Global Overview
1.1 Behind the Numbers

Global Overview

Behind the numbers

It is a decade since Harm Reduction International began compiling the *Global State of Harm Reduction*. While our coverage of harm reduction policies and services has evolved and broadened in scope, the same cannot always be said for harm reduction in practice around the world.

According to a 2017 systematic review in the *Lancet Global Health*, injecting drug use is present in 179 of 206 countries throughout the world, with HIV and hepatitis C prevalence 17.8% and 52.3% respectively among the 15.6 million people who inject drugs.[2]

Despite this heavy burden of diseases, effective harm reduction interventions that can help prevent their spread are severely lacking in many countries. The number of countries providing needle and syringe programmes (NSP) and/or opioid substitution therapy (OST) has more or less stagnated since 2014. Currently, just 86 countries implement NSP to varying degrees (a drop from the 90 that did so in 2016) and 86 have OST (a moderate uptick of six countries compared to two years ago).

Compounding this relative dearth of services is a funding crisis for harm reduction that rages in the low- and middle-income countries (LMICs) where injecting drug use is most prevalent. UNAIDS sounded the alarm in 2018 over the 20% shortfall in funding for the global HIV response. Our research found that when it comes to harm reduction in LMICs, this funding gap is close to an alarming 90%.[4] When juxtaposing global aspirations to end AIDS by 2030 and the vulnerability of people who inject drugs to contracting HIV, it is difficult not to question states' genuine political commitment to the agreed-upon goals.

Harm reduction is not just about commodities to address HIV and other blood-borne viruses. It encompasses a range of health and social services, policies and approaches that address the harms of illicit drug use and drug policy. To reflect this, the 2018 *Global State of Harm Reduction* is our most comprehensive yet, and includes for the first time dedicated sections for each region on harm reduction for amphetamine-type stimulants (ATS), overdose response and funding for harm reduction, as well as analyses of harm reduction for women.

ATS use is increasing around the world, and harm reduction interventions for people who use these substances remain underdeveloped. Drug-checking is having a relative boom in some regions, but only in certain settings (for example, festivals and night clubs). Drug consumption rooms in many countries, meanwhile, remain largely focused on serving people who inject drugs rather than including space for those who may smoke or snort drugs.

This says nothing of one of the most pressing crises in harm reduction today – fatal drug-related overdose. North America and parts of Western Europe continue to see overdose deaths climb, primarily those related to opioids and linked to polydrug use, while data in many regions fail to properly track these fatalities. Though naloxone – an opioid antagonist medicine that can reverse the effects of an overdose – is increasingly being deployed in the countries most affected by this crisis, it is not always placed in the hands of those who need it most, i.e. people who use drugs and their peers.

Finally, as with the diversification of interventions based on drug used, different populations are better served by tailored approaches. This report notes, in particular, the need for gender-sensitive services to address the acute vulnerability faced by women who use or inject drugs. Most services worldwide remain male-focused. This is compounded by the fact that women who use drugs face heightened levels of stigma because of unfair (and outdated) expectations of a woman's role in society. Sadly, the most vulnerable women who use drugs may be subject to intimate partner violence and are effectively excluded from any support services.

Underpinning the gaps in harm reduction is a political and legal environment in most countries that continues to demonise and/or criminalise people who use drugs. This manifests most brutally in countries that have pursued a bloody crackdown on the drug trade, notably the Philippines, where over 20,000 people have been killed (many the result of extrajudicial killings) since 2016.[5]

Hostile political and legal contexts ensure barriers for people wanting to access health and social services, and put some of the most vulnerable people in society at risk of incarceration. Prisons represent high-risk environments for the transmission of blood-borne viruses, yet there are even fewer harm reduction services on offer compared to those available in the community.

While this all paints a bleak picture of harm reduction worldwide, there are examples of innovation and perseverance in this report that give hope and demonstrate that progress is possible. It is important, too, to not overlook the fact that harm reduction has come a long way over the past two decades.

The evidence is clearly in favour of harm reduction. It is time that more countries acknowledge this and implement the services that are proven to advance public health and uphold human rights.

The Global Harm Reduction Response

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

Country or territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid substitution programme operational	At least one drug consumption room	At least one naloxone peer distribution programme operational	OST in at least one prison	NSP in at least one prison
ASIA							
Afghanistan	✓	✓	✓	×	✓	✓	×
Bangladesh	×	✓	✓	×	×	×	×
Bhutan	×	×	×	×	×	×	×
Brunei Darussalam	×	×	×	×	×	×	×
Cambodia	×	✓	✓	×	×	×	×
China	×	✓	✓	×	×	×	×
Hong Kong	×	×	✓	×	×	×	×
India	✓	✓	✓	×	✓	✓	×
Indonesia	×	✓	✓	×	×	✓	×
Japan	×	×	×	×	×	×	×
Laos	×	×	×	×	×	×	×
Macau	✓	✓	✓	×	×	✓	×
Malaysia	✓	✓	✓	×	×	✓	×
Maldives	×	×	✓	×	×	×	×
Mongolia	×	✓	×	×	×	×	×
Myanmar	✓	✓	✓	×	×	×	×
Nepal	✓	✓	✓	×	×	×	×
Pakistan	×	✓	×	×	×	×	×
Philippines	×	×	×	×	×	×	×
Singapore	×	×	×	×	×	×	×
South Korea	×	×	×	×	×	×	×
Sri Lanka	×	×	×	×	×	×	×
Taiwan	✓	✓	✓	×	×	×	×
Thailand	✓	✓	✓	×	×	×	×
Vietnam	✓	✓	✓	×	×	✓	×
EURASIA							
Albania	✓	✓	✓	×	×	✓	×
Armenia	✓	✓	✓	×	×	✓	✓
Azerbijan	×	✓	✓	×	×	×	×
Belarus	✓	✓	✓	×	×	×	×
Bosnia and Herzegovina	✓	✓	✓	×	×	✓	×
Bulgaria	✓	×	✓	×	×	✓	×
Croatia	✓	✓	✓	×	×	✓	×
Czech Republic	✓	✓	✓	×	×	✓	×
Estonia	✓	✓	✓	×	✓	✓	×
Georgia	✓	✓	✓	×	×	×[a]	×
Hungary	✓	✓	✓	×	×	×[a]	×
Kazakhstan	✓	✓	✓	×	×	×	×
Kosovo	✓	✓	✓	×	×	×	×
Krygyzstan	✓	✓	✓	×	×	✓	✓
Latvia	✓	✓	✓	×	×	✓	×
Lithuania	✓	✓	✓	×	×	×	×

a OST is available in prison, but for detoxification purposes only.

Country or territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid substitution programme operational	At least one drug consumption room	At least one naloxone peer distribution programme operational	OST in at least one prison	NSP in at least one prison
Macedonia	✓	✓	✓	×	×	✓	✓
Moldova	✓	✓	✓	×	×	✓	✓
Montenegro	✓	✓	✓	×	×	✓	×
Poland	✓	✓	✓	×	×	×[a]	×
Romania	✓	✓	✓	×	×	✓	×[b]
Russia	×	✓	×	×	×	×	×
Serbia	✓	✓	✓	×	×	✓	×
Slovakia	✓	✓	✓	×	×	×	×
Slovenia	✓	✓	✓	×	×	✓	×
Tajikistan	✓	✓	✓	×	×	×	✓
Turkmenistan	×	×	×	×	×	×	×
Ukraine	✓	✓	✓	×	✓	✓	×
Uzbekistan	✓	✓	×	×	×	×	×
WESTERN EUROPE							
Andorra	nk	nk	nk	×	nk	nk	nk
Austria	✓	✓	✓	×	×	✓	×
Belgium	✓	✓	✓	✓	×	✓	×
Cyprus	✓	✓	✓	×	×	✓	×
Denmark	✓	✓	✓	✓	✓	✓	×
Finland	✓	✓	✓	×	×	✓	×
France	✓	✓	✓	✓	×	✓	×
Germany	✓	✓	✓	✓	×	✓	✓
Greece	✓	✓	✓	×	×	✓	×
Iceland	✓	✓	✓	×	×	nk	nk
Ireland	✓	✓	✓	×	×	✓	×
Italy	✓	✓	✓	×	✓	✓	×
Luxembourg	✓	✓	✓	✓	×	✓	✓
Malta	✓	✓	✓	×	×	✓	×
Monaco	nk	nk	nk	×	nk	nk	nk
Netherlands	✓	✓	✓	✓	×	✓	×
Norway	✓	✓	✓	✓	✓	✓	×
Portugal	✓	✓	✓	×	×	✓	×
San Marino	nk	nk	nk	×	nk	nk	nk
Spain	✓	✓	✓	✓	×	✓	✓
Sweden	✓	✓	✓	×	×	✓	×
Switzerland	✓	✓	✓	✓	×	✓	✓
Turkey	×	×	✓	×	×	×	×
United Kingdom	✓	✓	✓	×	✓	✓	×
CARIBBEAN							
The Bahamas	✓	×	×	×	×	×	×
Dominican Republic	✓	✓	×	×	×	×	×
Guyana	×	×	×	×	×	×	×
Haiti	×	×	×	×	×	×	×
Jamaica	×	×	×	×	×	×	×

b NSPs are officially available in Romanian prisons, but are reported to be inaccessible to prisoners in reality.

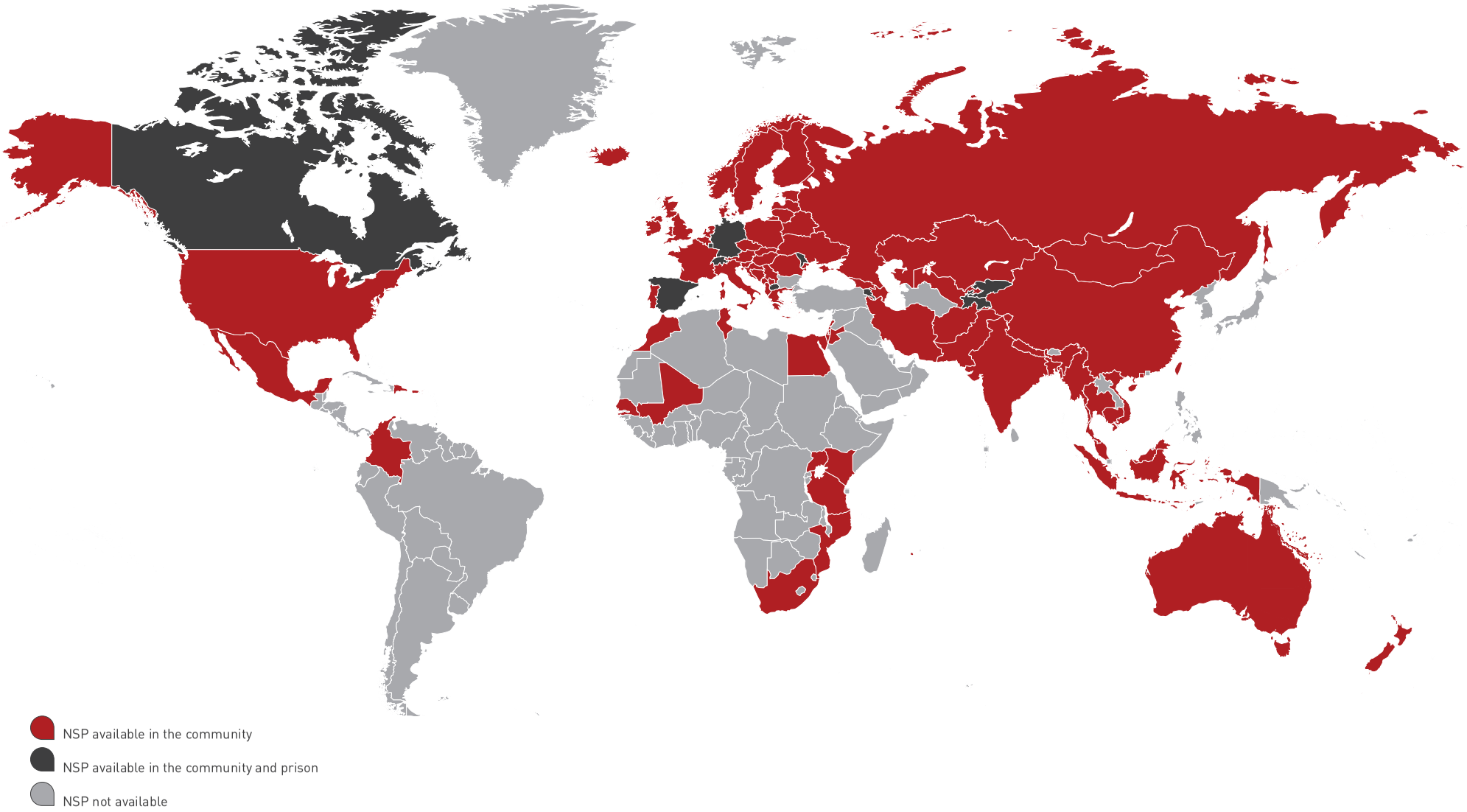
Country or territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid substitution programme operational	At least one drug consumption room	At least one naloxone peer distribution programme operational	OST in at least one prison	NSP in at least one prison
Puerto Rico	✓	✓	✓	×	×	✓	×
Suriname	×	×	×	×	×	×	×
LATIN AMERICA							
Argentina	✓	×	✓	×	×	×	×
Bolivia	×	×	×	×	×	×	×
Brazil	×	×	×	×	×	×	×
Chile	×	×	×	×	×	×	×
Colombia	✓	✓	✓	×	×	×	×
Costa Rica	✓	×	✓	×	×	×	×
Ecuador	✓	×	×	×	×	×	×
El Salvador	×	×	×	×	×	×	×
Guatemala	×	×	×	×	×	×	×
Honduras	×	×	×	×	×	×	×
Mexico	✓	✓	✓	×[c]	✓	×	×
Nicaragua	×	×	×	×	×	×	×
Panama	×	×	×	×	×	×	×
Paraguay	×	×	×	×	×	×	×
Peru	×	×	×	×	×	×	×
Uruguay	✓	×	×	×	×	×	×
Venezuela	×	×	×	×	×	×	×
NORTH AMERICA							
Canada	✓	✓	✓	✓	✓	✓	✓
United States	✓	✓	✓	×	✓	✓	×
OCEANIA							
Australia	✓	✓	✓	✓	✓	✓	×
Fiji	×	×	×	×	×	×	×
Kiribati	×	×	×	×	×	×	×
Marshall Islands	×	×	×	×	×	×	×
Micronesia	×	×	×	×	×	×	×
New Zealand	✓	✓	✓	×	×	✓	×
Palau	×	×	×	×	×	×	×
Papua New Guinea	×	×	×	×	×	×	×
Samoa	×	×	×	×	×	×	×
Solomon Islands	×	×	×	×	×	×	×
Tonga	×	×	×	×	×	×	×
Vanuatu	×	×	×	×	×	×	×
MIDDLE EAST AND NORTH AFRICA							
Algeria	×	×	×	×	×	×	×
Bahrain	×	×	✓	×	×	×	×
Egypt	✓	✓	×	×	×	×	×
Iran	✓	✓	✓	×	×	✓	×
Iraq	×	×	×	×	×	×	×
Israel	✓	✓	✓	×	×	✓	×
Jordan	×	✓	×	×	×	×	×

c Though no official DCRs operate in Mexico at the time of reporting, a facility exclusively serving women exists in Mexicali, Baja California.

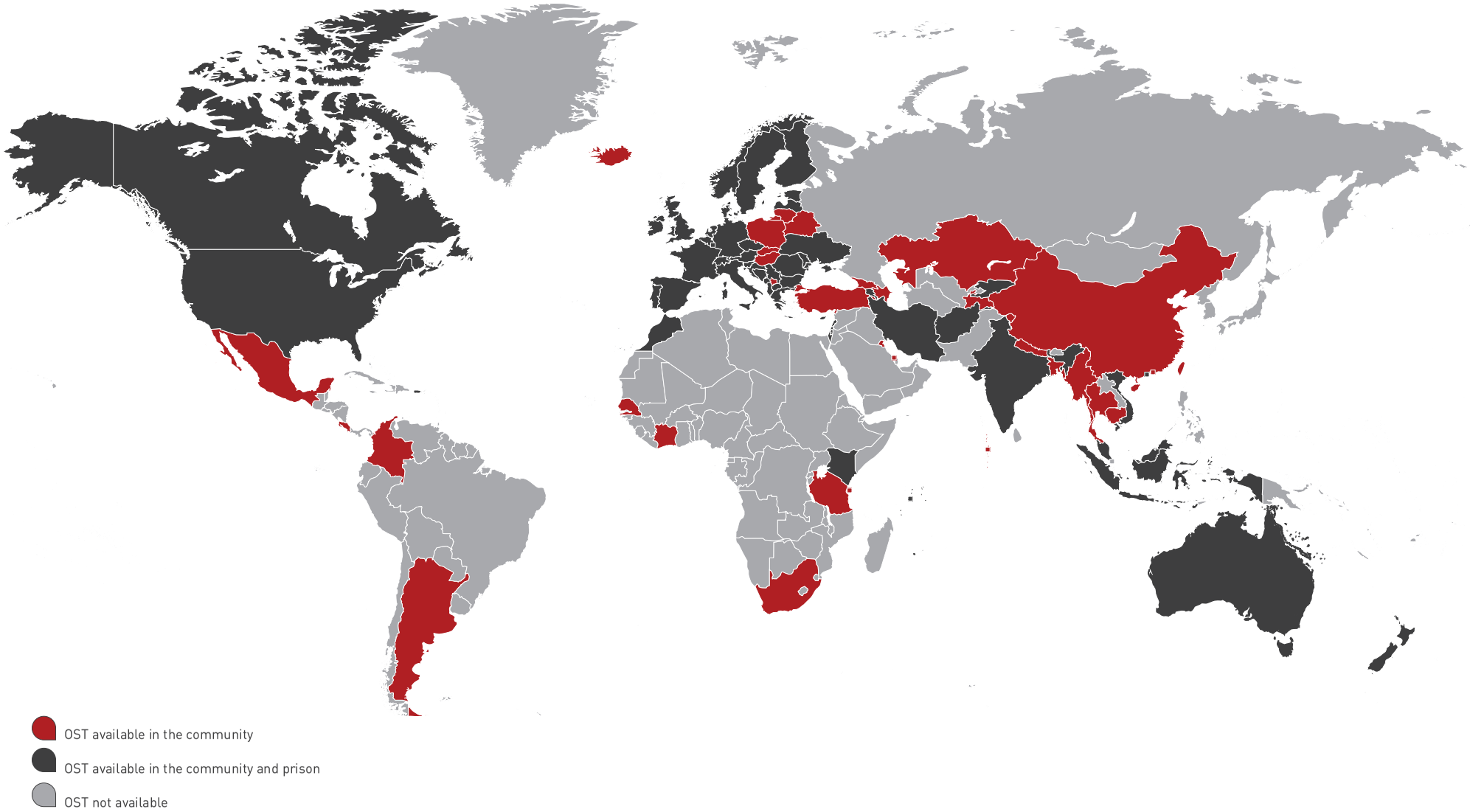
Country or territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid substitution programme operational	At least one drug consumption room	At least one naloxone peer distribution programme operational	OST in at least one prison	NSP in at least one prison
Kuwait	×	×	✓	×	×	×	×
Lebanon	✓	✓	✓	×	×	✓[d]	×
Libya	×	×	×	×	×	×	×
Morocco	✓	✓	✓	×	×	✓[d]	×
Oman	✓	×	×	×	×	×	×
Palestine	✓	✓	✓	×	×	✓	×
Qatar	×	×	×	×	×	×	×
Saudi Arabia	×	×	×	×	×	×	×
Syria	×	×	×	×	×	×	×
Tunisia	×	✓	×	×	×	×	×
United Arab Emirates	×	×	×[e]	×	×	×	×
Yemen	×	×	×	×	×	×	×
SUB-SAHARAN AFRICA							
Benin	×	×	×	×	×	×	×
Burkina Faso	×	×	×	×	×	×	×
Burundi	×	×	×	×	×	×	×
Côte d'Ivoire	×	×	✓	×	×	×	×
Democratic Republic of the Congo	×	×	×	×	×	×	×
Ghana	✓	×	×	×	×	×	×
Kenya	✓	✓	✓	×	×	✓	×
Lesotho	×	×	×	×	×	×	×
Liberia	×	×	×	×	×	×	×
Madagascar	×	×	×	×	×	×	×
Malawi	×	×	×	×	×	×	×
Mali	X	✓	×	×	×	×	×
Mauritius	✓	✓	✓	×	×	✓	×
Mozambique	X	✓	×	×	×	×	×
Nigeria	✓	×	×	×	×	×	×
Rwanda	×	×	×	×	×	×	×
Senegal	✓	✓	✓	×	×	×	×
Seychelles	✓	×	✓	×	×	✓[f]	×
Sierra Leone	×	×	×	×	×	×	×
South Africa	✓	✓	✓	×	×	×	×
Tanzania	✓	✓	✓	×	×	×	×
Tanzania (Zanzibar)	✓	×	✓	×	×	×	×
Togo	×	×	×	×	×	×	×
Uganda	×	✓	×	×	×	×	×
Zambia	✓	×	×	×	×	×	×
Zimbabwe	×	×	×	×	×	×	×
TOTALS	85	86	86	11	12	54	10

d OST in prisons is reported to be largely accessible.
e OST is available for detoxification only.
f The extent to which OST is available in practice in prisons is unknown.

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



Needle and syringe programmes (NSPs)

Since the *Global State of Harm Reduction* last reported, there has been a small decline in the number of countries implementing NSPs, from 90 in 2016 to 86 in 2018. This is in part due to the withdrawal of services in Latin American countries (such as Argentina and Brazil), where civil society organisations report there are no longer significant populations of people who inject drugs.

However, NSP services have ceased to operate due to changes in policy in Bulgaria, Laos and the Philippines, where punitive drug policies result in people who use drugs experiencing harsh criminalisation. On the other hand, three new countries in sub-Saharan Africa have adopted NSPs: Mali, Mozambique and Uganda.

According to the available data presented in this report, 29 countries have increased the number of NSP sites since 2016, while 15 have reduced the number of sites. In Eurasia, 10 of the 27 countries have expanded the number of NSPs in operation, while countries in Asia have seen the greatest decline in the number of services. However, it is important to note that while the data presented here represent the most reliable estimates available, these are not always recent, and considerable improvement in the availability of accurate and systematically captured data at national level is necessary to make this kind of monitoring more robust.

The existence of NSP sites in a country does not mean these sites are universally accessible to people who use drugs. Discrimination and stigma are frequently cited by networks of people who use drugs, civil society organisations and academics as reasons that people who use drugs might decline to access such services. This is particularly true among already stigmatised or marginalised groups, such as women who use drugs, men who have sex with men, homeless people, migrants, ethnic minorities and indigenous peoples. Geographic variation, where services are concentrated only in certain regions or exclusively in urban environments, is also a barrier to access identified in Oceania, sub-Saharan Africa and Western Europe.

Opioid substitution therapy (OST)

The number of countries in which OST is available has increased since 2016, from 80 to 86. The countries that have introduced or re-introduced OST since 2016 are: Cote d'Ivoire and Zanzibar (Tanzania) in sub-Saharan Africa; Bahrain, Kuwait and Palestine in the Middle East; and Argentina and Costa Rica in Latin America. OST remains entirely unavailable in a number of countries, most notably Russia, where OST is prohibited by law.

Data on the total number of sites offering OST in a country are often unavailable, for example in Western Europe, where there is considerable overlap with other medical services. However, according to the data that are available, 17 countries worldwide (eight of which are in Asia) have increased the number of OST sites operating since 2016. There are reported to be fewer OST sites in four countries than in 2016: Albania, Malaysia, Mexico and Serbia.

Where OST is available, methadone continues to be the most commonly prescribed substance, followed by buprenorphine; though in Oceania and Western Europe, buprenorphine-naloxone combinations are increasingly prevalent. Heroin-assisted therapy has been found to be highly effective in increasing adherence to OST, reducing use of illicit heroin and producing better health outcomes.[6] Despite this, it is currently only available in seven countries, all of which are in Western Europe or North America: Belgium, Canada, Denmark, Germany, the Netherlands, Switzerland and the United Kingdom.

As with NSPs, the geographic distribution of OST facilities is reported to be a barrier to access in Asia, the Middle East, North America and Western Europe. In some cases this is due to a scarcity of approved prescribers, as in Germany[7] and the United States.[8] A lack of specialised and accessible services for women and migrants also presents a barrier in all regions, as does stigma and discrimination towards people who use drugs.

Viral hepatitis and HIV

Globally, prevalence of hepatitis C antibodies among people who inject drugs is estimated to be 52.3%, prevalence of hepatitis B surface antigens is estimated to be 9.0%, and HIV prevalence is estimated to be 17.8%.[1] Non-injecting drug use, particularly inhalation of crack cocaine and cocaine paste, has also been shown to be associated with greater risks of viral hepatitis and HIV infection.[9-14] There is significant regional variation in prevalence of blood-borne viruses among people who inject drugs. For example, the early implementation of harm reduction approaches (such as NSPs and OST) is credited with maintaining low prevalence of HIV among people who inject drugs in Australia and Switzerland, among others.[15,16]

Integrating viral hepatitis and HIV care with harm reduction services, and in particular the use of peer workers in such services, is reported to be effective in increasing access to healthcare among people who

use drugs in Oceania and Western Europe. In other regions, including Eurasia, Latin America and sub-Saharan Africa, the integration of health services for blood-borne viruses is sporadic and reliant on civil society organisations.

Despite the World Health Organization target of eliminating both hepatitis C and hepatitis B by 2030, countries in each world region continue to restrict access to direct-acting antivirals for hepatitis C for people who inject drugs. *The Global State of Harm Reduction 2018* highlights new efforts to ease these restrictions. In Western Europe for example, only two countries retain restrictions on access to direct-acting antivirals for people who inject drugs (Cyprus and Malta).[17] High costs associated with treatment for both viral hepatitis and HIV, where not covered by national health insurance programmes, have been reported as a further – sometimes prohibitive – barrier to treatment.

In a positive step towards addressing the high cost of hepatitis C treatment for both individuals and national health systems, in November 2018 it was announced that the Medicines Patent Pool had signed a royalty-free licence agreement with pharmaceutical company AbbVie. The license will permit the development and sale of affordable generic direct-acting antivirals (glecaprevir/pibrentasvir) in 99 low- and middle-income countries and territories.[18]

Even where national policy dictates that people who use drugs should be able to access treatment, they continue to face stigma and discrimination from health professionals when they do so. These issues are exacerbated by a lack of specialised services for other marginalised populations, such as LGBTQIA+ and indigenous people.

Amphetamine-type stimulants (ATS), cocaine and its derivatives and new psychoactive substances (NPS)

For the first time, the *Global State of Harm Reduction* dedicates sections in each regional chapter to harm reduction programmes for use of ATS, cocaine and its derivatives, and NPS. In several regions, notably North America, Asia and sub-Saharan Africa, use of ATS is increasing, though the harm reduction response to ATS remains relatively underdeveloped. A recent report by Mainline, a Netherlands-based harm reduction organisation, provides the most comprehensive review of stimulant harm reduction programmes and practices to date. [19] These include: safer smoking kits for people who smoke drugs (including crack cocaine and methamphetamine); drug consumption rooms; substitution therapies; outreach and peer-based interventions; drop-in centres; housing first; and drug-checking services, among others.[19]

Drug-checking services are reported to operate in five of the world regions (Eurasia, Latin America, North America, Oceania and Western Europe). Such services aim to reduce the harm caused by high-purity and adulterated substances by ensuring that people who use drugs are aware of what is in the substance they are taking. They include on-site services at parties and festivals, fixed-site laboratories accessible by post, walk-in services and self-testing kits. In almost every case, with the notable exception of Canada, drug-checking services only receive private funding, meaning their ability to roll out large scale programmes to meet need is limited. In Canada, drug-checking services have increasingly been integrated into safe injection sites.

The use of cocaine and its derivatives continues to be a public health concern, particularly in Latin America and the Caribbean, where prevalence of use is highest and relatively few harm reduction programmes exist to address use of these substances.

NPS present an ongoing challenge to public health and drug policy. Synthetic cannabinoids appear to be the most widespread form of NPS, and have emerged as an issue among homeless and incarcerated populations. As with ATS, the harm reduction response remains limited; for example, to drug-checking services that can identity potency and adulteration.

Drug consumption rooms (DCRs)

Drug consumption rooms, also known as safe injecting facilities or safe injecting sites (SIFs/SISs), are professionally supervised healthcare facilities where people can consume drugs in a safe and non-judgmental environment. DCRs attract hard-to-reach populations who may usually use drugs in risky and unhygienic conditions, and reduce morbidity and mortality by providing a safe environment and training people on safer drug use.

Drug consumption rooms now operate in 11 countries around the world, with Belgium implementing its first facility in 2018. Australia, Canada, France, Spain, Switzerland and Norway have also opened new sites since 2016, with at least three further countries expected to open new facilities in 2019 (Ireland, Mexico and Portugal). In total, 117 sites operate at the time of reporting, compared with 90 in 2016. The increase since 2016 is mainly due to 24 new sites opening in Canada.

While many DCRs are focused on people who use opioids and reducing the incidence of opioid overdose, others also serve populations who inject or inhale amphetamines and cocaine derivatives. For example, in the Netherlands, a number of facilities cater primarily to people who inhale drugs, in accordance with the landscape of drug use in that country. In these circumstances they ensure safe equipment is being used, and can serve as a link between people who use drugs and other health services.

Overdose

In recent years, a worrying increase in fatal drug-related overdose has been observed in some world regions. The US now has the fastest annual percentage rise of drug-related fatal overdose ever recorded, with an increase of 21.4% between 2015 and 2016 alone.[20] In Canada, opioid-related deaths have also dramatically increased: 72% of deaths involved fentanyl or fentanyl analogues in 2016, and 81% of overdose deaths in Canada were linked to fentanyl.[20,21] Fentanyl and its analogues are highly potent synthetic opioids. Canada reports 92% of its opioid-related deaths as accidental/unintentional.[21] The worrying increase in opioid-related overdose deaths has been met with a public health response which broadly encompasses the principles of harm reduction, but to differing extents in the US and Canada.

Naloxone is a highly effective opioid antagonist used to reverse the effects of opioid overdose in minutes. The medicine, which can be delivered in various ways (intra-nasal, sublingual and buccal) can, however, only be effective if accessible.[61-64] In an evaluation of community opioid overdose prevention, researchers found 83-100% survival rates post-naloxone treatment, demonstrating that non-medical bystanders trained in community opioid prevention techniques were effectively able to administer naloxone.[61] In Canada, scaled up naloxone provision and the establishment of drug consumption rooms (DCRs) or safe injecting facilities (SIFs) have been critical to the overdose response. In the US, naloxone's status as a prescription medicine creates a barrier to distribution.[26,27]

In Western Europe, overdose deaths have also increased in number since 2016.[28] An estimated 84% of overdose deaths in the region involved opioids in 2016, almost two-thirds of which occurred in Germany, Turkey and the United Kingdom.[28,29] In Turkey for example, the number of drug-related deaths almost doubled from 2015 to 2016, with a particularly stark rise in deaths related to amphetamine-type substances and synthetic cannabinoids (synthetic cannabinoids were present in one third of cases in 2016).[30] In the UK, the number of drug-related deaths continued to be among the highest on record, with a 101% rise in deaths related to heroin and/or morphine from 2012 to 2017.[31,32] High numbers of drug-related deaths have also been observed in Norway and Sweden.[28] Naloxone peer-distribution programmes currently operate in four countries in Western Europe (Denmark, Italy, Norway and the UK)[g] with take-home doses available in a further four (Germany, France, Ireland and Spain) and plans in development for take-home naloxone in three more (Austria, Cyprus and Luxembourg).[35-37]

The emergence in Europe of fentanyl should instil greater urgency in preventing drug-related deaths. While Europe is not yet experiencing the prevalence of fentanyl or fentanyl analogues seen in North America, its rise as a public health concern and the high risk of overdose adds weight to already strong arguments for increasing the availability of naloxone and DCRs.[29]

In total, peer-distribution schemes, whereby individuals can pass on naloxone without each recipient requiring a personal prescription, operate in only 12 countries in the world.[h]

Prisons

Since 2000, the world prison population has grown by 20%, faster than the increase of the general population (18%).[38] During this period, while the male prison population has risen by 18%, the female prison population has increased by 50%.[38] Despite some momentum around decriminalisation, the global response to drugs remains predominantly punitive,[20] with approximately 83% of drug offences recorded by law enforcement for simple possession.[39] Imprisoning people for drug use is not only costly, it is demonstrated to be systematically discriminatory.[40]

Very few countries have a decriminalisation model that works well in practice. In other countries, only cannabis has been decriminalised or reduced to a minor offence, e.g. Georgia[41] and several US states (although the decriminalisation of cannabis is not *federally* sanctioned in the US).[42] In others, prison terms for drug possession have been replaced with monetary fines, such as in Kyrgyzstan, Ghana and

g In the United Kingdom, this refers to a programme in Glasgow.[33] In Norway, this refers to a multi-site pilot programme.[34]
h Afghanistan, India, Estonia, Ukraine, Denmark, Luxembourg, Norway, the United Kingdom, Mexico, Canada, the United States and Australia.

Tunisia. However, reforms such as these need to be closely monitored, as at time of publication, the *minimum* fine for drug possession in Kyrgyzstan was the equivalent to 18 months' full-time salary.[43]

Prisons continue to represent high-risk environments for the transmission of blood-borne infections for a number of reasons. These include: the over-incarceration of populations (including people who use drugs) at greater risk of contracting HIV, hepatitis C and TB; risky behaviour in prisons, such as unsafe injecting drug use; inadequate healthcare and late diagnosis of disease; substandard prison conditions and overcrowding; poor ventilation and repeated prison transfers, which encourage transmission of viruses; and the absence of harm reduction services.[44,45] United Nations human rights mechanisms and the European Court of Human Rights [46] have commented on the fact that inadequate prevention or treatment of HIV, hepatitis C, TB or drug dependence meet the threshold of ill treatment and create conditions that aggravate the transmission of these diseases.[45,47]

Despite this, only 10 countries in 2018 implement needle and syringe programmes (NSPs) in at least one prison: Armenia, Canada, Germany, Kyrgyzstan, Luxembourg, Macedonia, Moldova, Spain, Switzerland and Tajikistan. In 2016, the *Global State* reported eight countries implementing programmes.[3] NSPs are entirely unavailable to prisoners in six out of the nine regions reviewed within this report.

At the time of publication, some form of opioid substitution therapy (OST) is provided in prisons in 54 countries,[i] and five countries (Afghanistan, Cyprus, Palestine, the Seychelles and Ukraine) began implementing this service since 2016. Although an increase is important progress, the quality of prison-based OST varies considerably and serious barriers, including stigma and discrimination, persistently impede access to this essential service where it does exist. OST in prison settings remains unavailable in Latin America, but this is often attributed to the low prevalence of opioid use in the region.

Availability, accessibility and quality of diagnostics, treatment and care for HIV, hepatitis C and TB in the world's prisons continue to fail to meet prisoners' needs in most countries.[48] At the same time, the fact that prisoners face a heightened risk of overdose following their release remains a very serious yet almost universally neglected issue in practice, with only five countries providing naloxone to prisoners on release: Estonia (all prisons), the United Kingdom (not routinely), the United States (two states), Canada (most prisons) and Norway (a pilot naloxone programme).

The provision of good-quality and accessible harm reduction, both inside and outside prisons, is not a policy option, but a legally binding human rights obligation.[49] It must be urgently prioritised – and resourced – by political leaders and prison authorities, and national, regional and international prison monitoring mechanisms should systematically examine issues relating to harm reduction during their prison visits.[47]

International policy and technical developments

Commission on Narcotic Drugs Ministerial Segment 2019

In 2009, member states at the Commission on Narcotic Drugs (CND) adopted the Political Declaration and Plan of Action,[50] which set the target "for States to eliminate or reduce significantly and measurably" illicit drug supply and demand within a decade.

In 2016, the UN General Assembly Special Session (UNGASS) on Drugs forged a new international agreement on drug policy. [51] The CND will convene a Ministerial Segment at its 62nd regular session in 2019[52] to take stock of implementation of the 2009 Political Declaration's commitments.[53]

The CND is yet to undertake a comprehensive review of the impacts of drug policies worldwide. However, the International Drug Policy Consortium's 2018 report *Taking Stock: A Decade of Drug Policy – A Civil Society Shadow Report* found that the targets and commitments made in the 2009 Political Declaration have not been achieved. [54] The report recommends that member states should identify more meaningful drug policy goals and targets in line with the 2030 Agenda for Sustainable Development, the 2016 UNGASS Outcome Document and international human rights commitments.

At the time of writing this report, it remains unclear what the objective is for member states as it relates to the outcome of the 2019 Ministerial Segment.

i *Asia*: Afghanistan, India, Indonesia, Macau, Malaysia, Vietnam. *Western Europe*: Austria, Belgium, Cyprus, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Malta, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, United Kingdom. *Eurasia*: Albania, Armenia, Bosnia and Herzegovina, Bulgaria, Croatia, the Czech Republic, Estonia, Kyrgyzstan, Latvia, Macedonia, Moldova, Montenegro, Romania, Serbia, Slovenia, Ukraine. *Caribbean*: Puerto Rico. *North America*: Canada, the United States. *Oceania*: Australia, New Zealand. *Middle East and North Africa*: Iran, Israel, Lebanon, Morocco, Palestine. *Sub-Saharan Africa*: Kenya, Mauritius, the Seychelles.

Global HIV Prevention Coalition

The 2016 Political Declaration on HIV/AIDS noted with alarm the slow progress in reducing new HIV infections globally.[55] Most significant for harm reduction were two commitments in the declaration:

- A 75% reduction in new adult HIV infections to less than 500,000 annually by 2020.
- For 90% of people at risk of HIV infection, including key populations, to have access to comprehensive HIV prevention services.

In order to galvanise greater commitment and investment in HIV prevention to meet the 2020 targets, the Global HIV Prevention Coalition was established in October 2017, and UNAIDS and partners developed the Prevention 2020 Road Map.[56]

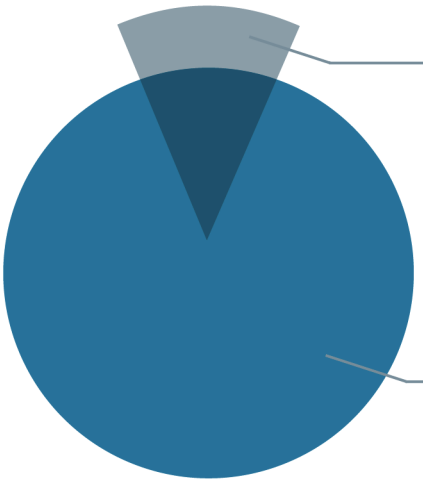
The road map provides the basis for a country-led movement to scale up HIV prevention programmes and is based on five prevention pillars. The second pillar is "combination prevention programmes for all key populations" and explicitly includes harm reduction services for people who use drugs. The road map is relevant for all low- and middle-income countries (LMICs), and focuses on 25 countries with high numbers of new infections in adolescents and adults in 2016.

Prevention scorecards were developed in order to summarise existing data on prevention progress in the priority countries. Harm Reduction International examined all 25 country scorecards[57] and concluded that 13 countries did not include data on HIV prevalence and nine did not include population estimates for people who inject drugs. It is crucial that all countries have population size estimates in order to set prevention targets and indicators for people who inject drugs.

Technical guidance

In 2017 and 2018, new guidance emerged with regard to key populations and specific groups of people who inject/use drugs, both from UN agencies and civil society

- In April 2017, a joint publication by the UN Office on Drugs and Crime, the World Health Organization, the International Network of People who Use Drugs, the Joint UN Mission on HIV and AIDS, the UN Development Programme, the UN Population Fund, the United States Agency for International Development and the President's Emergency Plan for Aids Relief was published under the title *Implementing Comprehensive HIV and HCV programmes with People Who Inject Drugs*.[58]
- In June 2017, the World Health Organization released an update to *Consolidated Guidelines on Person-centred HIV Patient Monitoring and Case Surveillance*.[59]
- In September 2017, the World Health Organization published an update to *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations*.[60]
- In October 2017, the European Monitoring Centre for Drugs and Drug Addiction published *Health and Social Responses to Drug Problems: A European Guide*, providing a reference point for planning or delivering health and social responses to drug problems in Europe.[61]
- In November 2017, the European Monitoring Centre for *Drugs and Drug Addiction and Europol published Drugs and the Darknet: Perspectives for Enforcement, Research and Policy*.[62]
- In July 2018, the World Health Organization published new *Guidelines for the Care and Treatment of Persons Diagnosed with Chronic Hepatitis C Infection*.[63]
- In July 2018, the European Centre for Disease Control and the European Monitoring Centre for Drugs and Drug Addiction published a joint report on *Public Health Guidance on Prevention and Control of Blood-borne Viruses in Prison Settings*.[64]



US$188 million allocated for harm reduction funding in 2016

In 2016, **just 13% of the required amount of funding** was allocated to harm reduction in LMICs

$1.5 billion required for effective harm reduction response

A lost decade for harm reduction funding[j]

HRI's research in 2018 found that harm reduction funding in low- and middle-income countries (LMICs) is in crisis.[4] In 2016, US$188 million was allocated to harm reduction in LMICs – the same amount as in 2007[65] and just 13% of the US$1.5 billion that UNAIDS estimates is required annually by 2020 for an effective HIV response among people who inject drugs.[66]

International donor support, which comprises the majority of harm reduction funding in LMICs, is declining. Donor governments are shifting bilateral harm reduction funding to countries in favour of contributing to multilateral institutions focused on HIV, most notably the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund). Yet this does not protect funding for harm reduction, and support from the Global Fund – which accounted for two-thirds of all donor funding for harm reduction in LMICs in 2016 – was 18% lower in 2016 than in 2011.

Our research found that 10 governments appear to be investing significantly (i.e. over $1million annually) in their national harm reduction response.[k] While encouraging, domestic investment was identified in only 19 LMICs overall, meaning harm reduction remains dangerously dependent on international donors.

To help address the funding crisis, a response is needed on all fronts. National governments should critically evaluate their drug policy spending and redirect resources from ineffective drug law enforcement to harm reduction. Our 2016 modelling shows that just a 7.5% shift in resources could bring about a 94% drop in new HIV infections among people who inject drugs by 2030.[33]

International donors must collectively increase their support for harm reduction – particularly for priority interventions like NSP and OST – to fill the sizeable funding gap. Any transition from international to domestic funding has to be gradual, with a concrete plan in place to ensure that donor withdrawal does not result in the disruption of harm reduction services.

The Commission on Narcotic Drugs recognises this dire situation, and in Resolution 60/8 urged member states and donors to continue to provide bilateral and other funding to address the growing HIV/AIDS epidemic among people who inject drugs.[31]

Unless the funding landscape for harm reduction changes urgently, the goal to end AIDS by 2030 will be missed. People who use drugs, as with other key populations, are being forgotten in the global HIV response.

Human rights and harm reduction

Since 2016, an increasing number of UN bodies and mechanisms have recognised that the right to the highest attainable standard of health requires all member states to provide quality, evidence-based and gender-sensitive harm reduction services for people who use drugs.[l]

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j This section is a summary of key findings from Cook C and Davies C (2018) *The Lost Decade: Neglect for Harm Reduction Funding and the Health Crisis Among People who use Drugs*. London: Harm Reduction International. To read the full report, please visit www.hri.global/harm-reduction-funding.

k India, China, Vietnam, Iran, Malaysia, Kazakhstan, Georgia, Ukraine, Thailand and Myanmar.

l Key human rights mechanisms have reiterated this principle, such as: the Special Rapporteur on the right of everyone to the highest attainable standard of mental and physical health; and Dainius Pūras's 'Open letter in the context of the preparations for the UN General Assembly Special Session on the Drug Problem (UNGASS), which will take place in New York in April 2016' of 7 December 2015.[49]

In March 2018, the Human Rights Council adopted a landmark resolution titled "Contribution of the Human Rights Council to the implementation of the Joint Commitment to effectively addressing and countering the world drug problem with regard to human rights".[67] This situates human rights as central to the development and evaluation of any drug policy, and calls for a comprehensive, balanced and health-centred approach to drugs.

The Human Rights Council also entrusted the Office of the High Commissioner for Human Rights with the drafting of a report on the implementation of the 2016 UNGASS Outcome Document. [51] The report, presented in September 2018, highlights best practices and human rights violations caused or enabled by repressive drug policies.[69] It notes harm reduction as an essential measure for people who use drugs, building on a growing body of literature and jurisprudence of human rights mechanisms.[69,70]

Notably, in late 2017 the Committee on Economic, Social and Cultural Rights (CESCR) expressed its concerns for the predominantly punitive approach of the Russian Federation towards people who use drugs, and condemned the absence of harm reduction programmes. The CESCR noted that "drug users tend to refrain from seeking medical treatment under the policy of criminalisation, which contributes to increased incarceration of drug users".[71]

Despite these developments, people who use drugs continue to endure a broad range of rights violations and abuses, and thus face significant obstacles in accessing health services.

The inherently discriminatory nature of punitive drug control measures was captured by the Special Rapporteur on Extreme Poverty and Human Rights, Professor Philip Alston, following his 2017 mission to the United States. In his scathing report, the Special Rapporteur blasted the country's "confused and counterproductive drug policies", condemning the predominantly punitive response to drug use and the "racial undertones" of this "urge to punish rather than assist the poor".[72]

Discrimination and prejudice, and ill-informed approaches to problematic drug use continue to result in systematic violations of the right to physical autonomy of people who use drugs, which also encompasses a right to refuse medical treatment. One manifestation of this violation is the implementation of drug courts.

Two recent reports critically reviewed the adequacy, effectiveness and cost-effectiveness of drug courts in the Americas, and questioned the alleged voluntary nature of the treatment imposed.[40,41] The studies revealed that in many cases court officials with no health expertise prescribe questionable forms of treatment to individuals who do not require it, while failing to address the needs of those who would actually benefit from treatment. As one report concludes, "drug courts aggressively insert the penal system into people's private and family lives and into their decisions about their health and medical care, reproducing and perpetuating the criminalisation of people who use drugs".[73]

Compulsory detention of people who use drugs remains virtually unopposed in many regions of the world. While these programmes vary, all are characterised by forms of ill-treatment, physical and mental abuse, denial of adequate food and water, poor sanitary conditions, imposition of treatment with no basis of scientific evidence, and sometimes sexual abuse and forced labour.

Compulsory drug detention centres are found in many countries in Asia – such as Laos, Cambodia, China, Malaysia,[74] Nepal[75] and Vietnam – where in 2017, almost 18,000 individuals were confirmed to be undergoing compulsory programmes under court orders.[76] Similar rights-violating programmes are reported in Latin America and the Caribbean, where many are kept in "comunidades terapeúticas", ostensibly providing treatment and rehabilitation while in practice imposing inhuman forms of drug treatment centred around deprivation and forced labour.

Finally, egregious human rights violations continue in the form of sentencing people to death for non-violent and often minor drug offences, the militarisation of anti-drug efforts, and campaigns of extrajudicial killings against people who use drugs. The brutal crackdown on drugs launched in the Philippines in 2016 continues unabated, with over 20,000 people killed since President Rodrigo Duterte came to office.[5] Bangladesh's prime minister called for a crackdown on drugs in May 2018, resulting in in over 260 suspected extrajudicial killings and tens of thousands of arrests.[77]

UN agencies and civil society continue to condemn human rights violations under the auspices of drug control. UN Human Rights Commissioner Michelle Bachelet stated in her first address to the Human Rights Council in September 2018 that: "Drug issues everywhere are best tackled through a focus on health, edutcation and opportunities – not the death penalty, or death squads".[78]

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