2.3 LATIN AMERICA & THE CARIBBEAN

ANTIGUA AND BARBUDA
THE BAHAMAS
BARBADOS
BELIZE
BERMUDA
CUBA
DOMINICA
DOMINICAN REPUBLIC
GRENADA
GUYANA
HAITI
JAMAICA
PUERTO RICO
SAINT KITTS AND NEVIS
SAINT LUCIA
SAINT VINCENT AND THE GRENADINES
SURINAME
TRINIDAD AND TOBAGO

ARGENTINA
BOLIVIA
BRAZIL
COLOMBIA
COSTA RICA
CHILE
ECUADOR
EL SALVADOR
GUATEMALA
HONDURAS
MEXICO
NICARAGUA
PANAMA
PARAGUAY
PERU
URUGUAY
VENEZUELA

TABLE 2.3.1:

Epidemiology of HIV and viral hepatitis, and harm reduction responses in the Latin America and the Caribbean

Country/ territory with reported injecting drug use[1]	People who inject drugs	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction response			
					NSP[2]	OAT[3]	Peer distribution of naloxone	DCRs[4]
Argentina	8,144[2]	3.5[3]	4.8[4]	1.6[4]	x	✓(M)[5]	x	x
The Bahamas	0[6]	nk	nk	nk	x	x	x	x
Bolivia	nk	nk	nk	nk	x	x	x	x
Brazil	nk [5]	9.9 [7]6	nk	nk	x	x	x	x
Chile	nk	nk	nk	nk	x	x	x	x
Colombia	14,893[8]	5.5[9]	31.6[9]	nk	✓[10,11]	✓(M)[10,11]	x	x
Costa Rica	nk[7]	nk	nk	nk	x	x	x	x
Dominican Republic	<1,359[13]8	3.2[13]9	22.8[14]10	nk	✓2[15]	x	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
Guyana	nk	nk	nk	nk	x	x	x	x
Haiti	nk	nk	nk	nk	x	x	x	x
Honduras	nk	nk	nk	nk	x	x	x	x
Jamaica	nk	nk	nk	nk	x	x	x	x
Mexico	164,157[18] 11	4.4[19] 12	96[20] 13	0.2[4]	✓[17]	✓(M)[21]	✓[21]	x[14]
Nicaragua	nk	nk	nk	nk	x	x	x	x
Panama	5,714[22]	nk	nk	nk	x	x	x	x
Paraguay	nk	nk	9.8[23]	nk	x	x	x	x
Peru	nk	nk	nk	nk	x	x	x	x
Puerto Rico	28,000[24]	11.3[25] 15	78.4 - 89[27,28] 16	nk	✓[29]	✓(M,B)[29]	✓[29]	x
Suriname	nk[30] 17	nk	nk	nk	x	x	x	x
Uruguay	nk	nk	nk	nk	x	x	x	x
Venezuela	nk	nk	nk	nk	x	x	x	x

nk = not known

1 Countries with reported injecting drug use according to Larney et al in 2017. The study found no reports of injecting drug use in Antigua and Barbuda, Barbados, Belize, Cuba, Dominica, Grenada, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines or Trinidad and Tobago.[1]

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

3 Opioid agonist therapy (OAT), including methadone (M), buprenorphine (B) and any other form (O) such as morphine and codeine.

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

5 Unpublished data from a national household survey coordinated by Francisco Bastos found very little evidence of injecting drug use in Brazil.

6 Based on data collected in 2009 in eight Brazilian cities.

7 Civil society organisations indicate that injecting drug use is minimal in Costa Rica.[12]

8 There are an estimated 56,632 people who use illegal drugs in the Dominican Republic, less than 2.4% of whom are reported to be people who inject drugs.

9 Estimate from 2012 for people who use drugs.

10 Based on data from 2008.

11 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.[16] 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.[17]

12 Based on data collected in 2006-2007.

13 Based on data collected in 2005.

14 Though one DCR operates in Mexicali, Mexico, this is not officially sanctioned by the state.[21]

15 Based on subnational data from 2015.

16 Based on subnational data from 2006-2015. Civil society organisations report that there is no effective system monitoring viral hepatitis infection among people who inject drugs in Puerto Rico.[26]

17 A 2008 government study estimated that 0.3% of Suriname's estimated 1,000 people who use drugs are people who inject drugs.

MAP 2.3.1:
Availability of harm reduction services

2.3
Harm reduction in Latin America and the Caribbean

NEEDLE AND SYRINGE PROGRAMMES (NSPs)

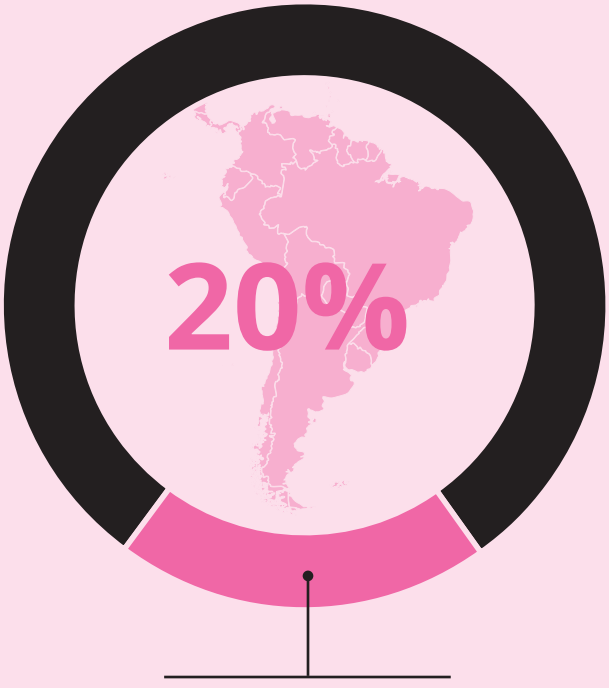
<5%

CIVIL SOCIETY ORGANISATIONS ESTIMATE THAT LESS THAN 5% OF THE PEOPLE WHO INJECT DRUGS IN MEXICO ACCESS NSPs.

Transition to domestic funding applies primarily to services for people who inject drugs, and there remain few funding opportunities for services for the majority of people who use drugs in the region who do not inject.

COCAINE

IN LATIN AMERICA APPROXIMATELY 40% OF PEOPLE IN CONTACT WITH THE CRIMINAL JUSTICE SYSTEM HAVE BEEN ARRESTED ON THE BASIS OF COCAINE-RELATED OFFENCES'



APPROXIMATELY 20% OF PEOPLE IN PRISON IN LATIN AMERICA ARE CHARGED WITH A DRUG OFFENCE.

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1. Overview

There are approximately 5.5 million people who use non-injected illegal drugs in Latin America and the number of people who inject drugs is very low compared with other regions.[31,32] This is largely due to the fact that, currently, injecting use is relatively rare outside Mexico and Colombia[33] and because the rate of use of cocaine and its derivatives (which are commonly not injected) in the region is among the highest in the world.[5,31,34]

The production and use of cocaine and coca derivatives is prevalent in South America, specifically Bolivia, Colombia and Peru, which are responsible for virtually all the world's coca leaf cultivation.[35,36] The smokable use of cocaine paste (an intermediate product in the production of cocaine also known as basuco, paco, base paste or oxi) is greater than that of opioids in Argentina, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru and Uruguay.[5,32,37–39] It is a cheaper alternative to cocaine in South America and people who use cocaine paste, as well as those who use crack cocaine, are usually from socially marginalised groups, are more stigmatised and face more barriers to access to health care and harm reduction programmes than other people.[5,11,12,34]

The rate of opioid use in Latin America and the Caribbean is lower than that of amphetamine-type substances (ATS) or other new psychoactive substances (NPS). However, opioid use is prevalent in Colombia, the Dominican Republic, Mexico and Puerto Rico.[11,15,21,29,31] NPS use is increasing in Argentina, Brazil, Colombia, Costa Rica, Mexico, Peru and Uruguay. MDMA is the most common substance among ATS, and NPS such as ketamine, synthetic cannabinoids and synthetic hallucinogens are also used in some countries.[11,12,21,32,37,39–41]

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 the use of the smokable forms of crack cocaine and cocaine paste. In some cases, there are community-based programmes that offer primary health services, food and hygiene services, legal advice and treatment to people who use non-injectable cocaine derivatives and other drugs.[5,42,43] Harm reduction programmes focused on people experiencing homelessness have been established in Argentina, Brazil, Chile, Colombia, Costa Rica and Uruguay.[12,44]

Harm reduction programmes for people who inject drugs, including opioid agonist therapy (OAT) and needle and syringe programmes (NSP), operate in Colombia, the Dominican Republic, Mexico and Puerto Rico.[11,15,21,29,45] In Mexico, primarily in the north close to the border with the USA, they also function as overdose prevention programmes, distributing naloxone and offering fentanyl strips. La Sala, a safe consumption space for women who use drugs, is the first drug consumption room (DCR) in the region, though it is not authorised by the Mexican government.[46]

Drug checking programmes (also known as substance analysis) have increased in the region since 2018, and are managed by civil society organisations, including in Colombia, Mexico, Peru and Uruguay.[11,39,44] There are other peer education projects in clubs and festivals that offer assistance, information and hydration points to reduce risk related to recreational drug use.[5,43]

There are several examples from recent years of regression towards more punitive drug policies in Latin America. For example, new governments in Brazil and Bolivia have explicitly rejected harm reduction as a response to illegal drug use and closed successful programmes, replacing them with abstinence-based, rehabilitation and law enforcement-led projects.[36] In several other countries such as Costa Rica, the Dominican Republic, El Salvador, Guatemala and Honduras, the response to drug use continues to be dominated by abstinence-centred programmes.[12,15]

With reductions in funding from international donors, the funding landscape for harm reduction in Latin America is becoming increasingly difficult. Due to the socio-economic crisis in the region caused by the COVID-19 pandemic, national government funding has also decreased. Many programmes are supported only by private contributions.

Based on the limited data available, prevalence rates of HIV, hepatitis C and tuberculosis (TB) are all higher among both people who inject drugs and non-injecting drug users than the general population. However, prevalence rates vary considerably across the region.

2. Developments in harm reduction implementation

2.1 NEEDLE AND SYRINGE PROGRAMMES (NSPs)

Latin America has one of the lowest rates of syringe distribution per person who injects drugs in the world.[31] Where injecting drug use has been identified, syringe distribution per person per year is lower than the World Health Organization recommendation for the elimination of hepatitis C of 300 syringes per person per year.[47] A relative absence of injecting drug use may make NSP implementation a lower priority in Bolivia, Costa Rica, Ecuador, Paraguay and Peru.[5,12,38,39] In Argentina, Brazil and Uruguay, cocaine injection is now minimal, so NSPs have redirected efforts towards harm reduction for non-injecting drug use.[3]

NSPs continue to operate in Colombia and Mexico, but a lack of funding and a regression towards more punitive drug policies in Latin America have caused a decrease in coverage of NSPs in both countries.[11,21,36] While services have recently been officially included in the HIV/TB response in Colombia, coverage has decreased since 2018 in Armenia, Bogotá, Cucuta and Bucaramanga[11] In Mexico, there were six active NSPs in 2018, including in the cities with the highest level of injected heroin use: Tijuana, Mexicali and Ciudad Juarez. However, civil society organisations estimate that less than 5% of the people who inject drugs in Mexico access NSPs.[21] In February 2019, the Mexican government ceased funding for citizen-led programmes, which forced some NSPs to reduce services.[48]

Even where NSPs are in operation, coverage is insufficient.[11,21] In Mexico, there is a shortage of syringes and people who inject drugs are reluctant to use those provided by the government because of concerns about quality and poor design.[21,49] There are geographical and organisational barriers to access in both Colombia and Mexico, and women and transgender people face additional barriers related to stigmatisation.[11,21] For example, in Mexicali, Verter reports that just one in ten of its NSP clients are women.[21]

Changes in NSP implementation in the Caribbean have been limited since 2018, and the Dominican Republic and Puerto Rico remain the only places where NSP services operate.[15,29] This is in large part due to the low recorded prevalence of injecting drug use in the region. For example, in the Bahamas and Saint Kitts and Nevis, governments report no injecting drug use and therefore no NSPs are in operation.[50,51] However, in several other Caribbean countries, no NSPs are in operation despite the acknowledged prevalence of small populations of people who inject drugs, for example in Dominica, Guyana and Jamaica.[52–55]

2.2 OPIOID AGONIST THERAPY (OAT)

No country in Latin America has newly implemented OAT since 2018. Despite OAT being available in Argentina, Colombia and Mexico, it is largely administered in an abstinence-focused manner rather than for harm reduction.[5,11,21]

OAT is available in Colombia in the form of methadone pills.[10,11] However, there are significant barriers to access for women, transgender people and people experiencing homelessness. Barriers include over-subscribed services; services that do not adjust to the needs of the most vulnerable groups; the fact that formal identification is necessary to access the state health insurance programme; long waiting times for appointments with specialists; and many medical practitioners and clients still considering methadone therapy to be a case of replacing one addiction with another.[10]

In Mexico, OAT is available only in private clinics and fee-charging government clinics, at high cost to the client. There are six centres in the three cities where injecting drug use is highest: Tijuana, Mexicali and Ciudad Juarez.[21] In Argentina, OAT is available in both public and private institutions in Buenos Aires.[5] In Costa Rica, Ecuador and Peru, prescription opioids are used for palliative care patients and for only a small number of people suffering from opioid withdrawal.[12,39]

Opioid use is relatively uncommon in the English-speaking Caribbean, with prevalence of 0.2% compared with 2% in the Americas as a whole.[56] However, both Puerto Rico and the Dominican Republic are home to significant populations of people who use opioids.[15,29] Puerto Rico remains the only place in the Caribbean where OAT is available, though civil society actors in Puerto Rico report that fewer programmes are operating in 2020 than in 2018 because of a lack of funding.[29]

In the Dominican Republic, no OAT services are available.[15] Law 50-88 (the primary drug control law in the country) specifically prohibits the use of methadone, but does not prohibit buprenorphine.[57] The National Drug Council is the state organ responsible for drug programmes, but only funds OAT for detoxification purposes with requirements for abstinence.[15] A long-awaited pilot OAT programme took place in 2019, providing services for 67 people. However, despite positive results, neither the government nor international donors were willing to fund a continuation of the programme.[15]

2.3 AMPHETAMINE-TYPE STIMULANTS (ATS) AND NEW PSYCHOACTIVE SUBSTANCES (NPS)

The use of ATS, including the non-medical use of amphetamine, methamphetamine and pharmaceutical stimulants, is lower in Latin America and the Caribbean than other regions. However, Central America[18] has higher rates of use than South America.[32] In South and Central America, the non-medical use of pharmaceutical stimulants is more common than the use of other amphetamines. The non-medical use of weight loss pills is reportedly more prevalent among women than among men, with pills such as sibutramine hydrochloride monohydrate (sold under the brand names Aderan and Ipomex) and phentermine (sold under the brand names Duromine and Suprenza), along with methylphenidate and amphetamine, reported to be the most commonly non-medically used pharmaceutical stimulants in those subregions.[31] Few harm reduction programmes addressing the use of ATS operate in the region.

Data on amphetamine-type stimulants is rarely collected systematically in the Caribbean.[58] According to the limited data available, prevalence of use appears to be low. For example, past-year prevalence of MDMA among secondary school students is estimated at 0.2% in the Dominican Republic and 0.3% in Barbados.[58]

Though the rates of NPS use in Latin America are lower than in other regions, NPS use has increased in the region among young people since 2018.[31,32] MDMA is the most common ATS in Argentina, Brazil, Colombia, Chile, Costa Rica, Mexico, Peru and Uruguay. NPS such as ketamine, synthetic cannabinoids and NBOMes (a group of synthetic hallucinogens commonly sold as LSD) are also used in some countries.[10,11,21,32,40,41,43,59]

Harm reduction programmes for ATS and NPS use in nightlife settings increased in the region. In Colombia, Peru and Uruguay there are drug checking programmes managed by civil society organisations, such as Echele Cabeza in Colombia, Imaginario 9 in Uruguay, and Latin America for a Sensible Drug Policy in Peru.[11,39,44] There are other peer education projects that offer assistance, information and hydration points to reduce risk related to recreational drug use such as Proyecto de Atención en Fiestas (PAF) in Argentina, Projeto Respire in Brazil and other similar services in Chile, Costa Rica and Ecuador.[5,12,43]

> *Drug checking programmes (also known as substance analysis) have increased in the region since 2018, and are managed by civil society organisations, including in Colombia, Mexico, Peru and Uruguay.*

18 This refers to: Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama.

The governments of Argentina, Chile, Colombia and Uruguay have established early warning systems on NPS at the national level.[59,60] In 2019, these systems were combined in the Early Warning System for the Americas, through which countries share information.[59,60] The early warning systems provide specific information on NPS including trend data, chemical details on individual substances and supporting documentation on laboratory analysis to public health institutions, including directly to frontline health workers in hospitals, to enable better responses to overdose. In many cases, including all alerts in Argentina, alerts are also made available to the public to inform people who use drugs and their families.[59] In Argentina, the system is operated by governmental agencies and does not source data or samples from organisations providing harm reduction services.[5] Barbados, Brazil, Costa Rica, Jamaica, Paraguay, Peru, and Trinidad and Tobago are developing national early warning systems in line with the recommendations of the Inter-American Drug Abuse Control Commission (CICAD).[59]

2.4
COCAINE AND ITS DERIVATIVES

Cocaine use in Central America (0.7% of the population) and South America (1.0%) is higher than the global average of 0.4% of the global population aged 15–64.[31,32] According to national estimates, between 4% and 6% of the general population have ever used powder cocaine in the English-speaking Caribbean[19] and less than 1% in the Dominican Republic, Haiti and Puerto Rico.[58] Prevalence of crack cocaine use is lower, but is still estimated at between 1% and 2% of people in the English-speaking Caribbean.[58] There is evidence that use of crack cocaine has increased over recent years across the Caribbean,[58] notably in Barbados, Belize and Dominica.[61–63]

With nearly 1.5 million past-year cocaine and crack cocaine users, Brazil is the largest cocaine market in South America.[31,43] Cocaine base paste, which was previously confined to countries where cocaine is manufactured (Bolivia, Colombia and Peru), is the most commonly used drug among many socio-economically deprived people who use drugs in Argentina, Colombia, Chile, Ecuador, Peru, Paraguay and Uruguay.[34,35] However, such use is difficult to estimate since people who use cocaine base paste are usually from socially marginalised groups that are not well captured by household surveys.[5,37,64]

Harm reduction programmes for people who use non-injectable cocaine derivatives are in place in Argentina, Brazil, Paraguay and Uruguay, with a particular focus on use of the smokable forms of crack cocaine and cocaine paste. Examples include the Casas de Atención y Acompañamiento Comunitario in Argentina, supported by the National Secretariat for Comprehensive Drug Policy (SEDRONAR) and implemented by civil society organisations, and the Centro de Convivencia E de Lei in Brazil, coordinated by a harm reduction organisation. Both are community-based programmes that offer primary health services, food and hygiene services, legal advice and treatment to people who use non-injectable cocaine derivatives and other legal and illegal drugs.[42,43] During the last two years, harm reduction programmes focusing on people experiencing homelessness have appeared in Argentina, Colombia, Costa Rica and Uruguay.[10,12,21,65]

In Puerto Rico, a few harm reduction programmes deliver safer smoking equipment to people who smoke crack cocaine, but these projects are small and do not have a steady source of funding.[29] Additionally, harm reduction organisations distribute fentanyl test strips to people who use cocaine as well as people who use opioids, as fentanyl is known to be present in both. This remains the only form of drug checking available on the island, mostly due to a lack of funding.[29]

Since 2018, many services to reduce and mitigate the consequences of crack cocaine and cocaine paste use have reduced their coverage due to lack of financial support and a regression towards more punitive drug policies in the region (see policy developments section). Conservative administrations in Argentina, Bolivia, Brazil, Chile, Colombia and Ecuador replaced funding for health programmes with funding for security measures focused on drug markets.[5,12,36,43,66] Some of them explored military responses to drug-related problems, for example Argentina, Brazil, Colombia, Mexico and Peru.[67] People who use cocaine paste are often subject to marginalisation, stigmatisation and violence.[34,64]

19 This refers to: Antigua and Barbuda, the Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines and Trinidad and Tobago.

Non-injected drug use and harm reduction

In much of Latin America and the Caribbean, injected drug use is uncommon, with smoking the preferred route of administration for crack cocaine and cocaine paste.[5,12,38,39] Non-injected drug use is less associated with blood-borne disease transmission, and in some cases can be an alternative to injection, which reduces the harms associated with injecting drug use, for example in 'pin-to-pipe' programmes.[68] However, there remain significant health risks associated with smokable cocaine. One harm reduction intervention that can address these risks is the provision of safer smoking equipment.

While the risk is lower than with sharing syringes, sharing smoking equipment remains a possible route of HIV and viral hepatitis transmission.[69,70] This risk is heightened where people have burns or cuts on their mouth or lips, often associated with the use of inappropriate or improvised smoking equipment.[34,68] Aside from infectious diseases, smoking drugs can also lead to pulmonary complications including chronic obstructive pulmonary disorder, emphysema and bronchitis.[34,71] As mentioned, this is frequently associated with improvised smoking equipment and the inhalation of toxic fumes, particularly where plastic or inked aluminium is heated at high temperatures.[34]

Distributing safer smoking kits can reduce sharing, reduce injuries to the mouth and lips, and lower the risk of damage to the lungs. Such kits may include glass stems and pipes, rubber mouth pieces and lip balm.[34] Some organisations also include condoms to prevent sexual transmission of diseases.[34] These kits must also be tailored to the needs of the local population. For example, one organisation in Colombia designed a pipe specifically for people who smoke cocaine paste, modelling the pipe on those already in use, but with safer materials and removable parts to facilitate cleaning and avoid sharing.[72]

2.5 OVERDOSE RESPONSE AND DRUG CONSUMPTION ROOMS (DCRs)

Since the last *Global State of Harm Reduction* report in 2018, the first official DCR in Latin America opened in Mexicali, Baja California, Mexico.[21] While the facility, under the name La Sala, briefly operated with the approval of the National Commission against Addiction (CONADIC), it has not been formally recognised by local or national government since 2018.[21] Verter, a harm reduction organisation that has operated since 2012, runs La Sala which serves women who inject drugs.[46] The DCR offers other harm reduction services such as reproductive and sexual health, legal support, peer counselling, drug checking, overdose response, HIV and hepatitis C prevention programmes and naloxone[20] distribution. However, with only one DCR operational in the country, the coverage is insufficient for more than 100,000 people who inject drugs. For this reason, civil society organisations established a peer distribution network of naloxone in those areas of northern Mexico where opioid use is prevalent.[21] However, the programme receives no government funding and these efforts remain unofficial.[73]

No data is available on the number of opioid overdose deaths that occur in Colombia, despite evidence suggesting that there are 15,000 people who use opioids in the country.[8,74] Civil society organisations highlight this lack of data as a key challenge when providing services and advocating for greater access to overdose prevention.[74] They also raise concerns that opioid overdose deaths are not formally recorded as such, but commonly referred to as death from cardiac arrest.[74] Naloxone remains highly limited in Colombia, where the primary barrier to distribution is restrictive legislation.[10,11]

A significant development in the response to opioid overdose has been improvements to the availability of naloxone in Puerto Rico. This is the result of a long advocacy campaign from civil society, as reported in the *Global State of Harm Reduction 2018*. Administrative Order 412 of the Department of Health permits non-governmental organisations to give out naloxone without a prescription, whereas previously harm reduction actors had been forced to act outside of the legal framework to ensure that people likely to witness an overdose had access to naloxone.[29] Accordingly, harm reduction outreach teams delivering sterile injecting equipment now distribute naloxone widely

20 Naloxone is a medication capable of reversing the effects of opioid overdose.

to people likely to witness an overdose, as well as providing overdose training and education.[29] However, civil society organisations report concern that as an administrative order with no accompanying legislation, this programme is subject to political changes and could be abruptly ended by a change of policy or government.[29]

The lower prevalence of opioid use in the region is one of the reasons for the absence of naloxone programmes in other countries.[5,12,32,38,39,44] For non-injecting users, emergency departments handle overdose and prevention is based on abstinence.[11,39]

2.6
HIV AND ANTIRETROVIRAL THERAPY (ART)

In Latin America there are approximately 1.9 million people living with HIV. In 2018, there were an estimated 100,000 new HIV infections in the region.[75] From 2010 to 2018, there was a 16% reduction in all new HIV cases in the Caribbean. Over the same period, only one country saw a rise in new infections (Belize) and in two countries the reduction was more than 20% (Cuba and the Bahamas).[76]

HIV testing is available in all countries in the region.[11,12,37,39,44,77] There are public programmes that provide HIV prevention services in several countries, such as Argentina, Brazil, the Dominican Republic, Mexico and Peru. In several countries, ART is available but very limited for people currently using drugs. Studies in the region show that stigma and discrimination towards people living with HIV persist in combination with stigma based on sexual orientation, gender identity, drug use or sex work, and remain prevalent in many settings.[78] Discrimination against people living with HIV in the Caribbean is particularly high. Up to two thirds of people in Jamaica and Haiti, and more than half of people in Antigua and Barbuda, the Dominican Republic, Grenada, Haiti and Guyana report negative attitudes towards people living with HIV.[76,79–81]

In the Dominican Republic, ART is available at no cost to people who use drugs and, since 2019, the national HIV agency CONAVIHSIDA has pledged to increase access to HIV care for vulnerable populations including people experiencing homelessness and/or use drugs.[15] However, civil society organisations report that, in practice, people who use drugs have not been prioritised in the response while other key populations have, and that they continue to face stigma and discrimination, as well as considerable out-of-pocket expenses when accessing services.[15,82] Similarly, in Puerto Rico, access to HIV treatment is covered by the territory's state insurance programme, La Reforma,[83] but only 62.5% of all people living with HIV are on ART, and 88.2% of those are virally suppressed.[84] Civil society organisations report that access to testing and treatment is particularly difficult for people who use drugs, as it requires physical attendance at a clinic which may be far from their place of residence and at which they may experience stigma and discrimination.[29]

Since the beginning of the HIV epidemic, the focus on HIV prevention, treatment and care among people who use drugs has concentrated on the needs of people who inject drugs, and mainly on those who inject opioids. In Latin America, data shows that use of stimulant drugs has also been associated with higher risk of HIV transmission through unsafe sexual behaviours.[85,86] Community-based programmes are an effective action to reduce the barriers to diagnosis and treatment for key populations such as people who use drugs, transgender people and people experiencing homelessness. However, not many countries in the region have these programmes. For example, in Brazil, the Consultorios de Rua (part of the Brazilian health system) in Salvador de Bahía and Rio de Janeiro offer access to rapid HIV tests and other harm reduction services to people experiencing homelessness. However, these services have reduced under the administration of President Jair Bolsonaro.[87] Casa Trans in Buenos Aires, Argentina, has provided the same services for transgender people since 2017.[5,43,88]

Addressing HIV among people who use drugs, including peer-to-peer work, the provision of ART to those living with HIV and the implementation of new prevention tools such as pre-exposure prophylaxis (PrEP), is still a challenge in the region.[37,75,78]

Migration, drug use and harm reduction

Migration is a significant phenomenon in Latin America and the Caribbean. In 2017, 37 million people in the region lived outside their country of birth, accounting for close to 15% of the worldwide number of international migrants.[89] Research suggests that migrant people who inject drugs have unique experiences of drug use and face barriers to harm reduction practices and services not faced by those without a history of migration.[90]

For people who use drugs, migration disrupts social networks for drug acquisition and use, as well as exposing migrants to different cultural practices, including those related to drug use.[83] This can put people at greater risk of infectious disease transmission (because of changes to drug use practices) or overdose (because of a lack of familiarity with the local drug supply).[83] For example, research on the Guatemala-Mexico border has found that recent migration is associated with higher-risk drug use practices.[91,92]

Undocumented migrants face particular challenges,[90] including barriers to accessing health care, based both on formal policies and social effects such as stigma, discrimination and fear of deportation.[93] Periods of detention due to migration status, most notably in the United States prior to deportation, are associated with initiation to injected drug use among both those who used non-injected drugs previously and those who did not use drugs before migrating.[90] Deportation from the United States is therefore associated with higher-risk drug use practices either learned or initiated in detention,[94]and higher prevalence of HIV and hepatitis C.[95]

Importantly, disruption to social networks can also affect the health and vulnerabilities of deported migrants, particularly those who have spent long periods of time outside their country of birth. Evidence suggests people deported from the United States to Tijuana, Mexico, face problems with social integration and financial hardship, which are associated with a lower likelihood of accessing HIV testing and other health services.[90] This emphasises the importance of recognising that migration is not a one-way street. Many migrants, whether by choice or through deportation, may travel numerous times between countries, and this has implications for approaches to harm reduction, such as prescribing medication, continuity of health care and trends in drug use practices.[83]

2.7 HARM REDUCTION IN PRISONS

There were approximately 1.6 million people incarcerated in Latin America and the Caribbean in 2018.[96] Approximately 20% of these people were charged with drug offences, either drug possession for personal use or drug trafficking.[97–99] Costa Rica, Chile and Ecuador have the highest rates of imprisoned people for drug offences in Latin America and the Caribbean.[100] Cannabis is the drug for which the most people are brought into contact with the criminal justice system in the world, but cocaine-related offences are particularly prevalent across the region (about 40% of cases).[99]

Punitive drug laws contribute to overcrowding in Latin American and Caribbean prisons.[97,101] The number of women incarcerated for drug offences has increased, and women are more likely than men in the region to be convicted of non-violent drug offences.[102] In Argentina, Brazil and Costa Rica, more than 60% of the female prison population is held for drug offences.[103] In the most extreme example, Brazil's female prison population increased by 342% between 2000 and 2016.[104] In Latin America, most women are arrested for first-time, non-violent, low-level but high-risk drug-related activities, such as small-scale drug selling or transporting drugs, or for simple drug use. They often engage in criminalised drug activities because of poverty, lack of opportunities and/or coercion. Most have suffered some form of sexual violence before and/or during their incarceration. Their incarceration can have severe and long-lasting consequences not only for themselves, but also for their families and communities.[104]

Prison populations are more vulnerable to infections such as HIV, hepatitis C and TB.[105] Prevalence rates are higher in prison populations compared with the general population, with higher risks of amplification and spread of infectious diseases within and beyond prisons.[106] Data on blood-borne diseases in prisons in the region is largely unavailable, though one study estimated that HIV prevalence in the Cuban prison system was 26%, more than 100 times higher than prevalence in the general population (0.2%).[107] The risk is even higher for incarcerated people who use drugs.[100] Condom distribution, HIV testing and ART are available in prisons in several countries in the region. Argentina, Paraguay, Peru and Uruguay have both viral hepatitis and TB programmes in prisons.[21,37–39,44,77] Since 2018, hepatitis C testing services have been introduced in prisons in Northern Mexico.[21] However, coverage is still insufficient across Latin

America and the Caribbean. HIV testing, ART and TB testing and treatment are available in Argentinian, Colombian, Mexican and Peruvian prisons. Specialised mental health services in Brazilian prisons closed and hepatitis C services were reduced in 2019 due to the withdrawal of government support.[43] In Paraguay, civil society organisation Enfoque Territorial implemented a pilot harm reduction programme in Asunción's prison, but it closed due to lack of funding.[38]

As reported in 2018, harm reduction services for people who use drugs are absent in prison settings across Latin America and the Caribbean. None of the countries where NSPs and/or OAT are available to the general population offer NSP or OAT in prisons.[11,15,21,29]

Drug court models have operated in the region since 2012, theoretically providing alternatives to incarceration and redirecting people charged with low-level drug offences to health services rather than prisons.[108] However, drug courts in Latin America exclusively provide abstinence-based treatment, limiting the harm reduction potential of these kind of programmes.[5,108] In Chile, Costa Rica, Puerto Rico and Mexico, the model is more established and is in a pilot phase in Argentina, Colombia, the Dominican Republic and Panama.[98] Ecuador and Peru are also considering the implementation of drug court programmes. Chile, Colombia and Mexico also have juvenile drug courts and other countries in the region have plans for their creation.

3. Policy developments for harm reduction

Drug policy development in Latin America is not homogeneous. Since the last *Global State of Harm Reduction* report in 2018, the differences have deepened. While drug policies in Brazil, Bolivia and Ecuador have become more punitive, Colombia is discussing cannabis and cocaine regulation.[11] Uruguay extended services and practices in favour of harm reduction and approved a new mental health law that includes a human rights perspective in drug treatment.[11,37,44,109] In Bolivia, the government has allowed farmers to grow a sufficient amount of coca for subsistence purposes since 2008, facilitating access to a national legal market for coca products, as well as improving access to safe water, education and other sources of income. A new unelected government has reduced these policies and imposed harsh drug control policies involving law enforcement and militarisation.[36,104]

New governments in Brazil, Bolivia, Colombia and Ecuador implemented drug strategies that explicitly reject the harm reduction approach.[36,37,109] The penalties for drug-related crimes, both possession and trafficking, have increased in Brazil and Ecuador. In 2018, the Technical Secretariat for Drugs in Ecuador was eliminated and its functions were divided between the Ministry of Security and the Ministry of Health. Recently, the Ecuadorian legislature approved a new law that penalises drug use in public spaces and gives more powers to the police force in drug-related offences.[110] In Brazil, changes in the Mental Health Law explicitly exclude harm reduction approaches and exclusively focus on abstinence-based treatment and government financial support to therapeutic communities. At a local level, several harm reduction services for people who use cocaine (primarily crack cocaine) in São Paulo closed and those in Salvador and Pernambuco reduced coverage due to decreased financial support.[43]

Of the 17 countries in the Caribbean region, Harm Reduction International has identified nine national drug policy plans and ten national HIV plans. Of the drug plans, only two contain any positive reference to harm reduction (the Bahamas[111] and the Dominican Republic[112]), though in both cases this has not been accompanied by practical application of government-supported harm reduction programmes. A further four drug policy plans contain references to the need to address HIV and the health of people who use drugs (Barbados,[113] Grenada,[114] Jamaica[115] and Suriname[116]), and three contain no reference to the health of people who use drugs (Antigua and Barbuda,[117] Guyana[118] and Trinidad and Tobago[119]). Among the HIV plans, eight refer to people who use drugs as a key population[21] but two contain no reference to people who use drugs (Grenada[128] and Saint Vincent and the Grenadines[129]).

The Caribbean has been a leading region in cannabis law reform, with several countries decriminalising cannabis for personal use including, since 2018, Antigua and Barbuda.[130] However, criminalisation remains in force in much of the region, and in the entire region for all drugs except cannabis. Some governments remain strongly opposed to any reform, for example the Cuban government has criticised other Caribbean governments for decriminalising or legalising cannabis,[131] and a report commissioned by the

21 These are: Antigua and Barbuda,[120] Belize,[121] Cuba,[122] the Dominican Republic,[13,123] Guyana,[124] Jamaica,[125] Saint Lucia[126] and Trinidad and Tobago[127].

government of the Bahamas recently failed to recommend any drug law reform.[132] Indeed, a recent government report in the Bahamas stated that increasing stigma towards people who use cannabis and alcohol to the levels experienced by people who use cocaine may be beneficial.[133]

Latin American drug control policies are still based on the general principles of eliminating the production, trade or use of any illegal psychoactive substance. The "war against drugs" in Latin America has not reduced drug trafficking, but it has led to more violence and human rights violations.[36,67,104]

Decree 1844 and civil society action in Colombia

Civil society advocacy in Colombia has had success in fighting back against President Iván Duque's increasingly punitive approach to drug policy.[73]

In 2018, Duque introduced Presidential Decree 1844, giving law enforcement officials additional powers to search and fine those in possession of small amounts of drugs. This is despite the fact that constitutional rulings in Colombia have decriminalised the possession of small amounts of cocaine and marijuana (known as the 'dosis minima') since the 1990s.[134]

Temblores, a civil society organisation, took the case to the constitutional court, highlighting disproportionate enforcement of the decree among racial and ethnic minorities and the targeting of people experiencing homelessness. In 2019, the court ruled the enforcement of the decree to be unconstitutional.[135–137]

Temblores, along with the José Alvear Lawyers Collective and member of the House of Representatives Katherina Miranda, then took the case to the Council of State, Colombia's supreme tribunal on administrative matters. On 19th July 2020, the Council of State officially nullified the effects of Decree 1844, preventing law enforcement from fining or arresting people in possession of drugs for personal use.[135–137]

4. Funding developments for harm reduction

As international donors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) withdraw from the region, the regional trend has been an increase in the proportion of harm reduction funding provided by national governments. However, domestic funding consistently falls short of what international donors have previously provided, leaving services without a sustainable source of finance and unable to provide continuous services to vulnerable populations.[5,11,21,43] Additionally, the transition to domestic funding applies primarily to services for people who inject drugs, and there remain few funding opportunities for services for the majority of people who use drugs in the region who do not inject.[87] Where the Global Fund continues to finance harm reduction, no country has community representation in their Country Coordinating Mechanism.[87]

In the Caribbean, the implementation of harm reduction is limited by a lack of funding as well as the absence of political will. No civil society organisations providing harm reduction interventions receive any state support for those services.[15,29] The withdrawal of the Global Fund from many low and middle income countries in the region has drastically affected the financial landscape for harm reduction.[138]

Barriers to accessing national public funding for harm reduction organisations increased during the period in each country due to the socio-economic crisis in the region and the regression towards more punitive drug policies. There is a clear, urgent and demonstrated need for declarations of political support for Latin American harm reduction programmes to be accompanied by financial support.

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