including morphine and codeine).

f Estimate from 1999: UN Reference Group.

g Estimate from 1994–1995: UN Reference Group.

Map 2.5.1: Availability of needle and syringe exchange programmes (NSP) and opioid substitution therapy (OST)

Harm Reduction in Latin America

HIV continues to affect marginalised populations across the Latin American region, including people who use drugs (PWUD). Though widely under reported, injecting drug use (IDU) is a significant route of HIV transmission in the region, especially in the southern cone of South America and in Mexico.[2] The Reference Group to the United Nations on HIV and Injecting Drug Use estimates that there were over two million people who inject drugs (PWID) in Latin America in 2008, with the largest number residing in Brazil (540,000). Where data on HIV prevalence among PWID are available, there are wide variations among and within countries. Latest UN Reference Group estimates are that over one quarter (580,500) of the 2 million PWID in Latin America were living with HIV.[3] The highest HIV prevalence among injecting populations was reported in Brazil and Argentina at 48% and 49.7%, respectively (see Table 2.5.1).

Further insights into the HIV epidemic among PWID in the region can be obtained from national reports to UNAIDS and WHO. For example, the following Latin American countries reported to WHO on HIV prevalence among PWID: Brazil (6%), Colombia (2%), Mexico (4%) and Paraguay (9%).[2] In Colombia, reported HIV prevalence among PWID ranged from 1.9% in Pereira to 9% in Cucata.[4] There are plans for further studies on HIV and injecting drug use in Cali, Armenia and Bogota, three areas where injecting heroin use is on the rise.[5] While unprotected sex between men remains the dominant mode of transmission in Mexico, intersections between IDU and sex work are reported to play an important role in Mexico's epidemic.[6]

There is increasing research into the prevalence and harms related to non-injecting use of cocaine and its derivatives within the Latin American region.[7] As in the Caribbean region (see Chapter 2.4), studies in several Latin American countries indicate that HIV prevalence among people who use crack cocaine is often elevated when compared with the general population.[7-10] In addition, the use of coca paste, *bazuco* or *paco* is of increasing concern in Colombia, Argentina, Bolivia, Chile, Ecuador, Peru and Uruguay.[11-12]

Civil society organisations continue to be the primary implementers of harm reduction initiatives in Latin America. Six countries are currently implementing harm reduction programmes: Argentina, Brazil, Colombia, Mexico, Paraguay and Uruguay. No additional countries have adopted a harm reduction approach in the past two years.[13] The vast majority of needle and syringe exchange programmes (NSPs) operate in Brazil, with projects also running in Argentina, Mexico, Paraguay and Uruguay. Opioid dependence is uncommon throughout much of Latin America, with most heroin use concentrated in Mexico and Colombia. Consequently, opioid substitution therapy (OST) coverage is low with services only available in these two countries (see Table 2.5.1).

Harm reduction programmes targeted towards people who use crack cocaine are operating in some countries but in general, these experiences are yet to be documented.

Across the region, there are very limited comprehensive care programmes available for those living with HIV, viral hepatitis or TB. Few health services target or address the specific needs of PWUD and linkages or referral systems between existing services for PWUD and other health services are often poor.[13] However, in Colombia there are indications that they intend to '[move] forward in the integration of the agenda of HIV with the agenda of drugs, which have historically worked very separately.'[5]

Latin America is at the forefront of a growing global movement to decriminalise drug use. Civil society advocacy in several countries has been instrumental in bringing about preliminary changes in national drug policy.[13] While these developments have clear implications for PWUD and harm reduction policy and practice, in no country have legal reforms been followed up with an increase in harm reduction services. Civil society organisations continue to be the primary service providers of harm reduction initiatives throughout the region. However, in the absence of state support they are frequently confronted with funding difficulties and are increasingly forced to rely on international resources.[13]

Multilateral agencies and international donors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the World Health Organization's Pan American Health Organization (PAHO) continue to provide limited support to harm reduction initiatives throughout the region.[13] However, the absence of adequate government support and poor financing for harm reduction continues to inhibit the introduction and/or scale-up of services in many Latin American countries.[13]

Developments in harm reduction implementation

Needle and syringe exchange programmes (NSPs)

Estimates of NSP coverage are very limited for Latin America. Where available, data indicates extremely low coverage with only 2% of PWID accessing NSP services across the region and 0.3 syringes received per PWID per year.[14] only five countries currently operate NSP programmes, leaving twelve that have reported injecting drug use with no available NSP facilities. No new countries have introduced NSP sites in the past two years, and there has been very little scale-up of established NSP services.[13] Brazil still reports the highest number of active NSP sites, with between 150 and 450 currently in operation[14] (see Table 2.5.1). Recent national reporting to UNAIDS indicates that 54.3% of PWID reported to have used sterile injecting equipment the last time they injected.[4]

In Paraguay this figure is reported at 92.11% despite there being only three NSP sites in operation.[4]

In Mexico, there are reported to be 0.4 NSP sites per 1000 PWID, providing equivalent to 2.7 syringes per PWID per year;[2] significantly higher than the regional average. State funds subsidise the distribution of sterile injecting equipment to Centres for Youth Integration (CIJ) and some CAPASITS (State Coordinating of HIV/AIDS/STIs).[13] In Ciudad Juarez, the NGO intervention Companeros Program distributes equipment packs containing sterile needles and HIV and hepatitis C prevention information.[13]

There are still no NSP programmes in Colombia, despite widespread heroin use and high-risk injecting practices. A recent study found that 40% and 60% of PWID in Medellin and Pereira respectively reported sharing injecting equipment.[4] The majority of participants reported using tap water to clean syringes, with a small number using alcohol. The interconnection between PWID and their sexual networks in HIV transmission has also been highlighted.[4] Approximately 22.9% of PWID in Medellin and 22.7% in Pereira reported giving a used syringe to a casual partner.[4]

The criminalisation of drug use and strict law enforcement across the region remains a significant barrier to PWID accessing health services. There are anecdotal reports from Mexican civil society of the frequent seizing of used injecting equipment from PWID to be used as evidence against them.[15] The registration requirements of Mexican NSPs are also reported to deter many PWID from accessing these services.

Prohibition policies in Colombia have given rise to high levels of stigma, social discrimination and exclusion of PWUD.[13] Discrimination against PWUD from health service providers is reported.[16] Studies in Medellin and Pereira revealed that, while the majority of PWID participants had purchased syringes in pharmacies, most reported discrimination by pharmacy employers.[4]

In those countries that offer limited harm reduction facilities, restricted access hours, waiting times, insufficient resources and inadequately trained service providers deter many PWID from accessing services.[13] The Brazilian NGO, Viva Rio, in coordination with the Department of Mental Health of Rio de Janeiro, is working to improve service access in the area, training community health operators who work in the *favelas* in harm reduction intervention.[h] [13] The Intercambios Civil Association, in coordination with the governments of various provinces and the support of the Levi Strauss Foundation, is also developing training in Argentina under the project 'Reducing stigma and discrimination of drug users'.[17]

Further research and programme-monitoring in countries implementing NSPs is required to determine accurate levels of coverage across the region. Although concentrated epidemics within key populations are reported throughout Latin America, services targeting the needs of vulnerable population groups are limited. More harm reduction initiatives that actively engage with networks of PWUD and include community and interdisciplinary interventions are required.

Further developments for harm reduction targeting PWID include the investment of US$500,000 of the National Drug Council of Uruguay to open two crisis centres for PWUD, based in the Maciel and San Jose Hospitals.[13] In Paraguay, the National Centre on Addiction Control with the National HIV/AIDS and STI Control Programme and regional NGOs, is developing harm reduction initiatives, although it is not yet clear what these will involve.[13] An Advisory and HIV Testing Centre has recently opened in Argentina.[4] The National Policy for the Reduction of Substance Abuse in Colombia is leading localised harm reduction developments for people who inject heroin.[13] Street-based outreach services are being initiated in accordance with local authorities to deliver educational activities and monitored distribution of condoms and sterile syringes. Pilot schemes have been established in the Cucata, Pereira, Santander de Quilichao, Cali, Armenia and Medellin areas.[13]

Harm reduction for people who use crack cocaine

As the association between HIV transmission and non-injecting drug use in the region is being increasingly reported, [4, 7] there is a need for guidance on the development of interventions that specifically aim to prevent HIV for those drug users who do not inject. This is of particular urgency in South American countries where researchers and CSOs have called for increased access to HIV prevention and voluntary counselling and testing (VCT) for crack cocaine users.[18]

Some harm reduction initiatives in the region are tailored toward people who use crack cocaine, but these need to be more systematically documented. One such programme was developed in 2010 in Rio de Janeiro. The 'crack-land' project provided a safe place for young people to congregate and smoke crack cocaine in the Rio favela of Yacarecinho.[13] Pipes, lip balms, condoms and syringes were provided by the scheme, which was run by health workers specifically trained in the needs of crack cocaine users. Though initially supported by a number of government and state bodies as well as UNODC, funds supporting the project have since been suspended.[13]

h *Favelas* are poor and precarious housing settlements.

Opioid substitution therapy (OST)

Opioid use is rare throughout most of Latin America. Mexico and Colombia remain the only countries with OST programmes in operation (see Table 2.5.1).[14] There have been limited developments in OST service provision in the past two years. In 2010, the estimated number of active services in Mexico was between twenty-one and twenty-five sites and in Colombia, four operational services were reported to be providing methadone maintenance treatment (MMT) across three districts.[14] In 2012, local respondents reported there being eight public OST programmes in operation across Colombia, each serving an average of 100 patients, with an additional four privately run institutions offering OST services.[13] It is also reported that expanding the range of available OST doses and forms is being considered in Colombia.[13]

Viral hepatitis

Population prevalence of HCV in Latin America varies by country but averages less than 1% across the region.[19] Contaminated blood products are responsible for most HCV infections in Latin America.[19] Injecting drug use is an important risk factor in parts of the region, most notably major urban areas and northern Mexico.[19] Data on viral hepatitis among PWID remains limited for the Latin America region. Estimates of hepatitis C antibody (anti-HCV) prevalence among PWID range from 9.8% in Paraguay to 97.4% in Mexico. Estimates for hepatitis B surface antigen (anti-HBsAg) are only recorded for three countries, and range from 2.3% in Brazil to 8.6% in Argentina (see Table 2.5.1). HCV prevalence is also elevated among non-injecting cocaine users in Brazil and Argentina. Studies have indicated high levels of HIV/HCV co-infection among PWID in the region.[19]

With the exception of one programme in Brazil,[13] there are currently no integrated HIV, tuberculosis (TB) and viral hepatitis testing and treatment programmes in Latin America. Attempts have been made to address this situation. The Ministry of Health and the Social Security (CCSS) in Costa Rica and Panama have pledged to guarantee access to testing and treatment services for HIV and viral hepatitis to all.[20] In 2011, the Ministry of Health of the province of Buenos Aires (Argentina) launched the Programme for Prevention and Detection of Viral Hepatitis to work in conjunction with the HIV/AIDS and Sexually Transmitted Infections (STIs) Programme.

Tuberculosis

Brazil is one of the twenty-two countries recognised as having a high TB burden, reporting forty-eight TB cases per 100,000 of the population in 2010.[21] Infections with drug-resistant strains are beginning to occur in areas of Central America. While research on TB prevalence among PWUD in Latin America is lacking, there is evidence to suggest that both injecting and non-injecting drug use are associated with elevated TB infection rates.[21]

Most countries in the region offer an HIV test to anyone presenting with TB.[13] Similar diagnosis services are, in theory, available for people who use drugs, though compliance to such practices is not always consistent.[13] Integrated TB and HIV programmes are beginning to emerge in the region, including in Uruguay, Argentina and parts of Central America. However, there are currently no services that specifically target PWUD.[20]

Overdose

Data on the prevalence of overdose in Latin America is very limited. Research in Colombia reported 25% and 33.3% of PWID in Pereira and Mendellin respectively to have experienced a non-fatal heroin overdose.[4] In both cities, six out of ten revealed that they would not access health services if they had another overdose episode for fear they would be referred to law enforcement authorities.[4]

There are currently no overdose prevention programmes established in the region.[13] Naloxone is registered in a number of South American countries including Argentina, Brazil, Peru, Chile, Uruguay, Mexico, Paraguay and Venezuela. However, it is not yet available to PWUD or for medical emergencies in any of these areas. In Colombia, where heroin and opiate use is more widely reported, naloxone is available and its use included in regional health care plans.[13]

Prevailing laws and the criminalisation of drug use continue to inhibit the introduction of overdose prevention and treatment initiatives in the region.

Antiretroviral therapy (ART)

Latin America and the Caribbean continue to lead globally in ART coverage levels for low- and middle-income countries.[22] In December 2010, it was reported that ART was being provided to 521,000 of the 820,000 (710,000–920,000) in need of treatment, which equated to 63% ART coverage.[2] Coverage varied between countries, from less than 70% in Ecuador and Guatemala to above 80% in Chile and Nicaragua.[22] Brazil is the only country with estimates for the number of PWID living with HIV and receiving ART. While past estimates have been much higher, the UN Reference Group found only 2,974 PWID to be receiving treatment: between one and four of every hundred PWID living with HIV in Brazil.[14]

Latin America reports twenty-four ART facilities per 100,000 of the population.[2] Yet at 11%, the region reported the smallest percentage increase in the number of people receiving ART between 2009 and 2010.[2] While ART coverage is generally high in the region, this figure may also reflect challenges in scaling up VCT and in early HIV diagnoses.[2] Significant improvements in access to adequate diagnosis and care services are necessary to reach all those in need of ART in the region, particularly vulnerable populations.[23]

The criminalisation of drug use continues to greatly inhibit service access and treatment adherence among key populations. Attitudes among health professionals that patients must stop the use of illegal drugs or alcohol to receive ART is also reported to be impeding the success of many ART treatment programmes.

Limited medical resources and the cost of ART are of growing concern in Latin America. In a survey conducted by PAHO/WHO in 2011, eight out of twelve countries in the region reported episodes of ART shortages, which required people to change treatment regimens or to have treatment interruptions, increasing the risk of HIV resistance and treatment failure.[24]

Harm reduction in prisons

In most Latin American countries, the cultivation, distribution and personal use of drugs remains a criminal offence. The predominant 'war on drugs' approaches in the region have led to large proportions of the drug-using population being incarcerated. While there are a lack of data on the prevalence of HIV, viral hepatitis and TB within Latin American prisons, it is clear that prison populations are at an increased risk of infection. In Argentina, for example, TB patients with a history of incarceration were six and 18 times more likely to test positively for HBV and HCV infection, respectively.[25]

More thorough and systematic research is required to provide an accurate analysis of the current situation of HIV, viral hepatitis and TB epidemics and drug use within prisons in Latin America. There are currently no prison-based harm reduction services operating in the region.[13]

Policy developments for harm reduction

As reported in 2010, six Latin American countries include harm reduction within their national policies on HIV and/or drugs: Argentina, Brazil, Colombia, Mexico, Paraguay and Uraguay. The extent to which this indicates government support for harm reduction varies. For example, though harm reduction is now recognised as part of national public health policy in Paraguay, it is implemented only by non-governmental organisations and often without the support of the state.[13] While there has been little development in the specific inclusion of harm reduction within national policy across the region, there has been a notable increase in the debate about drug policy and legislation at both national and international levels. In most Latin American countries, and particularly in Central America, drug policy and legislation remains focused on supply reduction and combating drug trafficking. These policies are largely determined by security and justice ministries and incorporate extensive military and policing operations.[26] However, during the 'Strategic Meeting of Public Security and Drug Policy', held in Rio de Janeiro in November 2011, law enforcement representatives from eighteen countries expressed concern at the negative consequences of the current 'war on drugs' strategy and called for more effective and constructive policy approaches.[27]

Moreover there is a growing awareness within policy circles of the vulnerability of key affected population groups. The 47th Regular Session of the Inter-American Drug Abuse Control Commission (CICAD/OAS) in May 2010 saw the approval of the new Hemispheric Drug Strategy.[28] Although there are no explicit mentions of harm reduction initiatives, the strategy does call for comprehensive evidence-based prevention programmes targeting key vulnerable and socially marginalised populations as well as a stronger institutional presence to establish and implement new policy initiatives.[28]

In September 2011, the 51st Directing Council of PAHO endorsed the Plan of Action on Psychoactive Substance Use and Public Health Strategy aimed at reducing the burden of drug use while strengthening an integrated public health response.[29] Shortly afterwards, delegations from the twelve UNASUR nations of the regional bloc met for the 2011 South American Council to discuss the ratification of the Drug Action Plan to reduce narcotic supply and demand. Prevention initiatives and treatment programmes for high-risk populations were addressed as well as institutional strengthening and the harmonising of anti-drug legislation to create mechanisms for regional coordination.[30]

In January 2011, representatives of The Latin American Commission on Drugs and Democracy (comprised of 17 drug policy campaigners, including former presidents of Brazil, Colombia and Mexico) presented an initiative to create the Global Commission on Drug Policy. The first meeting and official launch of the Global Commission was held in Geneva, June 2011. Chaired by Fernando Henrique Cardoso, the Global Commission condemns the global 'war on drugs' as a failure and advocates a paradigm shift towards harm reduction, decriminalisation of drug use and the legal regulation of certain substances. It seeks to create space for a debate on evidence-based drug policies.[13, 31]

There have been several developments in drug policy in the region that have implications for harm reduction, some of which are summarised below. For more information on these and other developments globally, refer to Chapter 3.4.

Drug policy developments in Latin America

In June 2011, the **Bolivian** government announced its formal withdrawal from the UN Single Convention on Narcotic Drugs of 1961. This followed the rejection of a proposal to amend Article 49 to remove the coca leaf from the list of classified drugs as identified by the Convention. Despite its withdrawal, Bolivia indicated its intention to adhere to the main outlines of the Convention with the exception of the prohibition of the traditional use of coca leaf. It remains explicitly in favour of criminalising the use of cocaine – 'Coca Yes, Cocaine No'.[13]

The **Chilean** government has decided to use Drug Treatment Courts for those convicted for problematic drug use. The initiative allows the accused to participate in a voluntary rehabilitation programme under the direct supervision of the judge, and on completion of the treatment, the case is dismissed and criminal records erased.[13]

In **Argentina,** the Mental Health Law now prohibits involuntary internment, previously a common practice for PWUD. It also denotes the rights of patients to be adequately informed of care options and to receive treatment that does not infringe on their personal freedoms. The regulation is still pending but the enactment of the law marks a step towards addressing addiction within mental health policy.[13]

Ecuador has some of the toughest drug laws in the region, resulting in the incarceration of many small-scale drug traffickers. The Constitution drawn up by the National Constituent Assembly in 2008 declared that drug consumption should be decriminalised and substance dependency addressed as a public health issue. A complete review of the judicial system has since been put forward by the Ministry of Justice and Human Rights. The proposed legislation distinguishes between small and large-scale drug trafficking and street distribution, and introduces proportional sentences. Yet there is still no guarantee that either the broader reforms or drug legislation will be implemented.[13]

In November 2010 in **Mexico**, the Law for Integral Support to Psychoactive Substance Use was approved. This law proposes an alternative justice model focusing on the prevention and treatment of addictions through public services.[32] However, drug policy in Mexico has continued to adhere to the 'war on drugs' approach.

The **Brazilian** government is to invest US$2 billion toward creating a public health network for the treatment of PWUD, with a particular focus on crack cocaine use. Funds are to be used to establish 300 health centres and 600 temporary shelters for drug dependency.[33]

In June 2012, **Colombia's** constitutional Court approved the government proposal to decriminalise the possession of small amounts of cocaine and marijuana for personal use.[34] The recent court ruling stated that anyone caught with less than 22g of marijuana, or less than one gram of cocaine, may receive physical/psychological treatment depending on their level of intoxication, but may not be prosecuted or detained.[34]

Civil society and advocacy developments for harm reduction

Civil society organisations (CSOs) have continued to play an important role in advocating for drug policy reform at both regional and national levels. A second edition of the Latin America Conference on Drug Policy was held in Rio de Janeiro in 2010, and a third in Mexico City in September 2011.[13] Organised by Intercambios Civil Association and its respective local partners, Psicotropicus and CUPIDH, the events brought together key representatives from across the region to promote and continue discussions on drug policy and reform.[13] Various satellite events were held at each conference to encourage further dialogue between governments and society. The 2011 Mexico convention incorporated a 'Drug Policy in Latin America' seminar for journalists, sponsored by PAHO, to generate a critical mass of trained reporters engaged with advocating for inclusive, harm reduction policy development in line with human rights.[13] Contact between regional civil society organisations and the International Network of People who Use Drugs (INPUD) led to the formation of the LANPUD (Latin American Network of People who Use Drugs)[13] which has plans to hold a further strategic meeting in October 2012.[35]

Such dialogues on drug policy, initiated in 2007 by the Transnational Institute (TNI) and Washington Office on Latin America (WOLA), to promote the free and confidential exchange of ideas between officials and nongovernmental experts, have continued to further the debate on current trends and how existing contradictions within international drug policy might be resolved.[13] In recent years informal dialogues have been conducted in Rio de Janeiro (February 2009 and 2010), Buenos Aires (October 2009), Montevideo (February 2011) and most recently in Lima (February 2012).[36]

i For more information about this topic, see TNI Publication, Drugs and Conflict, Debate Documents, Nº 13, May 2006, 'Coca Yes, Cocaine No' Legal Options for the Coca Leaf, http://www.tni.org/briefing/coca-yes-cocaine-no.

The RAISSS network of institutions includes many community-based organisations committed to addressing the problems of drug use and harm reduction in conditions of social inequality across the continent.[13] It currently comprises organisations throughout Latin America and the Caribbean, in Brazil, Chile, Haiti, Guatemala, Honduras, El Salvador, Nicaragua, Costa Rica, Panama, Bolivia, Mexico and Colombia. RIOD is a similar non-profit organisation network of Latin American NGOs working on prevention, treatment and social inclusion within the drug field.[13]

At the national level, CSOs continue to play a key role in advocating for drug law reform and the increase of harm reduction service provision. CSOs in Colombia are calling for a reform of the national drug statute to align drug policy with human rights and public health.[13] Advocating a rejection of compulsory treatments and the repression, persecution and criminalisation of PWUD, they have demanded that the government readdress the failure of the punitive policies of previous years.[13] Civil society advocacy for harm reduction and the involvement of drug users remains weakest in Central America, although some NGOs cover these issues in their work.[13]

Multilaterals and donors: developments for harm reduction

Multilateral agencies and international donors have continued to support several harm reduction initiatives in Latin America in recent years.[13] As in other regions, the most significant donor has been the Global Fund. Over the past five years, close to US$90 million has been allocated to programmes in Argentina, Panama, Peru, Uruguay, Colombia and Honduras.[13] However, the 2011 selection of proposals was made in the context of a global financial crisis. With imposed restrictions on the access to resources for middle-income countries, the sustainability of many of the projects in Latin American is now at risk.

UNAIDS and WHO recently investigated the challenges specific to Latin America of engaging PWID in HIV prevention trials. Information collated at the regional consultation held in Buenos Aires in 2011 has been used to supplement previous guidance on ethical considerations in biomedical HIV prevention trials initially conducted in 2007.[13, 37] WHO, UNODC and UNAIDS have also produced a region-specific draft of their Technical Guide for countries to identify and set targets for universal access to HIV prevention, treatment and care for PWID.[13, 38] The modified document addresses HIV transmission risks and interventions for PWUD in the regional context of Latin America and the Caribbean. The HIV/STI Project of PAHO/WHO held a regional consultation in April 2010 in El Paso, Texas. Experts met to discuss research, policy and intervention strategies to address HIV transmission associated with or resulting from drug use in the region of the Americas. A draft for discussion to review the state of harm reduction in Latin America and the Caribbean was produced.[13] In June 2011 the Global Commission on HIV and the Law hosted a Regional Dialogue to discuss the experiences and perspectives of individuals, communities, policy makers and law enforcement officials in the Latin American region.

Open Society Foundations (OSF) continues to support advocacy activities of regional CSOs in drug policy reform and advocacy for harm reduction.[13] Caritas (Germany) has provided support to the RAISSS network activities and the Levis Straus Foundation has continued its support for projects in Argentina.[13]

Government support is essential for sustainable harm reduction programmes within the region. In addition, and particularly given the global economic crisis, support from international donors and multilateral agencies in the region remains critical to ensuring that harm reduction forms an integral part of drug policy and public health responses throughout the region.

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