

Regional Overview

2.5 Latin America



Table 2.5.1: Epidemiology of HIV and viral hepatitis, and harm reduction responses in Latin America

Country/territory with reported injecting drug use	People who inject drugs	HIV prevalence among people who inject drugs(%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs(%)(¹)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%) (¹)	Harm reduction response ⁱ			
					NSP ^a	OST ^b	Peer-distribution of naloxone	DCRs ^c
Argentina	8,144 ^[1]	3.5 ^[2]	4.8 ^[3]	1.6 ^[3]	x ^{d[4]}	✓(1)(M) ^[4]	x	x
Bolivia	nk	nk	nk	nk	x	x	x	x
Brazil	nk ^e	9.9 ^{f [5]}	nk	nk	x ^{d[4,6]}	x	x	x
Chile	nk	nk	nk	nk	x	x	x	x
Colombia	14,893 ^[7]	5.5 ^[8]	31.6 ^[8]	nk	✓ ⁽⁹⁾	✓(M) ^[9]	x ^g	x
Costa Rica	nk ^h	nk	nk	nk	x	✓(1)(M) ^[9]	x	x
Ecuador	nk	nk	nk	nk	x	x	x	x
El Salvador	nk	nk	nk	nk	x	x	x	x
Guatemala	nk	nk	nk	nk	x	x	x	x
Honduras	nk	nk	nk	nk	x	x	x	x
Mexico	164,157 ^[13]	4.4 ^[14]	96 ^{k [15]}	0.2 ^[3]	✓6 ⁽¹⁹⁾	✓(6)(M) ^[12,16]	✓ ^[12]	x ^m
Nicaragua	nk	nk	nk	nk	x	x	x	x
Panama	5,714 ^[17]	nk	nk	nk	x	x	x	x
Paraguay	nk	nk	9.8 ^[18]	nk	x	x	x	x
Peru	nk	nk	nk	nk	x	x	x	x
Uruguay	nk	nk	nk	nk	x ^{d[4]}	x	x	x
Venezuela	nk	nk	nk	nk	x	x	x	x

nk – not known

a All operational needle and syringe exchange programme (NSP) sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = pharmacy availability.

b Opioid substitution therapy (OST), including methadone (M), buprenorphine (B) and any other form (O) such as morphine and codeine.

c Drug consumption rooms, also known as supervised injecting sites.

d In Argentina, Brazil and Uruguay, needle and syringe programmes previously operated when injecting cocaine use was more prevalent. However, as injecting drug use declined, these programmes have since closed or been redirected towards harm reduction for non-injecting drug use.^[4]

e Unpublished data from a national household survey coordinated by Francisco Bastos found very little evidence of injecting drug use in Brazil.

f Based on data collected in 2009 in eight Brazilian cities

g Between 2015-2017, naloxone peer distribution networks existed in Colombia, but the programme was closed in January 2018.

h Civil society organisations indicate that injecting drug use is minimal in Costa Rica.^[10]

i Based on data from 2011 National Addiction Survey. There may be limitations to the representativeness of this data, as household surveys are known to exclude people living outside traditional households, such as people who are homeless or incarcerated.^[11] Civil society organisations believe that this figure may be an overestimate, with the true number of people who inject drugs in the country being around 30,000.^[12]

j Based on data collected in 2006-2007.

k Based on data collected in 2005.

l Of these, four NSPs operate year-round and two for six months per year.

m Though no official DCRs exist in Mexico, a small facility exclusively serving women exists in Mexicali, Baja California.^[12]

Map 2.5.1: Availability of harm reduction services



Harm reduction in Latin America

Overview

There are approximately 4.5 million people who use illicit drugs excluding cannabis in Latin America,ⁿ and levels of injecting drug use are very low compared with other regions.^[3] This is largely due to the fact that injecting opioid use has been confined to the US-Mexico border and Colombia, and is not widespread elsewhere.^[19,20] In other parts of the region, cocaine injection has historically been more common than opiate injection, but currently is relatively rare.^[1,6] Conversely, Latin America has the world's highest levels of smokable cocaine use,^[21] and this is therefore the focus of much of the harm reduction effort in the region. Innovative harm reduction responses in the region are also increasingly tailored towards people who use amphetamine-type substances (ATS), in line with growing prevalence of ATS use in the region.

Data on drug use in Latin America, especially injecting drug use, is scarce and there is a clear need for more research in this field. Civil society organisations report that states in the region do not regularly or systematically collect data on injecting drug use and people who use drugs, meaning that policies are often built on minimal, inaccurate and out-of-date evidence that has little relation to reality.^[22] Based on the limited data available, prevalence of HIV, hepatitis C and tuberculosis are all higher among both people who inject drugs and non-injecting drug users than the general population. However, prevalence varies considerably across the region, as demonstrated in Table 2.5.1.

Latin America and the Caribbean is the only world region in which use of cocaine derivatives is greater than that of opioids.^[3] Almost all the world's coca leaf cultivation takes place in just three Latin American countries – Bolivia, Colombia and Peru – and prevalence of the use of cocaine and its derivatives in the region is among the highest in the world.^[3,21] Harm reduction programmes for people who use non-injectable cocaine derivatives are in place in several countries in the region, with a particular focus on use of the smokable forms of crack cocaine and cocaine paste.^o For example, the Casa Masantonio project in Buenos Aires, Argentina and the Casa Normal project in Rio de Janeiro, Brazil both offer advice and support on accommodation, employment and legal proceedings to people who use cocaine derivatives.^[2,24] Elevated prevalence of HIV and other blood-borne diseases have been

observed among crack and cocaine paste users, and have been associated with higher-risk sexual practices.^[25-27] The Casa Masantonio project, funded by the city of Buenos Aires, also offers HIV, hepatitis C, tuberculosis and syphilis treatment to cocaine paste users free of charge.^[24]

In recent years a slight increase in opiate use across Latin America has coincided with an increase in opium poppy cultivation in Mexico, Colombia and Guatemala.^[3,19] In 2016, a small population of people injecting opiates was identified for the first time in Mexico City.^[20] However, opiate use remains uncommon outside northern Mexico and Colombia.^[12,19,20] Harm reduction programmes for people who inject drugs, including opioid substitution therapy (OST) and needle and syringe programmes (NSP), operate in the Mexican and Colombian cities where injecting drug use is most prevalent. Developments since 2016 have been mixed: some NSP services in Mexico have been expanded to open year-round, but sites in Bogotá and Dosquebradas in Colombia have been closed.^[12,16,23]

A range of harm reduction services for ATS and new psychoactive substances (NPS) have been implemented in Latin America. Since 2012, the Colombian Échele Cabeza (Use Your Head) project has operated drug-checking services at festivals and raves to test samples of ATS and NPS for purity.^[28,29] Between 2012 and 2015, the organisation saw a 25% reduction in adulterated samples and a 50% reduction in emergency room visits due to ATS use in Bogotá, which civil society organisations attribute in part to the success of harm reduction interventions.^[30] However, in 2016 the incoming mayor of Bogotá ended support for these projects.^[16] Similar services, supplemented by hydration points, staff training workshops and awareness-raising campaigns, also now operate in Argentina, Brazil, Mexico and Uruguay.^[4,31]

There are examples from recent years of progress towards less punitive drug policies in Latin America. Colombia's supreme court ruled that individuals should not be automatically criminalised for possession of illicit drugs for personal use in 2012, and Uruguay became the first country to legalise cannabis for non-medical use in 2013.^[32,33] However, since 2016, concerning political developments have restricted harm reduction programmes and space for civil society engagement with governments.^[34] For example, a new government in Brazil has explicitly

n This is a cumulative figure based on UNODC estimates of the number of opioid, cocaine and amphetamine users in Latin America, and does not account for poly-drug use.

o Also known as basuco, paco, base paste or oxi, cocaine paste is an intermediate product in the production of cocaine. It is marketed as a cheaper alternative to cocaine in South America.

rejected harm reduction as a response to illicit drug use and closed successful programmes, replacing them with abstinence-based, rehabilitation and law enforcement-led projects.^[6,35] The election of Iván Duque as president in Colombia in June 2018 was met with concern by civil society organisations who fear a resurgence of prohibitionist policies.^[22] Similar developments have occurred in local government, with newly elected city-level administrations in Bogotá, Colombia and São Paulo, Brazil also rolling back harm reduction projects.^[4,16,36] In several other countries in the region, such as El Salvador and Guatemala, the response to drug use continues to be dominated by abstinence-centred programmes, often led by non-specialist and religious organisations.^[37,38] Across the region, rehabilitation centres continue to operate with little or no oversight by health authorities, meaning that the human rights of people who use drugs can be neglected with impunity.^[22]

With reductions in funding from some donors in the region, including the Global Fund, the funding landscape for harm reduction in Latin America is increasingly difficult. With some exceptions, such as the Colombian government taking responsibility for funding certain NSPs, national governments have failed to meet the funding shortfall left by the departure of these international donors.^[22,39] An additional funding challenge for programmes in Latin America is that internationally funding for harm reduction is largely drawn from HIV prevention budgets. As injecting drug use is low, many harm reduction programmes do not have an HIV component and therefore have limited funding opportunities.^[9,12,16]

Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

Although the prevalence of injecting drug use is low, the Latin America and the Caribbean region has one of the lowest per user rates of needle distribution in the world. Where injecting drug use has been identified, only between 0.1-0.5 needles are distributed per person per year, compared with the World Health Organization (WHO) recommendation of 200.^[40] Since the *Global State of Harm Reduction* last reported, developments in the region have been mixed. NSPs are known to operate in Colombia and Mexico, but in other countries with very low prevalence of injecting drug use, such as Costa Rica, they are largely deemed unnecessary.^[6,10]

Outside Colombia and Mexico, injecting cocaine was prevalent two decades ago and has been more common than opiate injecting; however, levels today are very low. Cocaine injection is associated with a higher risk of blood-borne infection transmission, due to the greater frequency of injection.^[41] In parts of the region where cocaine injection has been prevalent, for example in Argentina, Brazil and Uruguay, NSPs have served these populations. However, as injecting drug use in these countries declined to minimal levels, these services closed or were redirected towards harm reduction for non-injecting drug use.^[4,42] This therefore represents a decline in the need for NSP services for this population, rather than a decline in harm reduction service provision.

Needle and syringe programmes have operated in Colombia since 2014, in the cities of Cúcuta, Cali, Pereira, Dosquebradas and Bogotá.^[4,16] The sites have served over 2,000 individuals during the course of their operation.^[16] Though the sites in Bogotá and Dosquebradas closed in late 2017, NSPs still operate in Cali, Cúcuta and Pereira. However, services are intermittent due to unreliable revenue streams and cash flow issues.^[4,16,23] In Pereira, civil society organisations report that opening hours, dress codes and locations for sites have been heavily regulated, and people who use drugs are required to provide official identification in order to receive safe injecting materials.^[16,22,23] No NSP services exist in Medellín due to significant local government opposition, despite this being the Colombian city with the highest population of people who use drugs.^[16]

According to a study carried out by Verter in Mexico, there are six active NSPs, at least one of which exclusively serves women who inject drugs.^[12] These sites have seen an expansion in their services since 2016: four now operate year-round, whereas before 2016 all but two only operated for six months of the year.^[12] All are run by civil society organisations, such as Verter and PrevenCasa, and funded by the national HIV prevention body.^[12] In Tijuana, an unusually high prevalence of use of high dead-space syringes has been noted.^[43] These are associated with a greater risk of blood-borne virus transmission through syringe-sharing than low dead-space syringes, due to the larger volume of blood left in the needle after injection.^[43,44] To address the risk of blood-borne virus transmission in this particularly high-risk group, the Tijuana NSP operated by PrevenCasa distributed approximately 50,000 syringes to the estimated 10,000 people who inject drugs in the city in 2015.^[45] This remains considerably below the WHO recommendation of 200 needles per person who injects opiates.

A primary barrier to accessing NSPs in Mexico is law enforcement. Despite the possession of needles and syringes being legal, police are known to destroy needles when interacting with people who inject drugs, therefore decreasing the effectiveness of NSPs and increasing the risk of unsafe practices such as needle-sharing.^[12,45] To ensure the effectiveness of NSP programmes in Mexico, greater cooperation between health services and law enforcement is necessary. Other key barriers to access to NSPs include the fact that syringes provided by the government are not the gauge preferred by people who inject drugs, and government funding is limited to nine months of the year.^[23]

From 2015 to 2018, Verter has operated three sites specifically serving women who inject drugs in Mexico, funded by a private women's rights foundation, Fondo Semillas. The programme, called Las Colectas, provides sexual and maternal health services, and support and care groups. Across the three cities, 100 women are estimated to attend the services regularly, and there are plans to share experiences with other organisations with the aim of expanding the service.^[12]

Despite the low prevalence of injecting drug use in the region, there is still a clear need for NSPs to facilitate safe injecting practices among those who do inject drugs. A recent government study found that 41% of people who inject drugs in Colombia had shared a needle in the preceding six months.^[7] In Argentina the figure is 32% for those who had ever injected drugs in their lives.^[1]

Opioid substitution therapy (OST)

Latin America has one of the lowest levels of OST provision per person who injects drugs in the world,^[40] with OST available in Colombia, Costa Rica, Argentina and Mexico.^[4,9,10,12,16,22,46] This lack of provision reflects the low prevalence of opioid use in the region.

OST is publicly available in Colombia, in the form of 10mg and 40mg methadone pills.^[9,16,22] However, significant barriers to accessing OST in the country have been noted, and it is increasingly used as part of a detoxification process rather than for harm reduction.^[9] Demand for OST outstrips the capacity of the few existing facilities, formal identification is necessary to join the state health insurance programme, there are long waiting times for appointments with specialists, and many medical practitioners and patients still consider methadone therapy to be a case of replacing one addiction with another.^[22] Women who inject drugs have been known to be excluded from OST centres, where

some practitioners consider them to be difficult patients and even a distraction to the rehabilitation of men.^[22] Additionally, stocks of methadone in the country have been known to encounter difficulties in reaching communities, leading to people who use opioids reverting to sourcing heroin or unregulated methadone from the black market.^[16,23]

In Mexico, methadone is also available for OST. However, it can only be purchased privately at a cost to the person, and is only available at six centres in the three cities where injecting drug use is most concentrated: Tijuana, Mexicali and Ciudad Juárez.^[12] Since 2016, methadone clinics in Nogales and San Luis Río Colorado have been closed due to a lack of government funding.^[12] In Argentina, OST is available in both public and private institutions in Buenos Aires.^[4] In Costa Rica, a single facility provides OST to a small number of people, including pain and palliative care patients, and healthcare professionals who use non-prescription opioids.^[10]

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

Harm reduction in nightclubs and festivals

In five Latin American countries (Argentina, Brazil, Colombia, Mexico and Uruguay), harm reduction interventions have been developed for the use of amphetamine-type substances (ATS) and new psychoactive substances in nightclubs and festivals.

Since 2012, Colombian NGO Acción Técnica Social has operated its Échele Cabeza (Use Your Head) drug-checking project at festivals and raves.^[29] To date, the project has tested over 4,000 samples, with 75% of 2CB samples, 12% of ecstasy pills and 13% of MDMA powders testing negative for any trace of the expected drug.^[16,28] Over 80% of service users chose not to consume samples that had tested negative, and from 2012-2017 the organisation saw a 25% reduction in adulterated samples and a 50% reduction in emergency room visits due to ATS use in Bogotá, which they attribute in part to the drug-checking service.^[30] However, due to a lack of state funding, the project can only operate where private actors are willing to pay for the service, meaning that the most at-risk populations cannot access the services.^[4,16]

Following the deaths of five young people due to stimulant use at a rave in 2016, civil society organisations

in Argentina successfully lobbied the city government in Buenos Aires to support them to carry out harm reduction interventions at festivals and raves.^[4] Since early 2018, Proyecto Atención en Fiestas (PAFI) has been financially backed by the city and national governments to attend 28 events, where it has distributed informational flyers, condoms, fruit and sweets.^[4,56] A motion was unanimously passed by the municipal council in Rosario to allow state-sanctioned testing of pills in bars and nightclubs, but was rejected by the city's executive.^[57,58]

Drug-checking and information services have been operating in several Brazilian cities since 2011, in coordination with the Brazilian Harm Reduction Association (ABORDA).^[4,59,60] Civil society organisations report that at least 31 such initiatives operate in the country, though they receive no public financial support and rely on volunteers and private funding.^[4] In Uruguay, a drug-checking facility operated at an electronic music rave for the first time in 2016,^[61] and the National Drugs Board has provided funding for harm reduction measures (including hydration points, specialised training for staff and awareness-raising campaigns).^[62] Drug-checking programmes are also operated in Mexico by the ReverdeSer Colectivo, where ATS use has increased significantly in the last ten years.^[4,12,63]

The World Drug Report 2017 notes that the use of hallucinogenic new psychoactive substances is increasing in South America, in particular derivatives of the psychedelic 2CB, a series of compounds whose use is associated with harmful and life-threatening intoxications.^[3] In both Chile and Colombia, evidence has been found that samples sold as LSD actually contained 2CB.^[3] The Échele Cabeza programme in Colombia found that 33% of LSD samples tested negative for LSD.^[28]

Harm reduction services in nightclubs and festivals, particularly drug-checking, have been shown to be an effective way to reduce harm and deaths caused by illicit drugs. The introduction, expansion and funding of such projects has the potential to save many lives, and should therefore form part of the national drug strategy for all countries in the region.

Latin America has high prevalence of use of three forms of coca leaf derivatives: cocaine powder, crack cocaine and cocaine paste.^[19] Crack cocaine and in particular cocaine paste are reported to be the most commonly used substances among many socio-economically deprived people who use drugs in Latin America.^[21] Use of cocaine paste has been

noted across South America, having previously been confined mostly to Colombia and Peru.^[16,47] A 2015 study by the Organisation of American States found that crack cocaine use was higher in Central America, with general population prevalence in the region of approximately 0.3%.^[19] Brazil is thought to be home to more crack users than any other country in the world, with an estimated 370,000 in 2014,^[36] while Colombia is the world's largest cocaine powder producer and has the lowest-priced cocaine powder in the world (€5.40/gram).^[3,48]

A key issue highlighted by harm reduction organisations is purity. Acción Técnica Social have found that only 4% of powder cocaine samples they tested at raves and festivals in 2017 contained more than 75% cocaine, and 5% contained no cocaine at all.^[28] Frequent adulterants include levamisole, caffeine, local anaesthetics and dairy products.^[16] Similarly, a 2015 study of the purity of smokable cocaine found proportions of adulterated samples ranging from 28.2% in Chile to 89.5% in Uruguay. Adulterated samples most often contained phenacetin, a local anaesthetic considered to have carcinogenic properties. Other common adulterants included caffeine and analgesics such as aminopyrine, paracetamol and lidocaine.^[49]

A diverse range of facilities aiming to reduce and mitigate the consequences of crack and cocaine paste use, rather than eliminate it, exist across Latin America.^[50] These range from low-threshold harm reduction services providing food, shelter and basic hygiene in Costa Rica^[10] to more extensive programmes among people who use crack and cocaine paste in Argentina, Brazil and Uruguay. The Casa Masantonio project, opened in 2016 in Buenos Aires, Argentina, provides people who use cocaine paste with HIV, hepatitis C, tuberculosis and syphilis testing and treatment, as well as advice related to accommodation, employment, relationships and legal proceedings.^[24] This is all provided free of charge, funded by the city of Buenos Aires.^[4] As of May 2018, it had an adherence rate of 92%.^[4] A similar service for crack and alcohol users, Casa Normal, opened in 2018 in Rio de Janeiro, Brazil.^[4] In Colombia, an initiative reducing harm among people smoking cocaine paste previously operated in Bogotá, but was closed in early 2017 by the new mayor.^[16] Acción Técnica Social in Colombia has developed an as-yet unfunded project to distribute safer pipes to cocaine paste users, and to use coca leaves for substitution therapy.^[16] Pilot projects have operated in Brazil, Colombia and Uruguay using cannabis as a means of controlling crack cocaine use.^[34]

A recent report from Mainline, a Netherlands-based harm reduction organisation, highlighted projects that view the use of cocaine derivatives as a symptom of wider social challenges, and implement a harm reduction approach. The Atitude project in four cities in the Brazilian state of Pernambuco is fully financed by the state government to assist people who use crack cocaine.^[51] It provides four services. An outreach service in areas with a high level of drug-related crime offers information, water, condoms and family counselling. Night shelters and drop-in centres provide around 30 clients per day with a space to sleep, wash and attend workshops, as well as eat two meals per day. Intensive shelters offer stays of up to six months with joint meals, housekeeping tasks and participation in groups and workshops, where people can acquire skills which can be used in the labour market. One intensive shelter is for use only by women and transgender women who use drugs, with a focus on those threatened by violence, who are pregnant or who are mothers. Finally, Atitude offers an independent social housing programme, which provides accommodation at low rent for up to one year, and also includes a monthly food parcel.^[51] In evaluations of the project, Atitude's clients report increased self-care, strengthened family relations, increased sociability and protection against violence, and a feeling of being welcomed and respected.^[51,52] These effects are particularly strong among those enrolled in the social housing programme.^[51] Substance use is not permitted within the project's facilities, as this would risk closure of the project, but clients are permitted to leave the building to use drugs, and are not excluded for ongoing drug use.^[51] While providing a positive experience to clients able to access the service, Atitude is consistently over-subscribed and cannot provide services to all people who use crack cocaine who need them.^[51] Staff are also concerned that current political developments in Brazil may create a considerably more challenging legal and financial environment for the project in the future.^[51]

Another project, Achique de Casavalle, provides support for social and labour-market integration to people who use cocaine paste in Montevideo, Uruguay. Funded by a mixture of city, state and national government bodies, the project provides a low-threshold drop-in centre, where service users prepare and eat meals together, can access personal hygiene and therapeutic services, and attend group leisure activities, as well as employment-oriented courses including computer use, carpentry and construction.^[51] Like Atitude, Achique de Casavalle focuses on increasing the self-esteem, independence and autonomy of its clients. However, it also suffers from a lack of resources: there is no computer or internet connection on site, and it lacks the staff

necessary to accompany clients to referral services. Staff at the project also report that access for women is insufficient. Many women who use cocaine paste in the area are mothers, but Achique de Casavalle is unable to accommodate children.^[51]

In the 2016 edition of the *Global State of Harm Reduction*, it was reported that the De Braços Abertos (Open Arms) project in so-called Crâcolândia, a stigmatising name for the open crack scene in São Paulo, Brazil, was to be closed under the city's new mayor, João Doria.^[29] Since then, De Braços Abertos has been replaced by the new Redenção (Redemption) project. Whereas De Braços Abertos provided health, employment and accommodation support to people who use crack with no precondition of abstinence or treatment,^[29] Redenção rejects the harm reduction approach.^[4] There have been reports that it requires that participants abstain from crack use and undergo mandatory drug tests or face eviction from the programme, though civil society organisations report that this has not yet happened.^[53,54] In its first eight months, Redenção saw an adherence rate of just 17%.^[55] In early 2017, there was a significant armed police operation to clear Crâcolândia. Local health workers have been recorded as saying that this operation increased mistrust of state services among people who use drugs, meaning they are less likely to access remaining health and harm reduction services.^[36] Projects similar to De Braços Abertos continue to operate elsewhere in Brazil, but many across the country have faced similar repressive government action since the 2016 municipal elections.^[6]

Overdose, overdose response and drug consumption rooms (DCRs)

Since the *Global State of Harm Reduction* last reported in 2016, opioid overdose response mechanisms in Latin America have stalled or reversed. Naloxone, a highly effective opioid receptor antagonist used to reverse the effects of an overdose, had previously been available outside hospitals in Paraguay, Colombia and Mexico.^[12,22,64] Despite being on the WHO List of Essential Medicines,^[65] there is no indication it remains available in Paraguay in any context. In Colombia, a naloxone peer-distribution programme operated by Acción Técnica Social saved 70 lives from 2014 to 2017, and included peer training in naloxone use and distribution.^[16] However, this programme was discontinued in 2017 due to Ministry of Health regulations stating that naloxone is only available for use in hospitals.^[16,22] New Ministry of Health guidelines on naloxone were due to be published in 2017, but there is no sign of their publication.^[16,22]

In Mexico since 2016, naloxone has been made available in Tijuana, Mexicali, San Luis Río Colorado and Ciudad Juárez. In Mexicali and San Luis Río Colorado, Verter has established peer distribution networks for naloxone, and La Casa del Centro has created a network in Tijuana.^[12,23] At the time of publication, distribution of naloxone has been minimal, with only 200 doses distributed in Verter's programmes.^[12]

Naloxone's availability remains highly limited across the region. The primary barriers to its distribution are a lack of funding and restrictive legislation.^[12,22] Naloxone has been shown to be highly effective in reducing overdose deaths, particularly when doses and training are made accessible in the community.^[66] For this reason, peer distribution of naloxone, such as the limited programme in Mexico, should form part of the harm reduction programme in those areas in the region where opiate use is prevalent.

Although no state-sanctioned drug consumption rooms exist in the region, a small facility run by Verter in Mexicali, Mexico provides a safe space for women to inject drugs as part of the Las Colectas project.^[12] The facility is limited to those already involved in other Las Colectas programmes for women who inject drugs.^[12] Civil society organisations note that they expect the region's first official drug consumption room to open in Mexicali in 2018,^[12] and that debates were held on their implementation in the Colombian congress in 2017.^[9,22] However, during the 2017 presidential campaign, the new president of Colombia, Iván Duque, committed to blocking the introduction of such facilities.^[16]

Viral hepatitis

Data on viral hepatitis among people who inject drugs is sparse and largely outdated in Latin America. Hepatitis C prevalence among people who inject drugs in the region has been recorded ranging from 6.7% in Bogotá, Colombia to 96% in two cities in Mexico, with a pooled regional prevalence of 49% according to a 2015 systematic review based on research carried out between 2000 and 2013.^[7,67] This is in line with the worldwide estimated prevalence of hepatitis C among people who inject drugs of 50%.^[67,68] The same systematic review estimated hepatitis B prevalence of 3.3% among people who inject drugs in the region.^[67,68]

The integration of viral hepatitis services with HIV and harm reduction services remains sporadic in Latin America. In northern Mexican cities where injecting drug use is more common, state-funded hepatitis C diagnostics and treatment are available to

people who inject drugs^[12]. By contrast in Colombia, hepatitis C services are only intermittently integrated with HIV and harm reduction services.^[9,16]

Four Brazilian studies published since 2016 have found evidence suggesting people who use crack and cocaine paste are also more vulnerable to viral hepatitis infection. Studies have suggested that this is associated with sharing pipes (with blood transferred from bleeding lips or gums) as well as higher-risk sexual practices.^[25-27,69,70] The Casa Masantonio project in Buenos Aires, Argentina opened in 2016, and integrates hepatitis C treatment into harm reduction services for cocaine paste users.^[24]

The need to address viral hepatitis among people who use drugs is clear from Table 2.5.1. It is essential that diagnosis and treatment is routinely integrated into harm reduction services, and that more data is collected on viral hepatitis prevalence among people who use drugs.

Tuberculosis (TB)

TB incidence in Latin America is generally high and stable. For example, in 2016 there were 117 cases per 100,000 people in Peru and 42 per 100,000 in Brazil, representing only minimal declines since 2014.^[71] Although data on TB prevalence among key populations is lacking, research suggests higher prevalence among people who inject drugs and prisoners than the general population.^[3,72]

TB testing and treatment is generally available across the region; for example it is offered free of charge or on state insurance in Brazil, Argentina and Peru.^[24,73,74] However, targeted TB services for people who use drugs are lacking. TB diagnosis and treatment is not integrated into HIV or harm reduction programmes for people who inject drugs in Colombia or Mexico.^[12,16] As with viral hepatitis, cocaine paste and crack use is associated with higher TB prevalence. The Casa Masantonio project in Buenos Aires, Argentina, integrates TB in its work with cocaine paste users.^[24]

HIV and antiretroviral therapy (ART)

In Latin America, new HIV infections among the general population have plateaued since 2010 having previously been declining, though small decreases were noted in 2015 and 2016.^[39] There is considerable variation in trends across the region: Colombia and Nicaragua both saw decreases of over 10% in the number of new HIV infections between 2010-2016; Chile, Costa Rica, Guatemala and Honduras all saw increases of more than 10%.^[39]

Of particular concern for HIV response in the region is the case of Venezuela. Since the escalation of the deep political and economic crisis in 2015, HIV prevention has largely collapsed, with 95-100% of hospitals holding no stock of antiretroviral drugs and the government unable to supply even basic means of prevention such as condoms.^[75,76] Isolated and indigenous communities have been particularly affected, with HIV prevalence of around 10% and rising by 10% each year in some communities, with no state capacity to respond to the epidemic.^[77]

Data on HIV among people who inject drugs is scarce. A Colombian study published in 2017 estimated HIV prevalence among people who inject drugs in the country at 5.5% (compared with the general population prevalence of 0.4%).^[8,78,79] In several countries, including Costa Rica, Mexico and Colombia, ART is unavailable or limited for people currently using drugs despite being available to the general population, with a lack of adherence cited as a reason.^[9,10,12] This is in contrast to evidence from several studies suggesting there is no clear link between drug use and ART adherence, particularly when the person is receiving OST.^[80-82] Additionally, in Colombia people must provide formal identification in order to access ART, making people who use drugs less likely to access services for fear of criminal repercussions and social stigma.^[16] Recent developments in the region have made pre-exposure prophylaxis and post-exposure prophylaxis for HIV – courses of medication that can reduce the chances of HIV infection either before or after exposure to the virus – available to key populations such as men who have sex with men. However, neither is currently available to people who inject drugs anywhere in the region.^[39]

High HIV prevalence has been found among crack and cocaine paste users as well as people who inject drugs. A 2017 study found prevalence of 2.8% among people who use crack in Goiás, Brazil, compared with a national general population prevalence of 0.6%.^[69,79] It is suggested that this is associated with pipe-sharing and higher-risk sexual behaviour, as has been shown by studies in Mexico and Brazil.^[25-27] HIV treatment is integrated into harm reduction services for cocaine paste users in the Casa Masantonio project in Buenos Aires, Argentina;^[24] however, outside this example, the population remains underserved in terms of a specialised response to HIV.

Harm reduction in prisons

As of 2016, there were approximately 1.4 million people incarcerated in Latin America, with a total

incarceration rate of 242 per 100,000.^[83] This population has grown over the past decade, but the growth of the population incarcerated for drug offences has been significantly faster. In Brazil from 2006-2014, the general population grew 8%, the prison population grew 55% and the population of people imprisoned for any drug offence grew 267%.^[84] In Colombia from 2000-2015 the figures are 19%, 142% and 289% respectively.^[84] In Argentina from 2002-2014 they are 13%, 49% and 127%.^[84] It is estimated that 20% of the region's prisoners have been detained for drug-related offences.^[84] The specific drugs involved vary by country. For example, in Colombia the most common is cocaine (47% of cases), while in Mexico and Brazil it is marijuana (62% of cases in both).^[84,85]

Though drug use and/or possession for personal use is decriminalised in some Latin American countries, these laws are often not implemented by law enforcement at street level.^[84,86,87] In practice, consumption and possession for personal use remain criminalised. Across the region, it is estimated that 25% of those in prison for drug offences in Latin America are there for crimes related to consumption.^[84,85]

Of particular concern is the rapid increase in the number of women incarcerated for drug offences. In Latin America, women are more likely than men to be convicted of non-violent drug offences, occupy low levels in the drug trade and tend to be primary caregivers.^[84,88] For example, since 1991, the number of female prisoners in Colombia has increased by 5.5 times (compared with 2.9 times for men) and 93% of women in prison are thought to be mothers.^[89] As a result of this trend, which is replicated across the region, a phenomenon has been noted in Argentina and Bolivia of children of women incarcerated for drug offences living inside detention centres with their mothers.^[90,91] Approximately 600 children as old as 12 were living in Bolivian prisons with one or both parents in 2017.^[92] A recent Inter-American Commission on Human Rights report recommended that states take gender into account in the judicial treatment of women who use drugs and women in the drugs trade, in order to limit the wider effects of incarceration on children and families.^[88]

The region has a high proportion of prisoners in pre-trial detention.^[84,88] In some countries, for example Mexico, pre-trial detention is obligatory for all drug offences (including possession and consumption). In others, such as Costa Rica, where pre-trial detention is not obligatory, it is often extended for drug offences.^[84,93] This practice of applying compulsory pre-trial detention to a specific category of offence has been condemned by the Inter-American

Commission on Human Rights, on the grounds that it frequently represents a punishment disproportionate to the crime committed.^[88]

Many Latin American prisons are characterised by overcrowding, violence, and scarce hygienic and medical resources.^[84,86,94] HIV, hepatitis C and TB prevalence are all elevated among Latin American prisoners compared with the general population, with health risks also transferred to non-prisoners who visit or work in prisons.^[84] A recent study of prisoners in Argentina found an HIV prevalence of 2.68%, rising to 44.6% among prisoners with a lifetime incidence of injecting drug use. This pattern was mirrored in the prevalence of both hepatitis C and hepatitis B.^[72]

Access to harm reduction services for people who inject drugs in prisons is severely limited; currently no country in Latin America offers NSP or OST in prison. Prior to 2016, NSP services operated in two Mexican prisons (in San Luis Río Colorado and Mexicali).^[12] As of 2018, however, neither Mexico nor Colombia, where NSP and OST are available to the general population, offer NSP or OST in prisons.^[12,16,22] Condoms, HIV testing and ART are available in both Mexican and Colombian prisons, but hepatitis C treatment is available in neither.^[12,16]

As in the continent at large, injecting drug use is largely absent from prisons in most countries in the region.^[10] However, use of cocaine (as powder, crack and paste) has been documented in the region's prisons.^[10,72,95] Harm reduction services for people who use cocaine are also largely absent in this setting.

Since 2012, drug treatment courts have operated in several countries in the region, with the aim of removing people who use drugs from the penal system. This option officially is available only to first-time offenders with diagnosed drug dependence, though it is frequently used for people accused of simple possession.^[94] However, an emphasis on abstinence and drug testing limits both the efficacy and the harm reducing potential of these programmes.^[94] The Inter-American Commission on Human Rights has noted that the use of drug courts in parts of the region has resulted in the criminalisation of drug possession or use, rather than providing a public health alternative to the criminal process.^[96]

As noted in the *Global State of Harm Reduction 2016*,^[29] privately run (though sometimes publicly funded) forced rehabilitation centres that violate the human rights of people who use drugs exist in several countries in Latin America. This continues despite the practice being condemned by the UN Special

Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, and the UN Special Rapporteur on health. In most, medication for withdrawal and even trained medical staff are unavailable.^[97]

Policy developments for harm reduction

In 2016, the *Global State of Harm Reduction* reported that Latin America was experiencing a shift away from a punitive approach to drug use and towards a model favouring harm reduction.^[29] Policy developments in favour of harm reduction in the region have slowed or stalled over the past two years, though. In Brazil, a new government came to power in 2016, and in 2018 implemented a new drug strategy explicitly rejecting the harm reduction approach and closing several programmes.^[6,98] At both a national and a local level, similar developments have been seen in Argentina, Colombia and in São Paulo, Brazil.^[4,16,52]

Despite these setbacks, harm reduction continues to progress in other parts of the region. In January 2017, the Costa Rican government, with the involvement of civil society groups, published a National Harm Reduction Model as part of national drug policy, with the explicit objective of implementing harm reduction services.^[10,99] Costa Rica has promoted harm reduction on the world stage, with statements in favour during the UN General Assembly Special Session on Drugs in 2016 and a side-event on harm reduction at the Commission on Narcotic Drugs in 2018.^[10,100] In Mexico, a commitment to harm reduction was included in the government's 100 day action plan on HIV prevention submitted to UNAIDS in 2018.^[101]

The Colombian national government remained supportive of harm reduction programmes up to 2018, and the Ministry of Health has developed guidelines on harm reduction (including the distribution of naloxone). However, the publication of these guidelines has been delayed without explanation.^[16,22] The peace deal signed in 2016 between the Colombian government and the Fuerzas Armadas Revolucionarias de Colombia (FARC) guerrilla group includes a commitment to take a human rights and public health approach to illicit drug consumption, and specifically references the role of harm reduction.^[103] Despite this, civil society organisations report that few policy steps have been taken to implement the peace agreement, and a 2017 reform to the police code introduced new sanctions for those found in possession of illicit drugs.^[16,22]

The election of Iván Duque as president of Colombia in June 2018 has cast further doubt on the future position of the Colombian government. Though Duque has a history of supporting harm reduction programmes, including a bill to introduce drug consumption rooms, his presidential campaign focussed heavily on a law enforcement-oriented approach to drugs.^[22,104] This included criminalising possession for personal use, rejecting harm reduction programmes and opposition to the 2016 peace deal.^[16,104]

The political pendulum

Since 2016, harm reduction in Latin America has been shown to be highly vulnerable to electoral outcomes, and to changes in public opinion at the local and national level. The pendulum effect brought on by changes in local or national administrations can make long-term planning and consistent service delivery difficult.

The case of Cracolândia, São Paulo's massive open drug scene, is representative of this issue. Local elections occurring every four years have triggered overhauls of the local government's approach to crack use in the city. The abstinence and rehabilitation-centred Recomeço project operated under state government control before 2012, when it was joined by the city government-funded, harm reduction-led De Braços Abertos project from 2014-2016.^[4,29,54] Since 2016, De Braços Abertos has been replaced by Redenção in a return to abstinence-focused projects.^[4,53] Civil society organisations identify these swings between administrations in favour of and against harm reduction as a reason for Cracolândia's resilience.^[36] Civil society programmes operating while state-led harm reduction is absent are interrupted when the state enters their space, and are unable to build legitimacy.^[36] The progress made under the state-led De Braços Abertos project, particularly in establishing trust between healthcare workers and Cracolândia residents, was lost once the project was closed and civil society organisations fear it will be difficult to regain.^[36,55] In this way, swings between political positions (not only the direction of political travel) have had a negative impact on the delivery of harm reduction programmes. This process has been mirrored in other parts of Brazil, where the national government, installed in 2017, has turned away from harm reduction and closed the majority of state-sponsored programmes.^[6,98]

Cyclical changes in levels of political commitment have also had an impact in Colombia. At times when local governments are in favour of harm reduction, state

agencies operate the programmes with no operational input from civil society (sometimes as a result of donor conditions stating that services must be provided directly by the state).^[16] This means that civil society groups are unable to build operational capacity, and therefore cannot provide services when the pendulum swings and the programmes are closed by the state.^[16] In Bogotá, a recent change in city government has led to the closure of NSP and OST programmes, with civil society ill-equipped – both financially and operationally – to fill the gap.^[16] This has left people who inject drugs in the city without harm reduction services.

Presidential elections in 2018 in Brazil, Colombia and Mexico have had the potential to advance or reverse harm reduction in each country, with leading candidates on both sides of the debate in all three elections.^[9,105-107] Civil society organisations have expressed concern that as long as there is no consensus among the political class on the benefits of harm reduction, there will always be a degree of uncertainty about their financial and legal sustainability.^[36] This is particularly relevant at a time when international donors are withdrawing from the Latin America region.

Civil society and advocacy developments for harm reduction

The Latin American Conference on Drug Policy continues to provide a forum for civil society to network, share experiences of best practice and develop advocacy strategies for harm reduction.^[52] The seventh iteration of the event was held in Mexico City in conjunction with the Mexican Conference on Drug Policy in October 2018, and sought to assess the current challenges in Latin American drug policy, the strength of the global reformist movement and proposals for the future of drug policy in the region.^[108]

Latin American regional meetings have taken place to discuss broadening the definition of harm reduction to include the wider social consequences of drug policies^[4]. These three meetings, held in Argentina, Uruguay and Brazil, have established a network of activists, academics and government officials that acts as a collaborative group, updating its members on progress and setbacks of the harm reduction movement across Latin America.^[4,109] The first meeting, held in Buenos Aires with participation

from Argentina, Brazil, Uruguay and Paraguay, produced a document that was widely distributed among different harm reduction groups in the region, sharing experiences in harm reduction implementation.^[109] The third of these meetings, held in Rio de Janeiro, produced the Letter from Manguinhos, calling for the protection of harm reduction programmes in the face of a growing wave of conservative politics and drug policy in Latin America. It also called for the inclusion of wider social issues into the harm reduction arena, such as the way drug policies have been used to target marginalised populations (e.g. women, indigenous peoples, black, LGBTI and youth).^[4,110]

Civil society groups, including Intercambios with support from the International Drug Policy Consortium, successfully opposed an amendment to the Argentinian National Mental Health Law that would have removed the obligation for the government to treat addiction as a mental health issue in Argentinian law, allowing for an expansion in the use of involuntary detention (either in prison or mental health facilities) for people who use drugs.^[4,111,112] Also in Argentina, an open letter was written in 2016 by 253 magistrates urging the government to enact a drug policy based on principles of human rights and harm reduction, rather than criminalisation and law enforcement.^[4,113]

The Latin American Network of People who Use Drugs (LANPUD) was founded in 2012 and continues to advocate on behalf of people who use drugs in the region, including signing the Letter from Manguinhos in 2017.^[110] In Brazil, two harm reduction networks, ABORDA (Associação Brasileira de Redução de Danos, Brazilian Harm Reduction Association) and REDUC (Rede Brasileira de Redução de Danos e Direitos Humanos, Brazilian Harm Reduction and Human Rights Network), have worked to create national networks of people who use drugs,^[6] complementing the work of LANPUD.^[29] A new Brazilian initiative launched in 2017, Intercambiantes, seeks to maintain a network of information on harm reduction programmes, conferences and meetings, publications, at the intersection of mental health and drug use^[4]. The Black Initiative for a New Drug Policy and the National Network of Anti-Prohibitionist Feminists aim to broaden the debate about drug policy to include the specific impacts on the black community and women respectively.^[4,114]

Although the Mexican Network for Harm Reduction has not been through any major developments since 2016, a meeting of civil society organisations in the country was held to present harm reduction proposals to the national HIV prevention body.^[12] In Argentina, 22 organisations from five provinces created a network, launched on 26 June 2017, to

advocate for the decriminalisation of drug users, less strict sentencing for low-level drug crime and drug policy focused on health outcomes and harm reduction.^[4] This was followed up in 2018 with a campaign based on the principles of Support. Don't Punish, highlighting the specific problems faced by women who use drugs.^[115]

Civil society groups in both Colombia and Costa Rica have been advocating for harm reduction policies. Colombian organisations have actively contributed to United Nations meetings supporting changes and reforms in drug policy,^[9] while in Costa Rica, the new national harm reduction model was developed with the participation of civil society.^[10] The Costa Rican Association for Study and Intervention on Drugs (ACEID), has used the Support. Don't Punish campaign to organise various high-level meetings with policy makers on the need for drug policy reform and harm reduction, and in 2016 held a workshop for NGOs working with the Global Fund on harm reduction.^[10] Colombian civil society groups remain optimistic that they are in a stronger position to oppose the new presidential administration's prohibitionist agenda than they were under the similarly inclined presidency of Álvaro Uribe two decades ago.^[16]

In April 2018, Colombian organisation Acción Técnica Social held its third Semana Psicoactiva (Psychoactive Week) conference on public policy to address psychoactive substances, with a strong emphasis on harm reduction. The conference brought together projects from across the Americas.^[16] Discussions and workshops were held on themes such as heroin use in Latin America, the role of psychoactive substances in the transmission of sexually transmitted diseases, and substance analysis of new psychoactive substances.^[116]

Funding developments for harm reduction

As reported in the 2016 edition of the *Global State of Harm Reduction*, the Global Fund and Open Society Foundations (OSF) have been the significant international donors funding harm reduction programmes in Latin America.^[4] Both funded NSPs and OST in Mexico and Colombia before 2016; however, since 2016 the Global Fund has gradually withdrawn funding.^[9,12,16,22] While efforts have been made by donors and civil society to ensure alternative sustainable funding is found, these have sometimes been unsuccessful. For example, in Cali and Pereira, Colombia, harm reduction measures have been funded by a combination of the Ministry of Health, National Drug Fund, local government

funding and OSF, since the withdrawal of the Global Fund. However, in other cities, such as Bogota and Dosquebradas, harm reduction programmes have been closed.^[22] Under the revised Global Fund Eligibility Policy, Argentina, Brazil and Mexico remain ineligible for funding.^[4,117]

Civil society organisations in Colombia have raised concerns that the requirement for Global Fund resources to be managed by the state leads to bureaucratic delays and inefficiency. For example, non-governmental organisations only received their funding for 2017 in July of that year, meaning that they had only six months to achieve targets intended for the entire year.^[16] They also fear that the explicit involvement of the state in all projects may dissuade people who inject drugs from accessing services.^[16] Reducing barriers for civil society organisations to access funds directly may help to alleviate these issues.

A key funding issue reported by civil society organisations is a focus on HIV programmes by both international donors and national governments. For example in Colombia, Global Fund support has prioritised programmes with an explicit HIV-prevention dimension (such as NSPs), leaving few financing opportunities for forms of harm reduction without an HIV focus.^[22] In Mexico, the only state funding for harm reduction comes through the national HIV programme; this means that harm reduction organisations compete with those working with other key populations, such as men who have sex with men and sex workers. The result is that, on average, only five harm reduction projects per year receive government funding.^[12] In Costa Rica, Global Fund support for harm reduction is only available for projects working with people who inject drugs, despite high HIV prevalence among people who use smokable cocaine, meaning that this population has no access to harm reduction services and abstinence-based models prevail.^[10]

With respect to national government investment, Resolution 518/2015 in Colombia allowed territories to pay for harm reduction measures from the Public Health Fund. However, the amount available is insufficient and there are other priorities that compete for these funds.^[9] Similar issues have been faced in Costa Rica, where the national harm reduction model states support for civil society organisations, but no funding has been made available.^[10] There is a clear, urgent and demonstrated need for declarations of political support for harm reduction programmes to be accompanied by financial support.

As international donors withdraw from the region,

the trend has been an increase in the proportion of harm reduction funding provided by national governments. When harm reduction services were first implemented in Colombia, 90% of funding came from international donors and 10% from national government; today civil society organisations estimate that 75% is from international donors and 25% from national government.^[9,16] However, national funding consistently falls short of what international donors have previously provided, leaving services without a sustainable source of financing and unable to provide continuous services to vulnerable populations.^[16]

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