

Global State of Harm Reduction 2008

Mapping the response to drug-related HIV and hepatitis C epidemics



ihra 

INTERNATIONAL HARM REDUCTION ASSOCIATION

Contents

Acknowledgements p2

Foreword by Professor Paul Hunt p3

Introductory comments from Gerry Stimson p4

Introductory comments from International Network of People who Use Drugs (INPUD) p4

Introduction p7

Section 1: A global perspective p9

Section 2: Regional overviews

Asia p21

Eurasia p33

Western Europe p47

Caribbean p57

Latin America p65

North America p75

Oceania p87

Middle East and North Africa p97

Sub-Saharan Africa p107

Section 3: Key issues

The Human Right to Harm Reduction p119

Beyond injecting drug use – the overlap between HIV and non-injecting drug use p123

Civil Society Engagement: Connecting the local with the global p125

The Global State of Harm Reduction 2008

Mapping the response to drug-related HIV and hepatitis C epidemics

Catherine Cook and Natalya Kanaef

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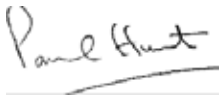
Foreword by Professor Paul Hunt

Since the earliest days of the global HIV pandemic, people who inject drugs have been identified as one of the groups disproportionately affected by the virus. In the mid-1980s, harm reduction arose as a series of targeted, low-threshold interventions aimed at preventing the transmission of HIV through unsafe injecting practices. In the two decades since then, comprehensive harm reduction services have proven time and again to be remarkably effective responses to HIV. But the health benefits of harm reduction extend beyond HIV prevention to preventing the transmission of other blood-borne viruses and to protecting people who inject drugs, and their partners, from the wide range of other negative health consequences associated with injecting drug use.

Today, despite endorsement by UNAIDS, WHO and UNODC, and the overwhelming evidence in favour of harm reduction as an effective HIV prevention strategy, the global state of harm reduction is poor. Less than 5% of those in need have access to harm reduction services. Up to 10% of new HIV infections worldwide are attributable to unsafe injecting. When sub-Saharan Africa is excluded, this figure rises to 30%. The figure is significantly higher still in some regions and specific countries, often the same places where access to harm reduction services is most limited. All over the world, people who use drugs remain marginalised, stigmatised and criminalised, with increasing vulnerability to HIV and decreasing access to essential health care services. In such environments, the full guarantee of the right to the highest attainable standard of health for people who use drugs is impossible.

In seeking to reduce drug-related harm, without judgement, and with respect for the inherent dignity of every individual, regardless of lifestyle, harm reduction stands as a clear example of human rights in practice. What began as a health-based intervention in response to HIV must today be recognised as an essential component of the right to the highest attainable standard of health for people who inject drugs. Every state therefore has an obligation to implement, as a matter of priority, national comprehensive harm reduction services for people who use drugs.

The Global State of Harm Reduction is a welcome and long overdue publication. As it develops, in print and online, it will, I hope, serve as a tool to assist not only in assessing the global state of harm reduction, but also the global state of the right to the highest attainable standard of health for people who use drugs.

A handwritten signature in dark ink, reading "Paul Hunt". The signature is written in a cursive, flowing style. Below the signature is a thin horizontal line.

Professor Paul Hunt

UN Special Rapporteur on the Right to the Highest Attainable Standard of Health

Introductory comments from Gerry Stimson

It is over two decades since the first harm reduction projects started in Europe, Australia and North America – grass-roots services delivered by civil society and endorsed and (soon after) funded by some governments. Since the late 1980s, harm reduction has grown exponentially in terms of acceptance, coverage, popularity, implementation and scientific knowledge. Harm reduction programmes currently operate in a wide variety of cultural, religious and political contexts, and the approach is supported by international organisations such as UNAIDS, UNICEF, WHO, UNODC and the World Bank. This report aims to consolidate this growth by assessing and documenting the global state of harm reduction in 2008.

In many ways, the scientific debate has been won and only ideological or moralistic criticisms remain. However, there are still numerous obstacles to the universal implementation of harm reduction, including resource shortages, re-emerging 'War on Drugs' approaches, legal restraints on substitution treatments, vociferous anti-harm reduction bodies and limitations on NGO operations in many developing and transitional countries. In order to overcome these barriers and move forward, harm reduction must become a truly global approach.

The International Harm Reduction Association (IHRA) was formed in 1996 (as a result of the annual harm reduction conferences) and has since become a leading organisation promoting evidence-based harm reduction policies and practices on a global basis for all psychoactive substances. This report is a demonstration of IHRA's commitment to the development of a conducive global environment for the promotion of harm reduction and the defence of the human rights of people who use drugs.



Professor Gerry Stimson

Executive Director International Harm Reduction Association

Introductory comments from International Network of People who Use Drugs (INPUD)

The global prohibition – imposed by the United Nations drug conventions – causes multiple damages to people who use drugs and the social environments in which we live. Under these circumstances, harm reduction is the only approach that really helps people who use drugs to survive. Harm reduction saves lives.

Harm reduction and our community of people who use drugs have a symbiotic connection. Most important in this relationship is the acknowledgement that voices of drug user activists are fundamental for shaping the response to all problems related to illegal drug use. In this sense, drug user activism IS harm reduction.

Drug user organising begins by addressing health-related issues. The drug user activists strive for political change. A recent online survey into the global state of drug user activism showed that 79% of responding organisations were engaged in advocacy, and 95% of them were purely peer-driven.

Drug user activists are becoming increasingly involved in the global drug policy debate. In July 2007, the International Network of People who Use Drugs (INPUD), the first international drug user organisation, was registered, and since then it has been represented at international conferences and high-level meetings including the EU Civil Society Forum on Drugs, UNGASS Regional Consultations, UN Civil Society Task Force and the Commission on Narcotic Drugs.

Nevertheless, the life conditions of millions of drug users worldwide are worse than ever before. The 'War on Drugs' continues to result in fear, repression, stigma, discrimination and unnecessary deaths. The practical implementation of the UN drug conventions results in constant abuse of the rights of the people who use drugs. For the vast majority of us, the inaccessible life-saving treatments, the inaccessible harm reduction services, the HIV and the HCV epidemics, the overdose-related permanent health damage and deaths are a one-way, dead-end routine. The only way that leads back to democracy and respect for human dignity is to declare zero tolerance to the ZERO TOLERANCE approach.

On behalf of INPUD, we would like to welcome the publication of IHRA's report on the Global State of Harm Reduction.



Stijn Goossens and Milena Naydenova

International Network of People who Use Drugs (INPUD)

Abbreviations and acronyms

AHRN	Asian Harm Reduction Network
AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral treatment
ATS	Amphetamine-type stimulants
CARICOM	Caribbean Community
CBO	Community-based organisation
CDARI	Caribbean Drug Abuse Research Institute
CDC	Centers for Disease Control and Prevention (US)
CHRC	Caribbean Harm Reduction Coalition
CIS	Commonwealth of Independent States
CND	Commission on Narcotic Drugs
DARE	Drug abuse resistance education
DCR	Drug consumption room
DFID	Department for International Development (UK)
DIC	Drug intervention centre
DRC	Drug rehabilitation centre
ECOSOC	Economic and Social Council (UN)
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
GHB	Gamma hydroxybutyrate
HAV	Hepatitis A virus
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HR2	IHRA's harm reduction and human rights programme
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDU	Injecting drug use
IEC	Information, education and communication
IHRA	International Harm Reduction Association
ILO	International Labour Organization (UN)
INCB	International Narcotics Control Board
INPUD	International Network of People who Use Drugs
LSD	Lysergic acid diethylamide
MDA	3,4-Methylenedioxymphetamine
MDMA	3,4-Methylenedioxymethamphetamine
MMT	Methadone maintenance treatment
MSM	Men who have sex with men
NGO	Non-governmental organisation
NIDU	Non-injecting drug use
NSP	Needle and syringe exchange programme
OST	Opioid substitution therapy
PAHO	Pan American Health Organization (WHO)
PBC	Pasta base de cocaine (Cocaine base paste)
PEPFAR	President's Emergency Plan for AIDS Relief
PICTs	Pacific Island Countries and Territories
PNEP	Prison needle and syringe exchange programme
PNG	Papua New Guinea
SIF	Safe injecting facility
STI	Sexually transmitted infection
UAE	United Arab Emirates
UK	United Kingdom of Great Britain and Northern Ireland
UN	United Nations
UNAIDS	Joint United Nations Programme on AIDS
UNDCP	United Nations Drug Control Programme
UNDP	United Nations Development Programme
UNESCO	United Nations Economic, Social and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
US	United States of America
VCT	Voluntary HIV counselling and testing
WFP	World Food Programme (UN)
WHO	World Health Organization

INTRODUCTION

About the Global State of Harm Reduction

In 2006, the International Harm Reduction Association (IHRA) received support from the UK Department for International Development (DFID) for a project to promote a global environment conducive to the implementation and scaling up of harm reduction interventions. The Global State of Harm Reduction represents an important part of this project.

The Global State report attempts to map harm reduction services, consolidate existing data on drug use and HIV and hepatitis C, record multilateral agency activities and document harm reduction policies and practices around the world. As such, the report provides a critical baseline through which progress can be measured in terms of the international, regional and national acceptance of harm reduction policies and interventions, and the performance of multilateral agencies.

This report, and its subsequent updates, will also identify key issues affecting harm reduction and global drug and HIV policy, such as human rights violations against people who use drugs, non-injecting drug use and instances where multilateral activities or national policies and programmes fail to meet local needs and experience.

The Global State report is designed to be an advocacy and reference tool for a wide range of audiences, including international donor organisations, multilateral and bilateral agencies, civil society and non-governmental organisations (NGOs), organisations of people who use drugs, researchers and the media.

The report will enable IHRA to engage with and work alongside a wide range of partners around the world – regional harm reduction networks, international human rights organisations and HIV and drug policy organisations – to advocate and lobby for harm reduction.

Methodology

The information in this report was gathered using existing data sources, including research papers, reports from multilateral agencies, international NGOs, civil society and harm reduction networks, as well as expert opinion from drug user organisations and those working in the harm reduction field. Within each region, IHRA enlisted support from regional harm reduction networks and researchers to gather existing data from published research.

Quantitative and qualitative indicators were developed consistent with those used in parallel data-gathering processes.^a These covered drug use, HIV and hepatitis C (HCV) and the response at the policy and programming level from government, civil society and multilateral agencies.

For the purposes of the Global State, regions were largely identified using the coverage of the regional harm reduction networks. Therefore, this report examines the regions of Oceania, Asia, Eurasia (Central and Eastern Europe and Central Asia), Western Europe, Sub-Saharan Africa, Middle East and North Africa, Latin America, the Caribbean and North America. Each regional overview section was peer reviewed by the regional harm reduction networks and other experts in the field (see acknowledgements).

A database containing country-by-country information and electronic copies of sources used in the data collection process are housed at the IHRA offices in London.

Data quality

Obtaining accurate data when researching 'hidden populations' is notoriously difficult. Globally, surveillance and monitoring systems are improving, however the data availability in many countries remains very poor, and in these cases the experience of those gathering the data and their contacts was called upon to provide a picture of the situation.

While the data presented here represent the best estimates currently available, lack of uniformity in measures, data collection methodologies and definitions render cross-national and regional comparisons difficult.

Limitations

This report attempts to provide a global snapshot of harm reduction policies and programmes, and as such has several limitations. It does not provide an extensive evaluation of the services or policies in place, and it must be recognised that the existence of a service does not necessarily denote quality and adequate coverage to have an impact on HIV or HCV transmission. More in-depth monitoring and evaluation of services for people who inject drugs will be an important part of achieving universal access to comprehensive HIV services.

While the Global State report covers the response to HIV and HCV epidemics among people who inject drugs, the full spectrum of drug-related harms and harm reduction interventions are not documented here. Further health-related harms (for example overdose, wound botulism, tuberculosis, STIs, hepatitis A and B) as well as social and legal harms (for example violence against people who use drugs, stigma and discrimination, violation of rights) affect people who use drugs globally. The extent to which people who use drugs have access to essential social and legal support interventions, mental health and primary health care services and the full range of drug treatment services is not explored here.

Worldwide, elements of harm reduction that mitigate HIV epidemics have received most attention, largely as a result of the funding environment. In practice, this can result in a somewhat fragmented approach to harm reduction. Policies and programmes that aim to reduce other harms faced by people who use drugs form part of a comprehensive harm reduction approach and, as such, require increased consideration from the international community.

The structure of this report

Section 1 provides a global overview of harm reduction policy and programming in response to HIV and HCV epidemics among people who inject drugs.

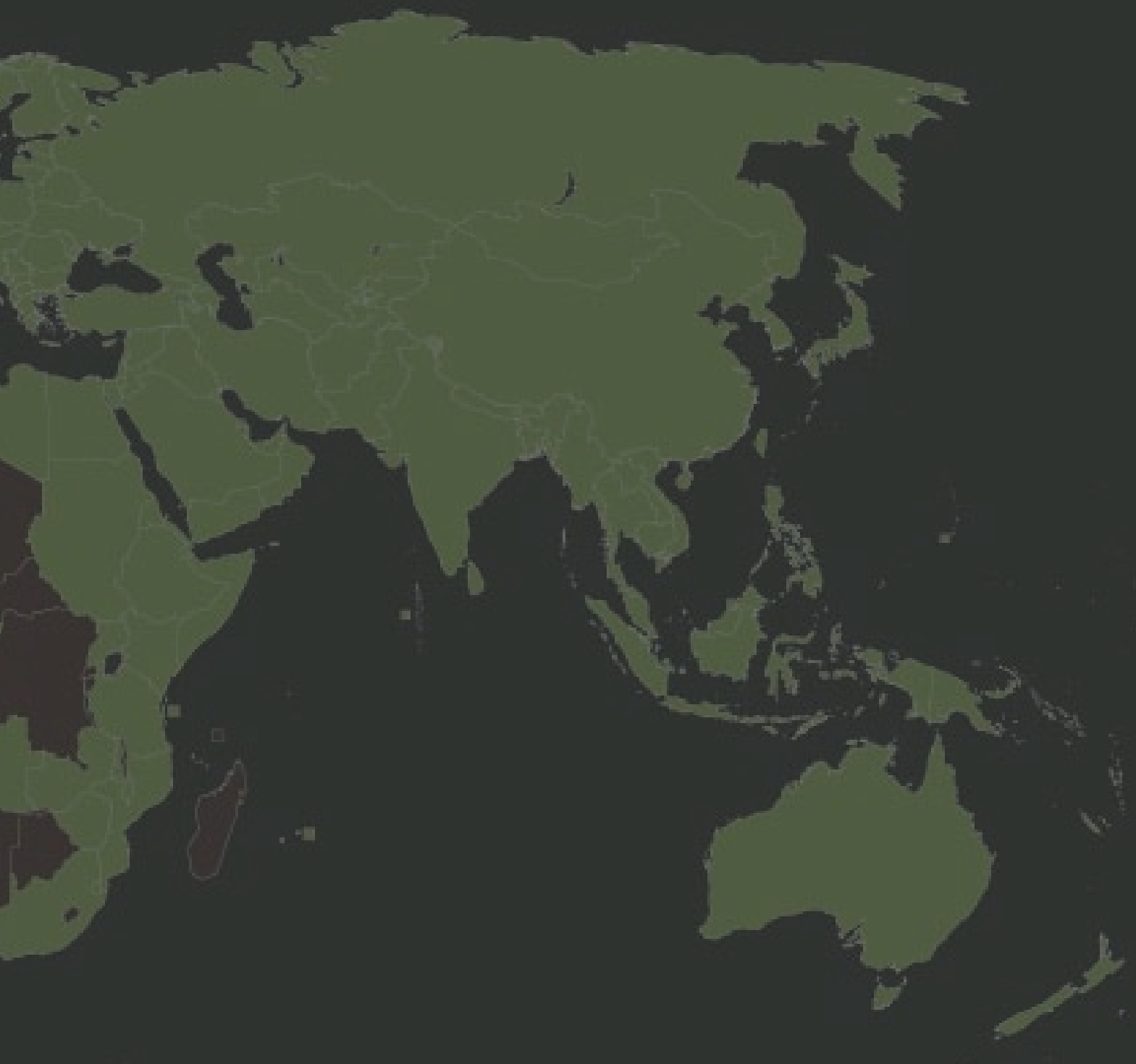
Section 2 contains nine regional overviews – Asia, Eurasia, Western Europe, the Caribbean, Latin America, North America, Oceania, Middle East and North Africa, and Sub-Saharan Africa – which examine the harm reduction response in further depth.

Section 3 explores issues that are key to assessing the global state of harm reduction, including human rights, non-injecting drug use and civil society engagement in multilateral processes.

a Epidemiological indicators matched those used by the Reference Group to the United Nations on HIV and Injecting Drug Use where possible. UN technical guidelines on setting targets for universal access to HIV prevention, treatment and care for injecting drugs users framed the indicators on harm reduction services.



HARM REDUCTION: A GLOBAL PERSPECTIVE



Harm Reduction: A Global Perspective

The term 'harm reduction' refers to policies and programmes aimed at reducing the health, social and economic harms associated with the use of illicit and licit psychoactive substances. Harm reduction is entrenched in both public health and human rights rationales, and takes a pragmatic and non-judgemental approach to addressing the problems associated with drug use. It works alongside consumption reduction approaches, but recognises that a drug-free world is an unrealistic ideal, and that individuals and communities must therefore be provided with information and tools for reducing the risks associated with using drugs.

A variety of interventions fall into the category of harm reduction. These include the dissemination of information on how to reduce risks associated with drug use (often through peer-led outreach), the provision of services which increase the safety of people who use drugs such as needle and syringe exchange programmes and safe injecting facilities, and a range of drug dependence treatment options including the medical provision of substitution for opiate dependence.

Harm reduction approaches also seek to identify and advocate for changes in laws, regulations and policies that increase harms or that hinder the introduction or efficacy of harm reduction interventions and health services for people who use drugs.

The Global State of Harm Reduction documents the current international harm reduction response with a particular focus on the response to the HIV and hepatitis C (HCV) epidemics around the world. For this reason, the focus of the report is primarily on harm reduction interventions related to injecting drug use, although recognising the growing body of evidence which suggests that the use of drugs generally, including alcohol, is associated with the sexual transmission of HIV and that harm reduction interventions can also address other drug-related harms such as overdose.

The Global State of Harm Reduction examines both 'the state of the problem' and 'the state of the response' in every region of the world, identifying areas of good practice and areas where the provision of these health interventions falls far short of what is needed. This report also provides an overview of the laws, regulations and policies related to harm reduction at the national and international levels.

Injecting drug use – A global phenomenon

Prior to the 1970s, injecting drug use was confined mainly to North America and Europe, but is now found in all regions of the world.

Injecting a psychoactive substance into the body is a very efficient method of drug consumption. However, injecting puts people who use drugs at greater risk of overdose, infections and health problems than if drugs are taken by alternative routes such as inhalation or swallowing. These dangers also include risk of transmission of blood-borne viruses such as HIV and HCV through the use/re-use of unsterilised injecting equipment.

In 1992, injecting drug use was reported in eighty countries and territories.¹ By 1995, this figure had increased to 121.² In 2008, injecting drug use has been reported in 158 countries and territories.

It is over two decades since the first harm reduction projects started in Europe, Australia and North America. These early interventions were mostly needle and syringe exchange projects and outreach services for people who use drugs, often led by community-based drug user organisations. For example, the first needle exchange was started in 1984 by drug users in the Netherlands as a response to a hepatitis B epidemic. From then, similar projects were quickly adopted around the world, driven by evidence of rapidly growing HIV epidemics in a number of cities.

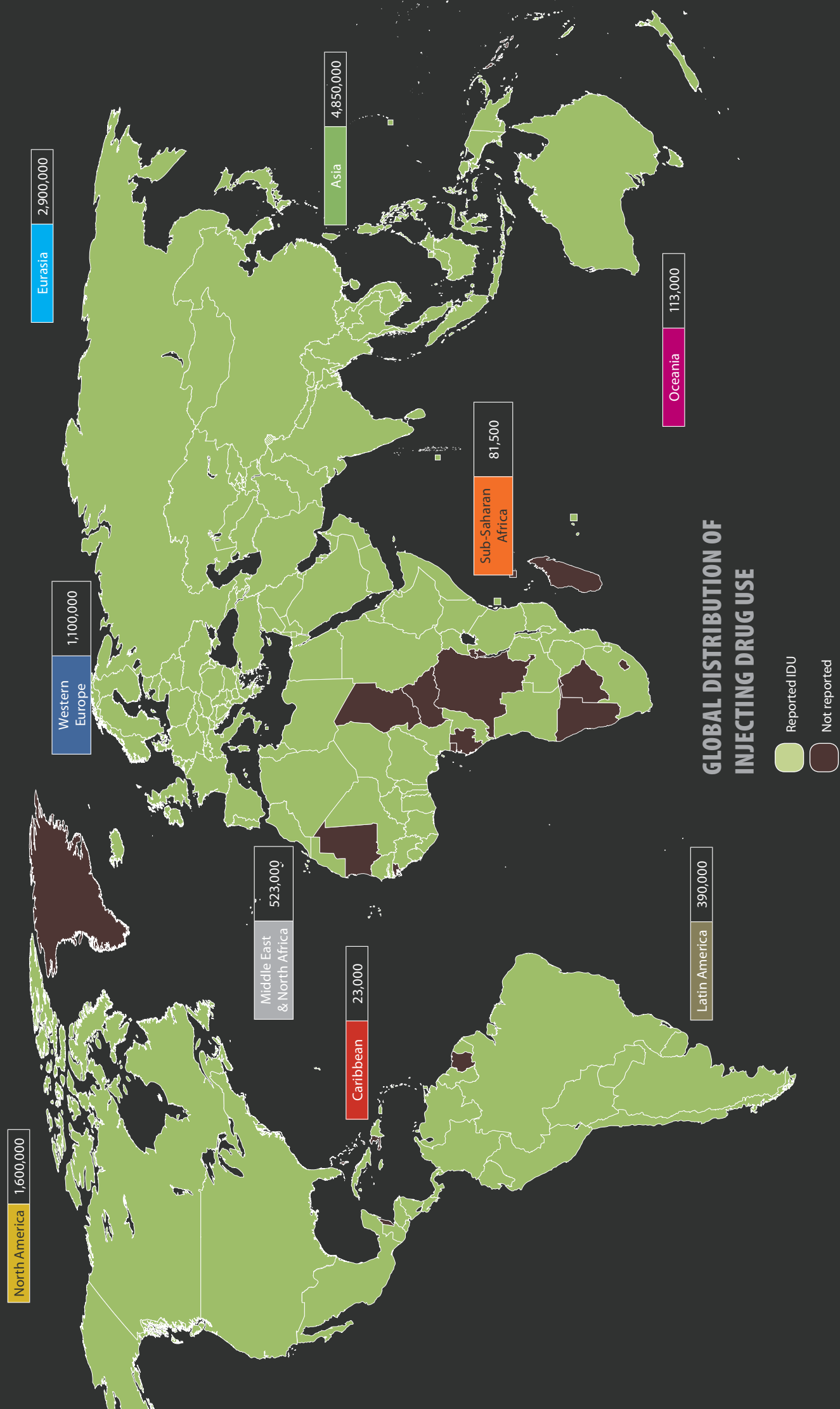
It was not long before some governments (including those in the UK, the Netherlands, Australia and Germany) adopted this 'harm reduction' approach as a general public health strategy. In the UK, an extensive range of harm reduction programmes soon developed, including the social marketing of safer drug use, outreach and peer advocacy, improved access to treatment and services and the extension of voluntary counselling and testing.

Since the late 1980s, harm reduction has grown in acceptance, popularity, scientific knowledge, advocacy methods and evidence base. The scientific debate has been won, and only ideological or moralistic criticisms of harm reduction remain. Harm reduction has been accepted by many governments and also by the international community and the United Nations system.

The harm reduction approach is currently endorsed by the majority of EU countries, Australia and a growing number of more recent converts including Indonesia, Malaysia, Taiwan, China, Iran and Morocco. Harm reduction programmes currently operate in a wide variety of cultural, religious and political contexts. They have been adapted to suit most settings, resource restrictions and populations. Harm reduction is a mainstay of United Nations policies and is supported by UNAIDS, UNICEF, UNESCO, UNODC and the WHO.

By 2008, there were at least seventy-seven countries and territories with some kind of syringe distribution programme, and approximately sixty-three with some type of methadone or buprenorphine substitution therapy.

GLOBAL DISTRIBUTION OF INJECTING DRUG USE



Estimates of the number of people who inject drugs are available for 128 of the 158 countries and territories where injecting is reported. Where estimates are not available, this is due to either a lack of drug use monitoring or because drug injecting is extremely rare (for example in most of the Caribbean region).

Based upon the data collected for this report, it is cautiously estimated that around 11.6 million people currently inject drugs worldwide. This figure is lower than the 2004 estimate of the UN Reference Group on HIV and Injecting Drug Use of 13.2 million people injecting drugs.³ The most commonly injected drugs around the world are heroin, cocaine and amphetamine-type stimulants (ATS).

Approximately 80% of people who inject drugs live in developing and transitional countries.³ Disaggregated data are rarely available. However, people who inject drugs are predominantly male, ranging from approximately 70 to 75% in Europe and North America to over 90% in many countries in Asia.⁴ The regions with the highest estimated numbers of people who inject drugs are Asia and Eurasia, with the largest numbers residing in Russia, China and India.

Global dynamics of injecting drug use

Studies of the spread of injecting (across regions, countries and communities) show that:

- The spread of injecting can be rapid. In many countries, it takes only a few years to occur. Therefore, countries with small injecting populations have an opportunity to act.
- Certain groups are more likely to encounter opportunities to use and inject drugs. Initial adoption is followed by more general dispersion. The spread of drug use and injecting may be understood in a similar fashion to the diffusion and adoption of other innovations.⁵
- Heroin and cocaine trading routes lead to spill over into local markets. Law enforcement against shipment routes in particular countries can adversely affect neighbouring countries by causing the shift of trading routes.
- Cultural, communicative and social links, as well as migration between population groups, are important factors in the spread of injecting.
- Legal, cultural, economic and political conditions influence new patterns of drug use. In some circumstances, this is linked to rapid social changes and greater inequalities in opportunity and wealth, as in the former Soviet Union.
- The spread of injecting is a sub-regional phenomenon rather than something only happening at a city or country level.
- Injecting first spreads among elites and more wealthy groups, with subsequent diffusion more generally in the population, before later markedly affecting impoverished communities.

Although it is difficult to establish trends in injecting drug use, in many countries, research, national treatment data and/or anecdotal reports from those working in the harm reduction field suggest that it may be increasing. This trend is most notable in Asia, Sub-Saharan Africa, Central and Eastern Europe and Central Asia.

Rapid spread of injecting in South-East Asia

The experience of South and South-East Asia is a classic example of rapid changes in patterns of drug use. In Thailand, opium smoking predominated until the late 1960s. Then followed an expansion of heroin production as a consequence of law enforcement activities against production in Mediterranean countries. Originally intended for export, the local production of heroin facilitated the emergence of local markets. In a period of twenty years, Thailand saw a transition from opium smoking to heroin smoking, and then to heroin injecting. Heroin for world export went in transit through Bangkok. However, with enforcement and government activities in Thailand and Myanmar, export routes shifted through Shan State to Yunnan in China and on to Hong Kong. In the 1980s, a further overland route developed through north-east Myanmar and north-east India. These routes had consequences for the spread of injecting in China, Nepal, Myanmar and Vietnam. The first large seizure of heroin in Vietnam was in the early 1990s. More recently, Cambodia and Laos have also seen the rapid spread of injecting.⁶

Injecting drug use and HIV epidemics

Injecting drug use provides an extremely effective transmission route for blood-borne viruses such as HIV. The sharing of injecting equipment is common in many parts of the world, and can result in the rapid expansion of HIV, HCV and HBV epidemics among people who inject drugs.

It has been estimated that up to 10% of all HIV infections occur through injecting drug use,³ meaning that, globally, there may be up to 3.3 million people who inject drugs that are living with HIV. Countries with large numbers of people who inject drugs, such as Russia and Ukraine, have been experiencing the world's fastest-growing HIV epidemics. In some areas, as many as 80% of people living with HIV are likely to have acquired the virus through unsafe injecting.⁷

There is wide variation in HIV prevalence among people who inject drugs. In some areas, such as much of Western Europe, as well as Australia and New Zealand, the prevalence of HIV infection among people who inject drugs remains below 5%. At the other extreme, in countries such as China, Estonia, India, Kenya, Myanmar, Nepal, Thailand and Vietnam, the prevalence of HIV infection has reached 50% or higher among people who inject.

There are also wide variations in HIV prevalence rates among injecting populations within countries. For example, HIV prevalence rates among people who inject drugs in India range from 1.3 to 68.4%. In Indonesia, the range is between 15 and 47%. These ranges reflect different surveillance methods and samples, and also the variable distribution of HIV epidemics within countries.

Some people who inject drugs are more vulnerable than others to HIV and other blood-borne viruses due to drug-taking behaviours, poor access to harm reduction services, and social and cultural factors. Young injectors or new injectors are often most vulnerable due to a lack of harm reduction knowledge. Women who inject drugs are particularly affected by HIV. For example in parts of Eastern Europe, Central Asia and Sub-Saharan Africa they experience higher prevalence rates than those among male injectors. Street-involved people are often more vulnerable

because they will inject urgently in order to not be seen by police or other members of the public. People injecting cocaine or ATS will often inject more frequently in order to maintain the drug's effect, increasing the chance of unsafe injecting.

HIV prevalence among prison populations is typically higher than that found in the population outside of prisons. This is related to the criminalisation approach to drug use adopted in most countries, which results in the incarceration of significant numbers of people who use drugs. It also reflects the lack of access to harm reduction measures inside prisons, which increases the likelihood of unsafe injecting.

Table A.1 contains some examples of available data on HIV prevalence among people who inject and among prisoners around the world. These examples are explored further in the regional overview chapters in section 2 of this report.

Table A.1: HIV prevalence among people who inject drugs and prison populations in selected countries

Country or territory	Adult HIV prevalence among people who inject drugs	HIV prevalence among prisoners
Brazil	28–42%	12.5–17.4%
Canada	2.9–23.8%	1–11.9%
China	0–80%	0–4% (among prisoners) 42% (among drug rehabilitation camp detainees)
Cuba	0.1%	25.8%
Estonia	54.3–89.9%	8.8–90%
France	1–32%	13%
India	1.3–68.4%	1–14% (female prisoners) 0–7% (male prisoners)
Indonesia	15–47%	20%
Italy	13.8%	17%
Jamaica	nk	12%
Kenya	68–88%	nk
Libya	0.5–59.4%	60% (prisoners with a history of injecting)
Malawi	0%	60–75%
Myanmar	37.1–63%	nk
Nepal	45–60%	nk
South Africa	10–20%	45%
Thailand	20–56%	nk
Ukraine	41%	13%
Vietnam	0–89.4%	28.4%
Yemen	nk	25.6%
Zambia	<1%	27%

nk = not known

Hepatitis C and people who inject drugs – The hidden epidemic

It is estimated that 3% of the world's population, or approximately 180 million people, are living with the hepatitis C virus (HCV).⁸ HCV is the most common infectious disease among people who inject drugs.⁹ The virus is more infectious than HIV and can be transmitted through the sharing not only of needles and syringes, but also of injecting-related paraphernalia such as cotton, water and spoons/'cookers'.¹⁰ Most HCV infections around the world occur through unsafe injecting drug use.

If left untreated, HCV leads to chronic infection in about 80% of cases. Of these, liver cirrhosis and liver cancer will develop in between 1 and 20% of people.¹¹ Due to the lack of symptoms, many people remain unaware that they have the virus, and therefore are less likely to seek treatment. This outcome is even more pronounced among populations who have poor access to general health care services, including people who inject drugs.

Extremely high proportions of people who inject drugs in all regions of the world are affected by HCV. A recent review of HCV prevalence among people who inject drugs worldwide found reports of prevalence rates of over 50% in forty-nine countries or territories. In some areas, HCV prevalence rates as high as 95% were reported.¹² The vast majority of people who inject drugs in countries as far-ranging as Indonesia, Thailand, Pakistan, Mauritius, Estonia, Lithuania, Russia, Ukraine, Luxembourg and Switzerland are living with HCV.

Prisoners are also highly affected by HCV, although a lack of HCV monitoring systems means that data are scarce.

Table A.2 contains some examples of available data on HCV prevalence among people who inject and among prisoners around the world. These examples are explored further in the regional overview chapters in section 2 of this report.

Table A.2: HCV prevalence among people who inject drugs and prison populations in selected countries

Country or territory	Adult HCV prevalence among people who inject drugs	HCV prevalence among prisoners
Bahrain	81%	nk
Brazil	39.5–69.6%	nk
Czech Republic	21–59%	18–78%
Estonia	90%	82–97.4%
Germany	75%	80% (prisoners with a history of injecting, Berlin)
India	92%	nk
Indonesia	60–98%	nk
Iran	35%	18.7%
Japan	55.1–60%	nk
Kazakhstan	65.7%	nk
Mauritius	95%	nk
New Zealand	70%	80% (prisoners with a history of injecting)
Pakistan	89%	nk
Saudi Arabia	69%	nk
Sweden	83.8%	nk
Thailand	90%	nk
Ukraine	70–90%	nk
United Kingdom	41%	30–44% (prisoners with a history of injecting)
United States	50–80%	30–40%

nk = not known

People who inject drugs are at increased risk of acquiring both HIV and HCV infection, which is known as HIV/HCV co-infection. The presence of both viruses has additional health implications. HIV/HCV co-infection accelerates the progression of hepatitis C and also complicates and compromises the efficacy of the treatment of HIV.¹⁰ End-stage liver disease caused by HIV/HCV co-infection has become one of the leading causes of death among people living with HIV in Europe.¹³ Several countries in Eurasia, Asia, North America and Western Europe have large numbers of people who inject drugs living with both HIV and HCV.

THE GLOBAL HARM REDUCTION RESPONSE

International endorsement – The UN response

At the international level, harm reduction is endorsed and promoted by multilateral and bilateral agencies, which provide technical and financial support to governments and civil society for harm reduction initiatives across the world. Numerous evidence-based technical papers, policy documents and best practice guidelines outline the importance of harm reduction and encourage governments to expand access to these services. For example:

- WHO, with co-sponsorship from UNAIDS and UNODC, has produced five policy briefings on HIV and injecting drug use, supported by seven evidence-for-action technical papers.* The papers cover needle and syringe exchange, opioid substitution therapy, injecting drug use in prisons, antiretroviral treatment for people who inject drugs, and preventing HIV transmission through drug dependence treatment and outreach. As of 2005, the essential medicines list from WHO has included methadone and buprenorphine.
- In 2008, the UNODC, in co-operation with the International Narcotics Control Board, released a discussion paper entitled 'Reducing the Adverse Social and Health Consequences of Drug Abuse: A Comprehensive Approach'. The paper lists a series of essential harm reduction interventions but stops short of supporting safer injection sites. It marks a significant development in the UNODC's public support for harm reduction interventions.¹⁴
- Almost ten years ago, UNAIDS and the International Parliamentary Union developed a 'Handbook for Legislators on HIV/AIDS, Law and Human Rights'. Among its recommendations are implementing needle and syringe exchanges, amending criminal legislation relevant to people who inject drugs so that HIV prevention efforts are not hampered and harm reduction in prisons (including safer tattooing equipment).¹⁵
- The 2005 UNAIDS policy position paper 'Intensifying HIV Prevention' includes harm reduction as an 'essential programmatic action for HIV prevention'.¹⁶
- The UNDP policy paper 'Reversing the Epidemic: Facts and Policy Options', which focuses on Eastern Europe and the Commonwealth of Independent States, calls on leaders to be 'informed by the logic of the harm reduction approach' and to 'robustly support' such interventions.¹⁷
- Harm reduction is also supported by the UN Committee on Economic, Social and Cultural Rights and the UN Special

Rapporteur on the Right to Health. Both have called on specific governments to scale up harm reduction services.¹⁸

In 2006, UN member states made the commitment to work towards universal access to HIV prevention, care and treatment services by 2010. UNAIDS provided guidance for the development of national indicators, and is now monitoring progress towards these objectives. In the guidance documentation, targets related to harm reduction interventions such as syringe exchange and opioid substitution therapy were explicitly recommended for those countries with high levels of HIV among people who inject drugs.¹⁹

In 2008, WHO, UNODC and UNAIDS released detailed guidance on setting targets related to HIV prevention, care and treatment for people who inject drugs.²⁰ This guidance highlights an essential package of comprehensive harm reduction measures, including needle and syringe exchange; opioid substitution therapy; voluntary HIV counselling and testing; antiretroviral treatment; STI prevention; condom programming; targeted information, education and communication (IEC); hepatitis A, B, and C diagnosis and treatment (and vaccination for HAV and HBV); as well as tuberculosis prevention, diagnosis and treatment.

Major funding for both government and civil-society-led harm reduction initiatives comes from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

A conducive environment for harm reduction

There are presently eighty-two countries and territories worldwide that support harm reduction (see Table A.3), explicitly in national policy documents (71 countries), and/or through the implementation or tolerance of harm reduction interventions such as needle exchange (77 countries) or opioid substitution therapy (63 countries).

There are also a substantial number of countries that are supportive of harm reduction internationally, either by assisting harm reduction programmes in other countries (or providing funds to international agencies that do) or by making explicit supportive reference to harm reduction in international forums such as at the UN Commission on Narcotic Drugs or at the UNAIDS Programme Coordinating Board. These include countries in Western Europe, Oceania, the Middle East and North Africa, and Latin America.

* All twelve documents are available online at <http://www.who.int/hiv/pub/advocacy/ndupolicybriefs/en/> (date of last access 9 April 2008).

Table A.3: Countries supporting harm reduction

Country or territory	Explicit supportive reference to harm reduction in national policy documents	Needle exchange programmes operational	Opioid substitution programmes operational
ASIA			
Afghanistan	✓	✓	x
Bangladesh	✓	✓	x
Cambodia	✓	✓	x
China	✓	✓	✓
Hong Kong	✓	x	✓
India	✓	✓	✓
Indonesia	✓	✓	✓
PDR Laos	✓	x	x
Malaysia	x	✓	✓
Myanmar	✓	✓	✓
Nepal	✓	✓	✓
Pakistan	✓	✓	x
Taiwan	✓	✓	✓
Thailand	x	✓	✓
Vietnam	nk	✓	✓
CARIBBEAN			
Puerto Rico	nk	✓	✓
EURASIA			
Albania	✓	✓	✓
Armenia	✓	✓	x
Azerbaijan	x	✓	✓
Belarus	✓	✓	✓
Bosnia and Herzegovina	x	✓	✓
Bulgaria	✓	✓	✓
Croatia	✓	✓	✓
Czech Republic	✓	✓	✓
Estonia	✓	✓	✓
Georgia	✓	✓	✓
Hungary	✓	✓	✓
Kazakhstan	✓	✓	x
Kyrgyzstan	✓	✓	✓
Latvia	✓	✓	✓
Lithuania	✓	✓	✓
Macedonia	✓	✓	✓
Moldova	✓	✓	✓
Montenegro	✓	✓	✓
Poland	✓	✓	✓
Romania	✓	✓	✓
Russia	x	✓	x
Serbia	✓	✓	✓
Slovakia	✓	✓	✓
Slovenia	✓	✓	✓
Tajikistan	✓	✓	x
Ukraine	✓	✓	✓
Uzbekistan	✓	✓	✓

nk = not known

Table A.3: continued.

Country or territory	Explicit supportive reference to harm reduction in national policy documents	Needle exchange programmes operational	Opioid substitution programmes operational
LATIN AMERICA			
Argentina	✓	✓	x
Brazil	✓	✓	x
Mexico	✓	✓	✓
Paraguay	x	✓	x
Uruguay	✓	✓	x
MIDDLE EAST and NORTH AFRICA			
Egypt	x	✓	x
Iran	✓	✓	✓
Israel	✓	✓	✓
Lebanon	x	✓	✓
Morocco	✓	✓	x
Oman	✓	✓	x
Palestine	x	✓	x
NORTH AMERICA			
Canada	✓	✓	✓
United States	✓	✓	✓
OCEANIA			
Australia	✓	✓	✓
New Zealand	✓	✓	✓
SUB-SAHARAN AFRICA			
Mauritius	✓	✓	✓
South Africa	✓	x	✓
Tanzania	✓	x	x
Zanzibar	✓	x	x
WESTERN EUROPE			
Austria	✓	✓	✓
Belgium	✓	✓	✓
Cyprus	nk	✓	✓
Denmark	✓	✓	✓
Finland	✓	✓	✓
France	✓	✓	✓
Germany	✓	✓	✓
Greece	✓	✓	✓
Ireland	✓	✓	✓
Italy	✓	✓	✓
Luxembourg	✓	✓	✓
Malta	✓	✓	✓
Netherlands	✓	✓	✓
Norway	✓	✓	✓
Portugal	✓	✓	✓
Spain	✓	✓	✓
Sweden	✓	✓	✓
Switzerland	✓	✓	✓
United Kingdom	✓	✓	✓

nk = not known

Civil society

As well as strong support for harm reduction from multilateral, bilateral and international donor agencies, the role of international non-governmental organisations (NGOs) in harm reduction advocacy and implementation is crucial. The International Federation of the Red Cross and Red Crescent Societies, Médecins du Monde, the International Harm Reduction Development Program, CARE International, the International HIV/AIDS Alliance and the International Harm Reduction Association are just some of the organisations supporting, or directly involved in, harm reduction initiatives globally.

NGOs and community-based organisations are integral to the harm reduction response, both in the provision of essential services and through their involvement in local, national and regional advocacy initiatives. Worldwide, every region has at least one harm reduction network or organisation involved in regional harm reduction advocacy. In at least sixty-seven countries and territories, civil society organisations are involved in harm reduction advocacy at national level.

The harm reduction response from civil society is expanding and gaining strength. This was evident at the 51st Session of the Commission for Narcotic Drugs in March 2008, where civil society representation was stronger than ever before.

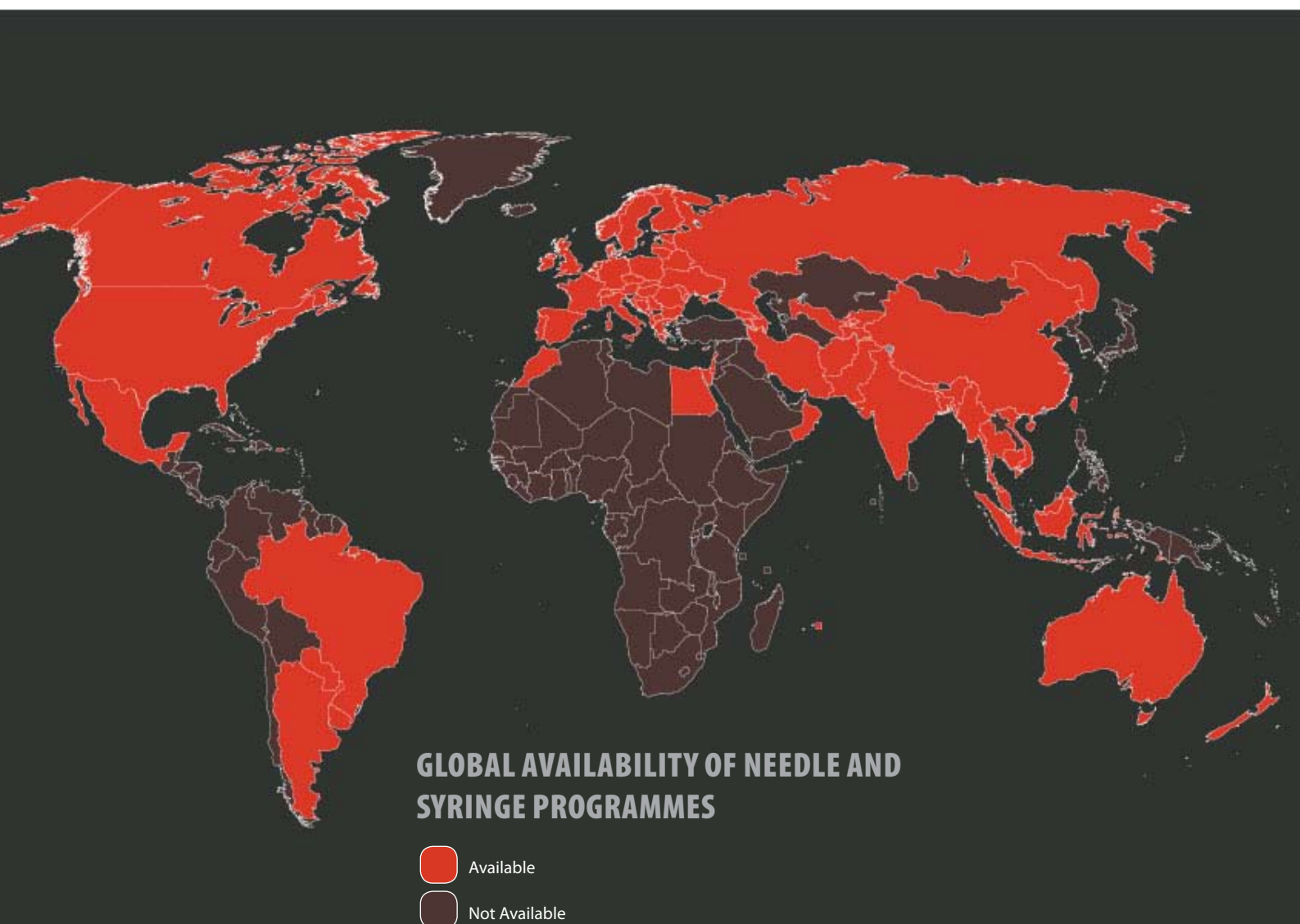
Drug user organisations are another fundamental component of the harm reduction response and their numbers are growing along

with their capacity to engage in advocacy initiatives. In more than thirty-four countries across Asia, Eurasia, Latin America, North America, Oceania, Sub-Saharan Africa and Western Europe, drug user organisations are involved in advocating for an increased harm reduction response.

The formation of the International Network of People who Use Drugs in 2007, and its regional bodies in Asia, Europe and, shortly, Latin America, will provide exciting new opportunities for drug user networking and increased involvement in international processes related to HIV and drug policy.

Global coverage of harm reduction services

Despite awareness from the mid-1980s of the increased risk of HIV faced by people who inject drugs, responding to unsafe injecting has remained a low priority in the global HIV response. In 2003, the estimated coverage of basic HIV services was 16% for sex workers, 11% for men who have sex with men and only 5% for people who inject drugs.²¹ The Secretary-General of the United Nations recently reported that 92% of people who inject drugs in low- and middle-income countries have no access to HIV prevention services of any kind.²² The limited and late response to HIV epidemics among people who inject drugs is clearly disproportionate.



Needle and syringe exchange programmes (NSPs)

There are seventy-seven countries and territories providing some level of needle and syringe exchange programming, whether through community-based outreach from specialist NSPs or pharmacy-based schemes. Where they exist, coverage is generally poor, especially in developing countries. Many countries, for example Cambodia, Malaysia, Israel, Morocco, Oman, Azerbaijan, Romania, Sweden and Slovakia, have only pilot programmes or very few NSP sites.

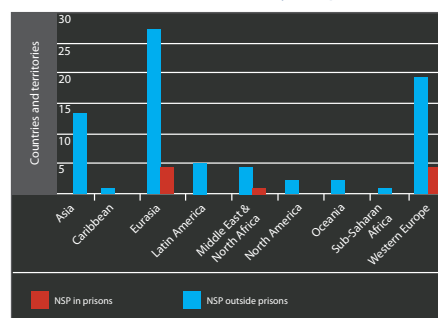
The most developed NSP access is found in Western Europe (for example, in the UK, Spain, Norway and France) and Australia. Some countries also have needle and syringe vending machines. Many countries allow pharmacy sales of syringes. However, even where these syringes are affordable, pharmacy staff are often reluctant to sell injecting equipment to people they suspect of drug use.

Legislation prohibits possession of injecting equipment in many countries, thereby creating a major barrier to encouraging safer injecting practices.

Globally, needle and syringe exchange programmes in prisons (PNEPs) are operating in only eight countries and territories.

In some countries, harm reduction efforts include the establishment of safer injecting sites, or drug consumption rooms. These currently exist in Australia, Canada and six Western European countries.

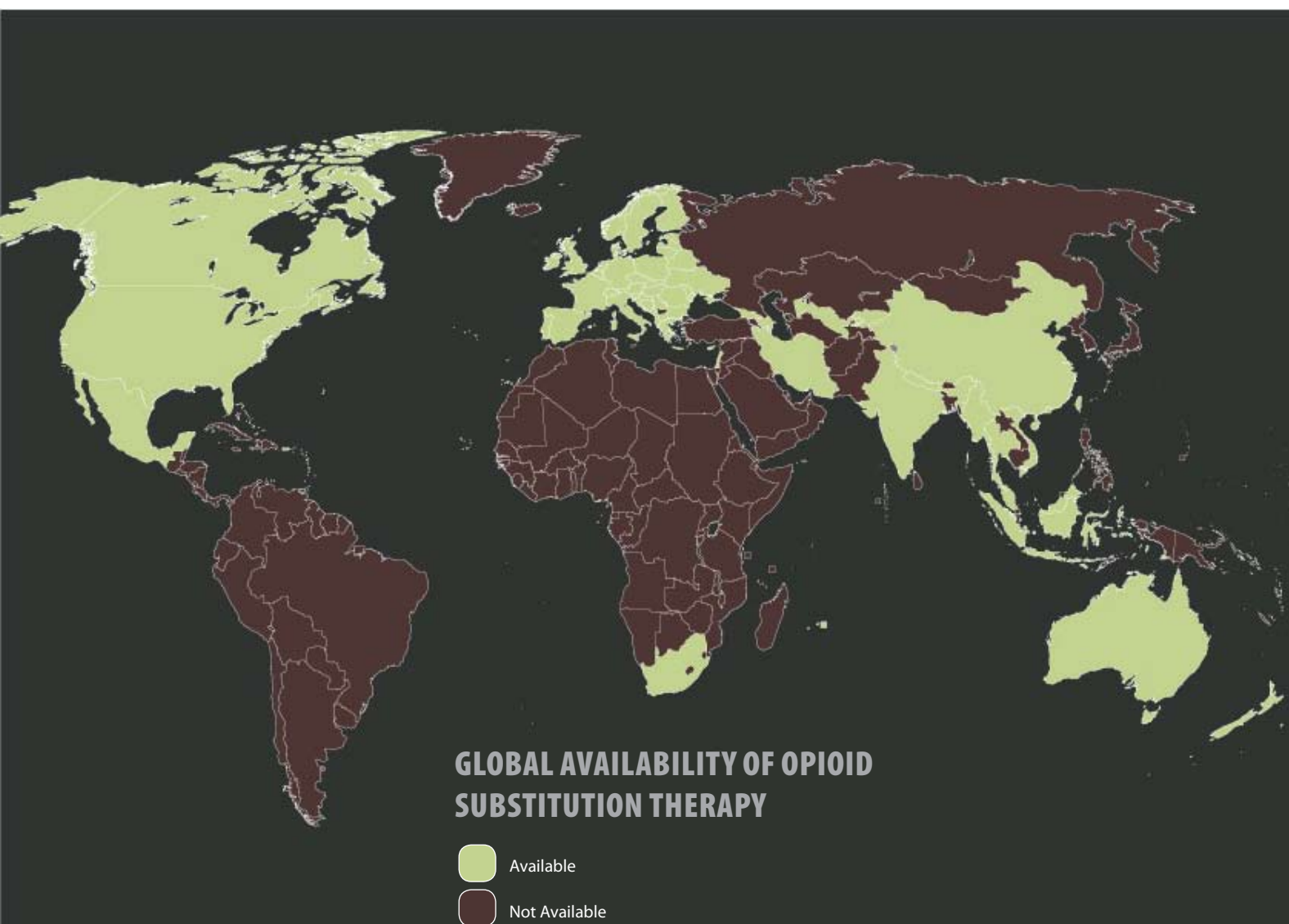
Figure A.1: Global needle and syringe exchange provision



Access to NSP services is often impeded by factors such as:

- Poor coverage
- Poor services (for example lack of, or inappropriate equipment; lack of community-based outreach workers; limited opening hours; lack of 'drug-user-friendly' services; lack of confidentiality)
- Repressive legislation criminalising NSP operation
- Police harassment or arrest
- Lack of funding for NSPs
- Lack of government and/or community support
- Stigma, discrimination and ideological and moralistic views on drug use.

People who inject drugs in developing and transitional countries are worst affected by these factors.

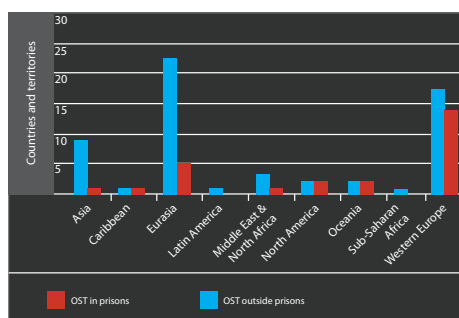


Opioid substitution therapy (OST)

Opiate substitution is prescribed for maintenance therapy in sixty-three countries and territories around the world, and mainly involves the use of methadone or buprenorphine. Based upon the data collected for this report, it is estimated that around 950,000 people with a history of injecting are receiving OST across the world. The size and scale of the programmes vary enormously. For example, there is one small OST programme serving less than twenty clients in Lebanon, whereas over 57,500 people are in OST in Iran, including 22,000 people who inject drugs.

OST is provided in prisons in thirty-three countries and territories. The largest programme is in Iran, where 10,910 prisoners are receiving methadone.

Figure A.2: Global opioid substitution therapy provision



Access to OST is impeded by several factors, including:

- Legislation or strict regulations prohibiting prescription of methadone and/or buprenorphine
- Poor availability
- Restrictive inclusion criteria
- Cost of treatment or (usually daily) travel to the treatment site
- Lack of confidentiality and protection of personal information (for example inclusion on 'drug user registers')
- Limited funding and/or government support
- Limited capacity within countries to deliver OST
- Stigma, discrimination and ideological and moralistic views on drug use.

These factors affect people who inject drugs in developing and transitional countries to a much greater extent than in other areas.

Limited access to HIV and hepatitis C prevention, treatment and care

In many countries, people who inject drugs, along with other key populations, have poor access to prevention, treatment and care services for HIV and HCV, as well as wider health care services. In much of Western Europe, North America and parts of Oceania, low-threshold services, community-based peer outreach and strong referral systems between services help to increase access for this key population. In some countries, programmes specifically targeted towards people who inject drugs aim to provide comprehensive harm reduction services, often on the same site.

However, in much of the world, access remains extremely poor for large numbers of people who inject drugs, leaving millions of people without the information and means to protect themselves, unaware of their HIV or HCV status and without necessary treatment.

Preventing the spread of injecting

Harm reduction has a necessary focus on public health emergencies and the need to deliver public health services to people who are injecting drugs. However, a parallel public health priority is to deter the spread of injecting itself.

Despite the rapid spread of injecting in many parts of the world in the last three decades, there are still many opportunities to discourage the diffusion of injecting. This is especially important in those parts of Africa, Latin America and Asia where injecting currently occurs among relatively small numbers of people. Many of these countries have poor health-care system capacity that would struggle to provide comprehensive harm reduction programmes to prevent HIV and other injecting-related harms.

The challenge for UN organisations, policy-makers, programmers and researchers is to develop low-cost ways to discourage the spread of injecting that do not further marginalise and repress people who do inject. This will involve programmes that help people not to inject as a method of ingesting drugs, as well as avoiding actions which encourage the spread of injecting.

Antiretroviral treatment for people who inject drugs

Worldwide, large numbers of people that need antiretroviral treatment (ART) are not receiving it. Access to this life-prolonging treatment is especially poor for people who inject drugs. At the end of 2004, it was estimated that ART was being received by 34,000 people who had previously or were still injecting drugs in developing and transitional countries. 30,000 of these people were in Brazil. The vast majority of people living with HIV in Central Asia and Eastern Europe are current or former injectors, however they made up only 14% of those receiving ART.²³ Even within the small numbers receiving ART, people currently injecting drugs are a small proportion, with most being former injectors and many also receiving OST. In many countries abstinence and maintenance therapy are conditions of ART access.

In some countries, particularly in Sub-Saharan Africa, access to ART is very limited and marginalised populations are generally the last to benefit. The reluctance of clinicians to prescribe ART to people who inject drugs is cited as a common barrier to accessing treatment, despite UN best practice guidelines clearly stating the evidence-base for treatment success and the necessity of providing ART to people who inject drugs.

In some countries, accessing ART services is simply not an option due to the severe stigma and discrimination associated with both HIV and drug use. Also, as with NSP and OST services, the associated costs are often prohibitive, the lack of confidentiality poses too great a risk and there is a fear of arrest or harassment.

Hepatitis C prevention and treatment for people who inject drugs

In Australia, Brazil and some Western European countries, national policies on HCV exist and targeted programmes (often comprehensive harm reduction programmes) reach people who inject drugs with HCV prevention, and referrals for testing and treatment. Despite this, access to antiviral treatment is reported to be limited for people who inject drugs.

In other regions, such as Sub-Saharan Africa and much of Asia and Eastern Europe, the response to HCV is nascent and governments and civil society alike are just beginning to form a response to growing epidemics. HCV testing, and particularly HCV treatment, remain largely unavailable to people who inject drugs. Poor availability, exclusion criteria and prohibitive cost are barriers to HCV treatment faced by people who inject drugs around the world.

Maintaining momentum in the international harm reduction response

Harm reduction measures to prevent HIV and HCV transmission and improve the lives of people who use drugs have been adopted by more countries than ever before. The establishment of the Global Fund, combined with increased emphasis from multilateral agencies, sees the global harm reduction response receiving enhanced international support.

As advised in UN guidance on monitoring progress towards 'universal access' to HIV prevention, treatment and care, many countries now specifically include people who inject drugs and harm reduction interventions in their national policies and plans. However, the majority of people who inject drugs remain unable to benefit from the harm reduction services to which they are entitled (see section 3 of this report for a discussion of human rights and harm reduction).

Severe stigma and discrimination is faced by people who inject drugs, further increasing the risk of drug-related harms. Governments continue to use punitive drug control measures that force people who use drugs underground, reducing their access to services and increasing their risk of drug-related harms. Pragmatic, human-rights-based approaches continue to be stalled by moral and ideological views of drug use.

Injecting drug use continues to drive HIV and HCV epidemics in several regions and opportunities for early intervention in areas where injecting is fairly recent are being missed. In order to have an impact on these and other drug-related harms, interventions like needle and syringe exchange and opioid substitution therapy must be dramatically scaled up.

The regional overviews in section 2 of this report provide further detail on the state of the harm reduction response around the world, highlighting positive developments in recent years as well as calling the attention of the international harm reduction community – networks, NGOs, researchers, governments, multilateral and bilateral agencies and funders – to areas where much more work is needed.

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Regional Overview

Asia



AVAILABILITY OF NEEDLE AND SYRINGE EXCHANGE PROGRAMMES AND OPIOID SUBSTITUTION THERAPY

- Both NSP and OST available
- OST only
- NSP only
- Neither available
- Not Known

HARM REDUCTION IN ASIA

Country/territory with reported injecting drug use ^a	People who inject drugs ¹	Adult HIV prevalence amongst people who inject drugs ²	Adult HCV prevalence amongst people who inject drugs ³	Harm reduction response		
				NSP	OST	HIV and HCV programmes targeted towards people who inject drugs ^b
Afghanistan	34,080	nk	nk	✓ ^{1site}	x	These programmes are very limited throughout the region. It is estimated that 1,700 people who inject drugs are receiving ART
Bangladesh	95,000	0.2–2.25%	25%	✓	x	
Bhutan	30–100 ⁴	nk	nk	x	x	
Brunei Darussalam	3,155	3.8%	nk	x	nk	
Cambodia	625	nk	nk	✓ ^{2sites}	x	
China	1,928,200	0–80%	nk	✓	✓	
Hong Kong	30,000	nk	nk	x	✓	
India	1,112,500	1.3–68.4%	92%	✓	✓	
Indonesia	561,925	15–47%	60–98%	✓	✓ ^{limited}	
Japan	325,000 ²	0–0.04%	55.1–60%	x	x	
Korea (Republic of)	3,000	0	nk	x	x	
PDR Laos	8,150	nk	nk	x	x	
Malaysia	195,000	10–40%	nk	✓ ^{pilot}	✓ ^{limited}	
Maldives	nk	nk	nk	x	x	
Mongolia	63	nk	nk	x	x	
Myanmar	60,000–90,000 ^c	37.1–63%	nk	✓	✓ ^{limited}	
Nepal	38,750	45–60%	nk	✓ ^{9sites}	✓ ^{2sites}	
Pakistan	125,000 ⁵	15.8% ⁶	89%	✓	x	
Philippines	17,000	1%	nk	x	x	
Singapore	15,000	1.7%	nk	x	x	
Sri Lanka	27,827	nk	nk	x	x	
Taiwan	60,000	nk	67.2%	✓	✓	
Thailand	90,080	20–56%	90%	✓	✓	
Vietnam	113,000	0–89.4%	nk	✓	✓	

nk = not known

^a There is no reported injecting drug use in the Democratic People's Republic of Korea.

^b These services include, among others, voluntary HIV testing and counselling; HIV prevention, treatment and care; hepatitis C testing and treatment; STI prevention and treatment; information, education and communication.

^c AHRN Myanmar estimate from data gathered over three years of implementation and service delivery.

The continent of Asia contains over half of the world's population.⁷ China and India together account for more than 36% of the global population and five Asian countries feature among the world's top ten most populous countries.⁸ The continent is culturally, linguistically, economically and politically diverse. Japan ranks much higher than the rest of Asia on the human poverty index and the lowest ranked Asian country is Nepal.⁹ Several Asian countries are affected by conflict and widespread human rights abuses, and there are estimated to be over three million displaced people in the region.¹⁰

DRUGS IN THE REGION

Cultivation, production and transshipment

Significant drug production occurs in a number of Asian countries and, subsequently, many countries are on drug transshipment routes. It is estimated that 92% of heroin in global circulation originates from opium poppy cultivation in Afghanistan¹¹, where a significant rise in production occurred following the US-led war and the end of the Taliban regime. The majority of opium poppy cultivation occurs in the southern Afghan provinces bordering Pakistan.¹² Heroin production occurs largely in the same provinces, with imported precursor chemicals used during the conversion process.¹³ Permeable national borders and weakened security allow for considerable smuggling to take place into both Pakistan and Iran.

Significant poppy cultivation occurs in Myanmar and to a lesser extent in the People's Democratic Republic (PDR) of Laos, but this has decreased in recent years.¹¹ Following this decline in production in the 'golden triangle', opium from Afghanistan is increasingly being trafficked to China, India and South-East Asia.¹³

China, Myanmar and the Philippines are the world's largest producers of methamphetamine. Large seizures of amphetamine have occurred in many Asian countries, including China, Hong Kong, Indonesia, Myanmar, Taiwan and Thailand. Afghanistan has also seen a recent increase in cannabis cultivation. Significant seizures of both opiates and cannabis resin were recently reported in Pakistan.¹⁴ However, caution must be used before interpreting increased seizures as evidence of increased production, as they could equally be indicative of enhanced policing and anti-trafficking efforts.

Drug use

The type and extent of drug use, as well as the route of administration, vary across the region. It is difficult to ascertain which are the most commonly used drugs, but the use of heroin and other opiates, benzodiazepines, cannabis, alcohol, tobacco and amphetamine-type stimulants (ATS) and pharmaceuticals is widely reported.¹⁵

Alcohol

As can be expected in a region as diverse as Asia, recorded alcohol consumption varies widely.¹⁶ It ranges from countries with official consumption rates below one litre of pure alcohol per capita (Bhutan, Brunei Darussalam, Cambodia, India, Indonesia, Myanmar, Nepal, Pakistan and Sri Lanka) including one country with an official level of zero (Bangladesh), to countries with much higher rates, such as Japan (7.38 litres), the Republic of Korea (7.71 litres), PDR Laos (6.72 litres) and Thailand (8.47 litres). No per capita data were available for Afghanistan, Hong Kong, the Philippines or Taiwan. Overall, alcohol use in the region is low compared to other

regions (such as Europe and Eurasia) – most likely due to various cultural and religious factors – but it is increasing at a faster rate.

The recorded data only provide a partial picture of alcohol use in the region. Rates of 'last year abstinence' are high in Indonesia (94.8%), Pakistan (94.5%), Cambodia (85%), India (79.1%), Singapore (74.5%) and Myanmar (69.5%), and are much higher for women than for men.¹⁶ This suggests that alcohol use among sub-populations who do drink may be more problematic than the official data imply.

Levels of unrecorded alcohol consumption (including home-brewed beverages, illicit products and use of non-beverage alcohol such as cleaning products) are estimated to be 2.0 litres per capita in Japan, Mongolia and Thailand, 3.4 litres in Malaysia and 7.0 litres in the Republic of Korea. In India, 'unrecorded alcohol consumption is estimated to be at least two thirds of all alcohol consumption'.¹⁶ Despite a low (but rising) recorded level of alcohol consumption (0.82 litres of pure alcohol per capita¹⁶), alcohol is, by far, the most common drug used in both urban and rural areas of India,¹⁵ and unregulated home-brewed beverages such as 'arrack' and 'tari' are common (and associated with high alcohol content, adulteration, eye damage and death).¹⁷

In many Asian countries, alcohol use is deepening existing health and social problems. In Malaysia, for example, alcohol is a 'major factor in exacerbating poverty ... and contributes to the breakdown of the basic social fabric of society'.¹⁶ In the Republic of Korea, chronic alcohol use (and the sharing of paraphernalia such as cups and glasses) is associated with high levels of hepatitis B transmission.¹⁵ In India, frequenting 'wine shops' has been associated with a number of high-risk behaviours and sexually transmitted infections, including HIV.¹⁸

Amphetamine-type stimulants (ATS)

The production and use of ATS has increased dramatically in Asia in recent years.¹⁴ The most commonly used ATS are reported to be methamphetamine, amphetamine, MDMA and ecstasy. Although injecting exists in many countries, other routes of administration are more common.

China is experiencing a rapid expansion in ATS use, particularly in urban areas, and ecstasy and methamphetamine appear to be the most popular drugs consumed.¹⁹ Methamphetamine and amphetamine injecting is reported in Japan, where it is particularly concentrated among young people.²⁰ In Cambodia, methamphetamine, known locally as 'yama', is reported to be the most frequently used drug. In PDR Laos, ATS use is also rapidly increasing and reports suggest that young people prefer ATS to opium. Evidence suggests that ATS are commonly used by sex workers and their clients, and are also popular among young people in the capital city, Vientiane. ATS use is also increasing in Malaysia, and the drug use reported to be most common in the Philippines is the inhalation of crystal methamphetamine, locally known as 'shabu'.¹⁹ In India, ATS use in general is reported to be increasing.¹⁴

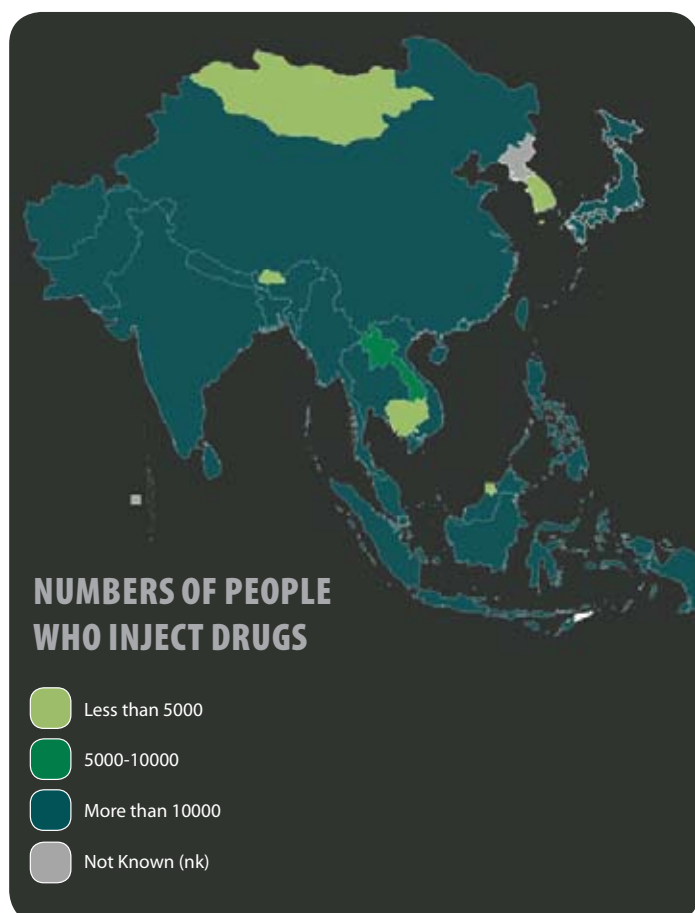
Opiates

Asia is home to the majority of the world's opiate users,¹⁴ including large numbers who use opium, in addition to people who use heroin, buprenorphine and opiates such as morphine. Opiates are among the most commonly used drugs throughout Asia, and use is reported to be increasing in many countries.¹⁵

Opium is smoked in cigarettes or through a pipe, dissolved in teas or, more rarely, dissolved in water and then injected (known as 'blackwater opium'). Opium smoking has traditional roots in some parts of Asia and as a result is sometimes considered more culturally acceptable than other drugs.

Opium use is reported in many Asian countries including Afghanistan, China, PDR Laos, Myanmar and Pakistan. In Afghanistan, the highest recorded rate of opium use is in the north-eastern province of Badakhshan, which lies along the border with Tajikistan, where it is estimated that between 20 and 30% of the local population use opium.²¹ Proximity to opium trafficking routes appears to be a factor in the concentration of opium users in the country.¹⁵ In PDR Laos, opium is the most commonly consumed drug and its use has remained steady in recent years.¹⁹

Heroin smoking and injecting is reported throughout Asia and its use is believed to be increasing in the region, with the largest increase in recent years reported in Afghanistan. There are an estimated 500,000 heroin users in Pakistan, a figure which is reported to have remained relatively stable since 2001. During this time, however, heroin injecting has increased markedly.¹¹ Heroin use is widespread in China²², with an estimated 600,000 people using the drug.¹¹ In several countries, including Cambodia, heroin is cheaper than other drugs and this appears to be contributing to an increase in its use.¹⁵



Map 1.2: Numbers of people who inject drugs in Asia

Injecting drug use

Asia is home to significant numbers of people who inject drugs. Estimates are available for most countries in the region and indicate that the largest numbers are in China, India, Indonesia and Japan. Injecting drug use is reported to be increasing in at least ten countries in the region (Afghanistan, India, Indonesia, Japan, PDR Laos, Myanmar, Nepal, Pakistan, the Philippines and Sri Lanka), while there are reported declines in injecting in Hong Kong and Taiwan.¹⁵

The substances injected in Asia are predominantly opiates, although ATS and pharmaceutical drugs are also used. The injecting of ATS may pose increased risk of HIV and HCV infection, as people will often inject more frequently than those injecting heroin.²³

In Afghanistan, drugs were predominantly consumed orally or through inhalation but, in recent years, there has been a marked increase in injecting. This increase coincided with the return of large numbers of displaced Afghanis, and it is suggested that many young men and ex-combatants began to inject heroin during their time as refugees.¹² There are also estimated to be 12,000 people who inject pharmaceutical drugs²⁴, which can be obtained without a prescription and in unlimited quantities from over 15,000 registered pharmacies, in addition to many unregistered pharmacies.²⁵

In Pakistan, injecting drug use is reported to be increasing, with heroin and a mixture of pharmaceuticals, as well as buprenorphine 'cocktails' being the most common substances injected.²⁶

In India, Bangladesh and Nepal, the most commonly injected drugs are heroin, buprenorphine and pharmaceutical drugs. In India, a crudely refined heroin base known as 'brown sugar' is most commonly injected. People injecting drugs are reported to be predominantly poly-drug users. Injecting drug use is reported to be rare in Bhutan, but as injecting is common on the other side of the Nepalese and Indian borders this could leave the country vulnerable to an increase.²⁷

In 2002, researchers reported that high purity heroin in Sri Lanka meant that people who used drugs found 'chasing the dragon' sufficient to achieve the desired effect, leaving no need to inject unless heroin supplies were unattainable.²⁸ When heroin was scarce, people injected pharmaceutical drugs instead. Injecting drug use is now reported to be increasing in the country, and heroin and pharmaceutical drugs are still the most commonly used substances.¹⁵

In Myanmar, there is an overall trend towards increased injecting drug use. Anecdotal evidence suggests that more people are injecting drugs because they are easily available and are a cheaper alternative to smoking drugs as the length and intensity of the effect is greater. Heroin is the most commonly injected drug, and there is a very small amount of injecting ATS, as well as injection of opiates and pharmaceuticals together.

While injecting drug use is thought to be limited in PDR Laos, there are increasing reports of 'blackwater opium' and heroin injection, and evidence that some groups are injecting ATS.¹⁵

Drug user networks in Thailand report that injecting is rising but becoming increasingly hidden due to fear of a possible re-ignition

of the government-led 'War on Drugs'. In Bangkok and the urban northern areas, heroin, methadone and benzodiazepines are the most commonly injected substances. In rural northern areas, opium is more commonly injected. ATS injecting exists across the country.¹⁵

In the Maldives, 'brown sugar', hashish oil and cannabinoids are reported to be the most commonly used drugs.²⁹ Drug use is reported to be increasing and anecdotal evidence suggests that injecting drug use is also increasing, although there is a lack of statistical research data to illustrate this.⁴

In Vietnam, heroin, 'blackwater opium' and diazepam are the most commonly injected substances. Heroin is the drug of choice among many young people, particularly in urban areas. 'Blackwater opium' use remains popular among older people and ethnic minority groups in rural areas, especially in the north-west region.

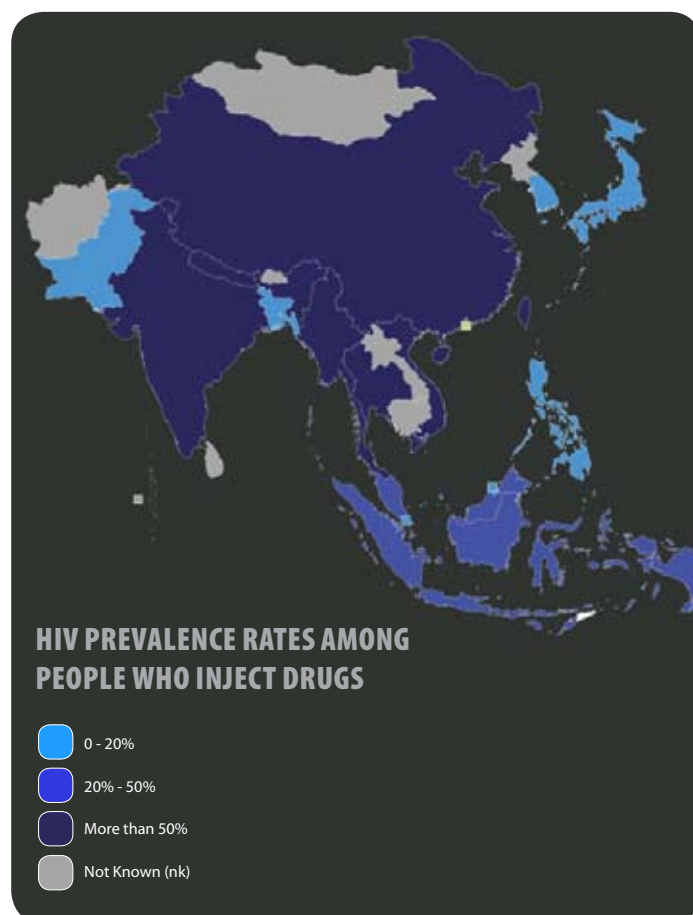
In Cambodia, it is reported that people who use drugs such as 'yama' and 'ice' often begin to inject heroin because it is cheaper and it provides a more prolonged effect. Currently, heroin is the most commonly injected drug and it is often mixed with other substances such as diazepam and valium. There is some anecdotal evidence of methamphetamine injecting, but this does not seem to be widespread.

In the Philippines, injecting drug use is increasing but is largely confined to urban slums in Visayas and Mindanao, where it is closely linked with the sex industry, and in coastal areas such as Mindanao among deep sea fishermen. Patterns of drug use are largely dependent on supply, but the most commonly injected drugs are non-opiate analgesics, as well as diazepam. There are also anecdotal reports of dissolved methamphetamine hydrochloride (also known as 'poor man's cocaine' or 'shabu') being injected.

In Indonesia, heroin is the most common drug for which treatment is sought, with rates of injecting appearing to be on the increase throughout the country. Other injected drugs include methamphetamine and cocaine.¹⁵

Estimates of the number of people who inject drugs in China range between 356,000 and 3.5 million, and numbers as high as ten million have been reported in Chinese media. Heroin, methamphetamine, diazepam, pethidine and morphine are the most commonly injected drugs. The level of involvement in sex work among female drug users is reported to be increasing, and in Guangxi it is estimated that 80% of female sex workers inject drugs. Heroin is also the most commonly injected drug in Hong Kong.¹⁵

In Japan, the most commonly injected drugs are methamphetamine, heroin and diazepam.²⁸ In the Republic of Korea, methamphetamine is the most commonly injected substance. The status of injecting drug use in Mongolia is unknown.



Map 1.3: HIV prevalence among people who inject drugs in Asia

Drug-related harms

HIV and AIDS

It is estimated that 4.9 million adults and children are living with HIV in Asia, with the vast majority in India and China, the region's most populous countries. South-East Asia is the most affected part of the region, and this is where the highest national HIV prevalence rates are recorded. Cambodia, Myanmar and Thailand are all reported to have experienced declines in national HIV prevalence, with a stabilisation or increase in HIV cases among people who inject drugs, while prevalence is increasing in Indonesia (particularly in the Papua province) and Vietnam.³⁰

A combination of factors increases the vulnerability of many Asian countries to rapidly expanding HIV epidemics. These include high criminalisation and stigma attached to drug use, sex work and sex between men, high prevalence of sexually transmitted infection, poverty, gender inequality, and a lack of HIV prevention, care and treatment service provision.¹⁵ Regionally, less than one in ten people living with HIV are aware of their status³¹, and among people who inject drugs this figure will be dramatically lower.¹⁵ It is estimated that in Pakistan, 4.5% of people who inject drugs are aware of their HIV status.³²

The use of unsterilised injecting equipment is driving HIV epidemics in many Asian countries. Elevated national HIV prevalence rates among people who inject drugs are indicated in Vietnam (0–89.4%), China (0–80%), India (1.3–68.4%), Myanmar (37.1–63%), Nepal (45–60%), Thailand (20–56%), Indonesia (15–47%) and Malaysia (10–40%).²

In Bangladesh, although national HIV prevalence is low (0.2–2.25%), sero-surveillance among key populations has found HIV prevalence rates of up to 10% in areas of central Dhaka. Importantly, this surveillance has shown HIV prevalence among people who inject drugs to be doubling every six months.³³ In Afghanistan, an HIV prevalence rate of 3.7% was reported among people who inject drugs in the capital city of Kabul.³⁴ The Thai government's UNGASS country progress report states a 'slow decline' in HIV prevalence among people who inject drugs. In Hong Kong, the proportion of HIV infections among people who use drugs increased from 3% prior to 1998 to 10% in 2003 and 2004.¹⁹

Non-injecting drug use also has an important role in HIV transmission in the region. In particular, the use of ATS has been highlighted in both Singapore and Cambodia as being associated with sexual HIV transmission.¹⁵

Hepatitis C virus (HCV)

Data published by the WHO in 1999 revealed that Asian countries have some of the highest national HCV prevalence rates in the world. Mongolia had the highest HCV prevalence rate in the region at 10.7%, while Vietnam, Thailand and Cambodia all had reported prevalence rates above 3%. South-East Asia is highly affected, with an estimated sub-regional prevalence rate of 2.15%³⁵, representing 25 million people living with HCV³⁶ out of a total of 220 million people living with HCV worldwide.

Extremely high rates of hepatitis C have been reported among people who inject drugs in the region. The highest rate is reported in Indonesia where various studies have indicated that between 60 and 98% of people who inject drugs are HCV positive. Figures are also available for India (92%), Indonesia (60–98%), Thailand (90%), Pakistan (89%), Taiwan (67.2%), Japan (55.1–60%) and Bangladesh (25%).³

In Japan, it is estimated that there are two million people living with hepatitis C³⁷, and evidence suggests that the vast majority of people who test positive for HCV are currently or have previously injected ATS.³⁸ In Afghanistan's capital city Kabul, HCV prevalence rates of 42% have been reported among people who inject drugs.³⁴ In Thailand's capital city Bangkok, HCV prevalence rates as high as 98.8% have been reported among people who inject drugs.³ Although other routes of transmission are also reported to be driving HCV epidemics in Asia, including tattooing in Japan¹⁵ and unsterilised medical injection in India,^{39,40} people who inject drugs are clearly disproportionately affected by HCV across the region.

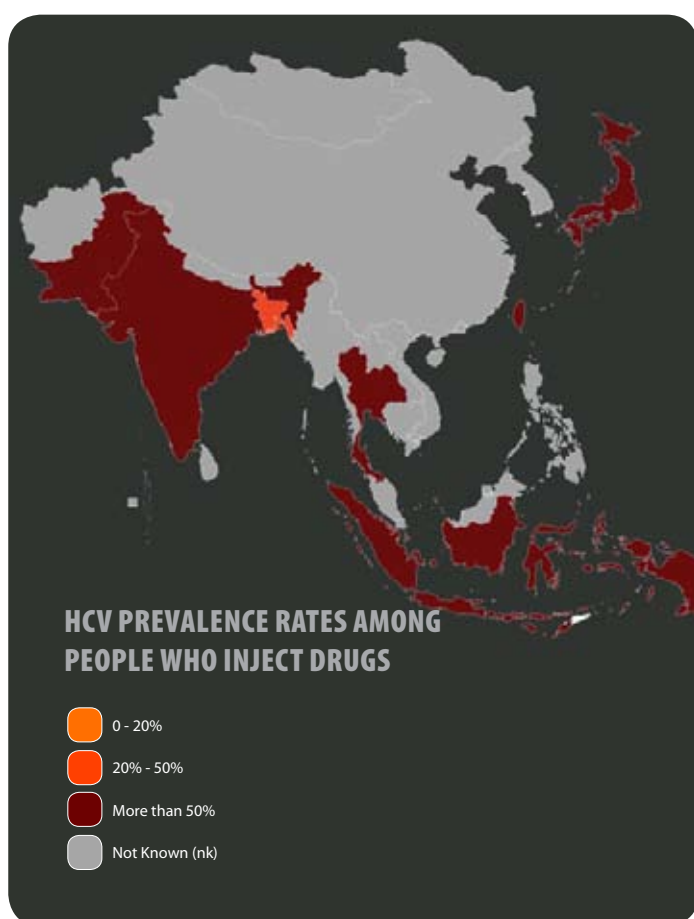
HIV and HCV co-infection rates are also very high among people who inject drugs in Asia. Among people living with HIV, studies have found elevated HCV prevalence rates in China (0–99.3%), Thailand (4.8–98.8%), Vietnam (98.5%) and Indonesia (10–40%).³ Extremely high levels of HIV and HCV co-infection have been found among people who inject drugs in the state of Manipur, India. HCV is very common in this population and a recent study found that 79.1% of people living with HIV also tested positively for HCV antibodies.⁴¹

Drug use and its related harms in prisons

With over 1.5 million people incarcerated, China has, by far, the largest prison population in the region. India and the Philippines have the highest number of prison facilities, and Singapore, Taiwan and Thailand have the highest regional incarceration rates.⁴²

Drug-related crime, including drug possession, receives extreme penalties in many Asian countries. Fifteen Asian countries are among the over thirty states that retain the death penalty for drug offences in legislation.⁴³ Evidence suggests that at least twelve Asian states have executed people for drug-related crime in recent years (Brunei Darussalam, Myanmar and Sri Lanka are reported to be abolitionist in practice⁴³).⁴ The prevailing view of drugs and those who use them as 'socially evil' fuels the grave human rights abuses the world has witnessed in recent years. Executions of people who use drugs have occurred en masse in China, to mark the UN's International Day Against Drug Abuse and Illicit Drug Trafficking,⁴³ and in Thailand, during the 'War on Drugs' in which over 2,800 people were killed.

Throughout the region, drug possession results in custodial sentences both in prisons and drug rehabilitation centres (DRCs), where forced detoxification as well as forced labour are in many



Map 1.4: HCV prevalence among people who inject drugs in Asia

cases the norm. There are overwhelming numbers of drug-related cases and convictions every year. In 2003, Sri Lanka had 10,000 drug-related convictions.⁴ In 2004 alone it is reported that Thailand had 100,511 drug-related cases.⁴⁴

Given that many of the harshest penalties for drug offences are reported in this region, it is very likely that a significant proportion of prisoners have a history of drug use, although estimates of the percentage of prisoners with a history of injecting drug use are only available for Hong Kong (24.8%), the Republic of Korea (3.3%)⁴⁵ and Malaysia (24%).²⁸

There is evidence of elevated HIV prevalence among prisoners and those held in DRCs in several Asian countries. Of particular concern are the high prevalence rates found among prisoners at a national level in Indonesia (20%)⁴⁶, where male prisoners account for 3% of people living with HIV in the country;⁴⁷ and Vietnam (28.4%), where up to 40% of prisoners in some facilities are living with HIV.⁴⁴ Clear evidence of elevated HIV prevalence rates in prisons has also been found in Cambodia (3.1%), China (0–4%), Chinese DRCs (42%) and Malaysia (6%).

There is no information available on HCV prevalence rates among prisoners or DRC residents in Asia, but rates are likely to be higher than outside prisons.

THE RESPONSE

Harm reduction services

While there are indications of increased acceptability of some elements of harm reduction in Asia, coverage in the region remains desperately low, and numerous barriers impede the access of people who use drugs to these as well as wider public health-care services. In South-East Asia, only 3% of people who inject drugs have access to harm reduction programmes and in East Asia this figure is 8%, with the vast majority of these people being in China.⁴⁸ Between 2003 and 2005, South-East Asia was the only region in the world to see a decline in harm reduction service coverage, from 5% to 3.2%.⁴⁹

Needle and syringe exchange programmes (NSPs)

Thirteen countries in the region have needle and syringe exchange services available to varying degrees.^d Afghanistan, Cambodia and Malaysia have very small provisions for distribution of sterile injecting equipment, through a single or small number of pilot sites in major cities. In Thailand and Vietnam, NSP services operate underground, unregistered or quasi-legally as laws prohibit their function. In Bangladesh, NSP sites are led by CARE Bangladesh in twenty-three districts.⁴ NSP services have been rapidly scaled up in China in recent years, from 92 sites in early 2006⁵⁰ to an estimated 775 sites in seventeen provinces in 2007.^e Estimates of the number of NSP sites are also available for Taiwan (427 sites), India (120 sites), Myanmar (24 sites) and Nepal (9 sites), but not in Indonesia or Pakistan.

Where NSP sites exist, it is reported that they use community-based outreach, although this is limited in several countries and not able

to extend to large sections of this highly mobile community. It is clear that, in general, Asian NSP services are far from sufficient to reach the numbers of people who inject drugs, or to have an impact on HIV or HCV infection rates. In China, it is estimated that 110 needles are distributed per person who injects drugs per year,⁵¹ and that only 7% of people who inject drugs have access to NSP services in areas where such services exist.⁵²

There are several barriers to accessing existing NSP services. In many countries these include lack of awareness of services and of risk behaviours in general; distance to services; limited opening times or outreach access points; limits on the number of needles per person per visit; lack of suitable needles (there are reports of unsuitably large needles being distributed in China); fear of arrest and police harassment; fear of being seen by family, friends or the wider community; and reliance on a peer educator with a limited needle and syringe supply and who, in many countries, may be at risk of arrest.⁵³

There are also many challenges to overcome in order to increase coverage and quality of NSP service provision. The most significant is the lack of government support for NSPs, and harm reduction in general, in many countries. Where NSPs exist, programmes are often run by non-governmental organisations (NGOs) without commitment or funding from national government.

National legislation in most Asian countries is prohibitive of NSP services. For example, it is illegal for anyone who is not a medical practitioner to be in possession of injection paraphernalia in the Philippines⁵⁴ and Sri Lanka,⁴ and the provision of needles and syringes is prohibited in Thailand, Sri Lanka, the Philippines, Myanmar, Malaysia, PDR Laos, Japan, Hong Kong, Bhutan and Bangladesh.

Unless law and policy reform is part of the response to drug use and HIV in Asia, NSP services will continue to operate at a sub-optimal level, being 'tolerated' by law enforcement, operating quasi-legally or remaining underground. Efforts must be made to ensure that policy and law reform translates into effective service implementation at local levels. In Vietnam, the criminalisation of possession of injecting equipment is not present in new legislation, but the legacy of former legislation has lingered at a local level, impeding service provision. Legal ambiguities and contradictory policies are considerable barriers to the scale up of NSP sites in the region.

In the last year, the number of NSP sites is reported to have increased in China, India, Malaysia, Myanmar, Taiwan and Nepal (small increase), although decreasing in Bangladesh.¹⁵

Needles and other injection paraphernalia are available from pharmacies in several countries, including Afghanistan,²⁵ Bangladesh, the Republic of Korea, Malaysia, Myanmar, Taiwan, Thailand and Vietnam.¹⁵ However, the associated costs may be prohibitive to people who inject drugs, many of whom are often unemployed. Accessing clean injecting equipment via pharmacy sales often poses risk of stigma, discrimination and a lack of confidentiality. Furthermore, as is evident in other regions, pharmacists are often reluctant to sell injecting equipment to people they suspect are using drugs.

^d In Hong Kong the international non-governmental organisation (NGO) Médecins Sans Frontières used to run an NSP programme inside a Vietnamese refugee camp where injecting drug use was high, but there are no current programmes running.

^e In the most recent estimate a 'site' is defined as a county or district in which NSP is available and in which multiple NSP outlets may exist.

Treatment for drug dependence

Eleven Asian countries and territories provide opioid substitution maintenance therapy to some degree: China, Hong Kong, India, Indonesia, Malaysia (pilot), Myanmar, Nepal, Pakistan, Taiwan, Thailand and Vietnam. Hong Kong has the most established methadone maintenance treatment (MMT) programme in the region, initiated in 1972. Twenty sites now receive 7,000 clients for daily doses.⁵⁶

***'Substitution therapy programmes appear to be entering a new era of acceptance in some parts of Asia.'*⁵⁵**

China, which had 320 opioid substitution therapy (OST) sites in late 2006, has pledged to scale up methadone provision to more than 1,000 sites by the end of 2008.⁵⁷ A recent estimate reported that 95,000 people are accessing MMT from 503 clinics.⁵¹

In Taiwan, MMT was initiated in February 2006. By December 2007, sixty-three hospitals were providing the treatment and 16,183 clients were receiving methadone.⁵⁸ Harm reduction in Taiwan is already reported to have shown a dramatic effect in HIV prevention among people who inject drugs.⁵⁹ Rapid scale up in Taiwan is a particularly important achievement given that the Taiwanese are not eligible for the assistance that UN member states receive.

In India, where estimates suggest there are over one million people who inject drugs, there are thirty-five sites⁶⁰ providing locally produced buprenorphine for limited periods, taken sublingually.⁴ In Thailand, OST is provided for a limited time period in 147 sites, all operated by the Thai government.⁶¹

Several Asian countries have very small scale or pilot OST programmes – Indonesia, Malaysia, Myanmar, Nepal – and some have plans to scale up these services. In Myanmar, MMT was started in March 2006 at four sites, and expanded to six in 2007. There is a target of providing services to 1,000 clients by the end of 2008. In Nepal, there are two sites providing MMT, and it is estimated that eighty-five clients are accessing this service. There are plans to initiate OST in Cambodia.⁶² There is a recognised need for OST in Afghanistan although no plans to initiate service delivery are in place.¹²

In at least twelve countries – Afghanistan, Bangladesh, Bhutan, Cambodia, Japan, Republic of Korea, Maldives, Mongolia, Pakistan, the Philippines, Sri Lanka and Singapore – methadone or buprenorphine are simply not available, despite being on the WHO's Essential Drugs List since 2005.

As with NSP, OST provision contradicts legislation and policy in several Asian countries. This means that although service provision is tolerated, a supportive legal and policy framework to scale up quality OST services does not exist. Methadone is illegal in India, Malaysia, the Philippines and Sri Lanka. Buprenorphine is illegal in Myanmar. Both are illegal in Bangladesh, Bhutan, Cambodia, Japan and Singapore. Drug policy reform must be a part of the response to drugs and HIV in Asia in order to move towards universal access to vital services for people who inject drugs.⁴

Where services exist, there are significant barriers for people in attempting to access OST. The initiation of OST is often dependent on conditionalities such as failed detoxification or served terms in DRCs, and in some cases is part of compulsory treatment, used

as an alternative to incarceration. Coverage is very poor. Even in countries where sites are more numerous, availability is largely restricted to certain areas, such as major cities. Travelling large distances to access services is not a practical or economically viable option for many people who use drugs, which further limits coverage. There are strict limits on the number of OST slots available, as well as long waiting lists.

The cost of OST may also be a barrier for many people wishing to initiate, or continue, maintenance treatment. When free treatment through pilot programmes is discontinued, some clients can no longer access treatment due to the prohibitive cost. Although minimal in many places, daily costs associated with OST can be enough to prohibit many from accessing it.

Initial experiences in China, where the average dose prescribed (38mg/day) was much lower than recommended within UN guidelines (60–80mg/day),⁶³ highlight the importance of prescribing a sufficient dosage to reduce drop-out rates. Success in OST also improves substantially when psychosocial support is available for clients, and this is an area which requires expansion across Asia.

Human resources and technical capacity on harm reduction are very limited, and many interventions have been scaled up rapidly without ensuring their conformity with international guidelines. No service outlet in Asia has a comprehensive package of interventions as defined in the Biregional Strategy for Harm Reduction 2005–2009.⁶⁴ Instead, many governments have prioritised either NSP or OST, focusing on a single intervention. Consequently, vital opportunities for gateways to a comprehensive range of harm reduction services are not utilised.¹⁵

Fear of arrest is a major deterrent to people accessing harm reduction services. In China, Public Security Bureau (PSB) officials often target NSPs or MMT clinics where they know people who use drugs congregate.⁶⁵

Stigma and discrimination, whether formalised in law or within communities and health services, is rampant within the region. Service delivery is often judgemental, with relapse interpreted as a failure instead of an expected milestone towards recovery, thus failing to meet the needs of people who use drugs. This stigma can be doubly powerful for people who are living with HIV and using drugs. In Yunnan Province in China, 30% of health professionals stated that they would not treat a person living with HIV.³⁰

This stigma is reported to be particularly pronounced for women. In India, there is great stigma attached to women seeking assistance and many cannot go into treatment for any period of time because they have children to look after. Studies have found that HIV prevalence among women who inject drugs and are also involved in sex work,²⁸ a highly stigmatised and criminalised group, is even more elevated than among non-drug-using sex workers in India. For example, in Manipur, HIV prevalence among sex workers who injected drugs (57%) was markedly higher than among those who did not inject (20%).⁶⁶ The particular needs of this group are often overlooked as interventions are targeted towards either those who inject drugs or those involved in sex work.

Across Asia, there are non-OST drug dependence treatment sites, often in the form of DRCs. In China, there are estimated to be 1,200 of these sites (700 compulsory, 300 camps, 200 voluntary

centres) where 'treatment' is typically abstinence-based and may include seven to twenty-one days of methadone, buprenorphine or traditional Chinese medicine (TCM).⁶⁷ In Pakistan, there were reported to be more than 280 sites providing mostly detoxification support in 2002.²⁸ In Nepal, there are approximately ninety sites providing rehabilitation treatment to 1,000 clients.⁶⁸

Targeted HIV prevention, treatment and care

Very few interventions targeting people who inject drugs are being implemented in Asian countries. Voluntary HIV counselling and testing (VCT) is not commonly available to people who inject drugs in the region. HIV testing occurs in DRCs and prisons, which in general will not include appropriate pre- and post-test counselling, informed consent and access to required treatment and care. These 'mandatory and other coercive forms of HIV testing do not serve a legitimate public health goal and jeopardize access to health services, reduce health-seeking behaviours and increase stigma and discrimination'.³⁶

It is difficult to ascertain exact numbers of people who inject drugs and are in receipt of antiretroviral treatment (ART) in Asia, as information is rarely disaggregated in this way. In at least six Asian countries (Bangladesh, Bhutan, Mongolia, Pakistan, the Philippines and Sri Lanka) overall ART access is limited to less than 200 people.⁶⁹ In South-East Asia, it is estimated that 80% of people who would benefit from ART are not currently receiving it.³⁶

It is clear, however, that people who inject drugs are disproportionately unlikely to access ART in the region. Amongst a total of 81,000 people receiving ART across fourteen South and South-East Asian countries, only 1,700 were people who currently or formerly injected drugs.⁶⁹ Formally, Indonesia is the only country in Asia that does not restrict people who inject drugs (including current users) from accessing ART, and it is also one of the few countries (along with India) that produces generic first-line antiretroviral medication.⁷⁰

People who currently or formerly inject drugs are reported to be receiving ART in China, Hong Kong, India, Indonesia, Malaysia, Myanmar, Thailand and Vietnam, but the numbers are very small and are not proportionate to the burden of HIV in this group. The largest reported numbers are in Indonesia (775), India (400) and Vietnam (250). A study of 315 people receiving ART in Kuala Lumpur, Malaysia revealed that only 2% were people who have injected drugs.⁷¹ In Thailand, where a policy excluding people who use drugs from accessing ART was changed in 2004, a lack of training and awareness raising among health care workers has left few benefiting from the reformed policy.⁷²

In Afghanistan, Bangladesh, Republic of Korea, PDR Laos, Mongolia, Nepal, Pakistan, the Philippines and Sri Lanka, there are no reports of ART recipients who are currently or have formerly injected drugs.

There are very few HIV treatment and care programmes which target people who inject drugs in the region and, where they do exist, they are initiatives involving international NGOs. In Vietnam, for example, a pilot programme run by Family Health International (FHI) Vietnam, will begin a joint methadone and ART clinic, which may use directly observed treatment (DOTS) to administer both treatments on a daily basis.⁷³

Targeted HCV prevention, treatment and care

Information on the availability of HCV-related services and their accessibility for people who inject drugs is largely unknown in the region. Blood screening for HCV infection has been initiated in Bangladesh, Bhutan, India, Indonesia, Japan, Republic of Korea, the Maldives, Myanmar, Nepal, Sri Lanka and Thailand. Many countries are just beginning to develop their response to HCV and this area has received very little attention from NGOs and governments alike in comparison to the HIV response. It is safe to assume, therefore, that there are few, if any, targeted HCV prevention, treatment and care interventions for people who use drugs.

Harm reduction in prisons

The extent of available harm reduction services in prisons and other detention facilities in some countries, such as PDR Laos, Malaysia, Singapore, Taiwan and Vietnam, is largely unknown.

From the available sources, it is clear that needle and syringe exchange is not available in any Asian prisons. Opioid substitution therapy is provided to a few select prisoners in four out of 378 Indonesian prisons.⁴⁷ Treatment for drug dependence is available in India, Myanmar, Sri Lanka (in one or more facilities) and Thailand. There are no harm reduction or drug treatment services in prisons in Bangladesh,⁴ although indications of pilot projects are emerging. Condoms are reported to be rarely available in some Indonesian prisons and their availability, while highlighted in prison policy in Nepal is, as in the rest of the region, unknown. VCT is available in prisons in Myanmar, Thailand, Vietnam and, to some extent, Indonesia. ART is available in Thailand, Myanmar and, for a few select prisoners, in Bali, Indonesia. In many countries, it is clear that hepatitis C testing and treatment are not available to prisoners, and in others, this information is not ascertainable.¹⁵

In Cambodia, three NGOs provide HIV-related services in custodial settings. For example, the Cambodian People Living with HIV/AIDS Network provides counselling, advocacy and medication in twelve provinces. Some detoxification centres and re-education through labour (RTL) camps in Kunming, Yuxi, Luoping, Chuxiong, Qujing and Yunnan receive NGO-provided VCT, psychological care, basic medical care and support group activities for people living with HIV.⁴⁴

Policies for harm reduction

Harm reduction does, in principle, form part of the response to drug use and HIV in Asia. Thirteen countries and territories have domestic policies on drugs or HIV that explicitly include harm reduction: Afghanistan, Bangladesh, Cambodia, China, Hong Kong, India, Indonesia, PDR Laos, Myanmar, Nepal, Pakistan, Taiwan and Vietnam. All Asian countries have national HIV action frameworks, several of which include harm reduction (twelve countries^f), injecting drug use (fourteen countries^g) and human rights (ten countries^h). The Chinese government is now extremely supportive of harm reduction and has recently introduced policy documents to guide the scaling up of these services.⁷⁴

For those countries without policies that include harm reduction, there are some indications that this may change. For example, in the Philippines, a harm reduction policy is currently being

f Afghanistan, Bangladesh, Cambodia, China, Hong Kong, India, Indonesia, PDR Laos, Myanmar, Nepal, Pakistan and Vietnam.

g Afghanistan, Bangladesh, Cambodia, China, Hong Kong, India, Indonesia, Japan, PDR Laos, Malaysia, Myanmar, Nepal, Pakistan and Vietnam.

h Bangladesh, Cambodia, Hong Kong, India, Indonesia, Japan, PDR Laos, Nepal, Pakistan and Sri Lanka.

developed, and in Pakistan, the government is supportive of harm reduction activities that are implemented by civil society. Thailand is the only country that has been explicitly opposed to harm reduction in international policy.¹⁵ However, Thailand's National AIDS Plan 2007–2011 states the aim of improving access to HIV prevention, treatment and care to both people who use drugs and prisoners.⁷²

The existence of national policy on harm reduction does not equate to the provision of the necessary components of a comprehensive harm reduction response. In the majority of countries in the region, drug control policy is in direct conflict with HIV-related policy, which undermines harm reduction in the region. It is imperative that governments harmonise policies to address drug use and its related harms in Asia effectively.

In 2003, the former Thai Prime Minister Thaksin Shinawatra launched the 'War on Drugs' during which over 2,800 extrajudicial killings occurred. This campaign was heavily criticised by the UN Human Rights Committee, among other human rights monitors. In 2008, there are indications from the Thai government that it plans to resume its 'War on Drugs'. Human Rights Watch, IHRA, the Canadian HIV/AIDS Legal Network and the Beckley Foundation Drug Policy Programme have called upon UN agencies and member states to 'recalibrate the regime' and ensure a human-rights-based approach to international drug control policy.⁷⁵

Estimates of national spending on HIV prevention, treatment and care for people who inject drugs are largely unavailable in the region, as budgets are not disaggregated to provide this information. In several countries, the total amount spent on HIV is also difficult to ascertain. It is clear, however, that funding in Asia is insufficiently channelled towards harm reduction.

In Nepal, for example, only 6% of the budget of the National Centre for AIDS and STD Control was spent on harm reduction programmes, despite injecting drug use being a major driver of the HIV epidemic in the country.⁵⁰

Asian countries are in general wealthier than those in other regions heavily affected by HIV, and therefore can expect to receive less support from international donor bodies. This situation, combined with the morally, ideologically and politically driven funding strategies of many Asian governments, results in inadequate and unsustainable resource allocation for harm reduction programmes.¹⁵

As of 26 March 2008, fifteen countries in this region had submitted their UNGASS Country Progress Reports to UNAIDS. This figure constitutes 60% (15 out of 25) of Asian countries; in contrast to 95% of countries in Eastern Europe and Central Asia, 95% in Latin American and 94% in Sub-Saharan Africa. There were also only two NGO Shadow Country Progress Reports submitted, from Indonesia and Thailand. This suggests that Asia may lag behind other highly affected regions in the response to HIV and AIDS.

There is a lack of transparency in government responses across the region. Vulnerable populations are still under-represented in monitoring systems, resulting in limited and often inaccurate

estimates of the size of high-risk groups, which in turn poses challenges for planning and monitoring targeted interventions.³⁶ In several Asian countries, including China, Myanmar and Singapore, government-imposed restrictions limit the civil society response. NGO sectors are often heavily linked to government ministries and activities are, in effect, largely controlled by government. In some countries there are limited possibilities for civil society to form a response to issues affecting their communities as necessary gatherings are often prohibited by government. The recent government cancellation of NGO (Guangzhou) and people living with HIV network (Hennan) meetings in China is an example of the 'repression of AIDS activists and organizations' in the region.⁷⁶

Despite these difficulties, there are several civil society organisations focusing on harm reduction policy, advocacy and practice in the region. An initial scoping exercise indicated that NGOs focused on harm reduction exist in at least twelve Asian countries. Several international NGOs also play a key role in supporting local harm reduction advocacy activities as well as the implementation of harm reduction services. These include Médecins du Mondes (Mdm), which provides the only NSP service in Afghanistan and also provides harm reduction services in China, Myanmar and Vietnam; and the International Federation of the Red Cross and Red Crescent Societies, of which nine Asian national groups signed up to the Rome Consensus for a Humanitarian Drug Policy in 2007.⁷⁷

The Asian Harm Reduction Network (AHRN) is a leading civil society organisation working to meet the needs of people who use drugs in Asia. In addition to delivering health and social services, capacity-building on harm reduction and HIV interventions, and information and research support to partners and constituents, AHRN is best known for its regional and international policy advocacy work.

AHRN generally works in partnership to build enabling environments – spaces where drug control and HIV laws and policies are harmonised and seek to achieve parallel objectives, where people who use drugs have a meaningful voice, and where health and social care services can be safely accessed in a locally tailored setting with sustainable human and financial resources.

To this end, AHRN has engaged in international UN processes on HIV and drugs to ensure linkages between those processes and move the harm reduction agenda as well as Asian health issues forward. In addition, AHRN is involved in the planning of major events such as the International Conference on AIDS, the International Congress on AIDS in Asia and the Pacific, the International Harm Reduction Conference as well as the Asian Consultations on HIV Prevention related to Drug Use. In sum, AHRN has been involved in developing policies, providing leadership, ensuring stakeholder accountability and sustaining effective responses across Asia.

There are also drug user organisations in at least five Asian countries, as well as the Asia Pacific Network of People who Use Drugs working at a regional level. In general within the region, engagement of people who use drugs in the design, implementation, monitoring and evaluation of policies and interventions that affect their community is poor. It is reported that they are often excluded from consultations in favour of including 'easier' vulnerable groups, which has led to growing resentment and increasing scepticism of interventions which are implemented without any input from the community they are designed to target.

Full and meaningful involvement of affected communities is necessary for an effective response. In order for this to occur, increased funding and commitment is necessary from those leading the international response.¹⁵

Multilateral support for harm reduction

In Asia there are numerous initiatives funded and led by UN agencies, several of which contain an element of harm reduction. For example, UNESCO is funding civil society working on harm reduction in Afghanistan, Cambodia and India; UNODC has supported a policy strengthening programme in the region; and UNAIDS supported the first national meeting on harm reduction in Thailand. The World Bank provides financial and technical support to NGOs and CBOs in Bangladesh, India and Pakistan working on HIV prevention in areas where injecting drug use is driving HIV epidemics. WHO has provided technical capacity-building for health care workers on ART and comprehensive care for people who are living with HIV and injecting drugs, as well as supported research into the effects of the antiretroviral drug Nevirapine among people who do and do not inject drugs.

Global Fund grants are supporting harm reduction initiatives in a number of Asian countries including China, the Philippines and Thailand, as well as prison health services (largely related to tuberculosis) in PDR Laos, Mongolia and Thailand.⁷⁸

Despite these initiatives, UN agencies, and in particular UNODC, could be doing more to ensure increased coverage and quality of harm reduction in the region. Two regional UNODC offices covering the Asian continent are mandated to lead on the issue of drug use and its related harms, including HIV and HCV. However, at the recent 'Beyond 2008' consultation in Macau, China, civil society in the region noted with frustration and disappointment their difficulties in working with UNODC.¹⁵ It is imperative that UNODC and other UN agencies ensure clear and consistent engagement with civil society to guarantee appropriate and effective responses to drug use and HIV in Asia.

Multilateral agencies must also provide clear messages to member states regarding their national responses to drug use, including unambiguous condemnation of human rights abuses in the region and support for governments in the scale up of services in line with UN best practice guidance. In countries where regimes impede civil society organising, where governments remain in denial of injecting drug use as an issue and where human rights of people who use drugs are routinely denied, the role of UN agencies in stimulating and guiding the harm reduction response is crucial.

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Regional Overview

Eurasia



AVAILABILITY OF NEEDLE AND SYRINGE EXCHANGE PROGRAMMES AND OPIOID SUBSTITUTION THERAPY

- Both NSP and OST available
- OST only
- NSP only
- Neither available
- Not Known

HARM REDUCTION IN EURASIA

Country/territory with reported injecting drug use ^a	People who inject drugs ¹	Adult HIV prevalence amongst people who inject drugs ²	Adult HCV prevalence amongst people who inject drugs ³	Harm reduction response		
				NSP	OST	HIV and HCV programmes targeted towards people who inject drugs ⁴
Albania	10,000 ⁴	nk	26–65% ⁴	✓	✓	<p>While there are some targeted HIV programmes reaching people who inject drugs in the region, coverage remains very low</p> <p>HCV services in the region are minimal</p>
Armenia	2,000 ⁵	6.78% ⁶	nk	✓	x	
Azerbaijan	80,000 ²⁰	19–24% ⁷	57% ¹⁷	✓	✓	
Belarus	49,896 ⁸	16.7% ⁹	39% ⁹	✓	✓	
Bosnia and Herzegovina	11,458	nk	30–35% ¹⁰	✓	✓	
Bulgaria	20,000–30,000 ^{†,11}	3.43% ¹²	nk	✓	✓	
Croatia	20,942	0.5–1.93%	58.3–68.6%	✓	✓	
Czech Republic	27,000 ¹³	0–2.7% ¹⁴	21–59%	✓	✓	
Estonia	13,800 ¹⁵	54.3–89.9% [‡]	circa 90%	✓	✓	
Georgia	80,000 ¹⁶	0.4% ¹⁷	64.6% ¹⁷	✓	✓	
Hungary	15,000 ¹⁸	<1.0% ¹⁴	14–24% ¹⁹	✓	✓	
Kazakhstan	186,000 ²⁰	3.9% ²¹	65.7% ²¹	✓	x	
Kosovo	nk	0 ²²	13–27% ²²	x	x	
Kyrgyzstan	44,000 ²³	3–9% ³³	28–43% ³³	✓	✓	
Latvia	18,725	22% ¹⁴	nk	✓	✓	
Lithuania	8,500	2.9% ¹⁴	79–95.9%	✓	✓	
Former Yugoslav Republic of Macedonia	nk	<1% ²⁴	85.6% ²⁵	✓	✓	
Moldova	34,000–52,000 ²⁶	21% ²⁷	nk	✓	✓	
Montenegro	400–500 ²⁸	nk	nk	✓	✓	
Poland	96,514	8.9–16% ¹⁴	55–68% ³⁸	✓	✓	
Romania	13,694–34,318 ²⁹	0–0.81%	44–80% ³⁸	✓	✓	
Russia	2,000,000 ³⁰	12–30% ³⁰	90% ³¹	✓	x	
Serbia	nk	nk	nk	✓	✓	
Slovakia	13,497	<1% ¹⁴	circa 45% ³⁸	✓	✓	
Slovenia	5,000 ³²	<1% ¹⁹	40% ³⁸	✓	✓	
Tajikistan	15,000 ³³	23.5% ³⁴	43.4% ²⁵	✓	x	
Turkmenistan	11,148	nk	nk	x	nk	
Ukraine	325,000–435,000 ³⁶	41.8% ³⁷	70–90% ³⁸	✓	✓	
Uzbekistan	80,000 ³³	15.33% ³³	5% ³³	✓	✓	

nk = not known

^a These services include, among others, voluntary HIV testing and counselling; HIV prevention, treatment and care; hepatitis C testing and treatment; STI prevention and treatment; information, education and communication.

[†] Estimate of numbers who use drugs problematically, including those that inject drugs.

[‡] Non-national estimate – from two sites.

There are over 400 million people living in the twenty-nine countries that comprise Eurasia (Central and Eastern Europe and Central Asia),³⁹ with over one-third residing in Russia. The region can be divided into the six diverse sub-regions of the Balkans, the Baltics, Caucasus, Central Asia, Central Europe, and the European countries of the Commonwealth of Independent States (CIS).

The Eurasian countries that rank lowest on the human poverty index are Tajikistan, Kyrgyzstan, Uzbekistan and Moldova. The wealthiest countries in the region are Slovenia and the Czech Republic.⁴⁰ Many Eurasian countries have experienced huge political, social and economic changes since the 1990s, following the fall of the Soviet bloc and the Berlin Wall. Several countries have experienced the rapid expansion of drug use, HIV, hepatitis C and tuberculosis epidemics in recent years.

DRUGS IN THE REGION

Cultivation, production and transshipment

Production of amphetamine-type stimulants (ATS) occurs in a number of Eurasian countries. Poland, and to a lesser extent Estonia and Lithuania, are the major amphetamine producers, and much of the European amphetamine market is supplied by these three countries. During 2005, a number of amphetamine manufacturing laboratories were dismantled in Bulgaria, Estonia, Lithuania and Poland.

Ecstasy is also produced in Poland, although not to the same extent as in some Western European countries. Methamphetamine manufacturing is predominantly limited to the Czech Republic (where it is known as 'pervitin'), although some production is reported in Lithuania, Moldova, Russia, Slovakia and Ukraine.⁴¹ Cannabis is also cultivated in the region, both naturally and hydroponically.

Opioid production is limited to relatively low-quality poppy straw and poppy concentrate for local consumption in Latvia, Lithuania and Poland, as well as Belarus, Russia and Ukraine, where an opiate extract known as 'kompot' or 'shirka' is produced from poppy straw.

Most countries in the region form part of one of two major heroin trafficking routes from Afghanistan to Western Europe. Countries that form part of the 'Balkan route' include the Former Yugoslav Republic of (FYR) Macedonia, Albania, Kosovo, Serbia, Montenegro and Bosnia and Herzegovina or Bulgaria, Romania and Hungary. The 'Silk route' involves Afghanistan's neighbouring countries in Central Asia and Russia, as well as Belarus, Ukraine, Estonia, Latvia and sometimes Bulgaria.⁴²

Some Eastern European countries are also beginning to play a role in cocaine transshipment routes.

Drug use

The main psychoactive substances used are alcohol, tobacco, cannabis and opiates (including heroin and locally produced poppy derivatives). Problematic and recreational use of ATS, (including homemade stimulants, for example in Georgia) is increasing. Use of cocaine is reported in several countries; as is the use of non-prescribed medications like sedatives and tranquilisers. Use of ecstasy and hallucinogens, although at a low level compared to other regions, has also been increasing in recent years.

The general trend is that illicit drug use has increased in this region since the end of the Cold War and during periods of conflict (in the Balkans and parts of Central Asia and Caucasus).⁴³ Throughout the region, countries report poly-drug use, for example combining opiates and stimulants, although the capacity to monitor the drug use situation is limited and, with some exceptions, data are scarce.

Alcohol

Alcohol consumption is relatively high across the region, with official per capita levels in seven countries (Croatia, the Czech Republic, Hungary, Lithuania, Moldova, Russia and Slovakia) among the highest twenty in the world. The Czech Republic, in particular, has the third highest level of official alcohol consumption in the world at 16.21 litres of pure alcohol per capita per year.

In addition, ten of the top twenty spirit-consuming countries are in Eurasia, including the country with the highest official levels (Moldova) and the country with the highest levels of official beer consumption (the Czech Republic). Across most of the region, alcohol is very accessible, with beer cheaper than soft drinks in Belarus, Bulgaria, Croatia, the Czech Republic, Hungary and Romania.⁴⁴

In addition to the official recorded data, 'certain countries in Eastern Europe and some of the former Soviet Union republics have a sizeable estimated unrecorded alcohol consumption' ranging from 4.5 litres in Croatia to 12 litres in Moldova.⁴⁴ In Russia, unrecorded alcohol consumption includes 'samogon' and counterfeit vodka (which is associated with high rates of alcohol poisoning),⁴⁵ and 'a significant number of Russian men are drinking products that have either very high concentrations of ethanol or contaminants known to be toxic'.⁴⁶ In Moldova and Uzbekistan, alcohol consumption has been identified as an important factor in HIV transmission due to increased sexual risk behaviour.⁴⁷

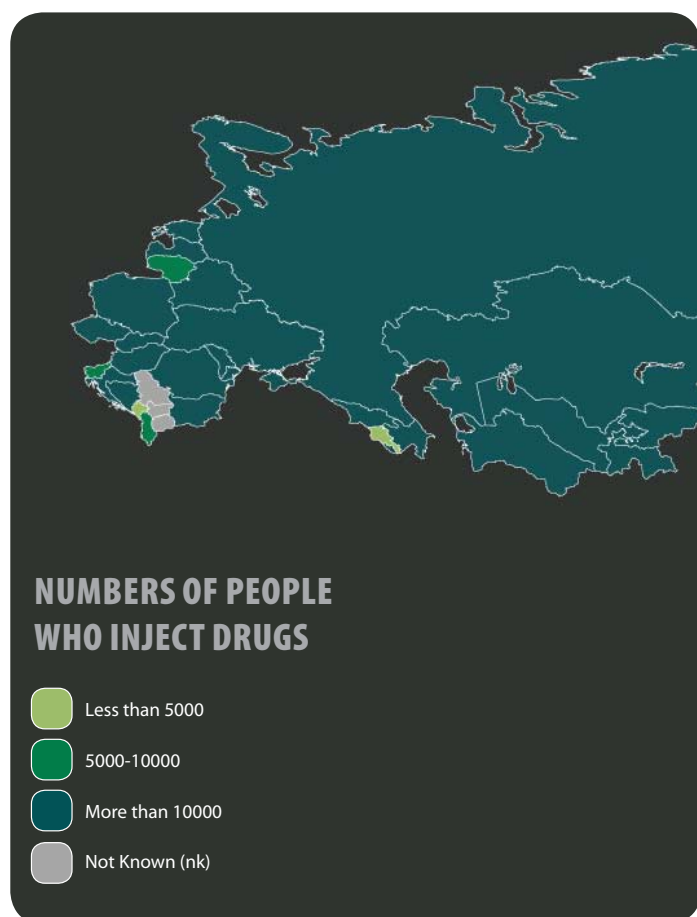
Amphetamine-type stimulants (ATS)

ATS are used in many countries in the region. Significant methamphetamine use is reported in the Czech Republic and Slovakia; as well as in Belarus and Georgia, where homemade ATS known as 'vint' or 'jeff' are often ephedrine and methamphetamine-based. Amphetamine is commonly used in Ukraine and Russia, and substantial use of ecstasy is reported in Moldova. There has also been a marked increase in amphetamine usage in south-eastern Europe.⁴³

The quality of ATS varies significantly and, even in production countries such as Lithuania, people who use drugs report major fluctuations in the composition and strength of locally produced and sold amphetamine. In Ukraine, manganese is usually used for producing methamphetamine, which includes very toxic chemical by-products. Although ATS injecting is reported in several countries, data are much scarcer than for opiate injecting.

Opiates

Opiate use in general is reported to be rising, particularly in countries along the Balkan trade route and in Russia. Heroin, opium, pharmaceutical opiates and various homemade opiates are used throughout the region. For example, 'kompot', a homemade opiate derivative of the pod and straw of the poppy, became widely used after the fall of the Soviet Union, when the region saw an influx of opiates from neighbouring countries. As with ATS, the quality of opiates and the purity of heroin vary substantially, with better-quality substances reported closer to Afghanistan and to heroin trafficking routes.



Map 2.2: Numbers of people who inject drugs in Eurasia

Injecting drug use

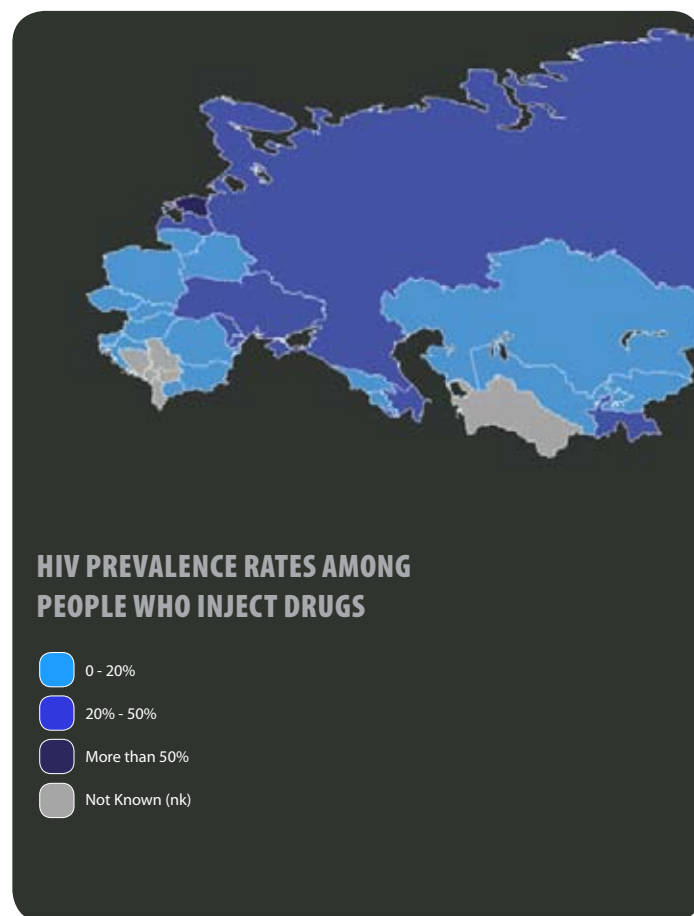
Injecting drug use rapidly increased in parts of Eurasia during the 1990s, and today is reported in all countries in the region. Estimates suggest there to be approximately 3.4 million people who inject drugs across the whole region, with the largest numbers living in Russia (2 million),³⁰ Ukraine (325,000–425,000)³⁶ and Kazakhstan (186,000).²⁰ Injecting drug use is reported to be increasing in the vast majority of countries in the region.* Injecting levels are reported to be stable in Croatia, the Czech Republic (although injecting may be increasing among young people), FYR Macedonia, Montenegro and Russia.

Decreases in injecting drug use are reported in Latvia, Poland and Slovakia.⁴⁷ However, apparent decreases may be related to recent improvements in the reliability of estimates of numbers of people injecting. Although the accuracy of estimates remains an issue in the region, some countries in Central Europe, the Baltics and the Balkans now utilise scientific methods rather than relying on 'drug user registers' or expert estimates.

Opiates are the most commonly injected substances in all Eurasian countries, these being predominantly heroin but also pharmaceutical opiates, opium extract and 'homemade' opiates. Belarus receives much of its raw opium (one of the most commonly injected drugs) from neighbouring Ukraine, where 'kompot' is widely used. Heroin is most commonly injected in Tajikistan, which borders Afghanistan, the biggest opiate-producing country internationally. In some countries, injecting of buprenorphine (for example Georgia and Armenia) and so-called 'street methadone' (for example Belarus and Armenia) is also reported.

Injecting of ATS, such as methamphetamine and ephedrine, is reported in an increasing number of countries including Belarus, Georgia, Moldova and Ukraine. As stimulant injecting requires a greater number of injections than opiate injecting in order to retain the drug's effect, it may be associated with the sharing of injecting equipment. Cocaine, which is more expensive in relation to other drugs in the region, is injected in countries such as Croatia, Kosovo and Poland, although to a lesser extent. In Armenia and Russia, there are reports of people injecting 'whatever they can get', such as prescription drugs like Coaxial (an antidepressant).⁴⁷

The average age of people injecting drugs in this region is very low. For example, in Kosovo in 2005, the average age was below 20 years.⁴⁷ In Romania, it is estimated that 80% of people injecting are aged under 29 years, and in 2004 the average age for initiating injecting drug use was between 17 and 19 years.⁴⁸ In FYR Macedonia, a 2002 UNICEF rapid assessment among young people who inject drugs found the age for drug use to be decreasing, with a growing number of 12 and 13 year olds using drugs.²⁵ In Lithuania, according to the Drug Control Department, more than half of the injecting population begin injecting opiates between the ages of 15 and 19 years.⁴⁹



Map 2.3: HIV prevalence among people who inject drugs in Eurasia

* Albania, Armenia, Azerbaijan, Belarus, Bulgaria, Georgia, Hungary, Kazakhstan, Kosovo, Kyrgyzstan, Lithuania, Moldova, Romania, Serbia, Slovenia, Tajikistan, Ukraine and Uzbekistan. The dynamics of injecting drug use are unknown in Bosnia and Herzegovina, Estonia and Turkmenistan.

Drug-related harms

HIV and AIDS

Eurasia has experienced the fastest-growing HIV epidemics in the world. Since 2001, the number of people living with HIV has more than doubled in the region, from 630,000 to 1.6 million. Russia and Ukraine, the largest countries in the region, have seen the most pronounced increases in recent years and are home to 90% of people living with HIV in the region. During 2006, almost two-thirds of new HIV diagnoses in Eurasia were attributable to injecting drug use.⁵⁰

Available estimates of HIV prevalence suggest that countries in Central Europe and the Balkans have few HIV cases among people who inject drugs and are less affected by HIV than the rest of the region, where high prevalence rates are found among this group. Estonia has the highest national HIV prevalence in the European Union (EU) at 1.3%⁵¹ and the highest reported HIV prevalence among people who inject drugs in Eurasia at between 54.3 and 89.9%.² HIV prevalence of over 15% is also reported in nine further countries (see Table 2.1).

Young injectors, who constitute a large proportion of the injecting population, are particularly vulnerable to HIV, HCV and other health and social harms related to injecting drug use. This increased vulnerability is largely because they are neglected by public policies and under-served by current harm reduction and drug treatment services.

Similarly, a lack of prison-based harm reduction and drug treatment programmes leaves prisoners, many of whom are current or former injectors, particularly vulnerable. In Moldova, female prisoners are particularly affected by HIV, in contrast to many countries where HIV is more prevalent among male prisoners.

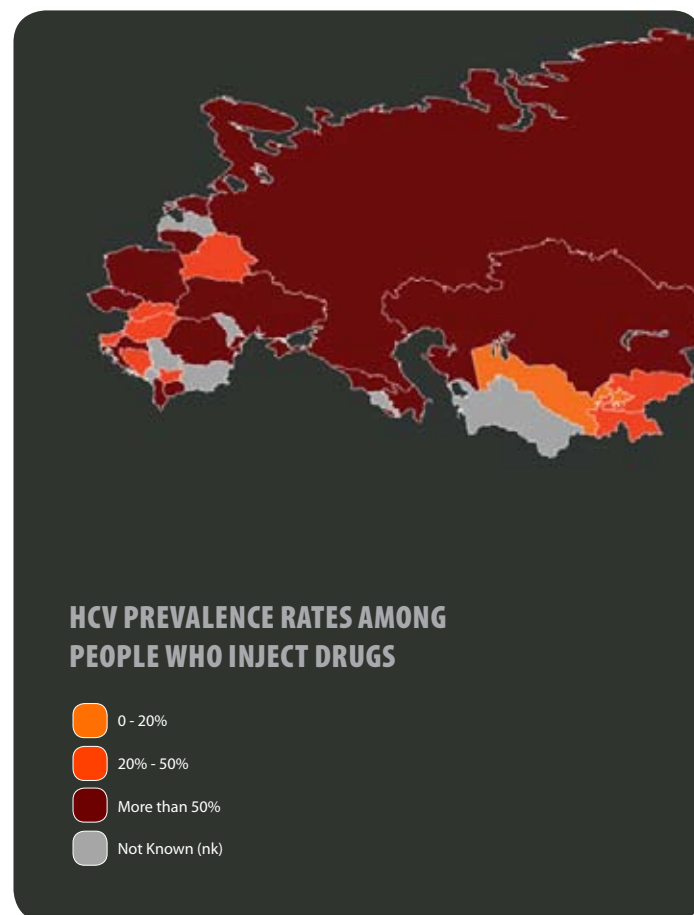
There are an increasing number of women who inject drugs in this region and several social factors contribute to their increased vulnerability to HIV and other drug-related harms.⁵² As in other regions, the overlap between sex work, injecting drug use and HIV is reported to be of significant concern.

Socially vulnerable communities such as Roma, migrants and displaced persons are also at increased risk of HIV transmission through injecting in several countries. In addition, a particular method used by people who inject opium (in Moldova for example) increases the risk of infections: when necessary ingredients are not available, blood is added during preparation to cool the drug – the final substance injected is known as ‘blood made drug’.

Hepatitis C virus (HCV)

In 1999, a WHO report revealed that most countries had national HCV prevalence rates of less than 2%. However, Moldova and Romania were more affected by HCV and had prevalence rates of 4.9% and 4.5% respectively.⁵³ Since the publication of WHO's report, the prevalence of both injecting drug use and HIV have dramatically increased in the region and, although current national HCV prevalence rates are not available, there are data that illustrate the scale of the HCV epidemic among people who inject drugs.

Extremely high rates of HCV have been reported among people who inject drugs, most notably in Estonia, Russia (both 90%) and Ukraine (between 70 and 90%). Across the rest of the region, HCV prevalence of over 50% is reported among people who inject drugs in Azerbaijan, Croatia, Georgia, Kazakhstan, Lithuania and FYR Macedonia.



Map 2.4: HCV prevalence among people who inject drugs in Eurasia

Large numbers of people who inject drugs in this region – mainly in HIV-affected Eastern Europe, the Baltics, Caucasus and Central Asia – are living with both HIV and HCV. End-stage liver disease caused by HIV/HCV co-infection has become one of the leading causes of death among people living with HIV in Europe.⁵⁴

Although data on HIV and HCV co-infection among people who inject drugs are limited, high HCV prevalence among those living with HIV has been reported in Russia (93% in Togliatti) and Poland (90% in Bialystok).³⁸ Among people living with HIV seeking treatment, HCV reaches up to 80% in Ukraine and Estonia, 61% in Latvia and 52% in Russia. In the Czech Republic and other Central European countries, studies have found that around one-third of injectors living with HIV also test positive for HCV.³⁸

Drug use and its related harms in prisons

Russia has the highest imprisonment rate at 600 per 100,000 in the population,⁵⁵ followed by Belarus (426) and Georgia (401).⁵⁶ There is mandatory sentencing for drug offences in at least seven countries in the region.[†] Alternatives to custodial sentences for drug offences exist in the legislation of at least ten countries.[‡] The majority of countries in the region impose coercive or compulsory treatment for people who use drugs, although in some cases this treatment is impeded by an absence of the relevant infrastructure and funding.[§]

Membership of the EU has had a positive impact on drug legislation in some new member states, with a reduction in penalties and terms of imprisonment and/or improvement to prison conditions.

[†] The Czech Republic, Georgia, Montenegro, Moldova, Romania, Russia and Uzbekistan.

[‡] Albania, Croatia, Estonia, Hungary, Latvia, Lithuania, Moldova, Poland, Slovenia and Ukraine.

[§] Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, the Czech Republic, Kazakhstan, Macedonia, Montenegro, Poland, Serbia, Slovakia, Tajikistan and Uzbekistan.

Injecting drug use is highly criminalised in the region. Available data, along with anecdotal evidence, indicate that there are large numbers of prisoners who have previously injected drugs and that injecting continues during incarceration. Several studies in Russia have found that a large proportion of people who inject drugs have been arrested and incarcerated,⁵⁷ and official data estimate that registered drug users constitute 6% of the prison population.⁵⁵ One study highlighted four health factors that were correlated with imprisonment: HIV infection, tuberculosis, overdose and abscesses.⁵⁸

In Kyrgyzstan, half of the prison population is reported to have a history of injecting drug use.¹⁹ In Moldova, this figure reaches 81.3%.⁵⁹ In Bulgarian prisons, the number of people using heroin has increased since 2004 following the introduction of stricter drug legislation in the country. In general, prisoners can access drugs, and injecting behaviour in prisons is reported to be highly risky.⁶⁰

HIV prevalence rates among prisoners are available for fourteen Eurasian countries, including FYR Macedonia (0%),⁵¹ Russia (6%),⁵⁵ Tajikistan (8.4%),³⁴ Ukraine (13%)³⁶ and Estonia (8.8–90%).⁶¹ Although estimates are not available in the other Baltic states of Lithuania and Latvia, it is reported that a large proportion of people living with HIV in these countries are in prison establishments. In 2002, injecting drug use was associated with extremely rapid HIV incidence in Alytus prison in Lithuania.

Across the region, people living with HIV are over-represented in prison populations. HIV prevalence is generally higher among prisoners who inject than among people who inject drugs in the community.

Information on HCV prevalence in Eurasian prisons is largely unknown. However, available data suggest that HCV is highly prevalent among prisoners in the Czech Republic (18–78%),³⁸ Slovakia (18.3%),⁶² Lithuania (53–70%)⁶³ and Estonia (82–97.4%). In Russia, it is reported that prevalence of HCV and HBV among prisoners is approximately 3%.⁵⁵

THE RESPONSE

Harm reduction services

Harm reduction initiatives in this region have largely been developed as part of the response to emerging HIV epidemics. This is reflected in the adoption of harm reduction in national HIV policies, in the package of harm reduction services advocated for and implemented, and in the origins of funding. However, the need for a broader spectrum of harm reduction service provision (including other health, social and legal services) and the sensitisation of existing services to the needs of specific underserved groups (including young injectors, women who use drugs and ATS users) is slowly being recognised.

Needle and syringe exchange programmes (NSPs)

All countries in the region have NSPs, with the exception of Turkmenistan and the recently independent state of Kosovo. Throughout the region, the availability of services varies considerably. For example, 129 sites provide NSPs in Kazakhstan,²⁰ 69 sites serve the vast country of Russia⁶⁴ and there are 362 sites in Ukraine (107 fixed sites, 207 street-based and 48 mobile units).⁶⁵ A new grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria will go towards the further expansion of services in Ukraine, including fourteen new mobile clinics, as well as increased HIV, HCV and overdose prevention, screening and treatment of STI programmes for people who inject drugs.⁶⁶

In other countries, such as Azerbaijan, Romania and Slovakia, NSPs are limited to less than five sites. Community-based outreach is used in all countries, which is vital in providing an alternative to stationary NSP services that are often targeted by police.

Kyrgyzstan, Slovenia and Ukraine are the only countries in the region with pharmacy-based NSPs as well as those that are not based within pharmacies.¹⁴ In Ukraine, for example, twenty-two pharmacies in eight cities are distributing syringes, condoms and information, education and communication (IEC) materials to people who inject drugs.

Where data are available, the highest estimated rates of syringe distribution per person per year are in Ukraine (80), FYR Macedonia (72), Kazakhstan (65) and Lithuania (41). Albania, Hungary and Bosnia and Herzegovina appear to have very poor syringe distribution rates, with less than two syringes distributed per person injecting drugs per year. There is a clear need to improve the scale of NSP service provision throughout this region.

In addition to NSPs, syringe vending machines provide an anonymous, 24-hour method of obtaining sterile injecting equipment in Hungary and Slovenia.¹⁴ Pharmacy sales are often the primary source of sterile injecting equipment for people who inject drugs, including those reached through NSPs.^{67,68} However, as in other regions, pharmacists are often reluctant to sell syringes to people they suspect of injecting drugs. For example, in FYR Macedonia, a survey covering forty-four pharmacies found that one-quarter did not sell syringes to people who inject drugs.²⁵

In a number of countries, it is reported that there is often a police presence at pharmacies which sell injecting equipment, particularly those operating 24-hours a day. In Romania, a campaign to sensitise pharmacists resulted in a position statement from the National Collegium of Pharmacists about their role in harm reduction. Further analysis is necessary to establish the extent to which people who inject drugs are able to access sterile injecting equipment from pharmacies.⁴⁷

The harm reduction response in Kyrgyzstan is one of the most developed in Eastern Europe and Central Asia. The collaboration of primary health centres and non-governmental organisations (NGOs) has improved access to NSP sites, increased their sustainability and helped to destigmatise NSP programming. NSPs are available in most prisons, and there are plans to launch a prison-based opioid substitution therapy (OST) pilot programme during 2008. A number of NGOs are collaborating with pharmacies to expand access to sterile injecting equipment.

The country is also home to many new initiatives in the region, such as country-wide scale up of OST programmes, provision of needles and syringes in tuberculosis clinics and a large-scale project involving collaboration between the Ministry of Justice and a network of community-based NGOs focusing on injecting drug use. Major considerations for the future of harm reduction in Kyrgyzstan include the sustainability and continuity of funds for service delivery, as well as the need to broaden harm reduction services beyond HIV prevention and care.⁴⁷

* Although it should be noted that the existence of sites does not necessarily guarantee that they are operational.

People who inject drugs face several barriers to accessing sterile injecting equipment. In some countries, the most significant barrier is the low availability of services. For example, in Belarus, Romania and Lithuania there are areas with large numbers of people who inject drugs that have no NSP outlets. In several countries, including Russia and Latvia, a lack of community-based outreach limits the numbers who benefit from NSP services.

Even where there are more services in existence, inaccessibility due to geographical location, the cost of travel and limited hours of opening can pose difficulties for many people. In Moldova, a lack of awareness among people who inject drugs of the existence of NSPs results in low service uptake.

Fear of arrest or police harassment also affect service uptake in a number of countries that have restrictive policies, such as Russia, Ukraine, Belarus and FYR Macedonia. A survey of people who inject drugs in FYR Macedonia found that just over half had either been taken to a police station or had their injecting equipment confiscated by police.²⁵ Fear of breaches in confidentiality, as well as stigma and discrimination, are also issues in many countries.

In Georgia, the current 'War on Drugs' has led to a huge increase in police activity and in the number of people apprehended for suspected drug use. In 2007, more than 57,000 people were stopped on the streets and taken for drug testing. Those who tested positive for traces of controlled substances were subject to fines and criminal sanctions.⁴⁷ In Lithuania, it is reported that the majority of the public hold the view that injecting drug use would be reduced if it commanded heavier prison sentences.⁶²

NSP services have increased in recent years and will continue to increase with support from national funding (the Czech Republic), the Global Fund grants (Albania, Bosnia and Herzegovina, Kazakhstan, Montenegro and Romania) and a combination of international and national funding (Estonia, Latvia and Lithuania). However, there are challenges to ensuring adequate quality and further scale up of these services.

Lack of funds is the primary difficulty in both expanding services and sustaining those already operating in some countries, for example Belarus and Slovakia. In Belarus, the number of people attending NSP sites decreased following a period where syringes were less available due to a funding gap.⁴⁷

In Russia, the establishment of further NSP sites is challenging, as permits must be granted by the local branch of the Federal Drug Control Service. In addition, there are limited organisations willing to provide services due to stigma and a lack of acceptance of harm reduction. In Moldova, data limitations are a barrier to scaling up services, as estimates of the numbers and distribution of people who inject drugs are lacking in reliability. Poor infrastructure adds further challenges to increasing NSP services.

There are often difficulties in attracting and retaining NSP staff due to high levels of burnout, low pay and social stigma associated with their work. This is particularly the case for outreach workers, 'gatekeepers', peer educators and volunteers, many of whom may be struggling with their own drug use.⁴⁷ In general, NSPs lack support from health and social services and are largely implemented by NGOs. This affects NSP sustainability, funding and staffing capacities.

Treatment for drug dependence

OST is provided for maintenance purposes in twenty-three countries in the region,[†] although in most countries service provision is small scale. OST is not available in Armenia,[‡] Kazakhstan, Kosovo, Russia and Tajikistan. Methadone and buprenorphine are still illegal in several countries. Methadone is illegal in Tajikistan and Russia, and buprenorphine is illegal or not used in at least twelve countries in the region.[§] Despite numerous efforts, Russia, which is home to about 2 million people that inject drugs, still prohibits the use of narcotic substances for drug treatment. As described by Human Rights Watch, the Russian drug treatment service 'requires rehabilitation'.⁶⁹

Across the region, at least 102 OST sites provide medically assisted treatment to over 16,230 people, a very small proportion of the estimated 3.4 million people injecting (mainly opiates). The largest reported numbers of people receiving OST are in three relatively small countries: Croatia (4,500), Slovenia (3,132) and the Czech Republic (2,586).²⁶ The volume of OST prescribing has increased in recent years in eleven countries.^{¶47}

In Ukraine, OST first became available in 2004, and there are now at least 756 clients receiving buprenorphine maintenance therapy in ten regions, including 155 people who are also receiving antiretroviral treatment (ART). Future expansion of OST provision is planned, and will involve the provision of methadone, the import of which was authorised by state law enforcement in 2007 following substantial advocacy efforts.

Even where services are available, many barriers remain that restrict access to OST. In Ukraine, for example, the names of people accessing OST are included on an official register, limiting their choice of professions that involve particular activities (for example driving or operating machinery). Information is often shared between medical and law enforcement institutions, putting people at risk of discrimination, police harassment and arrest. The 'drug user registers' that exist in a number of countries have continued from the Soviet era and pose a major barrier for many wishing to access treatment.

The geographical location of services has a huge impact on the ability of many to access OST. As take-home doses are usually prohibited, daily visits to treatment provision sites are normally required. Most countries have less than ten OST sites and in Albania, Latvia and Montenegro, OST access is limited to a single site. With so few sites and treatment places, people also often face long waiting lists and strict inclusion criteria.

In general there is a charge for OST, and in some cases medical insurance is required, making treatment access difficult for many people and particularly for those who are unemployed. Although some countries have developed national OST guidelines, limited training and technical support opportunities restrict the number of services able to adhere to the guidelines. In some countries, such as Uzbekistan, low awareness of the existence of services is also a limiting factor in service uptake.

There is a clear need for the scale up of OST provision in this region, both in countries that have been providing OST for almost

[†] Albania, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, the Czech Republic, Estonia, Georgia, Hungary, Kyrgyzstan, Latvia, Lithuania, Macedonia, Moldova, Montenegro, Poland, Romania, Serbia, Slovakia, Slovenia, Ukraine and Uzbekistan.

[‡] OST is planned to start in June 2008. Information was not available for Turkmenistan.

[§] Armenia, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Georgia, Hungary, Kosovo, Kyrgyzstan, Poland, Russia, Serbia and Tajikistan.

[¶] Albania, Azerbaijan, Belarus, Bulgaria, Estonia, Georgia, Hungary, Moldova, Serbia, Ukraine and Uzbekistan.

a decade and in those where it has been more recently introduced. In Russia, home to the majority of the region's opiate users, advocacy efforts focus on changing legal restrictions on OST provision and raising knowledge of OST. A lack of political will and funding, poor health system infrastructures and a lack of capacity, as well as resistance to OST within the community, health sector and government all pose significant challenges to increasing services. Continued international financial and technical support, combined with sustained advocacy efforts, are necessary to scale up OST accessibility in this region.

Non-OST treatment for drug dependence is available in all twenty-nine countries, although this varies in form and availability. For example, in Ukraine, this largely involves detoxification, short-term in-patient treatment or drug-free rehabilitation, which is usually twelve-step or religion-oriented.

In several countries, including Georgia, there are few facilities and what treatment is available is very expensive, making it inaccessible for the great majority of those who wish to access it. In Moldova, drug treatment is largely limited to twelve-step programmes run by NGOs. In general, throughout the region, drug treatment or 'narcology' is poorly integrated with other medical disciplines.

Targeted HIV prevention, treatment and care

The extent to which HIV services reach people who inject drugs varies throughout the region, with several countries using targeted programmes to increase the numbers reached. Voluntary HIV testing is available in all countries (this may often be without proper pre- and post-test counselling) and targeted programmes are in place to increase uptake of people who inject drugs to these services in much of the region.*

In Ukraine, people who inject drugs often access voluntary HIV counselling and testing (VCT) via NSP sites. Since June 2006, almost 28,000 consultations and rapid HIV tests have been provided through NSPs.⁶⁶ In Lithuania, some NSPs offer VCT, and rapid HIV testing, to a lesser extent. Those who identify themselves as people who inject drugs can access VCT free of charge.⁴⁷ However, this may not be an agreeable option for all. In Romania, where VCT is free for people who inject drugs, only 620 out of over 220,000 people accessing VCT in 2007 reported injecting drug use.⁷⁰

NSP client data indicate that the proportion of people who inject drugs that are aware of their HIV status varies dramatically in the region, from about 9% in Georgia to over 60% in Latvia and Lithuania.

Targeted programmes reaching people who inject drugs with HIV and STI prevention measures (including IEC materials and condom distribution) are limited throughout the region. Where they exist, these services are usually integrated to some extent with NSPs or low-threshold programmes. HIV prevention coverage of people who inject drugs in Russia is estimated to be as low as 3%. In contrast, the Czech Republic, a relatively small country, has almost ninety low-threshold programmes targeting people who inject drugs with HIV prevention.

In general, most targeted reproductive health programmes aim to reach sex workers (including those who inject drugs) rather than people using drugs who are not involved in sex work. In Lithuania, for example, only those low-threshold services working with sex workers who inject drugs offer STI testing on site.

Estonia, Hungary, Kyrgyzstan and FYR Macedonia have more substantial programmes reaching people who inject drugs with both STI prevention and referral to testing and treatment services. Many condom distribution programmes are reaching people who inject drugs in Albania, Croatia, Kyrgyzstan, FYR Macedonia, Moldova and Ukraine, although these programmes are heavily dependent on the availability of resources.⁴⁷

Data limitations make it difficult to establish the extent to which people who inject drugs are receiving ART. Where data do exist, often no distinction is made between people who continue to inject drugs and those who no longer do so. However, available information indicates that access to ART among this key population is poor in many countries, particularly for people who currently inject.

In 2006, a review found that 14% of those receiving ART in the region were current or former injectors, a low proportion given the high prevalence of HIV among this population. Estimates of current or former injectors receiving ART are available for only fourteen countries in the region, totalling approximately 4,270. However, drawing national or regional conclusions is made difficult by the differences in the definitions used in each country.

The largest numbers accessing treatment are reported in Ukraine (1,776)¹⁹ and Poland (1,531),⁷¹ although these figures remain small in comparison to those needing ART. However, in Estonia, it is estimated that 85% of people receiving ART are current or former injectors,⁷² the majority falling into the formerly injecting category. In several countries there are less than fifty current or former injectors receiving ART,[†] and in Hungary none are currently in receipt of this treatment.⁷³

Several barriers limit access to HIV services for people who inject drugs. Comprehensive services offering harm reduction and HIV prevention, treatment and care are rare in the region. As a result, opportunities for reaching people through NSP or OST services are often missed.

VCT and ART clinics are often not 'drug user friendly'. Many are not low threshold, require referral and have costs attached or a requirement of medical insurance, making access difficult for many people injecting drugs. Programmes supporting people to adhere to complicated ART regimens (often in combination with OST) are also rare in the region.

Although VCT is provided free of charge to those who declare their injecting drug use in some countries, fear of stigma and discrimination associated with both HIV and drug use acts as a powerful deterrent. In Azerbaijan, this particularly affects women, who are often reluctant to actively seek care for HIV and other STIs, a situation compounded by a general lack of services.¹⁹ In Uzbekistan, limited training materials are available in the Uzbek language and the curricula of medical schools lags behind up-to-date practice on HIV prevention, treatment and care.

In most countries, ART will not be provided unless people have stopped injecting, or are receiving OST, making the lack of OST availability a significant factor in ART access.

* Information was not available for Azerbaijan or Kosovo.

† Armenia, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Kosovo, Kyrgyzstan, Lithuania, Slovakia and Slovenia.

Targeted HCV prevention, treatment and care

It is difficult to assess the availability of HCV-related services for people who inject drugs in this region, and to distinguish between short-lived interventions related to pharmaceutical companies and sustained regular practice. However, it appears that HCV testing is available to people who inject drugs in ten countries.[‡] In six additional countries, availability is very limited, due to restricted testing sites, or the requirement of a doctor's referral.[§] In Ukraine and Belarus, low threshold and free of charge HCV testing is not available for people who inject drugs.

However, even where HCV testing is available, many people who inject drugs will not be able to access the necessary treatment if testing positive. HCV treatment is unavailable in several countries. Many have guidelines that exclude people who are currently injecting drugs or require a period of abstinence before treatment will be prescribed. In some countries, including the Czech Republic, Hungary, Romania, Slovakia and Slovenia, people receiving OST have better access to HCV treatment, although this is also limited and can be refused by doctors.

Aside from exclusion criteria and lack of availability, HCV treatment often has associated costs, making access difficult for many people who inject drugs, as well as, in many cases, people who are living with HIV. As with OST and ART, limited awareness of HCV treatment is reported both within the health sector and within groups vulnerable to HCV.

Since HIV accelerates HCV progression, people living with HIV may have more urgent need for HCV treatment. In some countries, including Belarus and Russia, there are initial efforts to enrol people with HIV/HCV co-infection in HCV treatment programmes. As a significant cause of death among people living with HIV and people who inject drugs in the region, it is imperative that HCV treatment becomes more easily accessible to these often overlapping populations.

Harm reduction in prisons

Harm reduction interventions are currently reaching few prisoners in the region. Prison needle and syringe exchange programmes (PNEPs) exist in Armenia (3 prisons), Kyrgyzstan (11 of 12 prisons) and Moldova (7 of 18 prisons). In Belarus, one PNEP was operating in 2006, but was closed in the same year. In Romania, legislation allowing the implementation of pilot OST and PNEP programmes is endorsed by the National Prison Administration and National Antidrug Agency, and in 2008 the Romanian National Prison Administration will pilot NSPs in 2 prisons with international technical and financial assistance.⁶⁸ In Tajikistan, AIDS Foundation East West (AFEW) distributes disinfectants to prisoners, as well as providing peer education and counselling and disseminating IEC materials.³⁵ However, in the majority of prisons in Eurasia sterile injecting equipment is not made available.

Most prisoners in Eurasia do not have access to OST, even if they were receiving it prior to incarceration. OST is available widely in Slovenian prisons, and to a limited extent in the Czech Republic (2 of 35 prisons), Moldova (3 of 18 prisons), Poland (5 of 213 prisons), Albania, FYR Macedonia, Montenegro and Serbia. It will soon be available in Kyrgyzstan. In Ukraine, the introduction of OST in prisons is currently under discussion,⁷⁴ and in Romania there are plans to pilot OST in one prison from April 2008.⁷⁵

However, very few people are currently receiving OST while incarcerated even where it is available. In Moldova, where OST first became available in prisons in 2005, the numbers receiving it are still very low due to restrictive inclusion criteria. There are reported to be twenty-seven prisoners in Moldova receiving OST. The numbers are even smaller in Serbia (10 prisoners) and Montenegro (5 prisoners).

Despite elevated HIV prevalence within prison populations throughout the region, HIV prevention, treatment and care within prison facilities is limited. Condoms are available in prisons in Armenia (3 of 12 prisons), Belarus (all prisons), Estonia (most prisons), Montenegro (1 of 3 prisons), Romania (all prisons), Ukraine (27 of 149 prisons) and in Tajikistan, where they are provided by the Global Fund, along with STI screening and treatment, peer education on HIV and IEC materials.³⁵ Peer education on HIV prevention and IEC materials are also available in 27 prisons in Ukraine. In Latvia and a number of other countries, condoms are available in prison 'shops' or healthcare units. In Russia, condoms are available in conjugal visit rooms in ten regions through the support of a Global Fund project called 'Globus'. In Slovakia, condom vending machines have been provided to prisons; however, these remained empty throughout much of 2007 due to a lack of funds.

The availability of voluntary HIV testing and counselling in prisons varies throughout the Eurasian region. It is available in all prisons in Belarus, Lithuania, Romania, Russia and Slovakia and in most prisons in Estonia and Bulgaria (12 of 13 prisons and 4 detention centres). Testing is also available in Latvia but is reported to be implemented poorly, with a large proportion of prisoners who have previously tested positive for HIV receiving additional HIV tests. In FYR Macedonia and Kosovo, community-based and mobile VCT units are used to provide prisoners with HIV testing and counselling as this service is not available in prisons.

Data on ART availability in prisons are scarce, but estimates suggest there to be 1,165 prisoners receiving the treatment in prisons in Belarus, Estonia, Georgia, Latvia, Lithuania, Moldova, Poland and Ukraine. According to Russia's Ministry of Justice, ART is currently received by 68% of prisoners who need it.⁵⁵

HCV testing and treatment is limited in Eurasian prisons and often dependent on conditionalities. HCV testing can be available only to prisoners living with HIV (Belarus, Latvia, Russia and Slovenia), on prison admission (Poland and Slovakia) or on request (Lithuania). In other countries such as Moldova, a lack of testing equipment prohibits availability in some prisons. HCV treatment is available in many prisons in Slovakia and Slovenia and in a very limited capacity in the Czech Republic, Estonia, Hungary, Lithuania and Poland. In other countries only the symptoms associated with HCV are treated, as antiviral medication is not available.

Policies for harm reduction

In recent years, international donors have supported the scale up of harm reduction services such as NSP and OST provision. However, government involvement in these initiatives has generally been limited. While there are references to harm reduction in government policy in this region, in practice the harm reduction programmes have largely been implemented by NGOs and governmental institutions led by motivated professionals, with support from international agencies.

‡ Armenia, Bosnia and Herzegovina, Bulgaria, Croatia, the Czech Republic, Georgia, Kosovo, Moldova, Romania and Slovenia.

§ Estonia, Hungary, Lithuania, Poland, Russia and Slovakia.

All countries in the region have a national HIV action framework, with the exception of Russia. The majority of these frameworks mention harm reduction (21 countries),* injecting drug use (24 countries) and human rights (16 countries). Twenty-four countries also have a policy or strategy on drugs. Many of the twenty-one countries† that include harm reduction in their drug policy are the same as those which include at least one harm reduction intervention in their HIV policy.

However, despite their apparent intention to implement harm reduction, many countries have limited budgets allocated to this. In addition, many have laws and regulations that directly conflict with harm reduction initiatives and impede access to existing services for people who inject drugs. For example, in Montenegro, NSP activity can be interpreted as enabling others to consume narcotics and Montenegrin legislation states this to be a crime punishable with prison sentences of between six months and five years. Enabling a minor to inject drugs commands prison sentences of between two and ten years, a law that in practice denies young people who inject drugs access to sterile injecting equipment.

In Latvia, which is supportive of harm reduction in both HIV and drug policy, limited government support has resulted in only one OST programme in the capital city. Lithuania is considered a good practice model in terms of harm reduction and has provided harm reduction trainings for practitioners in Eastern European and Central Asian countries. However, harm reduction has still been attacked and used as a political tool by politicians.

Budapest-based NGOs signed a contract with the police to set up a new NSP client identification system in order to ensure that clients possessing needles are not harassed by police. However, when they attempted to broaden the scope of this contract to the whole country, the General Prosecutor's Office issued a statement which called needle exchange provision a crime.⁴⁷

Joining the EU has had a positive impact on drug policy in some new member states in the Baltics, Central Europe and parts of south-eastern Europe. It has facilitated reductions in penalties and prison sentencing for drug use and helped to 'normalise' harm reduction. In addition, the EU Action Plan on Drugs articulates the necessity of harm reduction initiatives.

Twenty-two countries in the region are member states of the Council of Europe, which in 2004 issued the Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia. This document explicitly states the need to scale up levels of access to harm reduction services for people who inject drugs and sets a target of reaching 80% of people who inject drugs with HIV prevention, treatment and care by 2010.⁷⁶ A report evaluating progress towards targets set in the declaration will soon be published by the WHO's Regional Office for Europe.

International NGOs have played a key role in harm reduction development in Eurasia, including the International Harm Reduction Development Program of the Open Society Institute, which has evolved from a key donor to a leading technical support provider and advocate in the region. The International Federation of the Red Cross and Red Crescent Societies has also played a major part in harm reduction service provision through its local partners in several countries.

* Albania, Armenia, Bulgaria, Croatia, the Czech Republic, Estonia, Georgia, Kazakhstan, Kosovo, Kyrgyzstan, Latvia, Lithuania, Macedonia, Moldova, Poland, Romania, Serbia, Slovakia, Slovenia, Tajikistan and Ukraine.
† Albania, Belarus, Croatia, the Czech Republic, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Macedonia, Moldova, Montenegro, Poland, Romania, Slovakia, Slovenia, Tajikistan, Ukraine and Uzbekistan.

Civil society organisations are integral to the response in Eurasia, and many work at the regional level to promote harm reduction and to improve the lives of people who inject drugs. These include the Eurasian Harm Reduction Network, the South-Eastern European Adriatic Addiction Treatment Network, the South Eastern European Collaborative on Human Rights and Treatment Network on Drugs and HIV, AIDS Foundation East-West (AFEW), the ENDIPP network (recently renamed Connections), the Correlation Network and the International HIV/AIDS Alliance.

Throughout the region there are also NGOs advocating for harm reduction at the local and national level (21 countries),‡ as well as providing community-based services. In Moldova, for example, approximately 95% of harm reduction services are provided by NGOs, largely funded by external donors such as the Global Fund. Drug user activism is also strong, with at least one drug user network operating in fourteen countries in the region.⁵

However, there are few examples of effective partnership between governmental and civil society sectors in the region and funding schemes for NGOs at country and municipal levels are largely underdeveloped.

The Eurasian Harm Reduction Network (EHRN, formerly Central and Eastern European Harm Reduction Network, CEEHRN) supports, develops and advocates for harm reduction approaches in the field of drugs, HIV, public health and social exclusion. Its work is guided by the principles of humanism, tolerance, partnership and respect for human rights and freedoms.

Founded in 1997, EHRN today unites more than 260 individuals and organisations from twenty-five countries in Central and Eastern Europe and Central Asia. The network's members come from both public and private sectors and include government agencies, drug treatment and HIV professionals, harm reduction organisations, researchers, community groups and activists (including organisations of people living with HIV, and people who use drugs), as well as supporters and experts from outside the region.

The main activities of the network include analysis of policies and practices, advocacy for improved policies on HIV and drugs, networking, informational support and exchange, and capacity-building of members and other stakeholders in harm reduction through the regional Harm Reduction Knowledge Hub. EHRN members and their allies seek to reduce drug-related harm, including the transmission of HIV and other blood-borne diseases, through facilitating the use of less repressive and non-discriminatory policies with respect to people who use drugs and other vulnerable populations.

‡ Albania, Azerbaijan, Bosnia and Herzegovina, the Czech Republic, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Lithuania, Macedonia, Moldova, Montenegro, Poland, Romania, Russia, Serbia, Slovakia, Slovenia, Tajikistan and Ukraine.
§ Bulgaria, Croatia, Georgia, Hungary, Kyrgyzstan, Lithuania, Macedonia, Poland, Romania, Russia, Serbia, Slovenia, Tajikistan and Ukraine.

Multilateral support for harm reduction

Multilateral agencies are supporting harm reduction programmes through the provision of financial and/or technical assistance to either government or NGOs, but this support is not homogenous across the region. Central European countries are mainly relying on national resources for developing, maintaining and building capacity of services for people who use drugs. In other countries which are 'eligible' for international support, UN agency support for harm reduction is largely related to HIV prevention, treatment and care and, as such, is concentrated in Eastern Europe and Central Asia.

Agencies are not currently supporting wider harm reduction activities such as overdose prevention or HCV-related services and minimal support is given to comprehensive drug policy development in the region.

The majority of financial support for harm reduction in Eurasia comes from the Global Fund. While it is not a technical support provider, the Global Fund plays a key role in strengthening harm reduction service provision in the region. Civil society organisations are principal and sub-recipients of Global Fund grants, including a harm reduction specific grant in Russia and a Ukrainian grant with a large harm reduction development component.

The Global Fund's transparent performance-based funding strategy resulted in the agency being instrumental in the initiation of methadone maintenance therapy (MMT) provision in Ukraine. The threat of potential grant suspension mobilised national authorities to issue import permits for methadone, which had been the main barrier. Major scale up of MMT is now planned in Ukraine.

UNODC has major projects in Estonia, Latvia, Lithuania, Romania and Russia, large components of which relate to the support of harm reduction approaches through service provision, capacity-building and advocacy. In Central Asia, a smaller scale project is also supporting harm reduction approaches.

UNICEF has played an integral role in the promotion of harm reduction, particularly in south-eastern Europe, where it has recently conducted situation assessments; and in Balkan states, where it actively supports the development of harm-reduction-friendly policy.

The World Bank has a limited number of projects in the region, the most prominent being the Central Asian AIDS Project. Harm reduction was recently identified as one of two priority areas of this project and there are plans to fund substantial harm reduction capacity-building and networking activities.

UNAIDS plays an important role in developing a comprehensive response to HIV in the region, and harm reduction is integrated into its initiatives.

WHO (via its Regional Office for Europe, as well as country offices, for example in Ukraine) is one of the leading region-wide advocates of harm reduction. It supports harm reduction through communication with government and ministries of health in the region, the publication of best practice guidelines and the provision of technical assistance (for example with OST programming, monitoring and evaluation and the development of harm-reduction-related Global Fund grant proposals).

The UNFPA often provides condoms to harm reduction programmes. Although harm reduction is not significant in its activities so far, there are attempts at the regional level to increase focus in this area.

In addition to UN agencies, it is important to mention the beneficial impact of the EU on the region and its drug responses, which has been particularly significant in the new EU member states of the region. For example, the EU has provided assistance in the development of drug information systems in the CIS countries (with the exception of Russia), and, to some extent, in the Balkans. The accession process to the EU has enabled a number of countries to 'normalise' their harm reduction approaches and has exposed them to good practices.

In other countries, the EU provides financial support to projects protecting the human rights of people who use drugs (for example in Georgia), has supported the development of harm-reduction-friendly drug policy in FYR Macedonia and facilitates the exchange of good practice through twinning projects for new members and accession countries. The EU also hosted a harm reduction conference with the participation of Russian, Ukrainian, Belarusian and Moldovan officials.

In 2007, a Memorandum of Understanding between the European Monitoring Centre on Drug and Drug Addiction (EMCDDA) and the Russian Federal Drug Control Service was signed to formalise plans to improve monitoring systems.

However, despite the work of the UN agencies and the EU in the harm reduction field, access to services is still very limited. While international support is essential in the region, particularly financial support from the Global Fund, it is fragile. As Eurasian countries become wealthier, international support for them will reduce substantially and not all governments will be willing to replace those funds. Decreased HIV funding in the region appears to be affecting HIV prevention (including harm reduction) first.

Estonia and Croatia are the first countries that could not reapply to the Global Fund following previous successful grants. Although Estonia managed to raise funding for HIV and harm reduction programming equivalent to that during 'Global Fund years', Croatia saw service provision return to levels existent prior to the Global Fund grant. Similarly in Romania, after successful implementation of a Global Fund grant, service provision began to shrink and harm reduction staff went unpaid. Eventually this funding gap was filled by a new grant from the Global Fund.

This issue poses particular concern in Russia, where harm reduction services are almost exclusively dependent on current Global Fund support. When the country is no longer eligible for these grants, it is unlikely that national funding will be increased to the levels necessary to support continued harm reduction initiatives.

The recent review of Global Fund eligibility criteria will soon exclude additional countries (for example Azerbaijan and Kazakhstan) from receiving this financial support, the ultimate expectation being that national governments will increase financial support in light of their improving economies. Safeguards must be put in place in order to mitigate the impact of this on harm reduction programming.

While international support for harm reduction is imperative to service provision in this region, there is a need for UN agencies to play a stronger role in supporting governments to reform repressive legislation, harmonise HIV and drug policy and scale up harm reduction initiatives. Alongside this, political and financial support from government is vital to ensuring that harm reduction services increase their coverage, effectiveness and sustainability.

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Regional Overview

Western Europe



AVAILABILITY OF NEEDLE AND SYRINGE EXCHANGE PROGRAMMES AND OPIOID SUBSTITUTION THERAPY

- Both NSP and OST available
- OST only
- NSP only
- Neither available
- Not Known

HARM REDUCTION IN WESTERN EUROPE

Country/territory with reported injecting drug use ^a	People who inject drugs ^{b 1}	Adult HIV prevalence amongst people who inject drugs ²	Adult HCV prevalence amongst people who inject drugs ³	Harm reduction response			
				NSP	OST	DCR ^f	HIV and HCV programmes targeted towards people who inject drugs ^c
Austria	17,500	11.9%	48%	✓	✓	x	Yes, but limited condom distribution
Belgium	25,800	2.7–12.9% ^d	50–80.7% ^d	✓	✓	x	Yes, but no targeted VCT, and HCV testing/treatment is limited
Cyprus	327	0.6%	9.1%	✓	✓	x	No targeted programmes, only limited condom distribution
Denmark	15,416	2.3%	58%	✓	✓	x	Yes, but no targeted VCT, and limited targeted condom distribution and HCV testing/treatment
Finland	15,650	0.2%	23–56.6% ^d	✓	✓	x	Yes, but unknown if targeted HIV and STI prevention is in place
France	122,000	1–32%	44–66% ^d	✓	✓	x	Yes, but limited condom distribution
Germany	120,000–150,000 ⁴	5.8% ⁵	75% ^d	✓	✓	✓	Yes
Greece	9,416	0.3%	43.3–61.7%	✓	✓	x	Yes, but it is unknown if targeted HIV and STI prevention is in place. Limited condom distribution and HCV testing/treatment
Iceland	1,000 ⁶	1.5% ⁶	nk	nk	nk	x	Not known
Ireland	6,289	12.5% ^d	72.3% ^d	✓	✓	x	Yes, but unknown if targeted HIV and STI prevention is in place. Limited condom distribution
Italy	326,000	13.8%	61.4%	✓	✓	x	Yes, but unknown if targeted HIV and STI prevention is in place. Limited condom distribution
Luxembourg	1,715	2.5–4%	71.8–90.7%	✓	✓	✓	Yes
Malta	1,725 ^e	0%	30.4%	✓	✓	x	The only known targeted programme is STI testing
Netherlands	3,115	9.5% ^d	64.6% ^d	✓	✓	✓	Yes, but no targeted VCT
Norway	14,810	0.4% ^d	69% ^d	✓	✓	✓	The only known targeted programme is STI prevention
Portugal	32,287	12–20.5%	38.4–84.3%	✓	✓	x	Yes, but no targeted VCT and unknown if targeted STI prevention is in place
Spain	83,972	25.4–39.7%	59.1–73.3% ^d	✓	✓	✓	Yes
Sweden	26,000–30,000	6.4% ^d	83.8% ^d	✓	✓	x	Yes
Switzerland	11,850 ⁸	0–1.7% ⁶	91% ⁸	✓	✓	✓	Yes
Turkey	99,887 ⁹	0	47.4% ^d	nk	x	x	No targeted programmes
UK	164,036	1.3% ¹⁰	41% ¹⁰	✓	✓	x	Yes, but limited targeted programmes to increase access and uptake of VCT

nk = not known

^a Information on injecting drug use was not available for Andorra, Liechtenstein, Monaco and San Marino.

^b Estimates are mid-points, based on the latest and most relevant EMCDDA data.

^c These services include, amongst others, voluntary HIV testing and counselling; HIV prevention, treatment and care; hepatitis C testing and treatment; STI prevention and treatment; information, education and communication.

^d Non-national estimate.

^e An estimate of the number of people using drugs 'problematically', of which people injecting drugs form a subset.

^f Drug Consumption Room (DCR)

Over 464 million people live in the twenty-five countries that comprise Western Europe. As well as a number of very small states such as San Marino, Andorra, Monaco and Liechtenstein, Western Europe includes larger states such as Turkey, Germany, France, Italy and the United Kingdom (UK). The majority of countries in this region are member states of the European Union (EU): Austria, Belgium, Cyprus, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Malta, the Netherlands, Portugal, Spain, Sweden and the UK. All countries in this region, with the exception of Turkey, fall within the top forty ranked countries on the human development index.¹¹

DRUGS IN THE REGION

Production and transshipment

Western Europe is a leading producer of amphetamine-type stimulants (ATS), and laboratories have recently been dismantled in the Netherlands, Belgium and Germany. Ecstasy production occurs on a large scale, predominantly in the Netherlands and Belgium.¹²

Drugs are smuggled into Western Europe via several major trafficking routes. The Balkan route brings heroin from Afghanistan via Pakistan, Iran and then Turkey, before splitting into a southern and a northern route which each transit several Western European countries. The silk route, which has been increasingly used since the mid-1990s, transits heroin via Central Asia and Eastern Europe to Estonia, Latvia, Germany and Bulgaria. Additional heroin trafficking routes into Western Europe also involve East and West Africa, Oman and United Arab Emirates.¹³

Cocaine in Europe predominantly originates in Colombia and reaches the region via Central America, the Caribbean and West Africa. Although many countries receive direct imports of the drug, Portugal appears to be the main entry point to the region, with Spain and the Netherlands acting as the principal distribution centres.¹⁴

Drug use

Western Europe is an important drug consumer market, alongside North America, Australia and New Zealand. As well as some of the highest recorded alcohol consumption levels, Western Europe has high levels of cannabis and 'party drug' use. Cannabis is the most widely used illicit drug. The use of cocaine is increasingly common, and opiate use is reported in the majority of countries. Heroin is the drug most frequently reported among people seeking treatment.¹⁵

Alcohol

The EU is the 'heaviest drinking region in the world',¹⁶ and twelve Western European countries (Austria, Belgium, Denmark, Finland, France, Germany, Ireland, Luxembourg, Portugal, Spain, Switzerland and the UK) can be found in the global top twenty-five in terms of recorded per capita alcohol consumption. The notable exception to this is Turkey, possibly due to its predominantly Muslim population.

Unrecorded alcohol consumption, such as home-brewed drinks, is also an issue, particularly in Turkey and in the Nordic countries. It accounts for around 20% of total alcohol consumption in Finland, and between 25 and 30% of total alcohol consumption in Norway.¹⁷

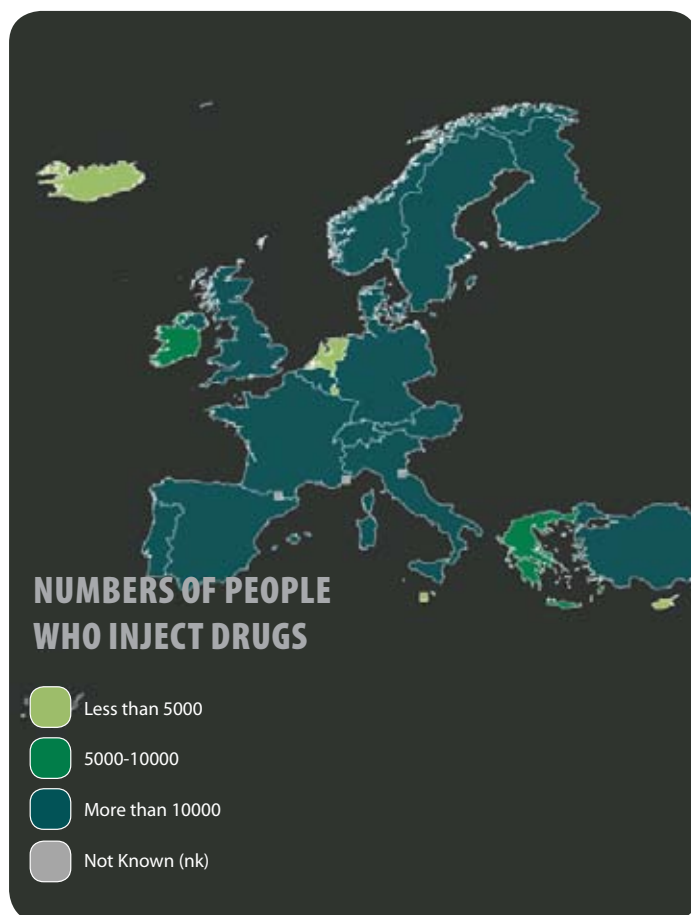
Cocaine and crack cocaine

Cocaine is the second most widely used illicit drug in the region, with Spain and the UK reported as having the highest levels of cocaine use. In the UK, it is reported to be the second most commonly injected substance. In Spain, it accounts for 40% of all drug treatment demands.¹⁸ Spain and the Netherlands serve as the primary distribution centres of cocaine.

According to treatment data, use of cocaine powder is reported by all strata of society, but is most common among those who are 'socially integrated'.¹⁵ However, cocaine injecting is more common among people who also inject opiates. Crack cocaine, an easily made derivative of hydrochloride cocaine, is reportedly more common among marginalised groups, including people who are homeless and sex workers.¹⁵

Heroin

The majority of heroin available in the region is the less-refined, brown heroin originating from Afghanistan. South-East Asian, white heroin can also be found but is much rarer and commands higher prices. Due to the recent flood of Afghan heroin into the market, street prices have dropped substantially and there are reports of heroin snorting and smoking becoming more prevalent with people who use drugs recreationally.¹⁵



Map 3.2: Numbers of people who inject drugs in Western Europe

Injecting drug use

Injecting drug use is reported in twenty-one countries in Western Europe, with the largest numbers found in Italy (326,000), the UK (164,036),¹ Germany (120,000–150,000)⁴ and France (122,000).¹ Commonly injected drugs include heroin, buprenorphine, cocaine, ATS and steroids.^{19,20} In France, buprenorphine is the most commonly injected drug, and in Finland it is reported as the main drug of use for 90% of those accessing treatment.²¹ However, in the majority of countries in the region, heroin is the most commonly injected drug.

The brown heroin widely available in Western Europe requires citric acid and water to be added to it and then needs to be heated before it is injected. This is a longer and more complex process than required for injecting the white, more-refined heroin, and can result in increased harms, particularly for those injecting on the street. In addition, the incorrect use of citric acid can cause vein damage.²² Overall, injecting drug use is reported to be decreasing in Western Europe.¹⁵

Although treatment data indicate that cocaine injecting is not common among people reporting cocaine as their main drug of use, it is more prevalent among those that also inject heroin. The common trend of injecting a mixture of heroin and cocaine, known as 'speedballing',^{23,24} can increase risk of overdose as well as vulnerability to HIV and HCV through the frequent injecting that is needed to retain a continual 'high'.

Drug-related harms

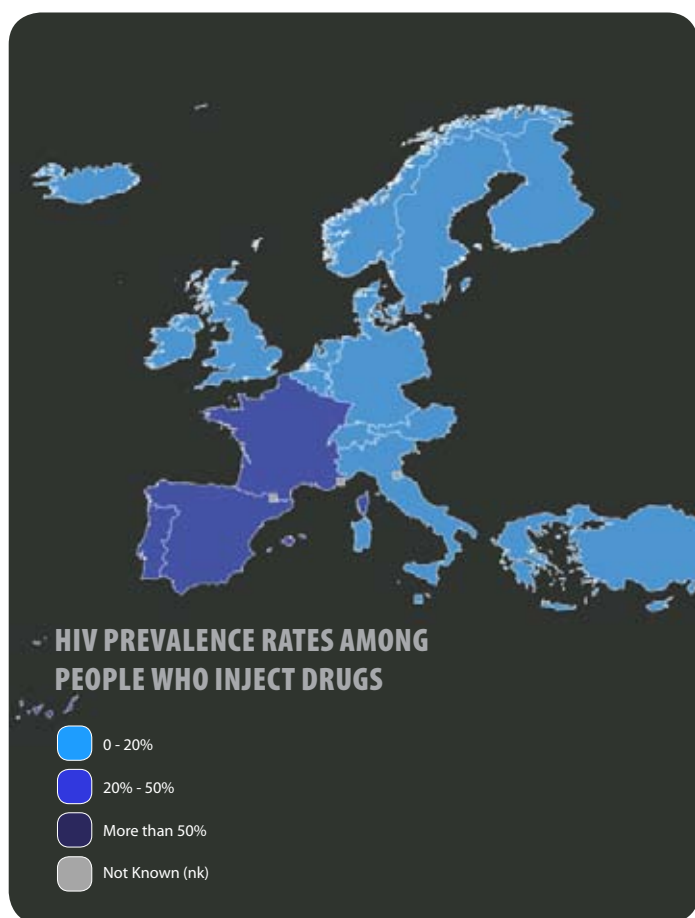
HIV and AIDS

While HIV prevalence in Western Europe is low, the overall numbers of people living with HIV have increased in recent years. This is partly due to the widespread availability of life-prolonging antiretroviral treatment (ART), but also a steady increase in HIV incidence. Heterosexual sex is the most common route of HIV transmission in the region, with a large proportion of new HIV diagnoses among ethnic minority populations and, increasingly, men who have sex with men. Spain, Italy, France and the UK have the largest numbers of people living with HIV in the region.²⁵

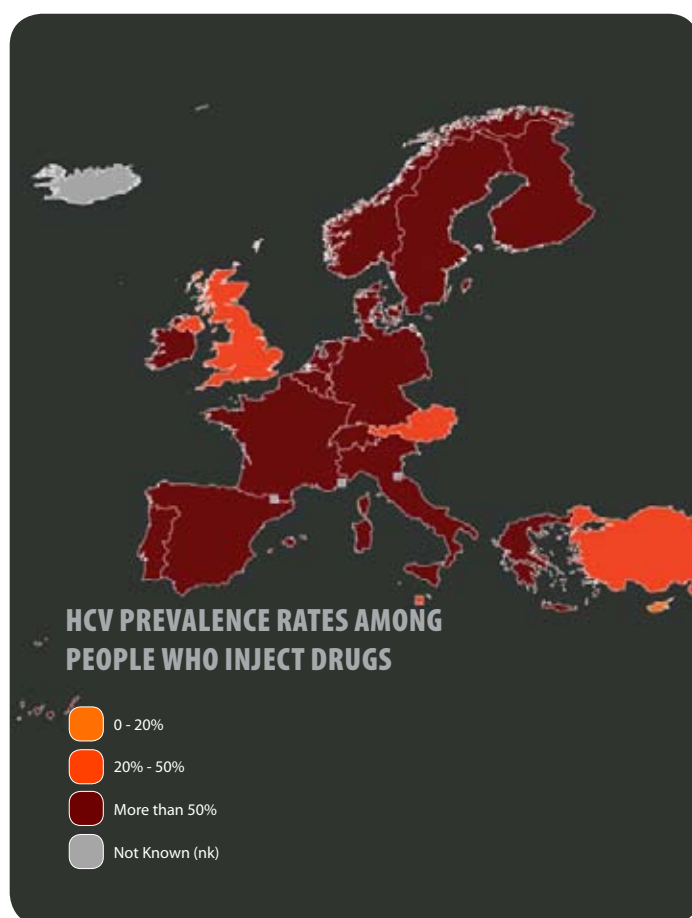
In 2005, 3,500 new HIV diagnoses in the EU were attributable to injecting drug use, and the figure for Western Europe is likely to be of the same order of magnitude.¹⁵ HIV prevalence at a national level among people who inject drugs is highest in Spain (25.4–39.7%), France (1.0–32.0%), Portugal (12.0–20.5%) and Italy (13.8%).²

Homeless people who inject drugs are particularly vulnerable to the transmission of HIV and other blood-borne viruses. They are less likely to have access to sterile injecting equipment, including clean water and spoons. Lacking a private space to inject, injecting will often be rushed to avoid being seen by police or other members of the public.

As in other regions, new injectors (those who have been injecting for less than a year) as well as young people are also particularly vulnerable to HIV and other blood-borne viruses as they are less likely to access NSPs and other harm reduction services.



Map 3.3: HIV prevalence among people who inject drugs in Western Europe



Map 3.4: HCV prevalence among people who inject drugs in Western Europe

Hepatitis C virus (HCV)

In 1999, a WHO report revealed that national HCV prevalence in Western Europe was low. The highest HCV prevalence rates were found in Turkey and Greece (1.5%), France (1.1%) and Belgium (0.9%).²⁶

Although data are not available for all the region, HCV prevalence estimates among people who inject drugs are extremely high in several countries. The highest of these are reported in Switzerland (91%),⁸ Luxembourg (71.8–90.7%) and Portugal (38.4–84.3%).³ In all countries, except Cyprus, Iceland (for which estimates are not currently available) and Malta, there have been reported HCV prevalence rates among people who inject drugs that exceed 40%.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) estimates there to be '1 million people living with an HCV infection in the EU who have ever in their lives been drug injectors'.²⁷ New injectors, young people and people who are homeless are often more vulnerable to HCV infection.

HIV/HCV co-infection is also prevalent among people who inject drugs in some parts of Western Europe. Spanish researchers found that between 11* and 95%† of people who inject drugs are living with both HCV and HIV. In Switzerland, one study found HIV/HCV co-infection among 91% of people who inject drugs.*

Drug use and its related harms in prisons

Luxembourg, the UK and Spain have the highest imprisonment rates in the region, with over 147 people imprisoned in every 100,000 in their national populations. The largest prison populations are in Turkey (82,742), the UK (80,229) and Germany (76,629). In the EU, it is estimated that between 10 and 30% of prisoners receive sentences related to drug offences.²⁸ The EMCDDA reports the proportion of prisoners in Europe who have ever injected drugs to be between 7 and 38%.²⁹

Although not available for all countries, existing information indicates that, in general, prison HIV prevalence is equal to or higher than among people who inject drugs outside prisons.³⁰ High HIV prevalence in prisons is reported in Italy (17%),³¹ France (13%), the Netherlands (11%), Switzerland (11%) and Spain (10%)³². The lowest are reported in Austria (1.43%), Germany and Malta (1%). Rates of HCV are also high in prisons in the region, particularly among people with a history of injecting. For example, rates of hepatitis C infection among prisoners with histories of injecting drug use range from between 30 and 44% in the UK to over 80% in Germany (Berlin) and Ireland.³³

THE RESPONSE

Harm reduction services

Needle and syringe exchange programmes (NSPs)

NSPs are legal (although in some cases strictly regulated), and operate in all Western European countries where injecting drug use is reported, with the exception of Iceland and Turkey. There are an estimated 24,885 NSPs in the region, including pharmacy-based facilities, but availability and scope is limited in some countries. The majority of Western European NSPs (18,000) are based in French pharmacies.³⁴ NSPs have recently been established in Cyprus, but as yet have not been officially endorsed by government. In addition to the provision of clean needles and syringes, the availability of other injecting equipment such as cookers, sterile water, filters and alcohol pads is becoming more common.³⁵

Pharmacy-based NSPs are more common than non-pharmacy-based NSPs in France, Spain, Portugal and the UK, and there is almost an equal number of each in Belgium. Pharmacy-based NSPs play an important role in terms of geographical coverage, but non-pharmacy-based NSPs often distribute more syringes per outlet. Non-pharmacy-based NSPs often also play an important role in engaging people who inject drugs with peer knowledge, support and harm reduction messages as well as providing links with other services.

Of the nineteen countries with NSPs,[‡] nine also provide community based outreach to some extent.³⁶ The annual distribution of syringes per person is highest in Norway at 290 and lowest in Greece at less than one. High distribution of sterile injecting equipment (over 140 needles and syringes per person per year) has averted or reversed HIV epidemics in several Western European countries.³⁷ Despite this, NSP coverage is far from enough to ensure that every injection is carried out with sterile equipment, or to reach the 80% coverage target articulated in the Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia.³⁸

In France, it is reported that some cities with over 100,000 inhabitants are not serviced by NSPs at all, and pharmacies (particularly in rural areas) are often unwilling to provide syringes to people who inject drugs.¹⁹ In Sweden, there are only two NSPs which reach approximately 1,200 people or 5% of the total number of people who inject drugs in the country. The service is available for two hours each week day, is closed during weekends and there is an age restriction which prohibits persons below twenty years of age from using the services. Injecting equipment cannot be obtained via pharmacies without a prescription, and it is reported that people who inject drugs are not able to gain prescriptions for injecting equipment.³⁹

Even in countries where NSPs are widely available, there are barriers to accessing these services. Impediments to the scaling up of NSPs throughout the region include limited funding, restrictive laws and government policies that are unsupportive of comprehensive harm reduction initiatives. Crack harm reduction kits are also distributed in some parts of the UK and Spain, although national laws may impede further scaling up of these initiatives.

Syringe vending machines (SVMs) exist in Austria, Denmark, France, Luxembourg, the Netherlands and Norway. The number of

* HIV/HCV co-infection among the whole sample of people who inject drugs (serostatus not known a priori).

† HIV/HCV co-infection among a sample of people who are living with HIV and injecting drugs.

‡ Austria, Cyprus, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Malta, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland and the UK.

SVMs almost equals the number of non-pharmacy-based NSPs in France, the country with the majority of SVMs in the region. SVMs provide 24-hour access to sterile injecting equipment for those who may not access NSPs due to fear of stigma, discrimination, lack of anonymity or inconvenient hours of operation.

Drug consumption rooms

Drug consumption rooms (DCRs) exist in six countries in the region. DCRs can help reduce the vulnerability to HIV and HCV transmission and help prevent overdose by providing facilities in which people can safely use drugs. They also provide important opportunities to engage people who inject drugs with harm reduction messages and to facilitate referrals to other services.

DCRs currently operate in the Netherlands (40), Germany (25 across 14 cities, including one mobile unit in Berlin), Switzerland (12) and Spain (6 including one site in Madrid which operates 24 hours a day). DCRs have also recently been established in Luxembourg and Norway.³⁵ In 2006, plans to establish a safer injecting facility in Portugal were approved by government. In recent years, proposals to establish similar facilities in the UK and Denmark have been blocked by government.⁴⁰

Opioid substitution therapy (OST)

Methadone and buprenorphine are legal throughout the region, and one or both are prescribed as substitution therapy in all countries where injecting drug use has been reported, with the exception of Turkey.

The extent of OST provision varies greatly across the region.⁴¹ The largest numbers of OST sites are reported to be in Spain (2,229)⁴² and the UK (1,030),⁴³ but seven countries in the region have fewer than twenty sites providing OST. The number of people receiving OST across Western Europe totals 582,478.⁴¹ The majority of OST recipients are in the UK (154,573),⁴⁴ France (99,446), Italy (96,972), Spain (83,469) and Germany (61,000).⁴⁵ It has been estimated that in some Western European countries up to 60% of people who inject drugs are receiving OST, which is cited as 'good coverage' within UN guidelines.⁴⁶ Methadone is the most commonly prescribed OST in the region, with the exception of France and Finland, where buprenorphine is more commonly used.⁴⁷

The volume of OST prescribing is reported to have increased in fourteen Western European countries in recent years (Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Norway, Portugal and Sweden). Decreases are reported in Malta and Spain.⁴⁵

Some European countries, including the Netherlands, Denmark, Germany and the UK, use a demand-driven approach to OST, ensuring that the volume of OST available is determined by trends in consumer demand. However, several other Western European countries, such as Norway, Sweden, Finland and Greece, use a supply-driven approach, which may result in insufficient OST supplies to meet demand.⁴⁸

In some settings where OST is available, a number of factors make it difficult for some to utilise this service effectively. For example, strict regulations associated with the prescription of methadone maintenance treatment (MMT) in Sweden include the requirement that all clients must abstain from illicit substances during MMT and failure to do so results in a six-month exclusion from the programme.³⁹ There are also reported to be waiting

lists of up to three years to access the limited places available in Swedish OST programmes.²⁰ In France, where OST is provided free of charge, every general practitioner (GP) is licensed to prescribe buprenorphine, but many are unwilling to do so.¹⁹

Injectable OST is prescribed in a number of countries, recognising that the act of injection itself is an important part of drug use for some and that they cannot or may not wish to stop injecting. It is available in limited capacities in the UK, Switzerland and the Netherlands. In France, the lack of this OST option is reported to deter some people from accessing OST services.¹⁹ Injectable heroin (diamorphine) has been used and/or trialled as a substitution therapy in Belgium,⁴¹ Germany, the Netherlands,⁴⁹ Spain, Switzerland,⁵⁰ and the UK. Consultations on this issue are ongoing in Luxembourg, and it has recently been announced that a similar trial will begin in Denmark.⁵¹

In addition to maintenance therapies, there are a wide variety of non-OST drug dependence treatment options in Western Europe. These are provided in a range of settings, including specialised inpatient treatment centres, outpatient centres, low-threshold services, psychiatric units or hospitals as well as self-help groups. Fees are associated with private treatment but, in general, there are also state-subsidised or free treatment services available. In Denmark, for example, drug-related treatment is the responsibility of local government and is provided free of charge. In 2006, a new law stipulated that people who use drugs and who want to access abstinence-based treatment are to be offered a place within two weeks.⁵²

Targeted HIV prevention, treatment and care

A recent report summarising policy and practice in EU member states indicated that the majority of countries include targeted programmes for people who inject drugs in their HIV responses.²⁹ Voluntary HIV counselling and testing (VCT) programmes that were available to people who inject drugs were reported in at least eleven countries,^{*} but programmes targeting this group specifically do not currently exist in Belgium, Cyprus, Denmark, the Netherlands or Portugal. At least eleven countries were reported to have STI prevention programmes reaching people who inject drugs.[†] Condom distribution programmes with a particular focus on people who inject drugs are numerous in nine countries[‡] and limited in a further seven countries.[§]

In Western Europe, ART is reported to be available to people who inject drugs in all countries, and no exclusion criteria are specifically targeted towards this group.²⁹ There are in excess of 314,000 people receiving ART in Western Europe,⁵³ and within this number are at least 33,329 people who inject drugs. Although eight countries are reported to have people who inject drugs receiving ART,[¶] the vast majority are in Spain (31,500).⁵⁴ A recent paper concluded that, in general, people who inject drugs in Western European countries have 'relatively equitable access' to ART.⁵⁴

Targeted HCV prevention, treatment and care

The Trimbos Instituut's assessment of harm reduction policies, evidence and practice in the EU stated that most countries have HCV testing and treatment and that this is available to people who inject drugs.²⁹ However, a recent report highlights significant stigma attached to HCV and states that in Germany, Italy, Portugal

* Austria, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Spain, Sweden and the UK.

† Austria, Belgium, France, Germany, Greece, Luxembourg, the Netherlands, Norway, Spain, Sweden and the UK.

‡ Belgium, Finland, Germany, Luxembourg, the Netherlands, Portugal, Spain, Sweden and the UK.

§ Austria, Cyprus, Denmark, France, Greece, Ireland and Italy.

¶ Andorra, Austria, Finland, Malta, the Netherlands, Portugal, Spain and the UK.

and Spain this is manifested in a lack of access to HCV treatment for people who inject drugs.⁵⁵

At least four countries (France, the Netherlands, Sweden and the UK) in the region have national strategies for HCV prevention and treatment. Results of a survey conducted by the European Liver Patients Association (ELPA) highlighted that HCV testing is not always free and treatment is part-subsidised in several countries by the government. For example, in Switzerland, patients must cover 10% of the cost of treatment.⁵⁵

Harm reduction in prisons

In Norway, France, Portugal and parts of the UK (England and Wales), health care within the prison system is the responsibility of the national health-care systems, whereas for the rest of the region it is controlled by the judiciary systems. Spain, where prison health is dealt with collaboratively by the Ministry of Health and the Ministry of Interior, is the only country with comprehensive harm reduction programmes in place in most prisons.⁵⁶

Several countries in the region have prison harm reduction programmes. There are prison needle and syringe exchange programmes (PNEPs) in Germany (1 prison), Switzerland (7 prisons), Spain (approved for all prisons, and operating in at least 38) and Luxembourg (1 prison).⁵⁷ Pilot programmes are in various stages of development in Portugal, Belgium and the UK (Scotland). PNEPs in Spanish prisons have been greatly scaled up in recent years, and they are now operating in more than half of the country's prisons. However, in Germany, the number of PNEPs decreased from seven to only one following the election of centre-right coalition governments with zero-tolerance drug programmes.⁵⁷

Prison policies in a number of countries in the region include the availability of disinfectants, such as bleach, for sterilising injecting equipment. However, this second-line intervention is significantly less effective in reducing HCV and HIV transmission and, as such, should not be considered an alternative to PNEP.⁵⁶

OST is provided in prisons in all countries with reported injecting drug use, with the exception of Cyprus, Greece and Sweden.^{**} MMT is available nationwide in prisons in Austria, Belgium, Denmark, Finland, Italy, Luxembourg and Spain. In France, Germany, Ireland, the Netherlands, Portugal and the UK, MMT is limited to specific geographical areas. Buprenorphine and Naltrexone are available in some prisons in the UK (England and Wales).²⁹ 19,010 prisoners are receiving OST in Spanish prisons, which is the highest number in the region. Estimates were also available for Ireland (1,295), Portugal (707), Belgium (300), Luxembourg (191) and Finland (40). Switzerland also provides heroin maintenance in two prisons.⁵⁸

While OST provision has increased in recent years and in some countries is available in a number of prison facilities, the regulations and practices of prison OST prescribing vary greatly and there is still a large gap between treatment demand and provision.²⁸ For example, in Swedish prisons, it is reported that the restrictions relating to OST prison programmes effectively prohibit the majority of prisoners from being able to access this service.⁷

Condoms are available in all prisons in eight countries (Austria, Belgium, Finland, France, Luxembourg, Portugal, Spain and Sweden) and in limited prisons in a further four countries (Denmark, Germany, the Netherlands and the UK). At least thirteen

national prison systems offer VCT in some prisons and prisoners are receiving ART in at least seven countries. HCV testing and treatment is reported to be available nationwide in prisons in Austria, Denmark, Finland, Greece, Ireland, Italy, Luxembourg, Portugal, Spain, Sweden and the UK.^{††}

A recent evaluation of the prison harm reduction response in the EU stated that 'EU Member States are not in accordance with the principle of equivalence adopted by the UN System'^{‡‡} and highlighted the need for increased interventions.⁵⁹ A recent WHO report also highlighted some shortcomings in current European prison harm reduction. As well as prisoners not being properly informed about the availability of services, the report states that they often do not receive essential HIV and HCV prevention information when accessing programmes.⁵⁶

Policies for harm reduction

The vast majority of Western European governments have defined the reduction of drug-related harm as a national public health objective. This position is reflected in national policies, strategies and plans on both HIV and illicit drugs. Sweden is the only country in which domestic policy is less than supportive of harm reduction, which is reflected also in the poor coverage of its harm reduction programmes. The UK's new ten-year drug strategy does not explicitly mention 'harm reduction' although there is very brief mention of 'harm minimisation' needle exchange and substitution treatment.⁶⁰

In international forums, most Western European governments are explicitly supportive of harm reduction, including the UK, Spain and the Netherlands. The British Department for International Development (DFID), the German Agency for Technical Cooperation (GTZ) and the Dutch Ministry of Foreign Affairs are all involved in supporting harm reduction initiatives around the world, with financial and/or technical support.

At a regional level, the necessity of harm reduction initiatives has been articulated in the EU Action Plan on Drugs. On 18 June 2003, the European Council put forward its 'Recommendation on the prevention and reduction of health-related harm associated with drug dependence'. This recommendation galvanised national adoption of harm reduction policy and programming in EU member states. A recent report monitored national progress against the sub-recommendations.²⁹

National HIV responses in Western Europe are also monitored against the Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia.³⁸ This document explicitly states the need to scale up levels of access to harm reduction services for people who inject drugs and sets a target of reaching 80% of people who inject drugs with HIV prevention, treatment and care by 2010. A report evaluating progress towards targets set in the declaration will soon be published by the WHO's Regional Office for Europe.

In addition, the European Commission has recently launched the Civil Society Forum on Drugs, which provides a mechanism for civil society involvement in the formation of drug-related policy and in particular the EU Action Plan on Drugs. An initial scoping report has revealed that there are at least fourteen countries in the region with civil society organisations that focus on harm reduction policy at the national level.^{§§} Many of the same countries and an additional few have drug user organisations which also focus on harm reduction policy and advocacy.^{¶¶}

^{††} However, access to hepatitis C treatment is disputed in Italy, Germany and Portugal in results from a recent survey by the European Liver Patients Association.

^{‡‡} Prisoners are entitled to the same healthcare as people outside prisons

^{§§} Austria, Belgium, Cyprus, Finland, France, Germany, Greece, Ireland, Italy, Netherlands, Portugal, Spain, Switzerland and the UK.

^{¶¶} Belgium, Denmark, Finland, France, Germany, Ireland, Italy, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland and the UK.

^{**} Information was not available for Iceland, Norway and Turkey

Multilateral support for harm reduction

Most support for harm reduction from multilateral agencies is not targeted towards wealthy countries in Western Europe. However, as the WHO European region stretches as far west as Portugal and as far east as Russia, many publications and initiatives of the WHO Regional Office for Europe cover countries in Western Europe. Of particular relevance are the initiatives regarding harm reduction in prisons, an area in need of improvement in this region.

For example, in 2002, Resolution EUR/RC52/R9 of the WHO Regional Committee for Europe called for member states 'to promote, enable and strengthen widespread introduction and expansion of evidence-based targeted interventions for vulnerable/high-risk groups, such as prevention, treatment and harm reduction programmes (e.g. expanded needle and syringe programmes, bleach and condom distribution, voluntary HIV counselling and testing, substitution therapy, STI diagnosis and treatment) in all affected communities, including prisons, in line with national policies'. The 'Status paper on prisons, drugs and harm reduction' published by WHO in 2005 emphasised the need for scale up of harm reduction in prison facilities in several Western European countries.⁵⁶

While harm reduction in Western Europe is much more established than in many other regions, there are still areas of weakness which require increased attention from government, multilateral agencies and civil society.

There are several strong networks in Western Europe which include harm reduction in their remit, including the Correlation European Network on Social Inclusion and Health, and the CONNECTIONS Project which focuses on prisons. There are also several strong national harm reduction networks. Discussions on the possible development of a Western European Harm Reduction Network are ongoing and it is proposed to cover all European countries that are not already represented by the Eurasian Harm Reduction Network.

In November 2008, Damon Barrett from IHRA's HR2 programme and Berne Stålenkrantz from the Swedish Drug Users Union (SDUU) made statements at the UN Committee on Economic, Social and Cultural Rights in Geneva, following the presentation of Sweden's fifth periodic report on its implementation of the International Covenant on Economic, Social and Cultural Rights (ICESCR). They criticised Sweden's denial of needle exchange, including within prisons, as a violation of the right to health contained in Article 12 of the ICESCR, raised concerns about the estimated 26,000 to 30,000 people who inject drugs in Sweden and called on the Committee to request information from Sweden on injecting drug use, harm reduction and HIV rates among people who use drugs.

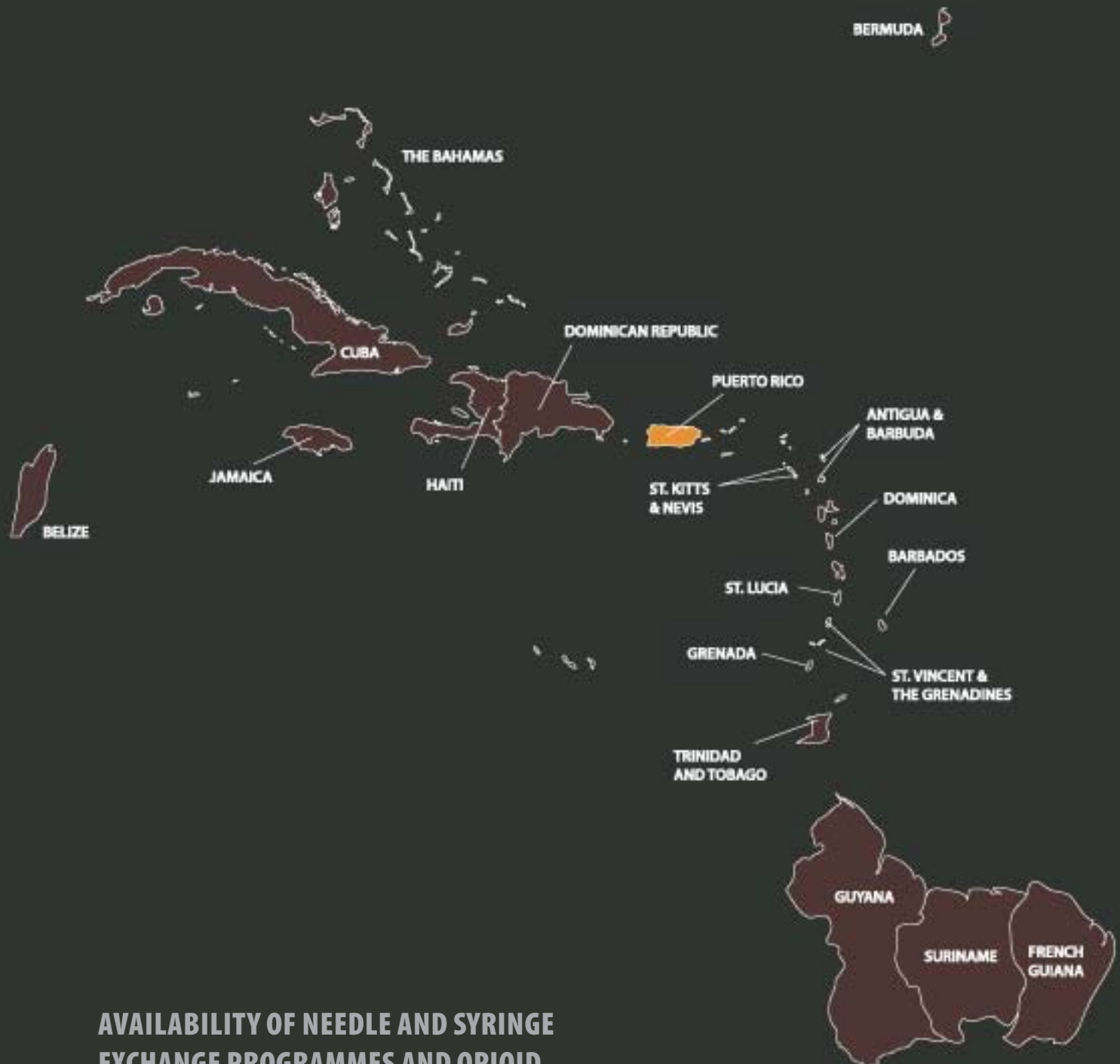
In its 'List of Issues' sent back to the Swedish government, the Committee requested that Sweden 'provide disaggregated data... regarding the coincidence of drug use and HIV/AIDS and indicate how successful harm reduction measures have been (such as needle exchange programmes), whether they are foreseen to be scaled up, and whether such programmes are foreseen in detention facilities'.⁶¹

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Regional Overview

Caribbean



AVAILABILITY OF NEEDLE AND SYRINGE EXCHANGE PROGRAMMES AND OPIOID SUBSTITUTION THERAPY

- Both NSP and OST available
- OST only
- NSP only
- Neither available
- Not Known

HARM REDUCTION IN THE CARIBBEAN

Country/territory with reported injecting drug use ^a	People who inject drugs ¹	Adult HIV prevalence amongst people who inject drugs ¹	Adult HCV prevalence amongst people who inject drugs ²	Harm reduction response		
				NSP	OST	HIV and HCV programmes targeted towards people who inject drugs ^b
Bermuda	40 ³	nk	nk	X	X	HIV, STI and, to a lesser extent, HCV services exist but there are currently very few/no targeted programmes in place to increase access for people who inject drugs
Cuba	8,255	0.1%	nk	X	X	
Dominican Republic	110	nk	nk	X	X	
Guyana	nk	nk	nk	X	X	
Jamaica	nk	nk	nk	X	X	
Puerto Rico	15,000	42.4–55.2% ^{c,4}	95.2% ^c	✓	✓	
Trinidad and Tobago	nk	nk	nk	X	X	

nk = not known

a No injecting drug use was reported in Antigua and Barbuda, the Bahamas, Barbados, Belize, Dominica, Grenada, Haiti, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, and Suriname.

b These services include, amongst others, voluntary HIV testing and counselling; HIV prevention, treatment and care; hepatitis C testing and treatment; STI prevention and treatment; information, education and communication.

c Sub-national figure: capital city.

The nations and territories of the Caribbean are home to over 39 million people.⁵ There are more than seven thousand islands in the region, which include seventeen independent countries and a number of Dutch, US, British and French territories. The disparity in wealth distribution in this region is among the most pronounced in the world. Throughout the region, an average of 25% of island populations live below their nationally defined poverty lines.⁶ At the extreme, the country most affected is Haiti, with 80% of the population living under the poverty line.⁷ Even in Trinidad and Tobago, a country rich in natural resources, 39% of the population is reported to be living on less than USD2.00 per day.⁸

DRUGS IN THE REGION

Cultivation, production and transshipment

The Caribbean is an important region in the global cocaine market. The mobility between islands, coupled with a prime geographic location between the producers in Latin America and the main consumers in North America and Europe, make the Caribbean islands part of a prominent cocaine trafficking route. Anecdotal evidence suggests that some areas of the Caribbean are also beginning to form part of heroin transshipment routes.

Drug use

The extent of 'problem drug use' in the Caribbean is difficult to quantify due to the lack of available research data. However, a picture of the regional situation may be developed using treatment monitoring data as well as various anecdotal sources. This evidence suggests that the main drugs used in the Caribbean are alcohol, tobacco, marijuana and crack cocaine ('crack'). The use of crack plays a role in the transmission of HIV in the region.

The high levels of tourism on which the Caribbean economy heavily relies, as well as the mobility of people between, to and from the islands, must be considered when examining drug use in the region. Such considerations are particularly important given that treatment access data are the primary source of information on drug use trends. For example, it is reported that, due to a lack of local facilities, state-sponsored people from the Dutch Caribbean islands travel to the Dominican Republic, while others with greater financial resources may travel to the Netherlands or the US, to access treatment services for drug dependence.⁹ In addition, the type and extent of drug demand by tourists is likely to have a direct impact on the drug market in the region.

Alcohol

Alcohol consumption plays a significant role in the lives of many people in the Caribbean, but recorded alcohol consumption is varied in the region – from 3.22 litres of pure alcohol per capita in Trinidad and Tobago to 12.92 litres in Bermuda. The consumption of spirits is relatively high, and six countries from the region (Barbados, Dominica, Grenada, Haiti, Saint Lucia, and Saint Vincent and the Grenadines) rank in the global top twenty of per capita spirit consumption.

Paradoxically, the region also has relatively high levels of 'last year abstainers' – including 60% of the population in Haiti, 57.6% in Jamaica and 49.5% in Barbados, Cuba, and Trinidad and Tobago.¹⁰ These figures suggest that alcohol consumption in the Caribbean is unevenly distributed – something that population-level interventions and analyses cannot account for, but that could be related to the growth of the Seventh-day Adventist and evangelical churches that preach abstinence as a primary doctrine.⁹

Crack cocaine

As with other regions of the world that fall along illicit drug shipment routes, the substances being transhipped have gradually come to form part of the local drug market. Payments 'in kind' to those involved in the drug trafficking trade are converted to cash through sales in the community. Exceptionally pure cocaine powder is easily converted into crack cocaine which is then sold at below market value, costing as little as USD1.00 per rock of crack. Crack smoking in the region is reported to be 'extensive', with crack available not only in the cities but in small villages and hamlets.¹¹



Map 4.2: Numbers of people who inject drugs in the Caribbean

Injecting drug use

Information on injecting drug use in the Caribbean is very limited. Official figures are largely unavailable, but existing evidence suggests that injecting is rare in many countries. The current absence of a major heroin trafficking route through the region is one suggested explanation for this.*

Exceptions to this are the Spanish-speaking Caribbean islands of the Dominican Republic, Cuba and the US territory of Puerto Rico, where there are estimated to be 15,000 people who inject drugs.⁴ Previously published research has reported injecting drug use in Bermuda and the Bahamas but enquiries by the Caribbean Harm Reduction Coalition (CHRC) when compiling this report failed to confirm any current injecting. Niche markets are reported in Guyana, Jamaica and Trinidad and Tobago, where anecdotal evidence indicates heroin injecting is evident among the upper classes. Heroin interdiction has been reported in the local media of Trinidad and Tobago and Guyana and there are indications that heroin use (primarily smoking) is increasing in both countries.

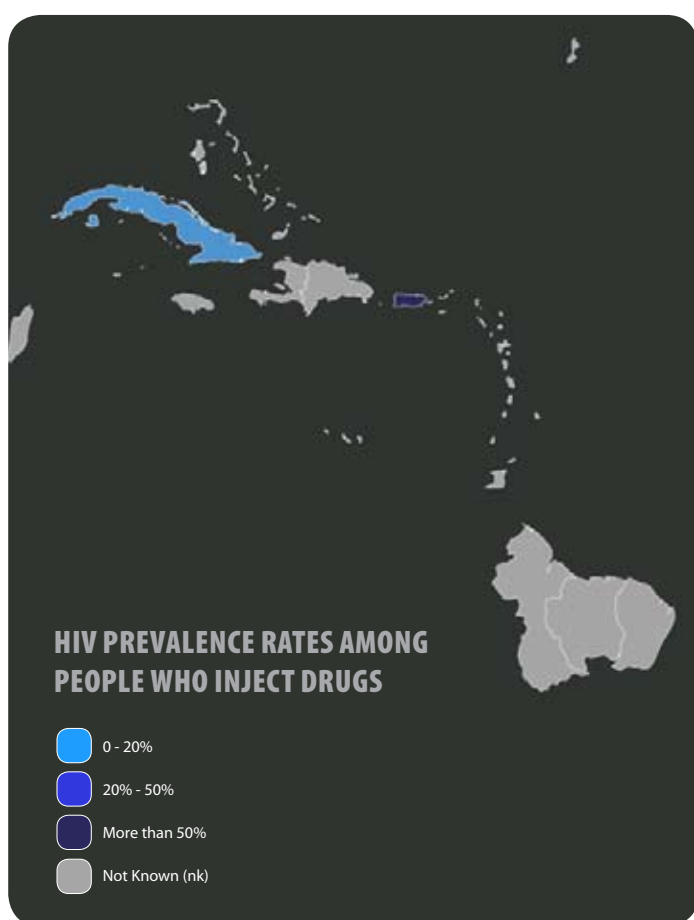
* Currently, the major heroin shipment routes are from South America through Central America and into North America, and from Afghanistan to Europe, therefore largely bypassing the Caribbean islands.

If the same pattern emerges with heroin as has been the case with cocaine – transshipment followed by the development of local markets – the Caribbean could experience a substantial increase in opiate use, similar to the explosion of crack use in the mid-1980s. A long-standing tradition of marijuana smoking could potentially increase the likelihood of the adoption of other smokeable substances. Whether heroin smoking will lead to heroin injecting remains debatable given the artificially low cost associated with transshipment-driven markets.

Drug-related harms

HIV and AIDS

After sub-Saharan Africa, the Caribbean is the region of the world most affected by HIV and AIDS. HIV prevalence is estimated to be 1%, and there are approximately 230,000 adults and children living with HIV in the region. The highest adult HIV prevalence rates are in the Bahamas (3%),¹² Trinidad and Tobago (2.6%) and Haiti (2.2%).¹³

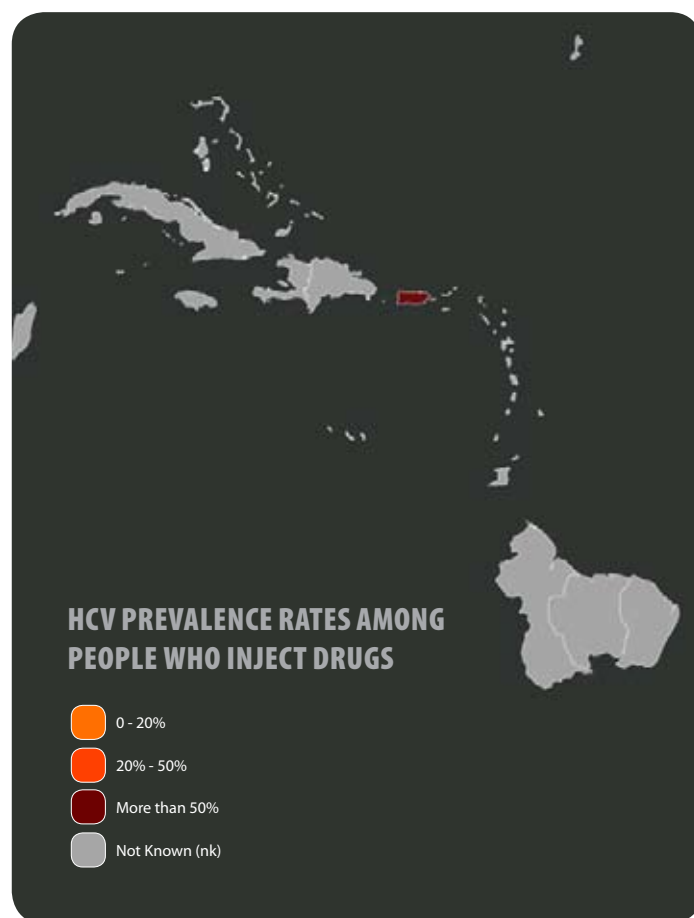


Map 4.3: HIV prevalence rates among people who inject drugs in the Caribbean

The primary mode of HIV transmission in the region is heterosexual intercourse. The exception to this is Puerto Rico where the majority of new HIV cases are associated with injecting drug use.¹³ HIV prevalence rates among people who inject drugs in the capital city of San Juan are reported to range from 42.4% to 55.2%.⁴ Cuba is home to the second largest number of people who inject drugs in the region, but the latest estimates suggest that HIV prevalence rates are not elevated within this group.¹

There is growing evidence to support a link between non-injecting drug use and the sexual transmission of HIV in the Caribbean.

For example, crack use was found to be associated with HIV infection among antenatal health clinic attendees¹⁴ and STD clinic attendees¹⁵ in the Bahamas, as well as male STD clinic attendees in Trinidad.¹⁶ See section 3 of this report for further exploration of the issue of non-injecting drug use and HIV.



Map 4.4: HCV prevalence rates among people who inject drugs in the Caribbean

Hepatitis C virus (HCV)

In data published by the WHO in 1999, HCV prevalence was significant among the adult population in Suriname (5.5%), Trinidad and Tobago (4.9%), the Dominican Republic (2.4%), Haiti (2%) and Puerto Rico (1.9%).¹⁷ These high prevalence rates, combined with reports of the presence of HCV in the blood supplies of both Trinidad and Tobago and Guyana, may indicate that drug injecting is more common in these countries than research data currently suggest.

One study in San Juan, Puerto Rico found an HCV prevalence rate of 95.2% among a sample of people who injected drugs. The same study found that 95.2% of those who injected drugs and were living with HIV also tested positive for hepatitis C.²

Drug use and its related harms in prisons

During the 1990s, and with the moral and more importantly financial support of the neighbouring US, the Caribbean 'War on Drugs' resulted in the incarceration of large numbers of people who used drugs and/or were associated with the drug trade. As a result, Caribbean prisons were left with some of the highest rates of incarceration in the world and severe overcrowding problems.¹⁸

Most countries in the Caribbean Community (CARICOM) have legislative provisions to offer alternatives to custodial sentences for non-violent drug offences. The outcome of a two-year project, funded by the UK's Department for International Development (DFID), to increase the use of non-custodial sentencing has led to diversion schemes being implemented in some countries.* However, more work is needed in this area if prison populations are to be reduced.

There is strong evidence that HIV prevalence in Caribbean prisons is higher than within the population outside of prisons, although national estimates are only available for Cuba (25.8%), Trinidad and Tobago (4.9%)¹⁹ and Jamaica (12%).²⁰ Survey reports from the Caribbean Epidemiology Centre (CAREC) indicate elevated HIV prevalence in prisons in much of the region.⁹ The prevalence of HCV within Caribbean prisons is unknown.

THE RESPONSE

Harm reduction services

The response to drug use in the Caribbean is largely high threshold, abstinence based and twelve-step oriented. With the exception of Puerto Rico, harm reduction services such as opioid substitution therapy (OST) and needle and syringe exchange programmes (NSPs) do not form part of the response to drug use due to the relative absence of injecting and of opiate use.

Syringes can be purchased without a prescription at pharmacies throughout the region, which may be a feasible option for some, particularly those among the middle and upper classes. However, pharmacists interviewed by the Caribbean Drug Abuse Research Institute (CDARI) stated that they would not sell syringes to persons they suspected of illicit drug use.⁹ Only in Puerto Rico, where there are substantial numbers of people who inject drugs and where a prescription is needed to buy syringes from pharmacies, are there NSPs run by civil society.

Both methadone and buprenorphine are legally available across the Caribbean but are only prescribed for pain relief, with the exception of Puerto Rico where methadone maintenance treatment is available. Abstinence-based drug dependence treatment is available in the majority of Caribbean countries, some of which is accessible free of charge. Throughout the region, seventy-nine sites provide treatment to an estimated 3,050 people,[†] the majority of whom are accessing treatment in the Dominican Republic.⁹

Targeted HIV and HCV prevention, treatment and care

In general, HIV prevention programmes in the Caribbean are not targeted towards people who use drugs, primarily because of the lack of injecting drug use in the region. In Saint Lucia, CDARI, CHRC, and the Ministry of Health collaborate to offer an HIV/STI clinic for street-involved people who use crack, which is the only targeted programme to increase testing for and treatment of HIV, STIs and HBV infection among people who use drugs in the region.

Antiretroviral treatment (ART) is available, and there are over 27,200 people[‡] receiving ART across the Caribbean region.²¹ However,

there are no figures available to indicate whether people who use drugs are currently accessing ART. In one CARICOM country, people who use drugs are not encouraged to access ART as they are considered 'noncompliant'.²²

Poor ART adherence can lead to the development of treatment-resistant HIV strains. In high income countries, this would be treated by altering the combination of antiretroviral medications, known as second-line treatment. In areas where second-line treatment is scarce and third-line treatment is non-existent, efforts to stem the development and transmission of ART-resistant strains are paramount. In the Caribbean, as in other regions, this is prioritised over the rights of people who use drugs to access life-prolonging treatment.

Further barriers to increasing the access of people who use drugs to HIV services include the high threshold of voluntary HIV testing and counselling facilities, as well as judgemental and stigmatising attitudes of health care workers towards drug use.⁹

There are no targeted HCV prevention, treatment and care programmes reaching people who use drugs in the Caribbean.

'For 10 years we have laboured to have drug users put on the HIV radar. Because Caribbean HIV policy is largely driven by external donors who only recognise IDU as the HIV risk, non-injecting crack users have been left out of any HIV intervention. Rather than a public health response, the Caribbean response to illicit drug use has been overwhelmingly a criminal justice one. Developing a model of harm reduction for a non-injecting population has been a challenge that CHRC has met. Meeting drug users where they are at, providing basic amenities such as clean water and bathing facilities, nutritional support, are just some of the programmes that CHRC advocates for in forums throughout the region.'

**Marcus Day, Coordinator,
Caribbean Harm Reduction Coalition**

Harm reduction in prisons

Non-OST drug dependence treatment is available in prisons in five Caribbean countries: the Bahamas, Barbados, Belize, Saint Vincent and the Grenadines, and the Cayman Islands. A positive evaluation of a pilot prison methadone maintenance programme (PMMT) in Puerto Rico has initiated the scale up of this service to 300 prisoners.²³ Buprenorphine maintenance will also shortly be initiated in one Puerto Rican prison.²⁴ Elsewhere in the region, there are no harm reduction services offered within prisons, and HIV prevention programmes are limited.

While homosexuality is not considered illegal, seven of the independent CARICOM states have laws in place that criminalise consensual sex between men. The existence of sexual HIV transmission within male prisons is not disputed, but extreme homophobia and stigma surrounding homosexuality has so far impeded the implementation of condom distribution programmes in Caribbean prisons. This was exemplified in 1997, when attempts by the Jamaican Ministry of Health to introduce condom distribution within prisons were halted after prisoner riots and a prison officers' strike.⁹

* The project was managed by the Caribbean Drug Abuse Research Institute in collaboration with DrugScope UK and the University of Kent.

† This does not include data from Puerto Rico or Cuba.

‡ This does not include data from Puerto Rico.

Voluntary HIV testing and counselling is available to all prisoners in the region, and no prisons impose mandatory HIV testing. ART is available in all Caribbean prisons, and with the exception of Jamaica is provided using directly administered anti-retroviral therapy (DAART). However, it is estimated that there are less than 200 prisoners receiving ART in the region,⁹ which, given the elevated HIV prevalence rates in prisons, suggests poor treatment access for incarcerated populations. People who receive a positive HIV diagnosis in Caribbean prisons often do so after presenting to the prison infirmary with an opportunistic infection, which can indicate severe depletion of the immune system. Late HIV diagnosis and therefore late initiation of ART can compromise the success of treatment.

No testing or treatment for hepatitis C is available within Caribbean prisons.

Policies for harm reduction

There is a strong commitment from Caribbean governments to respond to HIV in the region. All of the islands have national HIV coordinating authorities as well as monitoring and evaluation systems for HIV programmes. Drug use is also on the policy agenda in the region, and all islands have in place national policies or strategies on drugs.

However, responses to drugs and HIV in the region are largely unrelated. HIV programmes often do not recognise people who use drugs as a key population, and drug programmes focus on zero tolerance anti-drug education. As such, harm reduction does not feature explicitly in Caribbean national or regional HIV or drug-related policy, and the response to drug use is overwhelmingly abstinence based.

The Caribbean Regional Strategic Framework for HIV/AIDS 2002–2006* and the draft framework for 2008–2012 define several objectives that should mandate the provision of harm reduction policies and programmes. For example, both frameworks seek ‘to strengthen understanding of the role of substance abuse and drug use in regional epidemiology of HIV/STIs, and to use information in appropriate prevention and care strategies’.^{25,26} The current framework contains the objective ‘to ensure that HIV/STI policies and appropriate prevention strategies and services are available and implemented in the prison system’.²⁶

Yet, despite these regional policy objectives, in 2007, no interventions were funded to focus on the needs of people who use drugs and only one prison assessment was carried out. Additionally the 2008–2012 framework calls for more research, thus leaving harm-reduction-oriented projects absent from HIV action frameworks in the region.⁹

Due to its proximity to the US, Caribbean policy and programmes are heavily influenced by the US government’s opposition to harm reduction. For example, the Drug Abuse Resistance Education programme (DARE) continues to be exported to the Caribbean, despite the poor evaluations of the programme in US schools.²⁸ In addition, several individuals and non-governmental organisations that have publicly supported harm reduction have lost their US funding.⁹

Harm reduction was introduced to the Caribbean in 1998 as part of an EU-funded programme to strengthen the provision of drug treatment services in the region.²⁷ During that same period, the organisations involved in the project formed the CHRC. While the funding for the EU project ended in 2003, the CHRC and its constituent organisations continue providing harm reduction services to their clients in the Bahamas, the Dominican Republic, Jamaica, Saint Lucia and Trinidad. There is no drug user organisation in the Caribbean. However, all of the organisations that make up the CHRC, with the exception of Patricia House in Jamaica, are run by people ‘in recovery’ who recognise the value of harm reduction in the continuum of care.

Multilateral support for harm reduction

Although there are a number of multilateral agencies with a presence in the Caribbean,[†] only the UNESCO secretariat is supporting harm reduction projects in the region. A total of USD195,000 is currently allocated to funding local partners working on harm reduction in Barbados, the Dominican Republic, and Trinidad and Tobago. In addition, a series of national consultations are being planned and undertaken by the agency with the aim of increasing awareness of harm reduction in Barbados, Jamaica, and Trinidad and Tobago.

UNODC, the UN’s lead agency on drug use, is the only multilateral agency that does not have a presence in the region. With the closure of the Barbados office in 2005, the nearest UNODC representative is now in Mexico City. In practice, this means that there is no agency to provide technical assistance on the issue of HIV transmission and drug use, an area highlighted in the Caribbean strategic plan on HIV and AIDS.²⁶ This lack of a regional presence has created a vacuum at the multilateral level that is being filled in an inconsistent manner. For example, the issue of HIV within prisons is currently being covered within the remit of UNAIDS, while the overlap between sex work and drug use is largely overlooked as the UNFPA primarily focuses on non-drug-using sex workers in the region.

* This Strategic Framework applied only to the CARICOM countries and the Dominican Republic. The overseas territories of the US were not included in this framework.

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Regional Overview

Latin America



AVAILABILITY OF NEEDLE AND SYRINGE EXCHANGE PROGRAMMES AND OPIOID SUBSTITUTION THERAPY

- Both NSE and OST available
- OST only
- NSE only
- Neither available
- Not Known

HARM REDUCTION IN LATIN AMERICA

Country/territory with reported injecting drug use	People who inject drugs ¹	Adult HIV prevalence amongst people who inject drugs ²	Adult HCV prevalence amongst people who inject drugs ³	Harm reduction response		
				NSP	OST	HIV and HCV programmes targeted towards people who inject drugs ^a
Argentina	65,000 ³	18.8–39.2%	nk	✓	x	Limited targeted programmes to increase access and uptake of VCT and provide HIV/STI prevention
Bolivia	200	nk	nk	x	x	X
Brazil	196,000 ⁴	28–42%	39.5–69.6%	✓	x	Limited targeted programmes to increase access and uptake of VCT and provide HIV/STI prevention; 30,000 current or former injecting drug users receiving ART ⁵
Chile	29,046 ^b	nk	nk	x	x	X
Colombia	5,000	nk	nk	x	x	X
Costa Rica	1,000	nk	nk	x	x	X
Ecuador	9,270	nk	nk	x	x	X
El Salvador	4,437	nk	nk	x	x	X
Guatemala	7,363	nk	nk	x	x	X
Honduras	4,335	nk	nk	x	x	X
Mexico	53,162	0–6%	nk	✓	✓	Limited targeted programmes to increase access and uptake of VCT and provide HIV/STI prevention
Nicaragua	3,424	nk	nk	x	x	X
Panama	2,090	nk	nk	x	x	X
Paraguay	3,825	nk	nk	✓	x	Limited targeted programmes to increase access and uptake of VCT and provide HIV/STI prevention
Peru	500	nk	nk	x	x	X
Uruguay	3500- 4500 ⁶	24.4%	nk	✓	x	Limited targeted HIV/STI prevention programmes
Venezuela	1,500	nk	nk	x	x	X

nk = not known

a These services include, amongst others, voluntary HIV testing and counselling; HIV prevention, treatment and care; hepatitis C testing and treatment; STI prevention and treatment; information, education and communication.

b Chilean UNGASS Country Progress Report (2008) states that 2% of accumulated HIV cases between 1987 and 2006 are attributable to injecting drug use (approximately 345 cases), suggesting that this estimate is high.

Over 515 million people live in the seventeen countries that comprise Latin America.⁷ The region is one of the most ethnically diverse in the world, being home to substantial populations of African and European descent as well as between 28 and 45 million indigenous people.⁸ 75% of people live in urban areas, and the majority of the population is Catholic, with significant proportions following indigenous beliefs and Christian-Protestant religions.⁹ Social inequality, income disparity and poverty are major issues in the region. Bolivia, Guatemala, Honduras and Nicaragua are the countries with the lowest human poverty index rankings.¹⁰

DRUGS IN THE REGION

Cultivation, production and transshipment

Several of the world's principal drug production countries are in Latin America, as well as a number of significant countries on global transshipment routes. Much of the cocaine in global circulation originates from coca leaf plantations in Colombia, Peru and Bolivia.¹¹ Poppy fields in Mexico and Colombia supply the raw material for heroin manufacture. Marijuana is grown in a number of countries in the region including Mexico, Paraguay, Colombia, Brazil and Guatemala.¹⁰ Vast proportions of the substances produced are bound for either the US or European consumer markets.

There is strong evidence to suggest that the role played by many Latin American countries in the cultivation, refinement and transshipment of drugs is related to the patterns of drug use in the region.¹² Efforts by the US and Latin American governments to eradicate crops and prevent production and export of drugs have been largely ineffective in supply reduction. They have, however, influenced the 'cultivation–production–export circuit' and, consequently, local drug use patterns.¹¹

Drug use

The most commonly used drugs in the region are alcohol, tobacco, cannabis and cocaine. Injecting of cocaine and heroin are of paramount importance in relation to HIV and HCV transmission in the region. Researchers have also highlighted the relationship between non-injecting drug use and HIV and HCV transmission as important.⁸

Cocaine and its derivatives

Coca, cocaine, crack cocaine and cocaine base paste (known by various names including pasta base de cocaína, or PBC and paco) are all used in Latin America. Overall, cocaine consumption is reported to have increased in recent years. Bolivia and Chile are reported to have the highest percentage of cocaine use among the general population and the most marked increases in consumption are reported in Bolivia and Venezuela, although the data do not distinguish between the different forms of cocaine used.¹⁰ Numerous manufacturing and refinement processes of varying sophistication produce rock or PBC derivatives.

Cocaine consumption in powder and crack rock form is reported to be increasing in parts of Brazil.¹³ Throughout the Southern Cone countries (Argentina, Chile, Paraguay and Uruguay) and in Brazil, there has been a marked increase in PBC use. Tighter controls in the Andean region have led to an increased involvement of South American countries in cocaine refinement in quickly established clandestine laboratories. This regional shift in production has led to the availability of PBC, the residue created through the cocaine hydrochloride refinement process. As a cheaper alternative, its use

has quickly formed part of local drug markets and a significant increase in use was reported in Argentina and Uruguay, where severe economic crises coincided with its introduction.¹¹ PBC is reported to be a more addictive and harsher substance than cocaine, with additional physical harms associated with its use.¹¹

Crop eradication

Traditional use of the coca leaf has been established for centuries, particularly in the Andean region, and limited coca leaf cultivation is permitted in several countries to supply this licit market. Production beyond certain limits is illegal and assumed to be for cocaine manufacture.

Efforts to eradicate crops resulted in human rights abuses and had a negative impact on the environment, with mass deforestation, and aerial eradication destroying subsistence crops. Crop eradication had little impact on the overall drug industry, simply creating a 'balloon effect' that displaced plantations and laboratories to other parts of the region. However, it influenced local drug markets in several countries, as well as the safety of people using drugs, with the growth of clandestine laboratories and domestic markets due to tighter drug transportation controls leading to the wider availability of drugs, some dangerously impure and at very low cost.

Alcohol

Levels of per capita alcohol consumption in Latin America vary widely, from 1.64 litres of pure alcohol in Guatemala and 1.99 litres in Ecuador to 8.55 litres in Argentina and 8.78 litres in Venezuela. In addition, Argentina, Chile and Uruguay are in the top twenty countries in the world in terms of wine consumption. However, these data are likely to underestimate the extent of problematic drinking due to high levels of self-reported abstinence as well as unrecorded alcohol consumption.

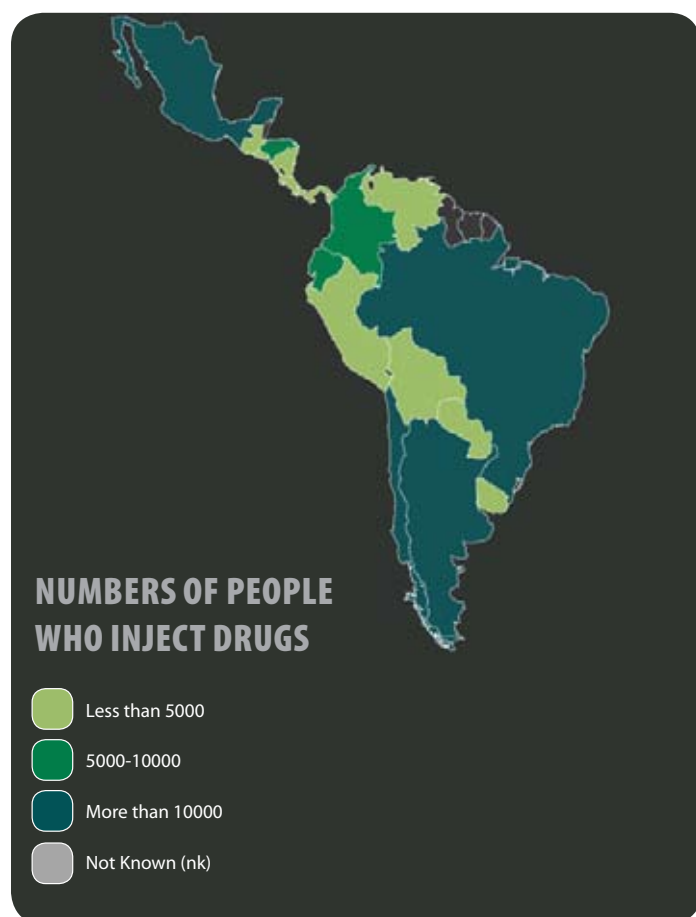
To demonstrate the complexity of alcohol consumption in the region, heavy drinkers account for more than 10% of the population in some countries (Argentina, Brazil and Mexico) and nearly one-third of the population in Colombia. In Brazil and Peru, more than 10% of the population are classed as alcohol dependent. At the same time, however, rates of 'last year abstainers' are also relatively high across the region – over one-third of the population in Bolivia, Cuba, Guatemala, Mexico and Venezuela, and over half of the population in Brazil and Costa Rica.¹⁴

Traditional beverages (illicit or unregulated alcohol) are commonplace across the region. These include cachaça and pinga (Brazil), aguardiente or 'fire water' (consumed across much of the region), pulque (popular among women in Mexico), and 'corn liquor' (consumed as a ritualistic beverage by indigenous people in Venezuela).^{15,16}

Brazil, in particular, has no licensing system in place for the production or sale of alcohol, and home-brewed beverages are common (as well as the consumption of cheaper domestic alcohol designed for cleaning).¹⁷ Such unregulated products are generally associated with higher (or less certain) alcohol content and numerous harms associated with intoxication and product safety.

Heroin

Heroin is used in northern Mexico and to a lesser extent in Colombia but is not widely used elsewhere in Latin America. Increased Mexican poppy cultivation and heightened security at the Mexican–US border following the events of September 11, 2001 are likely to be contributory factors to local heroin use, which is particularly concentrated in the border cities of Ciudad Juarez and Tijuana.¹⁸ The ‘black tar’ heroin produced in Mexico has a tacky consistency and requires heating prior to use, unlike further refined heroin powder found in South-East Asia. Injecting ‘black tar’ heroin is associated with an increased risk of wound botulism.¹⁹



Map 5.2: Number of people who inject drugs in Latin America

Injecting drug use

The most significant numbers of people who inject drugs are reported to be in Brazil (196,000),⁴ Argentina (65,000)³ and Mexico (53,662)¹. Demographic information on people who inject drugs is scarce due to a lack of disaggregated data. However, a study in Argentina found that 77.4% of people who inject drugs were male, echoing findings from other regions.²⁰ Cocaine is the most common substance injected throughout the region, with the exception of Mexico, where heroin injecting is more common.¹⁷

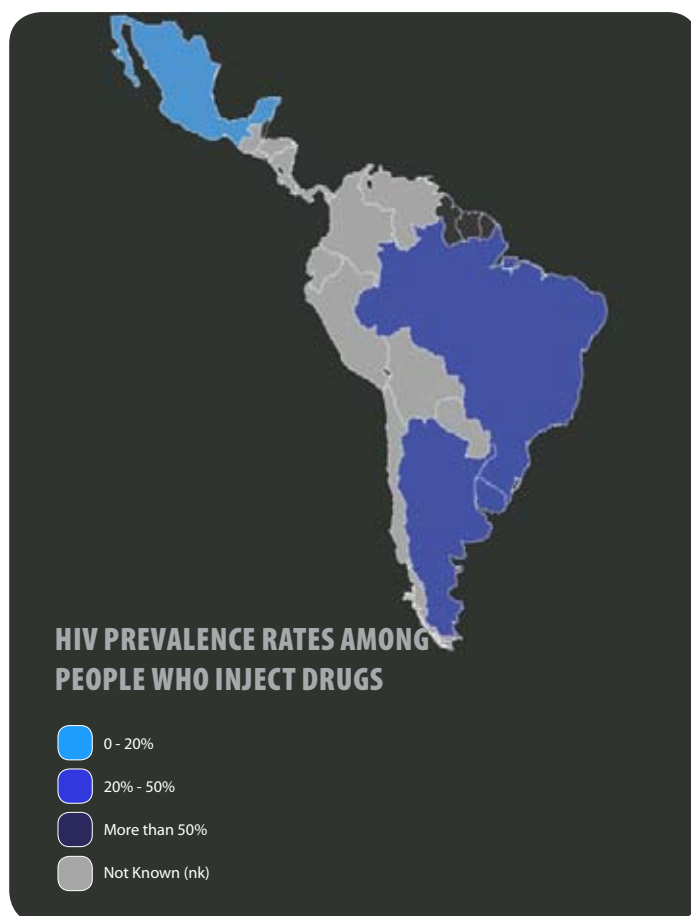
In 1998, after over a decade of poppy cultivation and heroin production in Colombia and an established cocaine production industry, injecting remained rare but was predicted to increase.²¹ A decade later there are an estimated 5,000 people who inject drugs in the country.¹ In Paraguay, injecting drug use has been reported primarily along the country’s borders, as well as within prison populations.²² In Brazil, the distribution of cocaine injecting appears to be related to drug trafficking routes in the south and

south-east of the country. Recent reports suggest that cocaine injecting is decreasing in the country as people are switching to cocaine sniffing and crack cocaine smoking.²³

Drug-related harms

HIV and AIDS

There are estimated to be 1.6 million people living with HIV in Latin America. HIV prevalence at a regional level is 0.5%, and most national HIV prevalence rates are below 1%. The epidemic is largely concentrated among marginalised groups, in particular sex workers and men who have sex with men, among whom very high prevalence rates have been found. Sexual transmission is the primary mode of infection in the region, however there is evidence of high levels of HIV among people who inject drugs in a number of major cities.²⁴

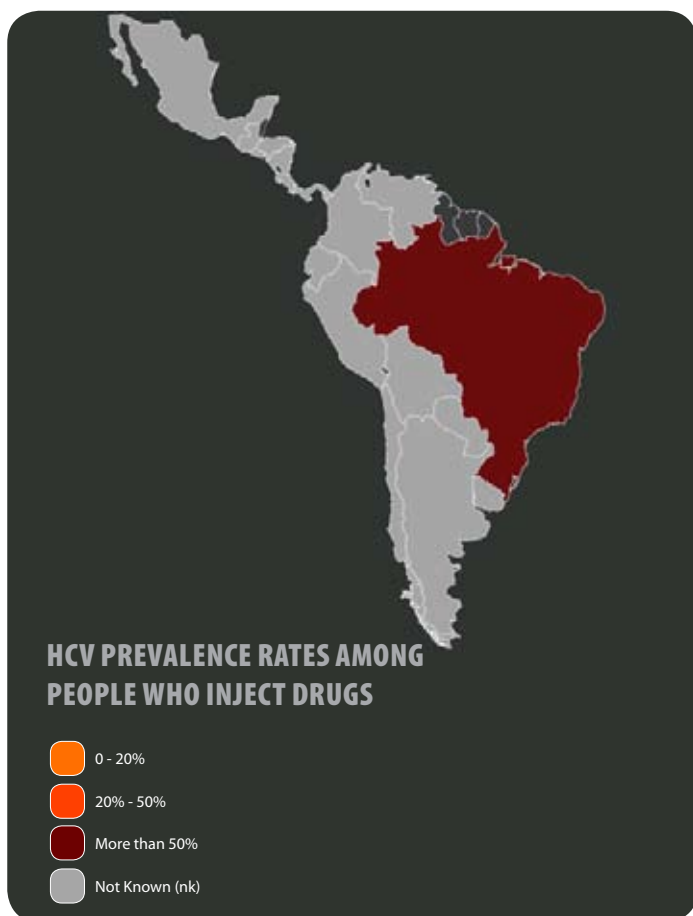


Map 5.3: HIV prevalence among people who inject drugs in Latin America

Injecting drug use is associated with new HIV infections in Argentina, Brazil, Chile, northern Mexico, Paraguay and Uruguay.²³ Estimated national HIV prevalence rates among people who inject drugs are available for Argentina (18.8–39.2%), Brazil (28–42%), Mexico (0–6%) and Uruguay (24.4%).² In Argentina, elevated HIV prevalence (6.3%) has also been reported among non-injecting cocaine users.²⁵

Hepatitis C virus (HCV)

According to the WHO in 1999, HCV prevalence was extremely high among the adult population in Bolivia (11.2%), high in Brazil (2.6%) and significant in both Peru (1.6%) and Colombia (1%).²⁶ A recent study in Mexico estimated national HCV prevalence to be 1.4%.²⁷



Map 5.4: HCV prevalence among people who inject drugs in Latin America

Amongst people who inject drugs in Brazil, it is estimated that between 39.5 and 69.6% are living with HCV.³ National HIV/HCV co-infection rates* among people who inject drugs in Argentina are estimated to be between 77 and 83.3%.³ In Buenos Aires, a co-infection rate of 88.3% was found.²⁸ Research findings in Brazil suggest that between 3[†] and 84.8% of people living with HIV also test positive for HCV.³ Elevated HCV prevalence has also been reported among non-injecting cocaine users in Argentina (7.5%)²⁴ and Brazil.²⁹ Similarly, research in Uruguay found HCV prevalence of 10.1% among non-injecting drug users and 21.5% among people who inject drugs.³⁰

Drug use and its related harms in prisons

The largest prison populations and the highest number of prison facilities are in the region's two most populous countries: Brazil and Mexico. The highest imprisonment rate in the region is reported in Panama, followed by Chile and Brazil.³¹

In all countries, mandatory prison sentences are applied for certain drug offences. Drug possession for personal use (depending on quantities and/or circumstances) does not receive mandatory

prison sentences in Bolivia, Brazil, Colombia, Costa Rica, Ecuador, Mexico, Nicaragua, Panama, Peru, Uruguay and Venezuela.

The majority of countries also use alternatives to custodial sentencing,³² which include compulsory therapeutic or educational measures. In Argentina, for example, Law 23.737, created in 1989, states that drug possession for personal consumption is punishable with a maximum prison sentence of two years. However, in cases where a person is considered to be drug dependent, a sentence may be avoided by entering drug treatment. Those considered to be one-time experimenters may escape a prison sentence by completing an abstinence-oriented drug education course.

During the recent 'Beyond 2008' Latin American and Caribbean NGO consultation, representatives highlighted the negative effects associated with prison sentencing for drug use and possession, as well as compulsory or coerced treatment as an alternative to incarceration.³³

There is evidence of elevated national HIV prevalence within prison settings in Brazil (12.5–17.4%), Argentina (7%), Honduras (6.1%) and Chile (0.6%).³⁴ There are no available data on HCV prevalence within prisons in Latin America.

THE RESPONSE

Harm reduction services

Needle and syringe exchange programmes (NSPs)

Five countries in Latin America provide access to NSPs: Argentina, Brazil, Mexico, Paraguay and Uruguay.[‡] There are reported to be 122 NSPs in total across the region, most of which are in Brazil (93) and Argentina (25). In all five countries, it is reported that NSPs employ community-based outreach to distribute injecting equipment.³¹

Despite the current drive towards universal access to HIV prevention services, the number of NSPs has remained stable in the region, with the exception of Brazil where they have slightly decreased in recent years.⁵ Crude calculations of the number of syringes distributed per injector per year (based on the latest estimates of the number of people who inject drugs) suggest this figure to be very low in both Brazil and Paraguay, indicating that less than two syringes are distributed per person in one year.³¹

In Brazil, it was reported that large areas of the country had limited NSP services, particularly outside the major cities in less populous areas of the north and north-east.³⁵ Lack of funding is reported to be the principal barrier to the scale up of NSP services in Brazil. Recent decentralisation of health service funding has left the prioritisation of harm reduction programmes up to states and municipalities and as a result local government can choose to ignore national harm reduction policy.²² Access to needle and syringe exchange, in addition to other harm reduction interventions, must be dramatically scaled up in order to reach coverage levels capable of making an HIV prevention impact.

Across Latin America, needles and syringes can be purchased from pharmacies.[¶] For more than 68,000 people who inject drugs in countries without NSPs, this is the only way to obtain sterile injecting equipment. As in other regions, pharmacists are

* Findings within samples of people previously identified as living with HIV.

† Finding from a sample of people who inject drugs, i.e. researchers had no prior knowledge of participants' HIV or HCV serostatus.

‡ Information was not gathered from Nicaragua and Panama.

§ Information was not known for Mexico.

¶ Information not known for Cuba.

resistant to the sale of injecting equipment to people they suspect of injecting drug use. An assessment in Argentina found that pharmacists who resisted selling injecting equipment often held the view that people who injected drugs were self-destructive and unconcerned about their own health. The study also found that pharmacists believed that if they did not sell the equipment to individuals, this would stop them from injecting drugs.³⁶

In the five countries where NSPs are operating, there are several barriers that make it difficult for people who use drugs to access these services. As a criminalised population, there is often a legitimate fear of arrest upon accessing NSPs. Ambiguous drug laws and a lack of clarity on the legality of possessing drug injecting equipment allow room for arbitrary interpretations by law enforcement officers. Anecdotal evidence from Brazil suggests that possession of drug injecting equipment has been used as additional proof for conviction during drug raids.³⁷

Stigmatising attitudes of health workers also dissuade people in the region from accessing health care services. People using drugs are often seen by health workers as a homogenous group regardless of the substance used, or the frequency, quantity and mode of use. Labelled as self-destructive addicts who are largely unconcerned about their own health, they are at risk of receiving sub-optimal health care.³¹

Treatment for drug dependence

Opioid substitution therapy (OST) is not part of the current response to drug use in the region, due, in part, to the relatively low use of opiates in many countries. Mexico is the country with the most heroin injecting and the only country where OST is provided, but possession of both methadone and buprenorphine is not prohibited in any country.

In recent years, OST availability in Mexico has increased and there are now twenty-one sites with more than 3,644 people receiving treatment. Three-quarters of the clients* are over thirty years of age, and 86.6% are male.³⁸ With an estimated 53,000 people injecting drugs in Mexico, predominantly heroin, current OST programmes are far from reaching the 40% associated with good coverage.[†]

All countries in the region have non-OST drug dependence treatment available. In Brazil, it is reported that much of the treatment provision uses abstinence-based, twelve-step approaches and is tied in with religion.³⁹ Records indicate that 1,078,821 people accessed non-OST drug dependence treatment across the region in 2007, with the largest numbers in Brazil (850,000), Argentina (144,120), Costa Rica (13,000), El Salvador (12,986)¹⁰ and Colombia (12,774).⁴⁰ It is not known how many of these people injected drugs.

Targeted HIV prevention, treatment and care

The extent to which HIV prevention and treatment is reaching people who inject drugs in Latin America is largely unknown. Voluntary HIV counselling and testing (VCT) is available in all countries in Latin America to varying extents. Current barriers to increasing access for people who inject drugs include discrimination and the legal framework regarding illegal drugs. Community-based outreach in HIV prevention programmes specifically targeting people who use drugs needs to be increased. Four countries in the region (Argentina, Brazil, Mexico

and Paraguay) have targeted programmes to increase access and uptake of VCT for people who inject drugs, although these are limited in reach. Targeted programmes reaching people who inject drugs on HIV and STI prevention, including information, education and communication (IEC) and condom distribution, are available but limited in Argentina, Brazil, Mexico, Paraguay and Uruguay.³¹

Antiretroviral treatment (ART) is available throughout the region, and over 330,000 people are currently receiving the treatment, the largest number being in Brazil (180,000 people), the first country in the region to introduce free ART provision through the health care system.⁴¹ In December 2004, there were 30,000 current or former injecting drug users receiving ART in Brazil.⁵

There are no data available on how many people who inject drugs are receiving ART in the rest of the region. Although there are no explicit policies excluding people who use drugs from accessing ART, misconceptions and uncertainties among health care workers often manifest in a reluctance to prescribe ART to this group. Wider training on the health care requirements of people using drugs and living with HIV should be made available to combat this. Currently, abstinence-based drug treatment is heavily recommended to people before they can initiate ART.³¹

Although local drug user initiatives exist, in Brazil for example, there are currently no national drug user groups or organisations involved in advocacy in Latin America. Individuals working in the region plan to form a Latin American network of people who use drugs (INPUD – Latin America) in the near future.⁴²

Targeted HCV prevention, treatment and care

No Latin American countries have programmes that are actively seeking to engage people who inject drugs in HCV testing and treatment. Access to these services is reported in Brazil, the only country in the region with a national HCV treatment programme, as well as to a lesser extent in Argentina and Mexico.

Throughout the region there is a need to expand access to HIV and HCV prevention, testing and treatment services to both injecting and non-injecting drug users.³¹ In Brazil, an operations research initiative of Psicotropicus and the Harm Reduction Association of Rio de Janeiro aims to reduce HCV infection and other drug-related harms for people who use cocaine. Distribution of kits containing straws for snorting cocaine, condoms and risk reduction information began in 2008.⁴³

Harm reduction in prisons

Information on drug treatment and HIV-related services within prisons is not easily accessible in this region, and further exploration is necessary to gain greater insight into the regional situation. It is reported that there are currently no prisons in Latin America with official needle and syringe exchange provision (PNEP) or opioid substitution treatment provision in place. In a small number of prisons along Mexico's northern border there are reported to be unofficial needle and syringe exchanges running inconsistently and at the discretion of prison coordinators.⁴⁴

* 14 out of 21 sites provided data.

† This figure is based on coverage reached in countries with well-established OST programmes and where HIV epidemics among people who inject drugs were stabilised, halted or reversed.

Non-OST drug dependence treatment is available within prisons in Argentina, Brazil, Chile, Guatemala, Mexico, Peru and Uruguay to varying extents.^{‡,31} It has been reported that condoms are available in all Uruguayan prisons, in most Mexican prisons and in some prisons in Argentina, Brazil and Chile. VCT is available in prisons in Argentina, Brazil, Honduras, Mexico and Uruguay. Prisoners are receiving ART in Argentina, Brazil and Uruguay. Testing and treatment for HCV infection is available in some prisons in Argentina, Brazil and Mexico but not elsewhere in the region.[§]

Policies for harm reduction

Governments in Latin America are responding to diverse contexts of national drug use, production and transshipment and many are under significant pressure from the US government to enforce supply reduction interventions. As such a prominent international relations issue, stemming the production and export of illicit drugs has taken political precedence over efforts to reduce the substantial harms associated with the use of drugs in the region. However, several governments have embraced elements of harm reduction within their domestic and international policies.

All countries have a national policy or strategy on illicit drugs and those of Brazil, Mexico and Uruguay include mention of at least one harm reduction intervention. Argentina, Brazil, Mexico and Uruguay are explicitly supportive of harm reduction in their domestic policies and six countries are explicitly supportive of harm reduction at the international policy level (Argentina, Brazil, Chile, Mexico, Paraguay and Uruguay). No government in the region is explicitly opposed to harm reduction in either domestic or international policy, although some are less than willing to address injecting drug use within their political agendas, denying either its existence or importance as a public health issue in their countries.³¹

‘Currently, political agendas rather than research and evidence are driving the response.’^{‡31}

The integration of harm reduction into government policy has stemmed from concerns about the role of injecting drug use in HIV epidemics. Throughout the region, countries have HIV/AIDS action frameworks or national strategic plans on HIV and AIDS and a number of these include harm reduction (Argentina, Brazil, Mexico, Nicaragua, Paraguay and Uruguay). Injecting drug users are highlighted as key populations in the majority of national strategies or plans (Argentina, Bolivia, Brazil, Chile, Guatemala, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay and Venezuela).[¶] Human rights are explicitly referred to in all plans within the region.

Thirteen out of seventeen countries have a national AIDS coordinating authority (Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay and Peru) and five countries have an agreed country-level monitoring and evaluation system for HIV/AIDS programmes (Brazil, Colombia, Costa Rica, El Salvador and Mexico).³¹

A lack of political will and, consequently, resource allocation is impeding the scale up of essential harm reduction services in Latin America. It is not possible to estimate the proportion of national HIV budgets allocated to HIV prevention, treatment and care for people who inject drugs, as expenditure is not currently

disaggregated to provide this information. Increased government commitment to evidence-informed policy and programming is necessary in order to respond to drug-related harms in the region.³¹ This would require improved mechanisms for civil society involvement in government policy-making processes, an area recently highlighted by NGOs as non-existent in some countries and as informal and inconsistent in others.³²

An initial scoping exercise indicated that at least seven countries (Argentina, Brazil, Chile, Colombia, Mexico, Paraguay and Uruguay) have national harm reduction networks or civil society organisations which focus on harm reduction policy and advocacy. The Latin American Harm Reduction Network (RELARD) and the Latin American Drug Policy Reform Network (REFORMA) were working at a regional or sub-regional level, but both have been less active in recent years.

Forming a large part of the national drug treatment response (and in some countries leading the response), civil society recently appealed for greater balance in efforts to reduce drug demand, as harm reduction currently receives less emphasis than primary prevention and treatment.³

In recent years, Intercambios Civil Association, an NGO based in Argentina, has expanded its harm reduction research and advocacy work to a regional level and is currently partnering with several organisations throughout Latin America on a number of research, training and advocacy initiatives.

Intercambios plays a key role in ensuring the participation of Latin American harm reduction representatives in regional and international policy initiatives such as the ‘Beyond 2008’ held in Lima in November 2007 and the International NGO Forum on the 1998–2008 UNGASS on drugs. Intercambios’ regional advocacy initiatives involve working with representatives from government, multilateral organisations and NGOs in the region.

Multilateral support for harm reduction

The multilateral presence in Latin America is strong, with several regional and country offices in the region. Technical and financial support for programmes focusing on HIV and AIDS is substantial, much of which is specifically targeted towards key populations, primarily men who have sex with men and sex workers.

The focus on injecting drug use, prisons and harm reduction appears to be much more limited.^{**} UNAIDS and UNODC have provided intermittent support to harm reduction programmes in the Southern Cone countries and Brazil, but there is not a consistent emphasis on this from the multilateral level. The Pan American Health Organization (PAHO), the WHO regional office, has provided technical support on harm reduction in some countries in the region, but it is reported that this requires further development. PAHO is not one of the four regional WHO offices to have a dedicated staff member working on harm reduction.

[‡] Information was not available for other countries in the region.

[§] Information was not available for Bolivia.

[¶] Accessing this information was not possible for Ecuador

^{**} As with national HIV budgets, it is not easy to establish which HIV programmes contain an element of harm reduction, or a focus on injecting drug use.

UNESCO's Road Shows programme includes national consultations in Brazil and Colombia with the aim of increasing awareness of harm reduction.⁴⁵

***'The United Nations should allow a broader and real participation of all the NGOs in each country and region.'*⁴³**

The key role of multilateral agencies, alongside civil society, in ensuring that governments adopt harm reduction measures in their response to both injecting and non-injecting drug use is not currently being fulfilled. The formation and strengthening of strategic alliances between multilateral agencies, in particular UNODC, and key civil society partners is necessary to increase achievements in this area. It is reported that UNODC largely communicates with NGOs through national governments in the region, rather than using formal mechanisms to ensure meaningful and consistent civil society involvement like those established by agencies such as UNAIDS.³² See section 3 of this report for further exploration of the issue of civil society involvement in multilateral processes.

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Regional Overview

North America



AVAILABILITY OF NEEDLE AND SYRINGE EXCHANGE PROGRAMMES AND OPIOID SUBSTITUTION THERAPY

- Both NSP and OST available
- OST only
- NSP only
- Neither available
- Not Known

HARM REDUCTION IN NORTH AMERICA

Country/territory with reported injecting drug use ^a	People who inject drugs	Adult HIV prevalence amongst people who inject drugs	Adult HCV prevalence amongst people who inject drugs ²	Harm reduction response			
				NSP	OST	SIF ^c	HIV and HCV programmes targeted towards people who inject drugs ^b
Canada	269,000 ²	2.9-23.8% ³	46-90%	✓	✓	✓	✓
United States	1,364,000 ⁴	14.5-47.9% ⁵	8-88.3%	✓	✓	x	✓

a There is no injecting drug use reported in Greenland. Mexico is included in the Latin American overview.

b These services include, among others, voluntary HIV testing and counselling; HIV prevention, treatment and care; hepatitis C testing and treatment; STI prevention and treatment; and information, education and communication.

c Safer Injecting Facility (SIF)

The United States (US) and Canada collectively are home to 332 million people. Both countries are among the wealthiest in the world and rank high on the human poverty index.⁶ Both countries have relatively strong economies and a high standard of living, although huge disparity exists, particularly in the US, between ethnic minority and white North American populations.

DRUGS IN THE REGION

Cultivation, production and transshipment

The US and Canada are primary consumer markets for illicit drugs. Some drugs, such as heroin and cocaine, are produced or cultivated elsewhere and smuggled into the region, primarily from Latin America, sometimes via the Caribbean. South-East and South-West Asian heroin also reaches North America, often via East or West Africa, or Europe.⁷ In the case of drugs such as cannabis and amphetamine-type stimulants (ATS), there is a significant domestic production capacity.

According to UNODC, the US and Canada are major producers of cannabis, and the US (along with Mexico) may be the largest cannabis herb producer globally. In the US, cannabis production is most widespread in the states of California, Kentucky, Tennessee, Hawaii and Washington. In Canada, production is concentrated in the provinces of British Columbia, Ontario and Quebec. UNODC notes that cannabis production in Canada 'remains significantly lower' than in the US.⁷

Both countries also have significant domestic production of ATS. North America is a main producer of methamphetamine internationally, although increased law enforcement activities, particularly in the US, have resulted in the movement of some of this production into Mexico. In recent years, ecstasy for consumption in the US and Canada is increasingly being produced locally, rather than imported from Europe.⁷

Drug use

In the US, the most commonly used drugs are alcohol, tobacco, cannabis and cocaine (including crack cocaine). In a 2006 national survey, it was estimated that 20.4 million people aged 12 years or older (8.3% of the population) had used an illicit drug during the previous month; a rate of use that has remained stable since 2003. The non-prescription use of pain relievers and tranquilisers is also common. Although heroin is not as commonly used as other illicit drugs in North America, it is one of the most commonly injected drugs in both countries. Heroin use is reported to have decreased in the US in recent years.⁷

In Canada, the most commonly used drugs are alcohol, tobacco, cannabis, hallucinogens and cocaine. There is evidence that crack cocaine use has increased, particularly among street-involved people who use drugs.⁸ Rates of illicit drug use vary substantially from one province to another, with figures for lifetime use of illicit drugs ranging from 36.9 to 52.7% and for past-year use varying from 10.7 to 17.5%. British Columbia, Quebec and Alberta have rates of use higher than the national average, while New Brunswick and Newfoundland exhibit rates of use below the national average.⁸ There are estimated to be between 25,000 and 50,000 people using heroin in the country, primarily in Vancouver, Toronto and Montreal.⁹

Alcohol

Per capita alcohol consumption in North America is relatively average by international standards: 8.51 litres of pure alcohol per capita in the US and 8.26 litres in Canada.¹⁰ However, the true patterns of drinking are more complex, with relatively high levels of self-reported 'last year abstainers' (33.9% of the population in the US and 22% of the population in Canada), and 'heavy episodic drinkers' (between one-fifth and one-quarter of the populations).¹¹

Just over half of people aged 12 years or older in the US in 2006 (50.9% or approximately 125 million persons) reported being current drinkers, a figure similar to that in 2005 (51.8%).¹² In Canada, a 2005 report found that 79.3% of people aged 15 years or older had consumed alcohol during the previous twelve months. This rate varied from a low of 70.2% in Prince Edward Island to 82.3% in Quebec. According to that survey, 22.6% of drinkers exceeded the 'low risk drinking guidelines', and 6.2% of drinkers were classified as 'heavy drinkers'.⁸

The US, with its high minimum age limit for legal alcohol consumption (21 years across all states), has relatively unique problems with underage drinking, particularly among college and university students with risky drinking patterns. Some US universities have applied a harm reduction approach to this problem by introducing 'medical amnesties', whereby intoxicated students can call emergency services when required without fear of reprimand despite being under the legal age to consume alcohol.¹³

Crack cocaine

It is estimated that in the US, in 2006, 1.5 million people (0.6% of the population) had used crack cocaine ('crack') within the previous year.¹² It is reported that, as of 2003, there has been a shift away from smoking to injecting crack in all major US cities.¹⁴ Studies have found crack smoking to be associated with sexual HIV transmission, with particularly increased risks among women who smoke crack.¹⁵

In Canada, there is evidence of increasing crack use since the 1990s, both via smoking and injecting. Data from many Canadian cities also show significant use of crack among people who inject drugs, although the rates of use vary between regions. For example, a 2004 Health Canada report noted that 52.2% of approximately 800 people who inject drugs surveyed in four cities (Toronto, Regina, Sudbury and Victoria) had smoked crack over the past six months. Rates of use ranged from 9.3% in Victoria to 63.3% in Toronto.¹⁶ A 2005 study of illicit opioid users in five cities found that over half (54.6%) had used crack in the past thirty days, 87.2% via smoking. Again rates of use varied, from 3.4% in Quebec City to 86.6% in Vancouver.¹⁷

Concerns about the potential transmission of HCV via shared crack pipes have prompted a number of US and Canadian cities to introduce harm reduction programmes specifically for people who smoke crack.

Methamphetamine

Treatment data indicated a large increase in methamphetamine use in the US between 1993 and 2003, and the number of seizures from illegal laboratories producing the drug increased between 2000 and 2005. However, methamphetamine use in the US remains lower than that of cannabis and cocaine (including crack).

Overall it was estimated in 2006 that 1.4 million people (0.6% of the population) had used methamphetamine in the US in the previous year. A study of young men (aged 15 to 22 years) who have sex with men between 1994 and 1998 found that 20% had used methamphetamine during the previous six months.¹⁸ Studies have found that methamphetamine use is associated with increased risk of sexual HIV transmission.



Map 6.2: Numbers of people who inject drugs in North America

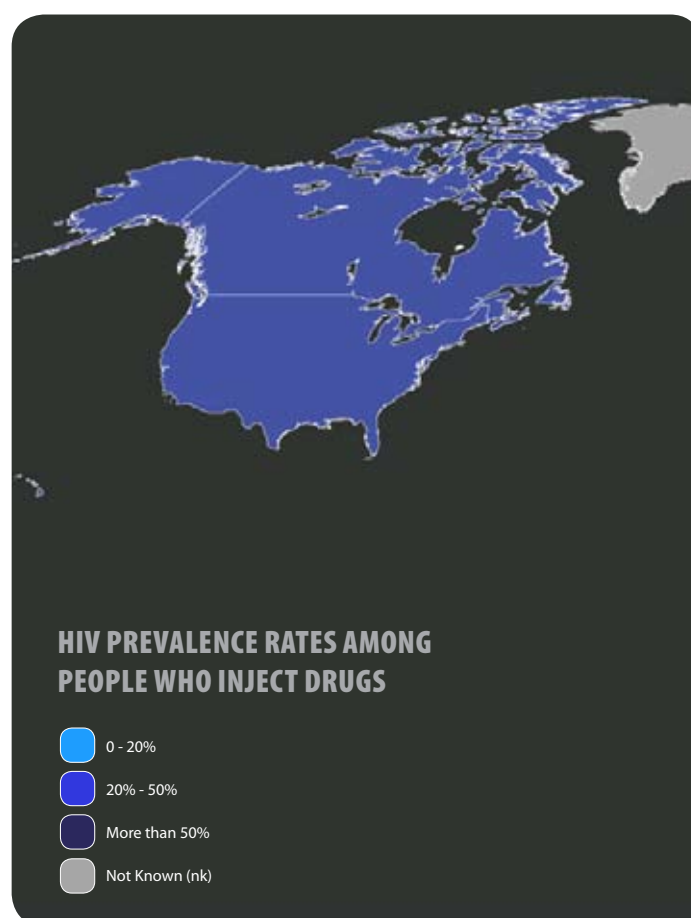
Injecting drug use

It is estimated that 1,364,000 people inject drugs in the US.⁴ The majority of people who inject drugs are male and living in urban areas, a large proportion in New York City.¹⁹ In 2002, the prevalence of injecting drug use per 100,000 in the general population was highest in Baltimore, Maryland (336); several cities in California, including Fresno (295), Stockton-Lodi (276), Bakersfield (240) and San Francisco (235); Tucson, Arizona (230) and Springfield, Massachusetts (224).²⁰

Overall prevalence of injecting drug use is reported to have declined in the US since the 1980s, with some variation by substance. People who inject drugs were recently described as 'an aging population', with decreasing rates of initiation of injecting among young drug users.²¹ The most commonly injected substances include heroin, cocaine (including crack) and methamphetamine.

In Canada, according to the Canadian Addiction Survey by Statistics Canada, 269,000 people reported having injected drugs in the past year, including steroids, in 2004.²² This represents an increase from 132,000 people in 1994 and estimates of 75,000 to 125,000 people in 1998. Injecting is reported in major cities including Vancouver, Toronto and Montreal and in small towns and rural

areas.²³ Commonly injected substances include heroin, cocaine (including crack), steroids, as well as controlled substances such as OxyContin, Talwin, Ritalin (in some areas) and Ketamine.²⁴



Map 6.3: HIV prevalence among people who inject drugs in North America

Drug-related harms

HIV and AIDS

In the US, there are an estimated 1.2 million people living with HIV,²⁵ and approximately 40,000 new HIV infections occur every year.²⁶ Almost three-quarters (74%) of HIV or AIDS diagnoses in 2005 were among men.²⁷

The black and Hispanic communities in the US are disproportionately affected by HIV. In 2005, black people, including African-Americans, accounted for almost half (49%) of the estimated number of HIV cases diagnosed, despite comprising only 13% of the US population. This situation is particularly evident among young people in the black community, as 61% of people under the age of 25 years living with HIV are African-American.²⁸ HIV-related illnesses are the leading cause of death among African-American women aged 25 to 34 years.²⁹

While sexual transmission remains the most common HIV transmission route, national HIV prevalence among people who inject drugs in the US is estimated to range between 14.5 and 47.9%.⁵ In 2007, the US Centers for Disease Control and Prevention (CDC) estimated that 18% of new HIV diagnoses are among people who inject drugs,³⁰ this figure rising to one in five new HIV diagnoses among women.²⁹ Among African-Americans, unsafe injecting

drug use is the second most common route of HIV transmission, accounting for about one-quarter of new HIV cases in 2005.²⁸

Certain sub-populations injecting drugs are reported to be more vulnerable to HIV, including new injectors, young people, street-involved people, people with a history of incarceration, transgender identified persons, gay men, African-Americans, Hispanic-Americans and Vietnam veterans.³¹ Those who inject ATS (such as methamphetamine) or cocaine may also be at increased risk of HIV transmission as these substances require more frequent injection to retain their effect.

There is considerable evidence of the link between non-injecting drug use and HIV, HCV and other STIs in the US through the sharing of paraphernalia and unprotected sex. For example, the use of crack cocaine has been linked to the transmission of HIV, particularly in circumstances where drugs are traded for sex, or when people engage in risky sexual behaviours while high on the drug.

A study of more than 2,000 young adults in three inner-city neighbourhoods found that crack smokers were three times more likely to be living with HIV than non-smokers.³² Researchers have also identified methamphetamine use as increasing the likelihood of risky sexual behaviours and the potential transmission of HIV and STIs.³³ The role of non-injecting drug use in HIV transmission is further explored in section 3 of this report.

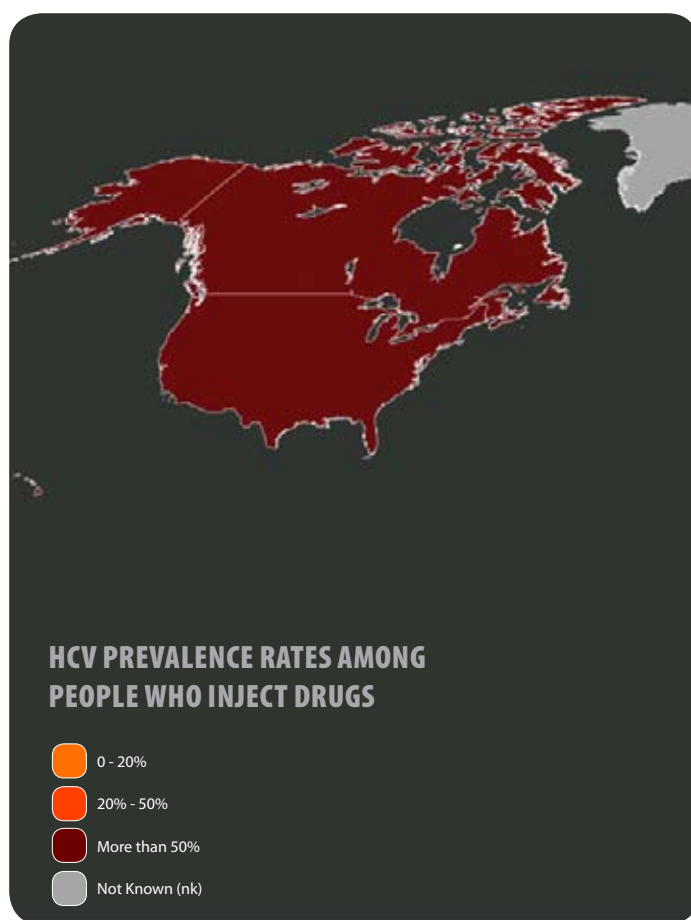
In Canada, there were estimated to be approximately 58,000 people living with HIV at the end of 2005. This represents a 16% increase from the estimated 50,000 people living with HIV at the end of 2002, which may be partly attributable to increasing numbers receiving life-prolonging antiretroviral treatment (ART). It is estimated that between 2,300 and 4,500 new infections occurred in 2005.

Over 95% of people known to be living with HIV in Canada reside in the provinces of Ontario, Quebec, British Columbia and Alberta, which together account for more than 85% of the total Canadian population.³ Aboriginal communities are significantly affected by HIV, and while Aboriginal people comprise 3.3% of the Canadian population they represent approximately 7.5% of people living with HIV.

HIV prevalence among people who inject drugs in Canada is estimated to be between 2.9 and 23.8%.³ In 2005, there were estimated to be 9,860 people who inject drugs living with HIV in Canada, comprising 17% of all people living with HIV in the country. Between 350 and 650 HIV diagnoses were attributable to injecting drug use that year, representing about 14% of all new diagnoses.³ HIV prevalence among people who inject drugs varies substantially across the country (Regina, Saskatchewan: 2.9%; Quebec City, Quebec: 7.1%; Ottawa, Ontario: 8%; Montreal, Quebec: 13.6%; Vancouver, British Columbia: 17%; Edmonton, Alberta: 23.8%).³

According to the Public Health Agency of Canada, 'national HIV estimates for 2005 show a slight decline in the number of new infections attributed to injecting drug use compared with 2002'.³ Women who inject drugs are disproportionately at risk of HIV infection, and since 1996 approximately 25 to 50% of positive HIV test results among Canadian women have been attributed to unsafe injecting drug use.³ More than half of all HIV diagnoses

among Aboriginal Canadians (53%) are the result of unsafe injecting drug use. This is much higher than that among non-Aboriginal Canadians (14%).³



Map 6.4: HCV prevalence among people who inject drugs in North America

Hepatitis C virus (HCV)

In the US, there are approximately 4 million people living with HCV, and there are estimated to be 30,000 new HCV cases each year. Unsafe injecting drug use is identified as the source of most new HCV diagnoses.³⁴ An estimated 60% of all new HCV infections annually in the US are related to unsafe injecting³⁵ and studies suggest that between 50 and 80% of people who inject drugs are living with HCV within five years of initiating injecting.³⁶

National HCV prevalence among people who inject drugs ranges between 8 and 88.3%. Across the US, this figure varies from 8% in Baltimore, to much higher levels in New York (61–71%) and Albuquerque (88%).¹ It is estimated that 50 to 90% of people living with HIV who inject drugs are also co-infected with HCV.³⁶

In Canada, there are between 250,000 and 300,000 people living with HCV (0.8 to 1% of the population). More than half of existing HCV cases, and three in four new infections, are related to unsafe injecting.³⁷ National HCV prevalence among people who inject drugs is estimated to be between 46 and 90% and studies in various Canadian cities have revealed HCV to be high among injectors in Vancouver (81.6%) and Montreal (70%).³⁷

A collaborative surveillance network involving multiple drug services in Ottawa, Ontario and in Quebec between 2003 and 2006

estimated HCV prevalence to be 62.2%.³ A study of illicit opioid users in five Canadian cities found that between 44.1 and 73.7% of people tested positive for HCV.³⁸ In Canada, it is estimated that between 5,000 and 10,000 people are living with both HIV and HCV.³⁷ In addition to unsafe injecting, there are concerns about HCV transmission via shared straws for snorting cocaine and shared pipes for smoking crack.³⁷

Drug use and its related harms in prisons

The US has the largest prison population and the highest incarceration rate in the world. Over 2 million people are behind bars in the US, a per capita incarceration rate of 714 persons per 100,000 in the general population.³⁹ Canada holds approximately 35,000 people in prison, and has an incarceration rate of 110 prisoners per 100,000.⁴⁰

In the US, harsh approaches to drug enforcement combined with mandatory minimum sentencing laws for drug offences at the state and federal levels have resulted in an exponential increase in the size of the prison population, and the number of non-violent offenders incarcerated for drug offences, over the past twenty-five years.

Drug enforcement has disproportionately affected the African-American community. While African-Americans comprise 14% of the overall drug-using population, they constitute 37% of those arrested for drug offences and 56% of those incarcerated in state prisons for drug offences.⁴¹

According to the US Bureau of Justice Statistics, 21% of state prisoners and 55% of federal prisoners in 2004 were incarcerated for violating drug laws.⁴² As a result, a significant proportion of people held in US prisons are current or former drug users, and it is estimated that 80% of prisoners have issues related to substance use.⁴³ In 2004, 56% of prisoners in state facilities and 50% of prisoners in federal facilities reported using illegal drugs in the month prior to their offence.⁴²

Similarly in Canada, various studies have found rates of injecting drug use among Canadian prison populations between 4.4 and 21%.⁴⁴ In 2008, the Canadian government announced that it would be introducing mandatory sentencing laws for drug offences.⁴⁵

Both countries have implemented drug treatment courts as one alternative to incarceration for people charged with low-level drug offences. In the US, the first drug court was established in Florida in 1989, and since that time over 1,600 have been established, with many hundreds more in development. In Canada, drug courts were established in Toronto (1998) and Vancouver (2001), and since that time have expanded to a small number of other cities, including Edmonton and Regina.⁴⁶

In the US, at the end of 2005, 20,888 people incarcerated in state prisons (1.8%) and 1,592 in federal prisons (1%) were known to be living with HIV. There is significant regional variation in HIV prevalence among US prisoners, from a low of 0.7% in the west to a high of 3.9% in the north-east. HIV prevalence is higher among women prisoners than among men, and higher among African-American and Hispanic American prisoners than among white prisoners.⁴⁷ HCV prevalence among US prisoners is estimated to be between 30 and 40%.⁴⁸

Estimates of HIV prevalence in Canadian federal and provincial prisons range from 2 to 8%, while studies of HIV prevalence in individual prisons report rates of between 1 and 11.94%. HCV prevalence among prisoners is between 19.2 and 39.8%.^{3,44} Several studies have found that HCV prevalence is elevated among female prisoners and prisoners who inject drugs.^{49,50}

THE RESPONSE

Harm reduction services

Needle and syringe exchange programmes (NSPs)

In the US, NSPs began in the mid- to late 1980s as unofficial, activist-based projects. However, over time, many states introduced legislation to allow NSPs to operate legally and to provide funding support for their implementation.⁵¹ As of November 2007, a total of 185 NSPs were operating in thirty-six states and the District of Columbia.

There has been an increase of funding at the state and local levels for NSPs in recent years, which has resulted in the number of programmes stabilising and their services expanding. For example, in 2006 the North American Syringe Exchange Network (NASEN) recorded 166 registered NSPs in the US, compared with 68 in 1994/1995, 101 in 1996, 113 in 1997, 131 in 1998, 154 in 2000, 148 in 2002 and 174 in 2004.⁵² However, despite this increased access, the Harm Reduction Coalition estimates that NSPs still reach less than 20% of people who inject drugs in the US.⁵³

The US government has placed a ban on federal funding for NSPs since 1988.⁵¹ The bulk of funding for these programmes (74 to 87%) therefore comes from city, county and state governments.⁵⁴ State support of NSPs is essential in enhancing service provision, and research has shown that the presence of government funding of NSPs in the US is associated with a larger number of syringes being exchanged and a greater variety of services being offered by the programmes, including increased likelihood of offering voluntary HIV counselling and testing (VCT).⁵⁵

According to the Harm Reduction Coalition, 'The federal funding ban also carries a significant symbolic weight in U.S. debates, rendering syringe exchange marginalized and controversial despite its long history and documented successes'.⁵¹ Indeed, research conducted across nearly 100 US cities concluded that need for an NSP is not a predictor of the presence of a programme.⁵⁶ A number of factors have been identified as limiting access to sterile injecting equipment in the US, including drug control and policing practices (i.e. by district attorneys, politicians or police) and syringe purchasing laws or laws criminalising the possession of drug paraphernalia.⁵⁷

In Canada, the first NSPs were opened unofficially in Toronto in 1987. The first official programme opened in Vancouver in 1989, followed soon after by projects in Toronto, Montreal and other major cities. As of 2007, the ministries of health in all ten provinces and two of three territories were providing support for NSPs.

Health Canada reported in 2001 that there were over 200 NSPs operating nationally, although the actual number of sites distributing sterile injecting equipment may be significantly higher.⁵⁸ For example, in 2007, the Toronto Department of Public Health listed over thirty needle exchange sites in that city alone.⁵⁹

However, only a small number of people who inject drugs have access to NSPs. It is estimated in Ontario that only fifty-three syringes are distributed per injector per year, about 5% of the number required. In Montreal, this figure is 6.6%.

A number of barriers have been identified by Canadian harm reduction advocates that limit the effectiveness of NSPs. According to research by the Canadian HIV/AIDS Legal Network, many regions of the country have little or no access to NSPs, particularly those outside of urban areas.⁵⁸ This may partly explain the findings of a survey done between 1995 and 2006 showing 'significant differences ... between urban and semi-urban (small communities) participants with regard to needle sharing and borrowing'. The survey found that 27.8% of people living in urban settings who inject drugs had lent used syringes to another person during the previous six months, while the figure for those living in rural areas was 36.2%. Similar differences were also found in the number of persons who had borrowed used syringes from another person during the previous six months (urban 32.9%, rural 41%).³

In rural areas, this gap in access is often exacerbated by restricted opening hours of those NSPs that do exist.⁶⁰ Other barriers that have been identified include policies at some NSPs that require a strict one-for-one exchange or that in other ways limit the number of syringes distributed to service users per visit. In each case, such policies can result in fewer syringes being provided than is necessary for the number of injections.

Pharmacy sales of syringes vary significantly between the US and Canada. In the US, there are numerous laws, regulations and pharmacy practices that severely limit the ability of people who inject drugs to purchase syringes legally from pharmacies. For example, in 2002, forty-seven states and the District of Columbia had enacted drug paraphernalia laws under which the distribution and possession of any item used to consume illegal drugs, including syringes, is prohibited. In addition, eight states also require prescriptions in order to purchase syringes legally.⁶¹ Pharmacy regulations or guidelines in twenty-three states also have the effect of restricting the sale of syringes to people who inject drugs.⁶²

In Canada, the sale of syringes through pharmacies is legal,^{*} and pharmacists are encouraged by Health Canada and the relevant regulatory bodies to sell syringes openly as a strategy to prevent HIV transmission. However, in practice the decision on how and to whom syringes are sold is left to the discretion of individual pharmacists. According to the Canadian HIV/AIDS Legal Network, 'There are reports from across Canada of pharmacists refusing to sell syringes to people who use drugs'.⁵⁸ This reluctance is reported to affect people in rural areas disproportionately as, in the absence of NSPs, pharmacies may be their only source for accessing sterile syringes.⁶³

Safer injecting facility

Canada has North America's first and only legal safer injecting facility (SIF), called Insite, which is reported to receive an average of over 600 daily visits.⁶⁴ It was opened in September 2003 in the downtown eastside of Vancouver, and is operated by the Vancouver Coastal Health Authority. The Canadian government originally granted the facility a three-year ministerial exemption under Section 56 of the Controlled Drugs and Substances Act, allowing the site to operate without either the service users or

the staff risking criminal prosecution for the offence of possessing illegal substances on the premises. The initial pilot phase was co-funded by Health Canada and the British Columbia Ministry of Health.⁶⁵

Scientific evaluations of the SIF project have identified significant positive outcomes, including a reduction in the sharing of injecting equipment both among service users and the community as a whole, as well as a reduction in the number of people injecting in public.^{66,64}

Despite the positive evaluations, Insite has come under political attack from Canada's Conservative government, which came into office during the course of the original three-year pilot phase.⁶⁷ The failure of the government to commit to renewing the exemption to the drugs laws allowing Insite to operate without risk of criminal prosecution were met with significant advocacy by harm reduction and HIV/AIDS advocates, drug user organisations and others, and attracted intense criticism during the 2006 International AIDS Conference hosted in Toronto. The result was a series of short extensions to Insite's exemption, the most recent of which is due to expire in June 2008.⁶⁵

The failure of the government to grant a permanent exemption has been severely criticised by harm reduction advocates. The Canadian HIV/AIDS Legal Network, for example, called it 'an irresponsible policy decision that's based on ideology rather than on evidence ... that is simply not in the public interest'.⁶⁸ Although the International Narcotics Control Board (INCB)⁶⁹ and the US government⁷⁰ have criticised Canada for allowing Insite to operate, other Canadian cities including Toronto, Montreal and Victoria have indicated their interest in initiating SIFs.^{71,64}

Safer crack kits

In response to the risk of HCV transmission and other health problems associated with the smoking of crack cocaine and, in particular, the sharing of pipes and other equipment, a number of US and Canadian cities have introduced harm reduction programmes targeted at people who smoke crack.

In Canada, 'safer crack kits' were initially distributed in Toronto in the late 1990s by the Safer Crack Use Coalition as both an outreach tool and an HIV/HCV prevention intervention. In addition to health information, the kits typically include supplies such as glass pipe stems, rubber mouthpieces and metal screens to help prevent mouth injuries such as burns and cuts and to reduce the sharing of these items. The kits also often include condoms, lip balm and alcohol swabs.

As with the Vancouver SIF, Canada was criticised by the INCB for this health programme.⁶⁹ However, despite such criticism, safer crack kit programmes have expanded from Toronto to several major cities including Winnipeg, Ottawa, Vancouver, Halifax, Gatineau (Hull sector), Montreal and Guelph.⁷²

Safer crack kits also form part of the harm reduction response in the US. In 2006, the Beth Israel Medical Center Survey of US Needle and Syringe Exchange found that out of 150 responding programmes, 51 programmes (34%) stated that they had distributed safer crack use kits that year. Safer crack use kits are available from programmes in a number of US cities including New York City, Bridgeport, Hartford, Providence, Marin County, San Francisco, Seattle, Chicago, Los Angeles, Minneapolis and Albuquerque.³¹

* Canada also has a drug paraphernalia law (Criminal Code, Section 462.2) but the definition of 'instruments for illicit drug use' explicitly excludes 'devices' as defined under the Food and Drugs Act (Section 2), which is what exempts devices like syringes from being captured by the definition of drug paraphernalia, and hence permits pharmacists to sell them.

Treatment for drug dependence

Methadone maintenance was pioneered in the US in the mid-1960s, and has a long history of use for opioid substitution therapy (OST) in the country. In October 2002, buprenorphine was also approved for use by the Food and Drug Administration.⁷³ Despite this early leadership in OST, access in the US remains inconsistent, and is marked by geographical inconsistencies in service provision.

Historically, expansion of methadone programmes in the US has been hindered by restrictive licensing and control; misinformation about the nature of the treatment among local communities, health care providers and the public; and fears that methadone clinics would create centres for crime and drug trafficking.⁷⁴ Harm reduction advocates and service providers also identify stigma, lack of financial resources, lack of health insurance and a mistrust of the treatment system among service users as creating further barriers to optimum access.³¹ It was estimated in 2000 that only 20% of US heroin users were receiving methadone.⁷⁴

In Canada, methadone is legally approved for use by Health Canada's Therapeutic Products Directorate and is available in all provinces. Buprenorphine was approved in May 2007, and became available in December of that year.⁷⁵ Although the number of persons accessing OST has increased since licensing was transferred from federal to provincial control in the 1990s, the number of opiate-dependent persons accessing methadone remains low, and is estimated to be 25%.⁷⁶

A number of barriers have been identified to optimal access to OST in the country. Tight regulation of methadone and under-funding of methadone programmes have been identified as limiting the number of physicians and pharmacies providing OST; and the number of physicians licensed to prescribe OST varies widely from province to province.⁷⁷ For example, it was reported in 2005 that there was only one physician in Newfoundland prescribing methadone, and the provincial health ministry was experiencing difficulty in recruiting physicians to staff a newly opened methadone clinic.⁷⁸ In New Brunswick in 2007 there were more people on the waiting list for methadone (628) than there were on the province's methadone programme (624), forcing people to travel to the neighbouring province of Nova Scotia to access treatment.⁷⁹

Restrictive rules and assessment procedures for patients, such as mandatory daily visits for dispensing, and abstinence as a condition of treatment (enforced through random urine testing), have also been identified as creating barriers to people accessing or remaining in OST programmes.⁷⁷

Both the US and Canada have non-OST drug dependence treatment available, including detoxification, inpatient and outpatient rehabilitation, psychosocial support (group and/or individual, professional, self-help, twelve step) and supportive housing, among others. However, in both countries, services are insufficient to meet the need.

Commenting in 2002 on the provision of drug treatment services in the US, the CDC noted that, 'A gulf exists between the number of people who want or could benefit from substance abuse treatment and the number of people who actually receive services'.⁸⁰ A recent study of people who inject drugs in 94 major cities across the US found that the percentage of people accessing treatment varied from 1.1 to 39.3%, with only nine cities reaching a coverage rate greater than 20%.⁸¹

Targeted HIV prevention, treatment and care

Although HIV prevention, treatment and care services are available in the US and Canada, stigma and discrimination against people who use drugs create barriers to access for this population in both countries. According to the Harm Reduction Coalition in New York, 'Pervasive stigma towards drug use among health care providers results in unequal treatment for people with a history of drug injection, leading to sub-optimal care. HIV-positive people who inject drugs face high barriers to medical care and antiretroviral treatment, and increased mortality from AIDS-related illnesses and other causes, including liver disease and overdose'.⁸²

VCT is available throughout North America, including anonymous HIV testing in many (but not all) US states and Canadian provinces. Research in the US has shown, however, that uptake of VCT is very low among people who inject.⁸³ Current barriers to increasing access for people who inject drugs include stigma and discrimination and the legal framework regarding illicit drugs.

In Canada, for example, it has been noted that people who use drugs often hesitate to use health services, including HIV testing, for fear that their drug use will be discovered and that they will face prosecution. Some also fear jeopardising their custody of their children if they are identified as people who use drugs.⁸⁴

Community-based outreach in HIV prevention programmes specifically targeting people who use drugs exist in both countries, including programmes run by and for people who use drugs. A number of US and Canadian cities have developed mobile harm reduction units that provide syringe exchange, condoms, VCT and other health-related services to street-involved populations of sex workers and people who use drugs. However, significant gaps still exist. Harm reduction advocates identify the need for interventions to address issues such as race, ethnicity, culture, gender, sexual orientation, age and socio-economic status in order to increase accessibility.

ART is available throughout North America, and approximately 268,000 people in the US and 21,000 people in Canada are receiving treatment.⁸⁵ A recent study of HIV prevalence among people who inject drugs in large metropolitan areas in the US, from 1992 to 2002, concluded that some HIV prevalence increases were at least in part due to increased access to life-prolonging ART.²⁰

However, in both the US and Canada, studies have shown that people who inject drugs are less likely to be receiving ART than people who do not use drugs.^{86,87} Although there are no explicit policies that exclude people who inject drugs from accessing ART, misconceptions and uncertainties among health care workers often manifest in a reluctance to prescribe to this group.

In Canada, the largest and most active group of people who use drugs is the Vancouver Area Network of Drug Users (VANDU), formed in 1997. In 2003, VANDU received funding from the Canadian government to assist drug users in local communities across the country to build capacity to form organisations. At present, groups of people who use drugs have been formed in Montreal and in Kingston, Ontario. There is also impetus to establish groups in the cities of Edmonton and Calgary.

In recent years, drug user representatives have been invited to participate in policy consultations at the local, provincial and national levels, including those leading the national action plan on HIV and AIDS. However, according to the Canadian HIV/AIDS Legal Network, 'meaningful participation of people who use drugs remains limited in shaping Canada's response to drugs and to HIV and HCV'.⁸⁸

In the US, extreme and punitive law enforcement policies and practices have made public drug user organising more difficult. However, advocacy still takes place in various locations and in various forms. Advocacy groups of people who use drugs have been organised at various times in New York, Oakland, Philadelphia and Denver. For example, in 2005, Voices of Community Advocates and Leaders (VOCAL) was founded in New York City as a membership-led body of 'drug users, those who identify with drug users and allies', which 'organizes as a movement for the education, prevention and treatment of HIV/AIDS and Hepatitis C (HCV) and sound public policies affecting drug users'.

Many more groups work less openly in order to avoid repression, or are active under the umbrella of local harm reduction programmes and services. Indeed, much of the activism around needle exchange provision in the US has involved significant participation and leadership from people who use drugs.⁸⁹

There was an effort made in the late-1990s to create an umbrella group of drug user advocates in both the US and Canada, called the North American Users Union, however that initiative is no longer active.

Targeted HCV prevention, treatment and care

In the US, it has been reported that an increasing number of health care settings are integrating HCV care into their programmes and services. These include primary health-care providers, methadone and drug treatment programmes and infectious disease clinics. In 2002, the National Institutes of Health updated its HCV treatment guidelines to include people actively injecting drugs, as well as methadone patients, as potential candidates for treatment.⁹⁰

People who inject drugs constitute the largest proportion of those living with HCV in the US, and yet research has shown that 'a disproportionately low number of people who inject drugs have actually received antiviral therapy for HCV'. This poor access to treatment exists despite the fact that a large proportion of people who inject drugs are interested in entering HCV treatment.⁹¹ A number of barriers have been identified in this regard, including a

lack of access to general health services among this population as well as a lack of funds or medical insurance.⁹²

In Canada, efforts to reach people who inject drugs with HCV services have largely been integrated into existing HIV and STI programmes. Despite this, 'most Canadian communities have no access to HCV-related services'.⁹³ HCV treatment access guidelines have been described as 'restrictive'. In 2005, it was reported that only 20% of all people living with HCV are indicated for treatment, with only 8% actually receiving it.⁹³ Although people who use drugs are not considered ineligible for treatment, treatment barriers similar to those described in the US have been reported.

Harm reduction in prisons

Neither the US nor Canada has implemented a comprehensive harm reduction response to address the issues of HIV, HCV and injecting drug use in prisons, as neither country has implemented NSPs in prisons. However, many more harm reduction components have been implemented in Canadian than in US prisons.

All fourteen Canadian jurisdictions provide voluntary HIV testing, and a small number also offer anonymous HIV testing.⁹⁴ Most prison systems provide condoms. Ten jurisdictions provide methadone maintenance, at least to those people who were on treatment before being incarcerated. Federal prisons, as well as provincial prisons in British Columbia, Ontario, Prince Edward Island and Saskatchewan, will also initiate OST. Three jurisdictions provide bleach for cleaning injecting equipment.⁹⁵

Few US prison systems have implemented harm reduction measures. Although several large, urban jails, including the Los Angeles and San Francisco County Jails, and one state prison system make condoms available, less than 1% of all US prisons do so.⁹⁶ Methadone provision is rare in US prisons. A small number of states (Rhode Island and Maryland) provide methadone in some prisons, as do a handful of county jails in states such as New York, Florida, California, New Mexico, Washington and Pennsylvania. Buprenorphine is currently being piloted in Rikers Island prison in New York.⁹⁷

Policies for harm reduction

In October 2007, the US's extension of its national strategy on HIV prevention contained the objective to 'increase the proportion of people who inject drugs who abstain from drug use or, for those who do not abstain, use harm reduction strategies to reduce risk for HIV acquisition or transmission'.⁹⁸ In addition, the 2001 National Hepatitis C Prevention Strategy supports harm reduction. According to the plan, achieving the goal of reducing HCV incidence 'requires: 1) harm reduction programs directed at persons at increased risk for infection to reduce the incidence of new HCV infections'.⁹⁹ However, the US National Drug Control Strategy does not support harm reduction.

In Canada, the Federal Initiative to Address HIV/AIDS in Canada is supportive of harm reduction.¹⁰⁰ In addition, a national framework developed through a multi-year, multi-stakeholder process explicitly includes measures such as NSPs, OST, SIFs and the greater involvement of people who use drugs.¹⁰¹

Canada's previous national drug strategy included harm reduction as one of its four pillars. However, the current Conservative government has shown hostility to harm reduction programmes¹⁰² and the new National Anti-Drug Strategy does not include it.¹⁰³

The new policy marks a shift away from harm reduction towards more enforcement and punishment. For example, the government has recently tabled legislation to introduce mandatory minimum sentences for drug offences, a punitive approach which the Canadian HIV/AIDS Legal Network has described as a 'proven failure'.¹⁰⁴

Several Canadian provinces support harm reduction in policy, including British Columbia, Ontario and Nova Scotia, and most other provinces and territories fund and have guidelines on specific harm reduction interventions such as NSPs and OST.⁹⁵

A number of North American civil society organisations advocate nationally (and in some cases internationally) for harm reduction approaches. These include the Canadian HIV/AIDS Legal Network and the Canadian Harm Reduction Network in Canada, as well as the Harm Reduction Coalition and the Harm Reduction Project in the US. In addition, the North American Syringe Exchange Network (NASEN) focuses specifically on supporting the existence and scale up of NSPs in the region.

There are also several organisations advocating for greater access to quality Hepatitis C prevention, testing and treatment for people who use drugs in North America.

The US government provides financial and technical support for HIV prevention, treatment and care through the President's Emergency Plan for AIDS Relief (PEPFAR) to levels exceeding any other national government. However, PEPFAR funds are not permitted to be used for NSPs and although OST programmes can be supported by these funds, PEPFAR guidelines only allow OST to be provided to people living with HIV.¹⁰⁵

The US government has continually opposed harm reduction in international forums such as the Commission on Narcotic Drugs (CND). This was reiterated at the CND 51st Session in March 2008, where the US delegation expressed its opposition to harm reduction, claiming that it encouraged drug use.¹⁰⁶

The Canadian International Development Agency supports harm reduction initiatives such as HIV prevention, treatment and care for people who use drugs, as well as drug treatment services in countries such as Georgia, Russia, Ukraine and Vietnam.

Multilateral support for harm reduction

There are no multilateral organisations currently providing technical or financial support for programmes focusing on HIV and AIDS in the US or Canada.

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Regional Overview

Oceania



AVAILABILITY OF NEEDLE AND SYRINGE EXCHANGE PROGRAMMES AND OPIOID SUBSTITUTION THERAPY

- Both NSP and OST available
- OST only
- NSP only
- Neither available
- Not Known

HARM REDUCTION IN OCEANIA

Country/territory with reported injecting drug use	People who inject drugs ¹	Adult HIV prevalence amongst people who inject drugs	Adult HCV prevalence amongst people who inject drugs ²	Harm reduction response			
				NSP	OST	SIF ^b	HIV and HCV programmes targeted towards people who inject drugs ^a
Australia	163,000 or 73,800 recent injectors ³	circa 1% ⁴	41–60%	✓	✓	✓	✓
Fiji	131	nk	nk	x	x	x	x
New Zealand	31,000	2% ⁴	70% ⁵	✓	✓	x	✓
Papua New Guinea	7,500	nk	nk	x	x	x	x
Timor Leste	105	nk	nk	x	x	x	x
American Territories: Guam and American Samoa	nk	nk	nk	x	x	x	nk

nk = not known

^a These services include, amongst others, voluntary HIV testing and counselling; HIV prevention, treatment and care; hepatitis C testing and treatment; STI prevention and treatment; information, education and communication.

^b Safer Injecting Facility

Oceania is home to more than 34 million people⁷ with over 1,200 languages and dialects. The region, made up of an estimated 7,500 to 10,000 islands, comprises twenty-four countries, including Australia, New Zealand and the Pacific Islands. Many Pacific Island Countries and Territories (PICTs) have economies heavily reliant on migration, remittances, aid and bureaucracy (known as MIRAB economies).^{8,9} Migration and rural–urban drift influence the demographics of these islands which have relatively young populations. In some countries, over 40% of the population are under fifteen years old.¹⁰ Australia and New Zealand experience relatively strong economies and a high standard of living, although huge disparity exists, particularly between the indigenous and non-indigenous populations.^{11,12}

DRUGS IN THE REGION

Production and transshipment

Pacific Island nations are relatively new states (most obtaining their independence within the last thirty years) and as such are still in the process of developing legislative systems and strengthening law enforcement capacities.¹³ This situation, alongside political instability, geographical isolation and close proximity to both major drug producing countries (Asia and South America) and high demand consumer countries (Australia and New Zealand) creates an ideal setting for illicit drug transshipment routes.¹⁰ A high volume of cargo transiting between Australia, New Zealand and Asia through the Pacific Island region brings opportunities for the smuggling of illicit drugs.¹³

In the Oceania region, the majority of seizures have been in Australia and New Zealand,¹⁴ the end point of the trafficking trade routes. However, there is evidence that some countries are used as a gateway, with recent reports of large seizures of heroin, methamphetamine and cocaine in Fiji, Vanuatu and Tuvalu.^{10,15}

There is also evidence that some countries are being used as drug production centres, such as Fiji, which in 2004 saw the dismantling of the largest methamphetamine laboratory in the southern hemisphere.¹⁶ Cannabis is a significant cash crop for some PICTs, especially Papua New Guinea (PNG) and to a lesser extent Fiji.¹⁷ Concerns have been raised that profits from these ventures could be diverted into the production of methamphetamine.^{13,15} As demonstrated in other regions, this could lead to an increase in the availability of illicit drugs in the local drug markets.¹⁷

Drug use

Due to insufficient or a lack of formal surveillance systems, little information exists on illicit drug use in PICTs, but a picture of the situation can be formed using local observations. While alcohol is the most commonly used drug overall,¹⁸ cannabis is the most widely used illicit drug¹⁷ and the traditional or ritualistic use of drugs such as betel nut and 'kava' have been a part of Pacific Island culture throughout history. Illicit drugs are thought to have been introduced to many of the nations by expatriates and colonisers.¹⁰

There is anecdotal evidence of 'shabu' smoking (the local term for methamphetamine) and the ready availability of benzodiazepines in Timor Leste.¹⁷ There is thought to be substantial use of heroin, methamphetamine (usage is increasing) and cocaine in the Federated States of Micronesia, but the route of administration is undocumented.^{19,15} The illicit use of prescription medication has also been reported in Fiji, PNG, Samoa and Tonga, as has the use of cocaine in PNG.¹⁷

Poly-drug use is common in New Zealand and is reported to be increasing in Australia as people are shifting away from sole use of heroin or methamphetamine.²⁰ The Illicit Drug Monitoring System found that the most commonly used illicit drugs by frequent poly-drug users in New Zealand are cannabis, ecstasy, methamphetamine, LSD and opiates.²¹

In Australia, the most commonly used illicit drugs are cannabis, amphetamine-type stimulants (ATS) and analgesics for non-medical purposes. Use of heroin and benzodiazepines as well as limited cocaine usage is also reported. Other 'party drugs' such as ketamine, MDA, GHB and hallucinogens such as 'magic' mushrooms and LSD are also available. 'Chroming', or the use of inhalants such as petrol, glue or paint, is common among certain key populations such as young people, juvenile detainees and indigenous people in rural and remote communities, but is generally rare outside of these groups.^{22,23} There is a reported increase in the illicit use of opioid pharmaceuticals such as oxycodone, especially in areas where heroin is difficult to purchase or when there may be a flux in the quality of the heroin available. It is also reported that benzodiazepines and cannabis are often used to aid in 'coming down' from certain ATS.

Alcohol

According to a major international review by the World Health Organization (WHO), the Western Pacific Region has seen 'recent and continuing increases in alcohol consumption'. The situation varies across Oceania, with under one litre of pure alcohol consumed per capita in the Federated States of Micronesia and the Solomon Islands to much higher levels in French Polynesia (7.68 litres), New Caledonia (7.83 litres), Australia (9.19 litres) and New Zealand, which has the highest recorded alcohol consumption in the region at 9.79 litres per capita.²⁴

These population-wide figures, however, mask the high levels of adult alcohol abstainers across the region (especially among women), including those in the Marshall Islands (66.3%), the Federated States of Micronesia (67.6%), Kiribati (73.1%) and Fiji (88.7%).²⁵ In Australia, alcohol use is very unevenly distributed, with 17.5% of adults abstinent in the last year, 13.4% classed as heavy episodic drinkers²⁶ and well-documented alcohol use and associated harms among Aboriginal communities.²⁷ It is reported that nearly 23% of indigenous Australians use alcohol to levels considered 'risky', whereas this figure is 10% among non-indigenous Australians.²⁸

It is also important to note the existence of 'dry communities' where prohibition of alcohol is enforced by the Australian Federal Police. Targeted towards remote indigenous communities in parts of Northern Australia, this localised alcohol control policy remains a contentious political issue, particularly as anecdotal evidence suggests that non-indigenous Australians in the same area are able to circumnavigate the policy.²⁹

Unrecorded alcohol consumption must also be considered, including home-brewed beverages such as 'kava' in the northern areas of Australia as well as throughout the PICTs, 'toddy' in Kiribati, 'jimanum' in the Marshall Islands and 'jungle juice' in PNG.²⁵

Amphetamine-type stimulants (ATS)

Oceania sees the highest ATS usage in the world at 2.5% of the regional population. Australia is reported to be the country with the second highest methamphetamine usage globally. New

Zealand has seen an increase in methamphetamine use since 2005,³⁰ but recent data indicate that this has levelled off and may be declining.²¹

These levels may be linked to the geographical proximity of Myanmar, the world's foremost producer of 'amphetamine tablets', and China, the world leader in crystal methamphetamine or 'ice' production as well as a source of pre-cursor chemicals.³¹ Methamphetamine is reported as the main drug of concern for 11% of people accessing treatment in Australia.²²

There are a number of territories in the region where significant ATS use is reported. In the US territories of Guam, the Commonwealth of the Northern Mariana Islands (CNMI) and, in particular, the island of Saipan, 'ice' (crystal methamphetamine) is reported to be the most commonly used drug.³¹ The cost of illicit substances in Guam and CNMI, including ATS and heroin, is significantly higher than in the mainland US, and as the islands are conveniently located close to the large-scale producer countries, they may be seen as a favourable destination for the drugs.³² The cost of 'ice' in Guam and CNMI, for example, is approximately seven times the purchase price in the US.¹⁹

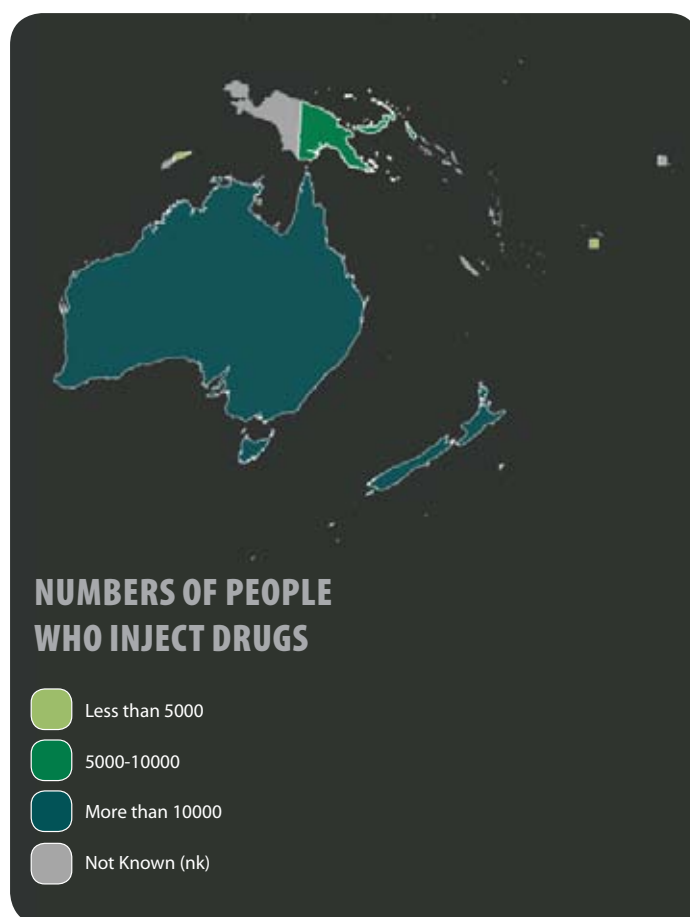
Heroin

With its proximity to Asia and the primary opiate-producing countries, Australia has access to high-grade 'China white' heroin. There have also been recent reports of less-refined, brown Afghan heroin entering the market.³³ Heroin was reported as the main drug of use for 17% of people in closed treatment episodes in Australia,²² and a recent survey found that heroin was the most commonly reported drug of choice among people who inject drugs.²⁰ Within the large numbers of people emigrating from South-East Asia to Australia, it is reported that many heroin users in this group make the transition from smoking heroin, or 'chasing the dragon', to heroin injecting.³⁴

In New Zealand, research indicates there to be between 10,000 and 15,000 people who use opioids either daily or almost daily.³⁵ There are reports of heroin use in the Federated States of Micronesia and to a lesser extent in Palau, although the route of administration remains unknown.^{15,17} There is also evidence of heroin use in CNMI and the Solomon Islands.⁹ South-East Asian heroin as well as 'black tar' Mexican heroin is reportedly found in Guam, and heroin use here is thought to be more common among tourists than locals.³²

Injecting drug use

There are over 163,000 people who inject drugs in Australia, including 73,800 people who are 'recent' injectors (those that have injected in the last twelve months).²² The number of young people injecting is reported to have fallen in recent years.³⁶ Heroin was briefly surpassed by methamphetamine as the most commonly injected drug in Australia following the 'heroin drought' of 2000 to 2002,³⁷ but in recent years has again become the most commonly injected drug, with 52% of people who inject reporting it as the main drug of choice in one national study.²⁰ Injection of morphine and oxycodone has increased in recent years, and there have been reports of other drugs such as ATS, cocaine, methadone, buprenorphine, benzodiazepines and even alcohol being injected, particularly in rural or regional areas.^{36,38}



Map 7.2: Numbers of people who inject drugs in Oceania

There are an estimated 31,000 people who inject drugs in New Zealand. The most commonly injected drugs are opioids and to a lesser extent ATS, including methamphetamine. The 2006 Illicit Drug Monitoring System found that the use of heroin and other opiates, as well as pharmaceuticals such as benzodiazepines and Ritalin, is more pronounced among people who inject drugs than those who consume drugs by other means. One-third of frequent methamphetamine users reported injecting the drug within the last six months.²¹

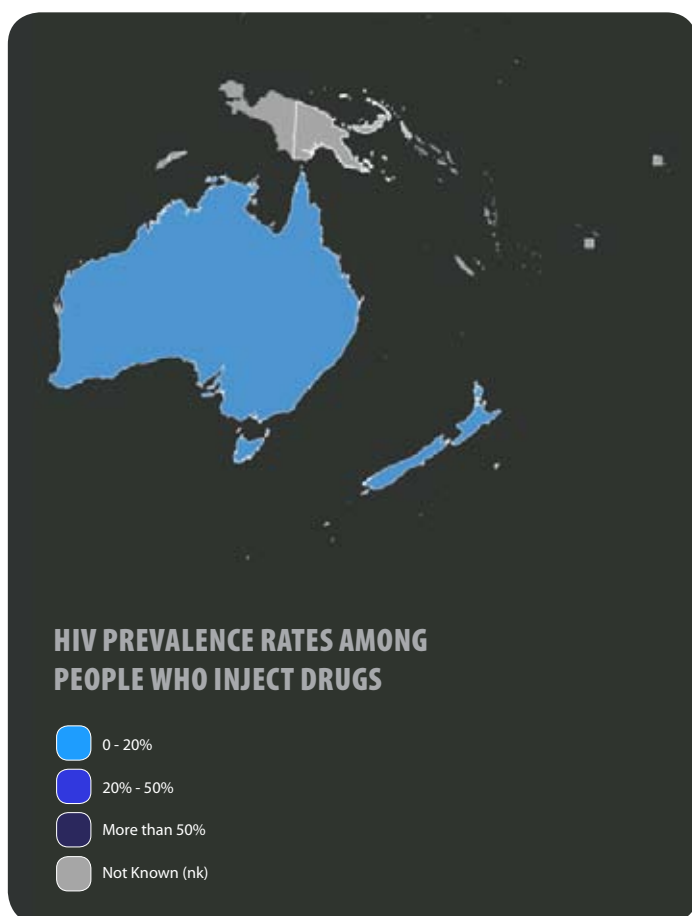
Little is known about the prevalence of injecting drug use in the PICTs as there is a lack of reliable surveillance systems in place. Injecting has been reported in six PICTs including Fiji, Timor Leste, PNG,¹ as well as Guam, Marshall Islands and American Samoa.³² Although there are an estimated 7,500 people who inject drugs in PNG, there is little research in the area. Anecdotal evidence of injecting was reported on the border of the Indonesian province of Papua.³⁹ There is reported to be an increase in the transition from methamphetamine smoking to injecting in the more affluent Guam and CNMI.¹⁰

Drug-related harms

HIV and AIDS

There are estimated to be 75,000 people living with HIV in Oceania, 70% of whom live in PNG,⁴⁰ which has the highest national HIV prevalence in the region at 1.3%.⁴¹ Fiji is reported to have the second highest HIV prevalence of the PICTs.⁹ A significant number of HIV cases have been reported in Guam, French Polynesia and New Caledonia.⁴² Niue and Tokelau are the only two islands in the Pacific region where no HIV cases have been recorded.⁴²

Heterosexual sex is reported to be the primary route of transmission in all PICTs, and alcohol use has been linked to HIV transmission in some islands.^{18,41}



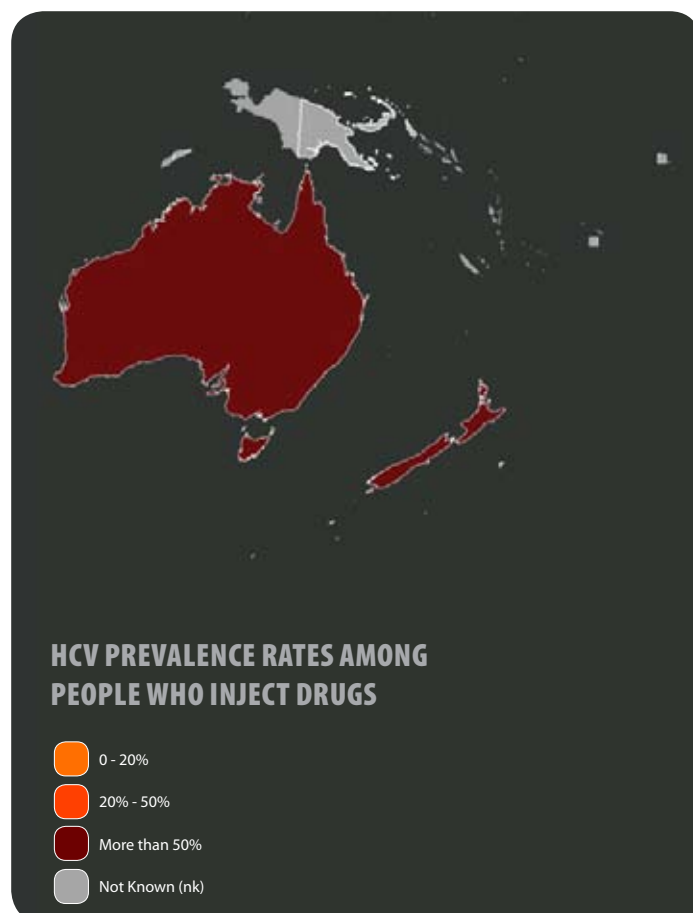
Map 7.3: HIV prevalence among people who inject drugs in Oceania

Overall, sex between men continues to be the main route of HIV transmission in Australia and New Zealand, which both have low national HIV prevalence rates of 0.1%,^{43,44} though the number of new HIV diagnoses in Australia has increased by 31% since 2000.⁴⁵ There are huge disparities between HIV prevalence rates in indigenous and non-indigenous communities in Australia, which are particularly pronounced for women. Indigenous Aboriginal women are eighteen times more likely to be HIV positive than non-indigenous women.³⁸ However, in New Zealand, HIV incidence appears to be low among both the indigenous and non-indigenous populations.

As there is little injecting drug use reported in the PICTs, no data were found on HIV prevalence within these small to non-existent groups. In Australia and New Zealand, HIV prevalence among people injecting drugs is relatively low, which is often cited as testament to the success of harm reduction programming in these countries.

In New Zealand, HIV case monitoring data indicate that 3.6% of HIV cases reported a history of injecting drug use in 2003 and no cases did in 2007.⁵ In Australia, HIV prevalence rates among people who inject drugs (and who have attended NSPs) have remained stable in recent years at around 1%, accounting for around 8% of all new HIV diagnoses.⁴⁵ However, HIV prevalence as high as 32.2% has been reported among males who inject drugs, access NSPs and 'report homosexual identity'.^{46,45}

HIV transmission attributed to injecting is reported to have increased from 5 to 18% within Australia's indigenous communities over the last two decades.⁴⁵ HIV prevalence is also reported to have increased in recent years among Australian-Asian people who inject drugs, especially those of South-East Asian descent.^{47,34} Low HIV prevalence rates are consistently reported among female sex workers, regardless of injecting drug use.⁴⁸



Map 7.4: HCV prevalence among people who inject drugs in Oceania

Hepatitis C virus (HCV)

WHO data in 1999 indicated that Kiribati had the highest HCV prevalence rate in the PICTs at 4.8% when compared to the other available estimates for the Federated States of Micronesia (1.5%), Solomon Islands and Vanuatu (0.9%) and PNG (0.6%).⁴⁹ No information on HCV prevalence among people who inject drugs is available for the PICTs.

The same WHO report stated that Australia and New Zealand both had national HCV prevalence rates of 0.3%.⁴⁹ An estimated 271,000 people live with HCV in Australia, with up to 16,000 new diagnoses occurring annually.^{45,50} Despite the success of harm reduction interventions in maintaining low HIV prevalence rates among people who inject drugs, HCV prevalence rates are very high among this group in both countries. In Australia, HCV prevalence rates among people who have ever injected drugs (and have accessed NSPs) has recently increased, in both indigenous (from 62% in 2002 to 70% in 2006) and non-indigenous (from 56% in 2002 to 60% in 2006) groups.⁵¹

Approximately 80% of existing HCV infections and 90% of new HCV infections in Australia are attributable to unsafe injecting

practices, a proportion similar to New Zealand, where 70% of people who inject drugs are living with HCV.^{6,50} In both countries, people who have been injecting for six to twelve months are susceptible to the virus, and in Australia young female injectors are particularly vulnerable.^{45,52} In Australia, HCV prevalence is higher among those who report heroin than among those who report methamphetamine as the last drug injected.⁵³ Although statistically there has been a noticeable decline in HCV prevalence among young Australians who inject drugs, it is important to consider that fluctuations in the numbers accessing services and receiving HCV tests may also affect this.^{53,47}

Drug use and its related harms in prisons

Palau has the highest imprisonment rate in the region,* followed by Samoa and New Zealand.⁵⁴ Alternatives to custodial sentences for drug offences exist in Australia and Guam,⁵⁵ which have drug courts in place. New Zealand has also piloted a youth drug court. The main objective of drug courts is to divert drug offenders away from prison and into alternatives such as compulsory treatment. In Australia, electronically monitored home detention bail, vocational training and intensive courses of compulsory treatment, including urinalysis, are also given as alternatives to incarceration (though this varies by state).⁵⁶

HIV and HCV prevalence within PICT prisons is unknown and there is no available information on the existence of previous injecting drug use among prisoners. In Australia, HIV prevalence in prisons is 0.1%, which is the same as the national HIV prevalence rate outside prisons.⁵⁷ This figure is not available in New Zealand. In both countries, HCV prevalence among prisoners appears to be higher than among non-prisoners. In New Zealand, 5.8% of all prisoners are living with HCV.⁶

An Australian national study found that 59% of prisoners had a history of injecting drug use and that HCV prevalence among this group was 56%.²⁸ New Zealand's 2005 prisoner health survey found one in three prisoners diagnosed with one or more communicable disease(s), including HCV. In a separate study, 80% of prisoners with a history of injecting were living with HCV.⁶ HCV prevalence is significantly higher among female Australian and New Zealander prisoners than their male counterparts.⁵⁷

Indigenous people make up a disproportionately large section of the both Australian and New Zealand prison populations. In Australia, indigenous people are thirteen times more likely than non-indigenous persons to be in prison.⁵⁸ Maori peoples make up around half of the total New Zealand prison population.⁵⁹ It is likely that HIV and HCV prevalence rates are elevated among indigenous prisoners in New Zealand and Australia.

THE RESPONSE

Harm reduction services

Needle and syringe exchange programmes (NSPs)

There is no evidence that needle exchanges exist in the PICTs, and it is unknown whether needle and syringes can be easily purchased. In Australia and New Zealand, NSPs are legal and outlets have been increasing since their initial establishment in the 1980s.^{60,61} The generally low HIV prevalence among people who inject drugs is attributed to the early implementation of such programmes.⁴⁸

There are estimated to be more than 3,200 NSPs (including pharmacy-based NSPs) in Australia and New Zealand, and community-based outreach, although limited in some areas, is used.^{60, 61} Needle and syringes are available to purchase in pharmacies,⁶⁰ though, as reported in other regions, this may not be a viable option for some, due to cost, discrimination from pharmacy staff and/or stigma and anonymity issues.⁴⁷ It is not illegal to obtain syringes for illicit drug use from registered NSPs or to carry used syringes in Australia (with the exception of Western Australia). In New Zealand, having syringes sourced from NSPs is a defence against charges of carrying syringes.⁶⁰ Australia and New Zealand are also among the few countries in the world that distribute pill or 'wheel' filters through some NSPs, which reduce harms such as abscesses and damage to veins by further filtering substances prior to injecting.⁶²

In New Zealand, over two million syringes are distributed per year, amounting to sixty-five syringes per injector per year.⁶³ In Australia this figure is 195 (NSPs under government auspices only),⁶⁴ one of the highest rates in the world, yet insufficient to ensure that every injection is carried out with new and sterile equipment.

Australia is often considered to set the world standard for needle and syringe provision, but there are still difficulties faced by some in accessing NSP services, including the cultural inappropriateness of services, lack of 24-hour outlets, lack of services in rural or regional areas, lack of availability in prison settings and staff attitudes in some settings.^{38,47} Low population density may also be a barrier to NSP coverage in New Zealand, although there are mobile NSP services. Fear of police harassment and law enforcement operations are also barriers in some areas, despite the existence of policies in some states and territories to protect people from being searched in the vicinity of NSPs.³⁴

There are low numbers of Australian indigenous people accessing NSP services, with reports of many obtaining equipment through relatives or friends who do access NSPs or who are diabetic.³⁸ There are also thought to be low numbers of new injectors accessing NSPs, with many obtaining needles and syringes through dealers or peer networks.⁴⁷ It is important therefore to ensure comprehensive risk reduction programmes are in place for people who may not be in contact with harm reduction services such as NSPs.

It is more than ten years since there has been a national HIV awareness programme specifically targeting people who inject drugs in Australia, and there are concerns that prevention messages are not reaching youths or new injectors.⁴⁷

Both New Zealand and Australia have needle and syringe vending machines, which increase the accessibility of sterile injecting equipment when NSPs or pharmacies do not operate, though numbers could be increased.⁶⁰

Safer injecting facility (SIF)

Australia is home to a single SIF, located in Sydney.⁶⁵ Melbourne was also prepared to house a similar facility, but numerous factors, including local opposition and a change in government, prevented the already built SIF from opening and halted plans to establish four additional sites.^{66,67}

* Figures were not found for other US territories in Oceania.

Treatment for drug dependence

Opioid substitution therapy (OST) is not available in the PICTs. Methadone and buprenorphine are both legal in Australia and New Zealand, with around 42,000 people receiving OST (3,000 to 3,500 of whom are in New Zealand).⁶⁸ The main barriers to accessing OST in both countries are availability, accessibility and costs of the programme, as well as fear of stigma.

It is reported that a significant proportion of potential OST consumers in Australia are not able to access OST when needed.⁴⁷ This could be due to a lack of prescribing doctors and dispensing pharmacists, particularly for those living in remote areas. OST in Australia and New Zealand is provided largely by pharmacies, which can have inconvenient dosing times. There are also often restrictions placed on takeaway doses, factors which together can make OST access difficult for those who work standard hours, seek employment or have children.

Methadone, buprenorphine and buprenorphine-naloxone are all subsidised by the Australian government, but pharmacies require a daily dispensing fee from customers, ranging from AUD2.50 to AUD12.00.⁴⁷ This fee has been cited as a principal reason for people deciding to leave an OST programme. Methadone is free in New Zealand, but buprenorphine is not yet subsidised.³⁵

Confidentiality and anonymity may be compromised when accessing OST at a pharmacy, particularly in smaller communities. In Australia, people may be concerned about inclusion on OST registers (lists of people who have accessed or are accessing OST), as the purpose of these registers, who has access to them and how to remove names from them are not made clear to OST consumers.⁴⁷

Heroin prescription trials have been debated in Australia's parliament for over ten years, but so far there has been no implementation.⁶⁹

A diverse range of non-OST drug treatment is available in Australia and New Zealand, though as with OST programmes there are often waiting lists and limited placements available. There is limited non-OST drug treatment available in Fiji⁷⁰ and Guam, where it is reported that there are large waiting lists, as a result of court orders.⁷¹ In Fiji, PNG and the Solomon Islands, treatment options for people who use drugs are limited to psychiatric wards or hospitals.⁷⁰

Targeted HIV prevention, treatment and care

Voluntary HIV counselling and testing (VCT) is available in both Australia and New Zealand for people who inject drugs. VCT is also available in some PICTs, but services are limited and there is no information available to indicate that people who inject drugs are accessing this service.⁷² The quality of VCT programmes in the PICTs remains questionable as there are reports of a lack of confidentiality and low levels of uptake from key populations.⁹

People who inject drugs and who are living with HIV have access to antiretroviral treatment (ART) in both Australia and New Zealand, although access to this treatment requires scaling up.⁷² In general, HIV service providers require further training in the specific needs and issues pertaining to injecting drug use. For example, health care workers are sometimes unable to inform or educate their clients of the interactions between ART and illicit drugs, OST or HCV treatment medications. Furthermore, the stigma and

discrimination that people who inject drugs may experience in the general health care system is also felt within HIV services.⁴⁷ In PICTs, it is reported that people living with HIV have poor or restricted access to ART.⁷³

Targeted STI prevention programmes to reach people who use drugs and their sexual partners exist in Australia and New Zealand, as well as targeted condom distribution programmes, and information, education and communication on HIV.⁷⁴

Targeted HCV prevention, treatment and care

New Zealand has an official government policy on HCV prevention, testing and treatment. In practice, NSP peer educators reach people who inject drugs with HCV prevention through community-based outreach.

In Australia, there are national best practice guidelines for HCV testing and treatment. However, drug user groups still receive negative reports from people living with HCV about the quality of HCV service provision. There are reports of a lack of pre- and post-test counselling, and that people are offered HCV tests at times when it may be difficult to refuse, for example upon initiation of OST or when first entering treatment. HCV-related discrimination reportedly exists across Australia's health care sector.^{47,75} Access to HCV treatment is government subsidised and costs around AUD30 a month for six to twelve months of treatment. It is estimated that as little as 1% of people living with HCV are accessing HCV treatment.⁵⁰

There is no evidence of HCV prevention, treatment and care interventions that are targeted towards people who inject drugs in the PICTs.

Harm reduction in prisons

Harm reduction services in prisons vary throughout Oceania, from limited HIV prevention, treatment and care in PICT prisons, to more substantial services in Australia and New Zealand. Prison needle and syringe exchange programmes do not exist in any prisons in the region.

In both Australia and New Zealand, disinfectants for cleaning syringe and tattoo equipment are available in some facilities, although access is reported to be limited.^{76,77} Methadone and buprenorphine maintenance treatment is available in most Australian prisons as well as naltrexone in a more limited capacity.⁷⁸ In New Zealand, OST is provided to those prisoners that were receiving it prior to incarceration but is not yet initiated in prisons, although this policy is under review.³⁵

VCT and ART are available in some PICT prisons, although the same barriers and lack of access to these programmes that exist outside prison are thought to exist to an even greater extent inside prison. A recent UNGASS country report stated that condom availability is included in prison policy in some PICTs.³⁹

VCT and ART are also available in prisons in Australia and New Zealand. In Australia, it is reported that very high levels of people opt to receive voluntary HIV and HCV testing and counselling upon prison admission, which may raise concern about the 'voluntary' nature of the tests, and whether there are perceived or actual negative consequences of opting out.⁵⁷ Condoms are available in a limited number of prisons in both countries.⁷⁹

Policies for harm reduction

The Pacific Regional Strategy on HIV/AIDS 2004–2008⁸⁰ does not mention illicit or injecting drug use or harm reduction. Drug legislation, based on the Illicit Drug Control Bill, now exists in Tonga and Fiji.⁸¹ Most PICTs have HIV action frameworks or national strategic plans, although funding for the implementation of these plans is limited.⁷³

Both Australia and New Zealand are explicitly supportive of harm reduction in both their domestic⁸² and international policies.^{82,83} Although Australia has been considered a leader in harm reduction policy since the early 1980s, funding for harm reduction interventions is still limited. Law enforcement receives up to 85% of the federal budget allocation for 'harm minimisation' (the official Australian government policy encompassing harm reduction, demand reduction and supply reduction).⁸⁴ New Zealand also addresses harm reduction in its national drug strategy (under the guise of 'problem limitation') and allocates funds to the implementation of harm reduction programmes.⁸²

As well as being recognised as a key population within New Zealand's domestic policy, a more comprehensive health strategy exists pertaining specifically to Maori, which mentions drug use and sexual health, although not harm reduction and HIV specifically.⁸⁵ Similarly, Australia has the National Aboriginal and Torres Strait Islander Peoples Complementary Action Plan, a supplement to its National Drug Strategy 2003–2006 that specifically addresses harm reduction, injecting drug use, HIV and HCV. Both governments provide funding to drug user organisations and these as well as other civil society organisations often play a significant role in policy development processes.⁸⁶

Multilateral support for harm reduction

Several multilateral agencies are funding HIV and STI-related initiatives in a number of PICTs, including UNAIDS, UNICEF and WHO. In 2006, French Polynesia, Nauru and New Caledonia were the only PICTs where multilateral agencies were not providing financial support.⁹ A number of initiatives are targeted towards key populations such as sex workers and men who have sex with men, but no available information indicates the presence of initiatives specifically focused on harm reduction or injecting drug use in the PICTs.

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) also has a presence in the region with funds directed to general HIV initiatives in eleven out of the twenty PICTs, without a focus on harm reduction or injecting drug use.

Australia's foreign aid and development programme (AUSAID), invests heavily in harm reduction programmes for people who inject drugs in Asia, and is also involved in HIV/AIDS prevention activities in the PICTs, especially in PNG, although without any explicit mention of harm reduction or injecting drug use in the region.^{39,82} New Zealand's foreign aid programme, NZAID, is also similarly supportive and committed to harm reduction throughout Asia and is funding UNICEF-led HIV initiatives in some PICTs.⁹

A multitude of civil society organisations are involved in harm reduction policy and advocacy at a variety of levels, in both Australia and New Zealand. Some of the principal organisations working at national and regional levels are the Australian National Council on Drugs (ANCD), Australian Drug Foundation (ADF), Australian Needle Exchange Network (ANEX) and the Centre for Harm Reduction (which is highly involved in harm reduction projects throughout Asia). Australia also has a national level drug user organisation, Australian Injecting and Illicit Drug Users League (AIVL), as well as a drug user organisation for each individual state and territory,^{**} which have regular involvement in both state and federal government policy. In New Zealand, drug user groups operate several NSPs⁸⁶ and there are organisations committed to policy and advocacy such as the New Zealand Drug Foundation and Needle Exchange New Zealand.

Some of the countries most affected by HIV and AIDS, such as Fiji, Guam, French Polynesia and PNG, have NGOs that focus on HIV prevention, treatment and care, though it is not known if these organisations specifically address injecting drug use or harm reduction.⁷³ Christian NGOs play a large role in HIV prevention in the PICTs, and some are reported to be very conservative in their approach.⁷³ Recently a new network has been launched, the Pacific Island Drug and Alcohol Research Network (PDARN), spearheaded by Australia's Centre for Harm Reduction.

* Australia elected a new Labor Party government in November 2007, which, at the time of publication, had not yet released its drugs strategy. It is predicted that harm reduction will be included as it has been written into Australian government policy since the early 1980s.

** Canberra Alliance for Harm Minimisation and Advocacy (CAHMA); Network Against Prohibition Northern Territory (NAPNT); New South Wales Users and AIDS Association (NUAA); South Australian Voice in IV Education (SAVIVE); Users Association of South Australia (UASA); Victorian Drug Users Group (VIVAIDS); Western Australia Substance Users Association (WASUA); Queensland Injectors Health Network (QUIHN); and Tasmanian Council on AIDS, Hepatitis and Related Diseases (TasCAHRD).

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Regional Overview

Middle East and North Africa



AVAILABILITY OF NEEDLE AND SYRINGE EXCHANGE PROGRAMMES AND OPIOID SUBSTITUTION THERAPY

- Both NSP and OST available
- OST only
- NSP only
- Neither available
- Not Known

HARM REDUCTION IN MIDDLE EAST AND NORTH AFRICA

Country/territory with reported injecting drug use	People who inject drugs ^{b 1}	Adult HIV prevalence amongst people who inject drugs ²	Adult HCV prevalence amongst people who inject drugs ³	Harm reduction response		
				NSP	OST	HIV and HCV programmes targeted towards people who inject drugs ^a
Algeria	40,961	nk	nk	X	X	Limited targeted HIV prevention
Bahrain	674	nk	81% ⁴	X	X	X
Egypt	88,618	0.6% ^{b,5}	nk	✓	X	X
Iran	240,000 ⁶	12% ⁶	35% ⁶	✓	✓	Targeted VCT, condom distribution, limited IEC and STI prevention, 125 people who inject drugs are receiving ART ⁷
Iraq	34,673	0	nk	X	X	X
Israel	9,000 ²	1–3% ⁸	54%	✓	✓	Targeted HIV programmes exist. 12% of the total ART recipients are people who inject drugs ⁹
Jordan	4,850	4.2% ^c	nk	X	X	X
Kuwait	4,100	0	nk	X	X	X
Lebanon	3,300	7.8%	5% ^d	✓	✓	Limited targeted HIV prevention
Libya	7,206	0.5–59.4%	nk	X	X	X
Morocco	18,500	nk	nk	✓	X	Limited targeted HIV prevention
Oman	500–1,000 ¹⁰	14% ¹⁰	31.1% ¹⁰	✓	X	Limited targeted HIV prevention
Palestine	1,850	nk	nk	✓	X	X
Qatar	1,190	nk	nk	X	X	X
Saudi Arabia	23,600	nk	69% ⁴	X	X	X
Syria	6,000	0.3% ^c	60.5%	X	X	X
Tunisia	13,163	0.3% ^c	nk	X	X	X
UAE	4,800	nk	nk	X	X	X
Yemen	19,700	nk	nk	X	X	X

nk = not known

a These services include, amongst others, voluntary HIV testing and counselling; HIV prevention, treatment and care; hepatitis C testing and treatment; STI prevention and treatment; information, education and communication.

b Among males who inject drugs.

c Figure previous to 1998.

d Non-national estimate – capital city.

Over 309 million people live in the Middle East and North Africa,¹¹ a region comprising eighteen countries and the Occupied Palestinian Territories (hereafter referred to as Palestine). Economically it is a very diverse region, ranging from wealthier nations such as Israel, United Arab Emirates (UAE) and Saudi Arabia, to poorer nations such as Yemen.¹² A number of countries are currently or have recently been affected by conflict, and the region remains politically important largely due to the export of oil and oil-related products. The majority of the region's population follows Islam, and the most widespread languages are Arabic (varying in dialect across different countries) and French (in North Africa).

DRUGS IN THE REGION

Cultivation, production and transshipment

Morocco is the world's foremost producer of cannabis resin and remains the main source of the drug for the consumer market in Western Europe.¹³ Khat, an amphetamine-like stimulant, is cultivated in Yemen predominantly for domestic use, which is widespread. There are recent reports of impoverished farmers in southern Iraq beginning to cultivate opium poppy fields.¹⁴

Many Middle Eastern and North African countries form part of the opiate trafficking routes originating in Afghanistan, the world's foremost opiate-producing country. Political instability in conflict-affected countries, strong black-market trade routes and easy access by air, land and sea are all factors which increase the ease of drug transshipment in the region. Iran is the country most affected by drug smuggling as it provides a corridor into the Middle East and North Africa, Central Asia or Western Europe. Iran sees 68% of the world's opium seizures.¹³ To a lesser extent, Oman and UAE are beginning to experience more drug smuggling, with heroin destined for Europe and North America via East and West Africa.¹⁵

Drug use

Information on drug use is limited as surveillance of this kind is not established in many countries. Reported alcohol consumption rates across the region suggest very low usage,¹⁶ with zero official consumption in three countries (Kuwait, Libya and Saudi Arabia), and per capita consumption below one litre of pure alcohol per year for all but five of the others. The exceptions are Bahrain (2.63 litres), Israel (1.99), Lebanon (4.13), Oman (1.32) and UAE (2.75). Data were unavailable for Palestine.

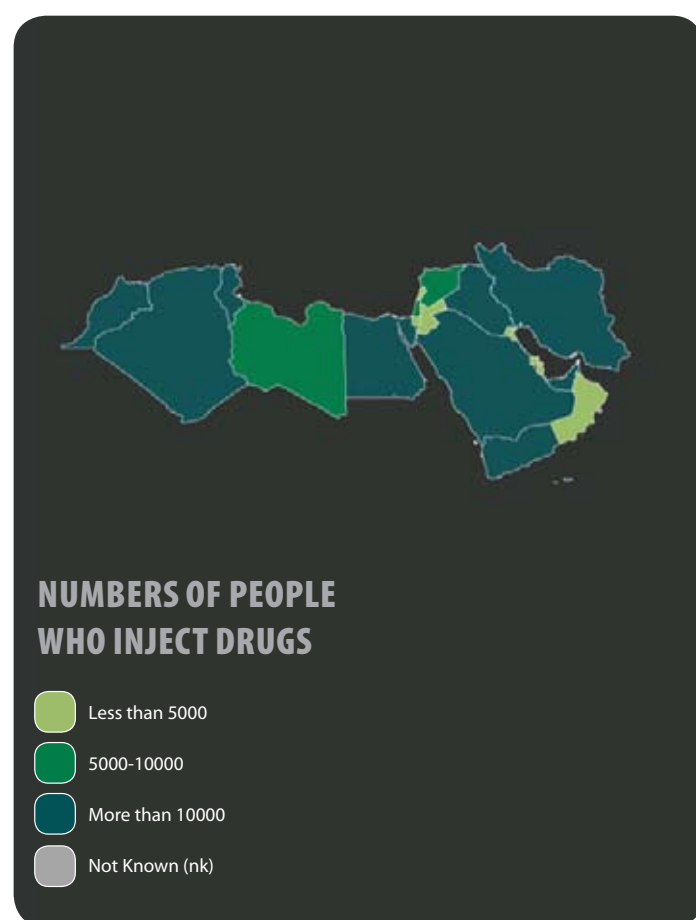
These low consumption rates may be due to the majority Muslim populations, high levels of self-reported abstainers across the region and the common policy responses such as bans on alcohol consumption for Muslim residents or total prohibition with severe penalties (in Iran, for example, death sentences have been imposed).¹⁷ However, the figures may also reflect under-reporting due in part to the stigma associated with alcohol use in the region.¹⁸

Cannabis or hashish smoking is reported to be the most prevalent drug use in the region. The use of Khat is highly prevalent in Yemen, and to a lesser extent in other countries of the Arabian Peninsula.¹⁹ Cocaine use is reportedly increasing in Morocco, but as yet cocaine injecting is not reported. In Israel, the use of cocaine, LSD, amphetamine and tranquilisers is reported.¹³ Opiate use is reported in many countries, and is prevalent in Iran, where over 1.2 million people smoke, inject or ingest opiates.¹³ Non-injecting drug use has not been highlighted as linked to the transmission of either HIV or HCV in Middle Eastern and North African countries.

Opiates

There has been a considerable increase in the number of people who use opiates in recent years, best documented in Iran, where opium smoking has historical and traditional roots dating back to Ancient Persia. The fall of the Taliban in neighbouring Afghanistan, and the political instability that followed, allowed for a rise in opiate production. As a result, Iran has seen an increase in the availability of both opium and heroin. Over 1.2 million people (2.8% of the population) are reported to use opiates in the country.¹³

In Iran and surrounding countries, opium smoking is considered medicinal by many people, and where public health systems have been disrupted by war and conflict it provides an easily attainable remedy for illness. Heroin is also easily available in many countries.



Map 8.2: Numbers of people who inject drugs in the Middle East and North Africa

Injecting drug use

The country in the region with the highest number of people who inject drugs is Iran, where the latest estimate places the number of injecting drug users at 185,000.¹ However, a national research centre has suggested this figure to be low, and estimates there to be approximately 240,000 people injecting, based on averaging data from multiple sources.⁶ After Iran, the countries in the region with the largest numbers of people injecting drugs are Egypt (88,618), Algeria (40,961) and Iraq (34,673).¹

The overwhelming majority of Iranians who inject drugs are males living in urban areas and more than half are above thirty years of age.²⁰ Similarly, in Oman, it is reported that over 90% of people who

inject drugs are male. Disaggregated information is not available in any other countries in the region.

Heroin is the most commonly injected drug in every country in the region, although it is not the only substance injected. In Iran, for example, there are also reports of buprenorphine, opium and benzodiazepines being injected, although these are much rarer than heroin injecting. In Oman, there are rare cases of barbiturates being injected. In Palestine, tranquilisers are sometimes injected. In Qatar and UAE, the injection of heroin and other opiates is reported. In Syria, diazepam is an injected drug.¹⁰

Injecting drug use is increasing in several countries. For example, sources in Kuwait identified a huge rise in both injecting and other drug use following the Iraq war.¹⁰ In Iraq itself, the status of injecting drug use is unclear as political instability and conflict have severely disrupted the health care system and surveillance mechanisms. Several factors in the country could contribute to an increase in drug use, including weaker border controls, potentially allowing more drugs to enter from neighbouring countries, as well as the beginnings of opium poppy cultivation in some areas.¹⁴ Injecting drug use is also increasing in Bahrain, Egypt, Iran, Syria and Yemen.

Conflicting reports make it difficult to establish whether injecting drug use is increasing or decreasing in Saudi Arabia. The only countries where decreases in injecting drug use are reported are Lebanon and Morocco.¹⁰

Drug-related harms

HIV and AIDS

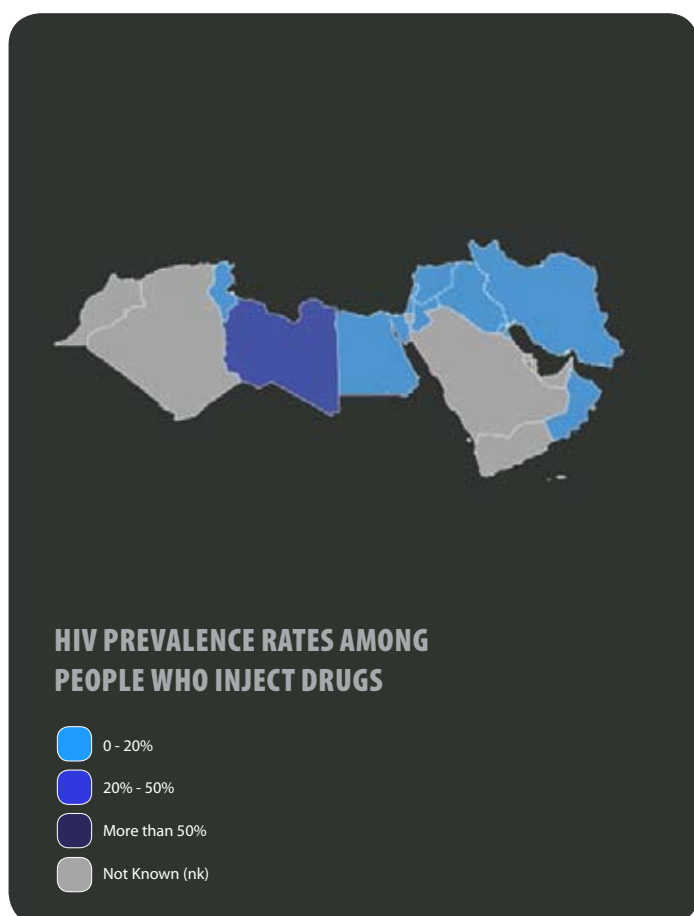
HIV and AIDS surveillance in the Middle East and North Africa is very limited. UNAIDS data show that HIV prevalence remains low; in 2006, the number of people living with HIV in this region was estimated to be 61,900.²¹ Men who have sex with men and people who inject drugs, both highly criminalised populations in this region, are more affected by the epidemic. Injecting drug use is a significant route of HIV transmission in Iran and Libya, and has contributed to HIV epidemics in Algeria, Israel, Morocco, Syria and Tunisia.²²

HIV prevalence rates among people who inject drugs are not available in six countries in the region, and those that are available are, in most cases, not very recent. Low HIV prevalence is reported among people who inject in Iraq (0%)² and Egypt (0.6% among males).⁵ Higher prevalence is found in Iran (12%)⁶ and Libya (up to 59.4%).²

Further insight into the extent to which HIV affects people who inject drugs can be gained from HIV case reporting. In Libya, for example, over 90% of HIV cases are attributable to injecting drug use. In Bahrain, this figure is reported to be 73%.²³ In Tunisia, 34% of reported HIV cases are attributed to injecting drug use.²⁴ This figure is lower in Algeria (18.4%),²⁴ Israel (16%),²⁵ Lebanon (8.5%)²⁶ and Morocco (5%).⁴ Although the Egyptian National AIDS Program reports consistently low HIV prevalence rates, injecting drug use is a significant risk factor and is the mode of HIV transmission in 6% of cases.²⁷

Across the region, injectors most affected by HIV are men who live in urban areas. In Palestine, those who return after travelling to other Arab and Western countries are reported to be more affected by HIV. Although HIV prevalence among people who inject drugs remains low in this region, several studies have found the sharing of injecting equipment to be common, for example in Algeria,²⁸ Lebanon²⁹ and Morocco.³⁰

The paucity of information on injecting drug use and HIV in some countries could be attributed to low levels of HIV transmission among somewhat small numbers of people who inject drugs. However, government reluctance to commission research or publicise information on these two highly stigmatised issues may equally be masking the true extent to which people who inject drugs are affected by HIV.¹⁰



Map 8.3: HIV prevalence among people who inject drugs in the Middle East and North Africa

Drug use and its related harms in prisons

Iran, where there are estimated to be over 150,000 people incarcerated in 200 prisons (excluding juvenile facilities),³⁴ has the highest prison population in the region.¹⁰ The country with the highest recorded imprisonment rate is UAE, and Iraq is reported to have the highest number of prison facilities (over 1,000).³⁴

Drug-related crimes are reported to represent three-quarters of all crimes committed in Israel.¹³ Libya is the only country for which there is an available estimate of the number of prisoners with a history of injecting drug use (approximately 60%).³⁵ However, as is the case in other regions where drug-related offences receive severe penalties, it is likely that a large proportion of prisoners are serving sentences for drug use as well as other drug-related offences.

Nine countries in the region impose the death penalty for drug-related offences. Executions for drug offences have taken place in Egypt, Iran, Kuwait and Saudi Arabia.³⁶ In Bahrain, Iran and Qatar, individuals receive mandatory sentences for drug offences. There are alternatives to custodial sentences for drug offences (12 countries)[†] and compulsory or coercive treatment is also used (13 countries).[‡]

In many countries, estimates of HIV prevalence within prisons are not available. Some estimates are not markedly different to reported national HIV prevalence rates, for example in Iran (2%), Lebanon (0.7%), Morocco (0.7% among male prisoners), Oman (0.2%) and Syria (0–0.2%).³⁵ However, evidence of increased HIV prevalence rates among prisoners has been reported in Yemen (26.5%),³⁷ UAE (18.4%, figure from 1998) and Libya, where anecdotal evidence suggests that HIV prevalence among people who inject drugs in prison may reach 60%.³⁵

Data on hepatitis C prevalence among prisoners are only available for Iran,[§] where the rate is reported to be 18.7%.^{38,39} More research is necessary to establish the extent to which HCV affects prisoners in this region. This is particularly important in countries with extremely high national HCV prevalence such as Egypt.

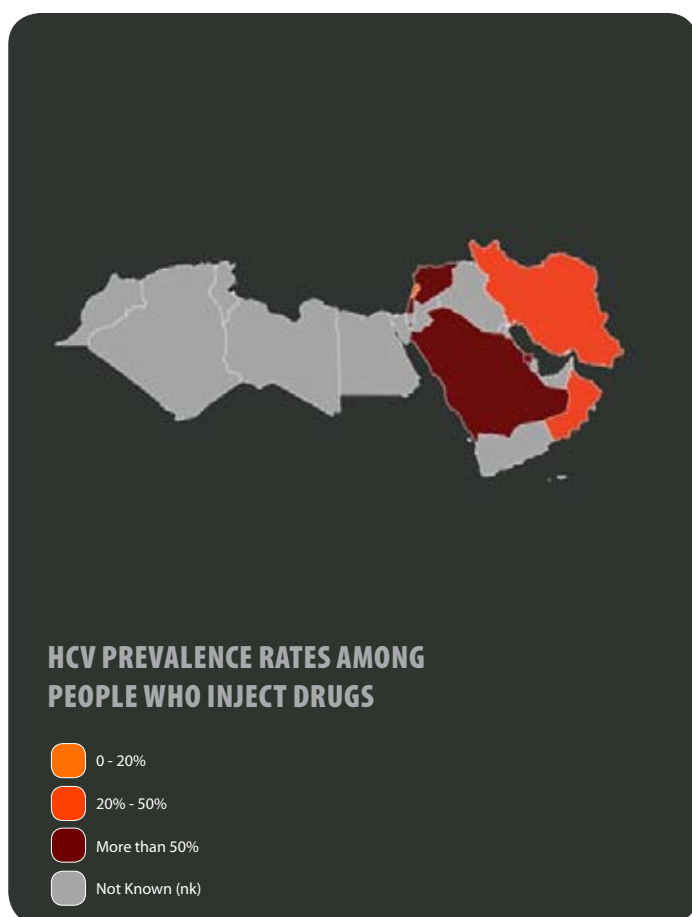
THE RESPONSE

Harm reduction services

Needle and syringe exchange programmes (NSPs)

NSPs operate in seven countries in the region: Iran, Israel, Oman, Morocco and small-scale syringe distribution is carried out in Egypt, Lebanon and Palestine.⁴⁰ In Morocco, civil society organisations are in the process of developing an NSP outreach strategy.⁴¹ In Iran, an estimated 1.4 million needles and syringes were distributed by 120 NSPs and 150 peer outreach teams in 2007. Based on an estimated 240,000 people who inject drugs in the country, this equates to almost six syringes per person in 2007, which is insufficient.

Many people cannot or do not access NSPs for various reasons. These include limited access due to few outlets and outreach teams, lack of awareness of the risks associated with sharing injecting equipment, lack of awareness of available services, inconvenience of regular attendance at services as well as fear of



Map 8.4: HCV prevalence among people who inject drugs in the Middle East and North Africa

Hepatitis C virus (HCV)

According to the WHO in 1999, national HCV prevalence was low in much of the region. Algeria, Iraq, Israel, Oman, Tunisia and UAE all had low HCV prevalence (less than 1%), while Jordan, Kuwait, Qatar, Saudi Arabia and Yemen had slightly higher HCV levels (between 1% and 4%). Egypt had the highest reported national HCV prevalence, regionally and globally, at 18.1%.³¹

Information on HCV prevalence among people who inject drugs is not available for most countries in the region,^{*} but, where reported, the data reveal high levels of HCV. In particular, very high HCV prevalence is reported among people who inject in Bahrain (80%),⁴ and high HCV levels are also reported in Iran (35%).¹⁰

Iranian research indicates that certain characteristics and behaviours are correlated with a positive HCV test, including being an older person who has been injecting for a number of years, having a history of imprisonment and men who report having had sex with other men.^{32,33} Most HCV cases have been reported in large cities, in particular Iran's capital city Tehran.

* Algeria, Egypt, Iraq, Jordan, Kuwait, Libya, Morocco, Palestine, Qatar, Tunisia, UAE and Yemen.

† Bahrain, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Morocco, Oman, Qatar, Saudi Arabia and Tunisia.

‡ Bahrain, Egypt, Iran, Iraq, Jordan, Kuwait, Morocco, Oman, Qatar, Saudi Arabia, Syria, Tunisia and UAE.

§ Estimate derived from two prison studies in 1999 and 2000 with a total of 567 prisoners.

becoming registered as someone who injects drugs and having this information shared with police. In Iran, those who are also receiving drug treatment from a Drug Intervention Centre (DIC) are given a card to show that they are accessing harm reduction services. This card can be used to protect from arrest for being an illegal 'addict'.¹⁰

In Israel, there are pilot NSPs in three major cities,⁴² and Morocco and Oman both have one NSP site each. This is clearly not enough to reach the 9,000, 18,500 and 500–1,000 people who inject drugs in each country respectively. Even in Iran, where the number of NSPs has been increasing in recent years, there are still not enough to reach all those who need this service.

Several factors hinder the scale up of NSPs and other harm reduction interventions in the region. The NGO sector often plays a large role in NSP service delivery, but in Iran and Oman there are limited NGOs working with harm reduction in their remit. There are restrictive regulations that limit the extent to which NGOs and other actors can become involved in service provision in both these countries. In Iran, the NSPs in existence are reported to have difficulties in both attracting and maintaining staff. In general, there is limited awareness of injecting drug use and the effectiveness of harm reduction at the governmental level. It is not prioritised and, as a result, there are limited funds and capacity within national and provincial bodies for the implementation and monitoring of interventions.

In several countries (Egypt, Iran, Iraq, Jordan, Lebanon, Morocco and Syria), injecting equipment can be purchased from pharmacies, but, as in other regions, stigma and criminalisation of people who inject drugs may make this very difficult in practice. In Yemen, the sale of needles and syringes in pharmacies is prohibited. In Oman, despite the prohibition of pharmacy sale being lifted in 2003, no pharmacy actually sells injecting equipment.

Treatment for drug dependence

Methadone is illegal in at least three countries (Jordan, Saudi Arabia and Syria) and regulatory barriers exist in most of the other countries in the region. Although some countries (Bahrain, Lebanon and Oman) use opioid substitution therapy (OST) in detoxification from heroin and other opiates, maintenance therapy is only available in Iran, Lebanon and Israel. Fifteen years ago, methadone maintenance treatment (MMT) was available in Oman, but this was discontinued following regulatory issues such as diversion and unsupervised prescription of take-home doses.¹⁰ In Morocco, authorisation has recently been given for methadone to be used.⁴¹

Iran has the most extensive OST provision, which has been scaled up rapidly in response to a growing HIV epidemic among people who inject drugs. There are now estimated to be 654 OST sites in Iran, made up of 130 public and 350 private treatment centres, 120 drug intervention centres (DICs) and 54 prisons. In 2007, it was estimated that 18,500 people in public treatment centres, 20,000 people in private treatment centres, 7,000 people in DICs and 10,910 prisoners were receiving MMT. Approximately half of these people inject drugs; the majority of the remaining OST clients are heroin smokers, followed by opium takers and smokers.¹⁰ A recent report estimated that there were 60,000 people receiving methadone and 6,500 receiving buprenorphine in Iran.⁴³ The provision of OST is so widespread and its necessity so ingrained that following the Bam earthquake in 2003 emergency supplies for survivors included methadone.

In Israel, methadone and buprenorphine maintenance therapy are available,⁴⁴ and it is reported that a pilot heroin prescription programme may be established.⁴⁵ Some longer-term clients receiving OST are given take-home doses of methadone, which means that daily attendance at a clinic or pharmacy is not necessary.⁴⁶

OST is also available in Lebanon via one NGO-based OST site providing buprenorphine maintenance therapy to less than twenty clients.⁴⁷ The Lebanese government has plans to expand this service.

In the countries where OST exists, there are several barriers to accessing it. In Lebanon, in addition to the cost barrier (approximately USD60 per week) the scale of OST provision is so limited that very few people are able to benefit. In Iran, OST sites do not exist throughout the country and are therefore inaccessible to some due to distance, however the main barrier is reported to be cost. Two-thirds of treatment centres are private clinics and therefore charge a daily fee for dispensing OST. There is also a charge to receive treatment in public centres, although this is much lower. While there are limited places in the DICs that provide access to OST free of charge, they are often full to capacity. There is also a lack of awareness of OST and the availability of services among people who use drugs in the region, and it is reported that some people hold legitimate fears of confidentiality breaches at treatment centres.¹⁰

In Iran, although OST service provision has been rapidly scaled up in recent years, there are barriers to further increasing this coverage. These are reported to include a lack of interest among physicians and others in the health sector to work in the field of drug dependency; limited funds to subsidise OST provision for those who cannot afford to pay for it; limited capacity of national and provincial bodies for planning, implementing and monitoring interventions; and restrictive regulations that make it difficult for other sectors (including NGOs and academic institutions) to provide services.¹⁰

In countries where OST is not yet provided, there are several challenges to establishing these services and initiating a harm reduction approach. Many countries are poor, politically unstable and/or in conflict or post-conflict situations. As a result, many have relatively weak health-care services that require significant strengthening to enable provision of comprehensive harm reduction services. The predominant response to drugs in this region has been to tackle drug supply rather than the health implications of drug use and, as such, punitive law enforcement has been the dominant approach.

Establishing the extent of drug use and the harms related to drug use has not been prioritised by governments. As a result, there are very limited surveillance systems in place to monitor trends, which in turn renders planning the response difficult. In most countries in the region, drug use is considered an antisocial, immoral behaviour in opposition to religious beliefs. Therefore, drug dependence treatment, where it exists, promotes an abstinence-based approach rather than a harm reduction approach.

Other (non-OST) drug dependence treatment is available in at least sixteen countries. Iran has the highest number of people accessing non-OST treatment, estimated to be 100,000.¹⁰ Algeria, Bahrain, Lebanon, Saudi Arabia⁴⁸ and Egypt⁴ have all had over 1,000 people registered in drug dependence treatment at one time since 1998.

The form, location and extent of treatment choice vary within the region. For example, in Yemen it is reported that no specific drug treatment centre exists. Oman has one facility based in a psychiatric hospital unit, while Egypt, Morocco and Iran all have many non-OST drug treatment options. Most countries fall somewhere in between. In Iran, these include outpatient and inpatient detoxification with or without clonidine, herbal medicine, psychosocial approaches, twelve-step focused self-help groups and therapeutic communities.

Limited inpatient and outpatient detoxification and rehabilitation services within, or attached to, psychiatric hospitals are available in countries including Algeria, Bahrain, Iraq and Kuwait. Some of these services also include psychosocial support and counselling. In many countries, traditional models are being used for detoxification and long-term residential rehabilitation. This response is predominantly led by the mental health sector and overseen by law enforcement. In Bahrain, where one psychiatric hospital (Al-Moayyed) houses a drug rehabilitation centre, it is reported that any other hospital, health centre or private practitioner is prohibited from treating alcohol or drug use problems. A two-year detoxification and rehabilitation programme in UAE explicitly states that people living with HIV are not permitted to join the programme.¹⁰

Targeted HIV prevention, treatment and care

Very few HIV programmes are designed to reach people who inject drugs in this region. They are largely limited to Algeria, Iran, Morocco and Oman, and they vary in scope. Although voluntary HIV counselling and testing (VCT) is available to people who inject drugs in at least seven countries, the extent to which they can access this service is unclear. In Iran, 7.4% of people who inject drugs are aware of their HIV status, and it is reported that legal, cultural and social restrictions limit VCT access for this key population.¹⁰ In Algeria, it is reported that 15% of 'problematic drug users' are aware of their HIV status and that, in general, HIV prevention knowledge within this group (including people who inject drugs) is low.²⁸ In Algeria, Morocco and Iran, HIV prevention programmes specifically target people who inject drugs.

Across the region (where estimates are available), the number of people in need of antiretroviral therapy (ART) exceeds 12,900,* but information on the numbers receiving ART is very limited.⁴⁹ A WHO review reported that 225 people in Oman and 49 in Tunisia were receiving ART at the end of 2006,⁴⁹ and a recent country progress report states that 246 people are receiving ART in Lebanon.²⁹

Although no country is reported to exclude people who inject drugs from receiving ART, information for most countries is not disaggregated to reflect the extent to which they have access to it. These data are only available for two countries. In Iran, 125 current or past injectors are receiving ART,⁷ and in Israel, an estimated 12% of the total ART recipients are past or current injectors.⁵⁰ While access may be limited for people who inject drugs in some countries, the lack of data should not lead to the assumption that this is the case throughout the region. In Bahrain, for example, where most people living with HIV are past or current injectors, the majority of those who need ART are currently receiving it.⁴⁰

Barriers to scaling up ART access for people who inject drugs in Iran include inadequate coverage of harm reduction services, which can provide referrals to ART providers, the need for increased VCT uptake, limitations of available ART medications, difficulties in

reaching criminalised and stigmatised communities and concerns held by health providers on treatment adherence.

Targeted HCV prevention, treatment and care

Information on the availability of HCV prevention, treatment and care programmes for people who inject drugs is very scarce in the region. Research has established that people who inject drugs have access to HCV testing in Iran and Oman and they are not excluded from HCV treatment provision in Iran.

Harm reduction in prisons

Iran is the only country in which NSP is available in some prisons. In five out of a total of 200 adult prisons, prisoners can access clean injecting equipment from 'Triangular Clinics', but it is reported that this service is rarely used. Iran is also the only country in the region where OST is available, with 54 large prisons providing MMT to 10,910 prisoners at the end of 2007.¹⁰

Condoms are available in conjugal visit rooms in all Iranian prisons, and 88 prisons also provide condoms on request from 'Triangular Clinics'. The same 88 prisons also offer VCT. Continuation of ART therapy is possible in some prisons, but only in one prison in Iran can ART be initiated. Testing for hepatitis C is available in the forty larger Iranian prisons, but treatment is not available in any prisons in the region.

Non-OST drug dependence treatment is available in all prisons in Morocco and Iran. In seven countries (Egypt, Iraq, Jordan, Oman, Palestine, UAE and Yemen), no drug treatment is available in prisons. Information could not be obtained for the remaining countries.

Drug policy shift in Iran

Prior to 1997, drug policy was strict in Iran, emphasising supply reduction and punishing drug use. This approach contributed to an increase in HIV among prisoners, particularly those who inject drugs. As much as 60% of prisoners were incarcerated due to drug convictions, and mandatory sentencing was the predominant approach. There was no alternative to imprisonment.

From 1997, Iranian government drug policies began to change. The current policy, while continuing a supply-reduction approach, also includes emphasis on harm reduction and drug treatment. The provision of harm reduction services, inside and outside prisons, and alternative facilities is now central to Iran's HIV response. This policy change was catalysed by advocacy and evidence from successful NGO and university-led harm reduction programmes, as well as close cooperation and common understanding between key stakeholders from various government departments. There is now a national harm reduction committee, which has representatives from various ministries, academic institutions and NGOs.¹⁰

* Data available for Egypt, Iran, Jordan, Lebanon and Morocco.

Policies for harm reduction

In general, the majority of Middle Eastern and North African countries do not currently include harm reduction in government policy on HIV or illicit drugs. The majority of countries have HIV action frameworks, some of which include mention of injecting drug use (Algeria, Iran, Lebanon, Morocco and Oman) and human rights (Algeria, Iran, Jordan and Morocco).

All countries in the region have legislation on drugs, and national policies or strategies on illicit drugs exist in twelve countries (Bahrain, Egypt, Iran, Iraq, Jordan, Morocco, Oman, Qatar, Saudi Arabia, Syria, UAE and Yemen). Harm reduction is included in drug and/or HIV policy in Iran, Morocco and Oman (although in the case of Oman this is limited to education on harms associated with drug use). Iran, Morocco, Oman, Egypt and Lebanon have all shown support for harm reduction in international forums.

The Middle East and North Africa Harm Reduction Association (MENAHRRA) was formed in 2007. This four-year regional project is an initiative of the WHO and IHRA, supported by the Drosos Foundation. It comprises three sub-regional knowledge hubs: the Iranian Centre for Addiction Studies in Iran, Soins Infirmiers et Développement Communautaire (SIDC) in Lebanon and Ar-Razi hospital in Morocco.

MENAHRRA aims to strengthen the role of civil society organisations in harm reduction in the region. It will provide direct support to civil society organisations to initiate or scale up harm reduction interventions, as well as supporting model programmes that demonstrate the feasibility of harm reduction services. In its first year, MENAHRRA focused on capacity-building, advocacy and information-sharing and is committed to creating an environment which is conducive to the implementation of life-saving harm reduction interventions.

An initial scoping report revealed that there are very few civil society organisations in the region focusing on harm reduction advocacy at the national level; these are currently limited to Iran, Lebanon and Morocco.

There are no drug user organisations in the region. Drug use remains greatly hidden within communities and people who use drugs are often deterred from accessing any health services for fear of being stigmatised and, in some countries, arrested. This stigma also silences the voices of people who use drugs in the region. They are not empowered to advocate for better access to services, or to be involved in the planning, implementation and monitoring of treatment provision to ensure their needs are met.

Multilateral support for harm reduction

Various initiatives of UNAIDS, WHO and UNODC focus on injecting drug use and HIV in this region, but multilateral support directly related to harm reduction policies or programmes is not extensive. Explicit support for harm reduction has come from WHO through the work of the Regional Advisory Panel on the Impact of Drug Use (RAPID), established in 2002, and the WHO Regional Committee for the Eastern Mediterranean (EMRO), which in 2005 passed a resolution on the 'substance use and dependence' in the region. This document urged member states to respond to 'the rise in injecting drug use in the Region' with a 'wide range of approaches and interventions' including 'harm reduction'.⁵¹

WHO EMRO has also been instrumental in the documentation of Iranian experiences in the rapid scale up of harm reduction programming and the promotion of this approach through regional advocacy. Along with WHO EMRO, the work of the UNODC Regional Office for the Middle East and North Africa (ROMENA) and UNAIDS contributes towards a conducive environment for harm reduction through support for drug use and HIV situation assessments, policy development and the design of interventions on HIV prevention, treatment and care for people who use drugs. A UNODC-supported project assessing HIV in prisons is planned for Algeria, Egypt, Jordan, Lebanon, Morocco and Palestine.⁴¹

At country level, several governments and civil society organisations are receiving support from multilateral agencies for initiatives related to HIV and drug use. For example, UNODC and UNAIDS, the World Bank, UNDP and WHO are providing technical and financial support to the government and/or civil society on activities related to harm reduction in Iran. Global Fund grants support the Iranian government and civil society to carry out HIV prevention, treatment and care work through harm reduction.

UNODC ROMENA is supporting governments and civil society on drug prevention, treatment and rehabilitation in several countries, including Algeria, Egypt, Jordan, Lebanon, Morocco and Palestine. For example, in October 2007, UNODC ROMENA launched 'Strengthening community resources in providing drug abuse treatment and rehabilitation for vulnerable groups in Jordan', which has among its objectives to increase access to community-based HIV prevention services for people who use drugs.⁵² In Morocco, UNAIDS is supporting the development of harm reduction advocacy workshops.⁴¹

While the issues of injecting drug use and harm reduction are being raised in several countries in the region, increased implementation of essential interventions, including NSP and OST, is necessary to have an impact on the HIV and HCV epidemics among people who inject drugs in the Middle East and North Africa.

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Regional Overview

Sub-Saharan Africa



AVAILABILITY OF NEEDLE AND SYRINGE EXCHANGE PROGRAMMES AND OPIOID SUBSTITUTION THERAPY

- Both NSP and OST available
- OST only
- NSP only
- Neither available
- Not Known

HARM REDUCTION IN SUB-SAHARAN AFRICA

Country/territory with reported injecting drug use ^b	People who inject drugs ¹	Adult HIV prevalence amongst people who inject drugs ²	Adult HCV prevalence amongst people who inject drugs ³	Harm reduction response		
				NSP	OST	HIV and HCV programmes targeted towards people who inject drugs ^c
Ghana	1,000	nk	nk	X	X	Largely non-existent in the region. Targeted HIV programmes, or drug treatment programmes referring people to HIV services, exist in Burkina Faso, Kenya, Mauritius, Mozambique and South Africa
Guinea	10 registered cases	nk	nk	X	X	
Kenya	0.3% of the male population ²	68–88% ³	nk	X	X	
Malawi	0–26 ^{d,4}	0 ^d	nk	X	X	
Mauritius	17,000–18,000 ⁵	nk	95% ⁶	✓	✓	
Niger	1,000	nk	nk	X	X	
Nigeria	5,000	nk	nk	X	X	
Somalia	1,000	nk	nk	X	X	
South Africa	16,000 ⁷	1–20% ⁸	7% ⁹	X	✓	
Sudan	37,828 ^e	nk	nk	X	X	
Tanzania	2,200 ¹⁰	nk	nk	X	X	
Zambia	6.7% of people accessing drug treatment ¹¹	<1% ¹²	nk	X	X	
Zanzibar	3.1% of adult drug using population ¹³	26.2% ¹³	22% ¹³	X	X	

nk = not known

a Due to difficulties in information gathering in the region, there are gaps in some of the data. These are particularly related to three East African countries (Madagascar, Rwanda and Ethiopia) and several Central and West African countries.

b Injecting drug use has also been reported in Angola, Benin, Burkina Faso, Cameroon, Cape Verde, Cote D'Ivoire, Djibouti, Ethiopia, Gambia, Liberia, Mali, Mozambique, Rwanda, Senegal, Seychelles, Sierra Leone, Togo, Uganda, and Zimbabwe. In the following countries, as yet there have been no official reports of injecting drug use: Botswana, Burundi, Central African Republic, Chad, Comoros, Democratic Republic of the Congo, Republic of the Congo, Equatorial Guinea, Guinea-Bissau, Gabon, Lesotho, Madagascar, Mauritania, Namibia, Rwanda, and Sao Tome and Principe.

c These services include, amongst others, voluntary HIV testing and counselling; HIV prevention, treatment and care; hepatitis C testing and treatment; STI prevention and treatment; information, education and communication.

d A recent rapid assessment found small numbers of people who inject drugs but none testing positive for HIV.

e This figure was coded 'D' by the Reference Group to the United Nations on HIV and Injecting Drug Use, indicating a lack of technical information to support the estimate. Country progress reports from north and south Sudan state that injecting drug use is not an issue in the country.

Over 754 million people live in the forty-seven countries that make up Sub-Saharan Africa.¹⁴ Countries in this region almost exclusively populate the lowest thirty on the human poverty index. The wealthiest countries are South Africa and Gabon.¹⁵ The vast majority of states are severely affected by poverty, many are politically unstable and several are currently in conflict or post-conflict situations. Swahili (or Kiswahili) is the most widely spoken non-European language, and there are over 2,000 local languages. English, French and, to a lesser extent, Portuguese are spoken in some countries.

DRUGS IN THE REGION

Cultivation, production and transshipment

Cultivation and production in Sub-Saharan Africa is mostly limited to cannabis and khat, which is legal in some parts of Africa. Much of the cannabis and khat is grown and consumed locally, for example in Tanzania¹⁶ and Kenya.²

In the past decade, West Africa in particular has become a major through-route for drug trafficking from Latin America to Europe. UNODC reports that thirty-three tons of cocaine have been seized in West Africa since 2005, a huge increase over prior figures, and more than had ever been seized in Sub-Saharan Africa previously.¹⁷ The largest seizures in 2007 occurred in Senegal, Mauritania, Guinea-Bissau, Cape Verde, Benin, Ghana, Guinea and Nigeria. Although trafficking cocaine via West Africa adds mileage to the transit route, poverty, political instability, weak law enforcement, corruption and, in some cases, conflict or post-conflict situations render the area ideal for drug trafficking.

As well as transit by air and sea, evidence suggests that the already established cannabis transit route from Morocco to Europe is now also being used to transport cocaine, with people travelling overland from West Africa to Morocco. A recent UNODC report highlighted the increasing cocaine trafficking in Guinea-Bissau, a country with linguistic ties to Brazil and Portugal, two important countries on global cocaine transshipment routes. The report indicated that the value of the drugs trade may be as high as the country's entire national income.¹⁷ UNODC estimates that about 27% of the cocaine that entered Europe in 2006 transited African countries.¹⁷

Drug trafficking is also reported in several countries in East and Southern Africa, including Kenya (although drug trafficking is believed to have reduced there in recent years) and South Africa, which provides the most lucrative cocaine market in Sub-Saharan Africa.¹⁸ Heroin enters Southern Africa largely through the 'Maputo Corridor' (from Maputo, Mozambique to Pretoria, South Africa), which functions as a conduit for heroin coming from Tanzania via Mozambique.¹⁹ Heroin trafficking from Afghanistan via East and West African countries to North America is also reported. Some seizures have been made in recent years, but these are very small in comparison to those made in other areas of the world.¹⁷

Drug use

There are limited data on the nature of drug use in Sub-Saharan Africa, apart from South Africa. In most countries, tobacco, alcohol and cannabis appear to be the most widely used substances. Data in West Africa show cannabis as the primary drug of use among people accessing treatment services.¹⁷ However, use of cocaine, heroin and methamphetamine has been reported in several countries. In Nigeria, heroin, cocaine and cannabis are

the most commonly used drugs.²⁰ 'Mandrax', a combination of methaqualone and antihistamine that has been prescribed as a sleeping tablet, is the second most commonly used drug in South Africa after cannabis.²¹ Increased use of methamphetamine (locally known as 'tik') is also reported, particularly among adolescents in Cape Town.²² Solvent use is reported in Uganda²³ and khat, also known as 'mairungi', is widely used in Kenya and other East African countries.²⁴

Alcohol

Recorded alcohol consumption is highly varied across Sub-Saharan Africa. Nine countries (Chad, Comoros, Guinea, Mali, Mauritania, Niger, Senegal, Sudan and Somalia) have some of the lowest levels of alcohol consumption in the world, and Somalia is one of only six countries globally with alcohol consumption recorded at zero. However, Burundi, Nigeria, Swaziland and Uganda have extremely high levels of alcohol consumption. Uganda has the highest recorded per capita rate of consumption in the world at 19.47 litres of pure alcohol. In addition, Gabon, Swaziland, Tanzania and Uganda have very high beer consumption levels.

Alcohol consumption is generally lower in East Africa (with the exception of Uganda) than in West and Southern Africa.²⁵ However, there is substantial unrecorded alcohol consumption in the region, including numerous home-brewed drinks and illicit alcohol. In East Africa, 'over 90% of alcohol consumed according to some estimates is unrecorded'.²⁶ In the Democratic Republic of the Congo, home-made liquor is becoming more widely consumed than beer, as the latter is expensive and often in limited supply.

There are also many countries that have high rates of adult lifetime abstinence, including Mali (95.6%), Mauritania (97.5%) and Senegal (94.4%).

At least nine countries (Benin, Comoros, the Republic of the Congo, Equatorial Guinea, Gabon, Gambia, Ghana, Guinea-Bissau and Togo) do not have age restrictions on alcohol purchases, and licences are not required for producing or selling all or some types of alcohol in Ethiopia, Gabon and Angola.²⁵

Cocaine

Cocaine is becoming increasingly available in Sub-Saharan Africa, largely due to the growing involvement of some countries in cocaine trafficking. Cocaine use is reported in several countries, including Burkina Faso, Ghana, Guinea, Kenya, Nigeria, Senegal, Sierra Leone, South Africa and Togo. Senegal and Guinea are seeing an increase in cocaine use and it is stable in both Nigeria and Burkina Faso. The use of crack cocaine has been reported in Nigeria, Ghana, Côte d'Ivoire and Gambia.

Cocaine use is most common in South Africa, where use has markedly increased in the past decade. In 2006, over 10% of people accessing drug treatment (including for alcohol use) named cocaine as the primary drug of use.²⁷

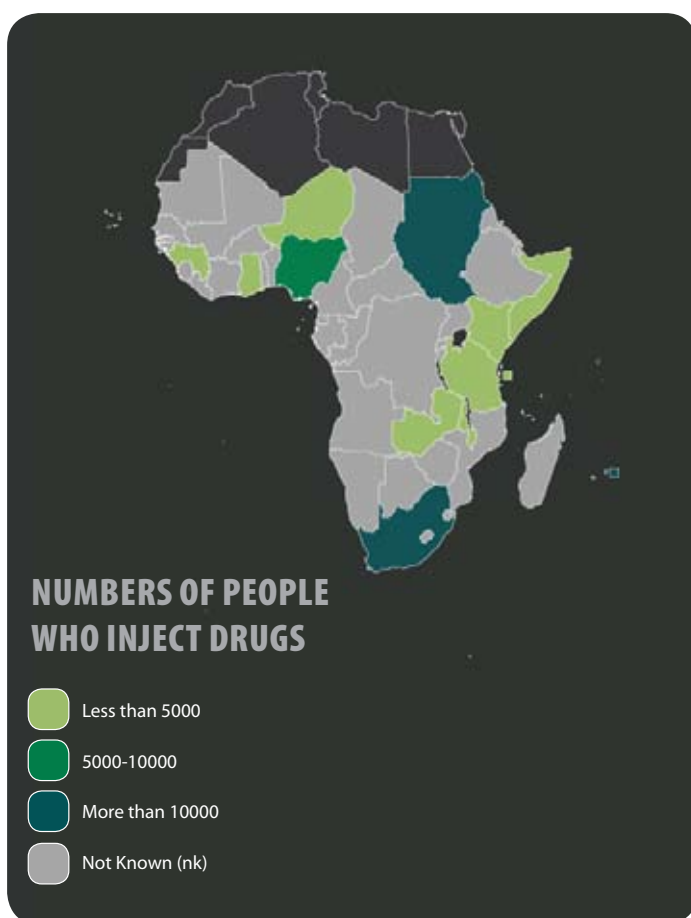
Heroin

Heroin first reached Sub-Saharan Africa in the 1980s, but was in limited supply for many years. The less-refined, brown heroin was the most commonly available until recent years, and was mostly inhaled, known as 'chasing the dragon'. With increased heroin trafficking in the past decade, the arrival of white, more-refined heroin (which cannot be 'chased') and lower prices, mean that the drug is now much more accessible and local consumer markets

have been established.²¹ It is estimated that in Africa (including North Africa), 0.2% of the population use opiates. This is almost exclusively heroin use, particularly in Sub-Saharan Africa.²⁸

Involvement in the trafficking of Asian heroin to consumer countries has led to increased availability and use of the drug in a number of countries, including Kenya, Mauritius, Mozambique, South Africa and Tanzania (including Zanzibar). It is reported that heroin is either injected, or smoked with cannabis and tobacco (known as 'cocktail' in Kenya²⁹ and 'pinch', 'unga' or 'nyaope' in South Africa). In Durban, South Africa, young people use low-grade heroin and cocaine mixed together, known locally as 'sugars'.³⁰ In Mozambique, heroin is reported to be more commonly used than cannabis, according to treatment centre data.

Treatment demand for heroin use is high in Tanzania (32.7% of all treatment demand), Mauritius (58%) and Mozambique (54.7%).¹⁸ In South Africa, heroin treatment demand rose from less than 1% to 7% of all treatment demand (including alcohol) between 1996 and 2006.²⁷



Map 9.2: Number of people who inject drugs in Sub-Saharan Africa

Injecting drug use

Due to a lack of drug use surveillance systems, estimates of the number of people who inject drugs are only available for thirteen countries and territories. However, according to the UNODC, there are at least twenty-seven countries* in Sub-Saharan Africa where injecting drug use has been reported in the past five years.³¹ In addition, there are reports of injecting in Guinea, Niger,¹ Zimbabwe³² and Djibouti.³³

* Angola, Benin, Burkina Faso, Cameroon, Cape Verde, Cote D'Ivoire, Ethiopia, Ghana, Gambia, Kenya, Liberia, Malawi, Mali, Mauritius, Mozambique, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, Somalia, South Africa, Sudan, Tanzania/Zanzibar, Togo, Uganda and Zambia.

Studies and anecdotal evidence suggest that injecting drug use, though very varied in the region, is increasing in some parts of at least nine countries (Ethiopia, Kenya, Mauritius, Rwanda, Somalia, South Africa, Tanzania, Uganda and Zambia), and that heroin is the most commonly injected drug.²⁴ Sudan and Mauritius are reported to have the largest numbers of people who inject drugs at 37,878 and 17,000 to 18,000 respectively. However, the Sudanese estimate is likely to be overstated, and injecting drug use was not mentioned in recent country progress reports to UNAIDS from north and south Sudan. Half of all people using drugs in Mauritius are reported to use heroin, and the overwhelming majority of those inject the drug.

Kenya has widespread injecting drug use in the capital city Nairobi and in the coastal areas of Mombasa, Kisumu and Nakuru. All of these lie along major highway routes to the Democratic Republic of the Congo and Sudan.²⁴ Tanzania (including Zanzibar) has considerable injecting drug use. It has also been reported in Uganda and more recently in the Seychelles, but there are very limited data on these countries.²⁴

Injecting drug use is also evident in several Southern African countries, but again there are limited data to illustrate its trends or extent. In Mozambique, the most commonly injected drugs are heroin, cocaine and methamphetamine. In Zambia, heroin and, to a lesser extent, diazepam injecting are reported.

In South Africa, heroin is the most commonly injected drug. However, the injecting of other opiates, as well as to a lesser extent amphetamine-type stimulants (ATS) and cocaine, are reported. Injecting drug use is increasing in Pretoria and Johannesburg, but decreasing in the Western Cape.³⁴ Of those accessing treatment and reporting heroin as their primary drug of use in three areas, 11%, 33% and 42% respectively reported injecting.³⁰

According to UNODC, injecting drug use is present in seventeen West African countries,[†] and anecdotal evidence also suggests that it is present, albeit very rare, in Djibouti.³³ However, very limited information on the extent and nature of injecting drug use in this area is available. It is reported to be increasing in many countries in the region, including Somalia.³⁵ In Nigeria, the most commonly injected drugs are heroin, cocaine, a combination of heroin and cocaine (known as 'speedball') and pentazocine.²⁰ In Liberia, cocaine and heroin are injected, but widespread poverty prohibits most from affording the drugs.³⁶

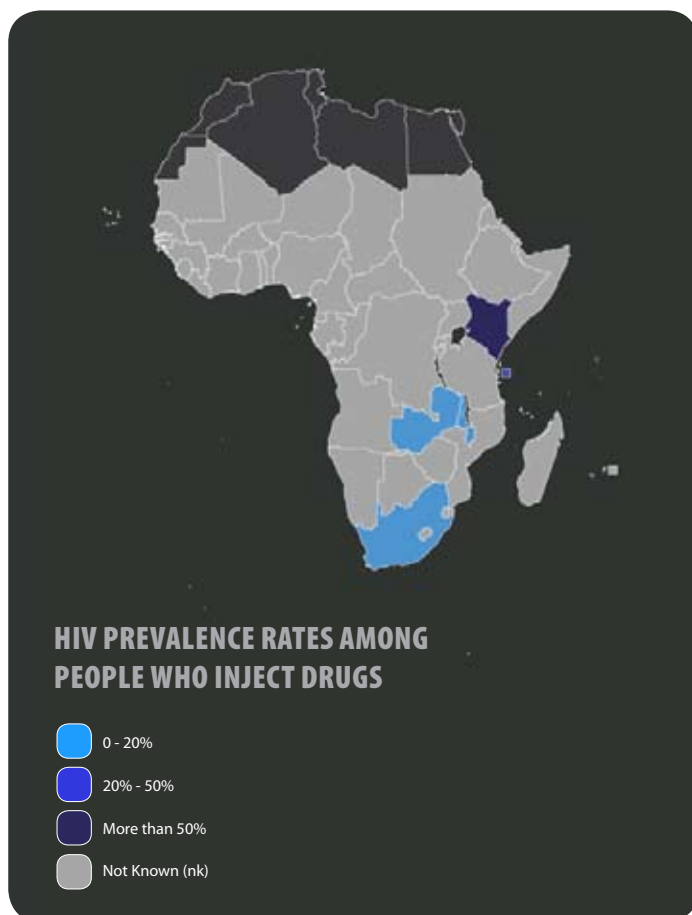
Drug-related harms

HIV and AIDS

Globally, Sub-Saharan Africa is the region hardest hit by HIV and AIDS. An estimated 22.5 million people are living with the virus in the region, 61.5% of whom are women. Southern Africa is particularly affected, and there are eight countries (Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe) with national adult HIV prevalence exceeding 15%.

The latest UNAIDS report indicates that in many countries, HIV prevalence is stable or showing small declines, most noticeably in Kenya and Zimbabwe. The report also highlights a 'shift towards safer behaviour' in some countries.³⁷

† Benin, Burkina Faso, Cameroon, Cape Verde, Cote D'Ivoire, Ethiopia, Gambia, Ghana, Liberia, Mali, Nigeria, Rwanda, Senegal, Sierra Leone, Somalia, Sudan and Togo.



Map 9.3: HIV prevalence among people who inject drugs in Sub-Saharan Africa

Although most new HIV diagnoses are attributable to sexual transmission, the influence of injecting drug use is increasing in many countries. Where data are available, they suggest HIV prevalence among people who inject drugs to be high. Due to a lack of available injecting equipment and low awareness levels of the associated risk, needle and syringe sharing is common practice.

In Tanzania, it has been reported that when sharing injecting equipment, people will clean the syringe by flushing it with water until no blood appears to be left.³⁸ 'Flashblood', a practice posing enormous risk of blood-borne virus transmission, has been reported both in Tanzania and Zanzibar. This process involves a recent heroin injector drawing his or her blood into a syringe for someone else to inject, in an effort to relieve withdrawal symptoms when heroin is unobtainable.^{38,39}

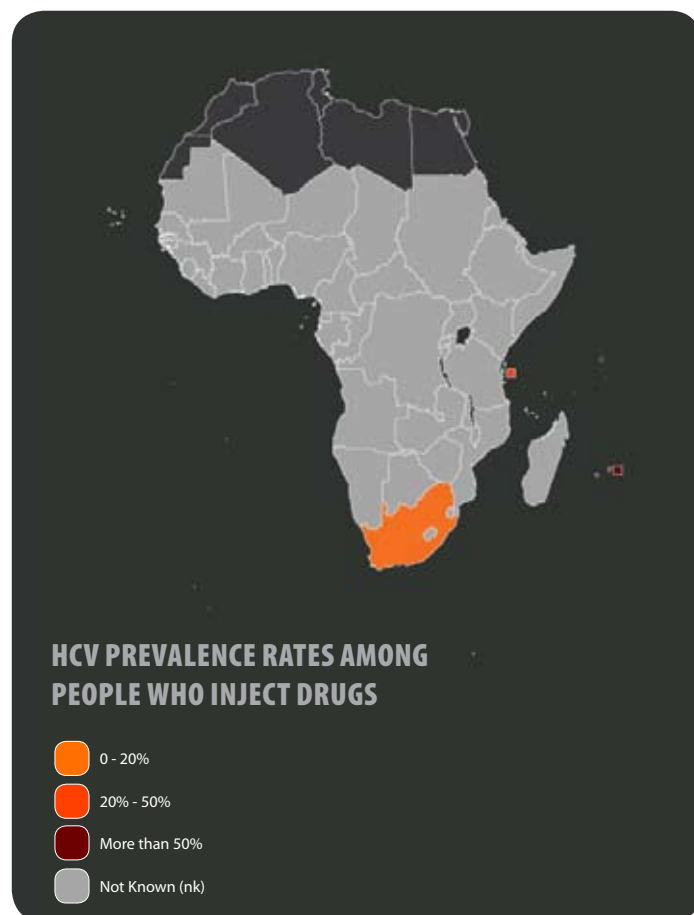
National estimates of HIV prevalence among people who inject drugs are only available in Kenya (66–88%),²⁸ Zanzibar (26%),³⁹ South Africa (1–20%)⁸ and Zambia (<1%).⁴⁰ In Mauritius, in 2005, 90% of HIV diagnoses were attributable to injecting drug use, in sharp contrast with the figure of 7% just four years earlier.⁵ There are also subnational estimates available which illustrate the severity of the situation in several African cities. In the capital city of Tanzania, Dar es Salaam, HIV prevalence among people who inject drugs has been reported as 42%.⁴¹ In Mombasa, Kenya, prevalence rates of 49.5% were found among those who inject drugs.⁴²

Several studies from various countries illustrate that women who use drugs (both injecting and non-injecting) are more vulnerable to HIV transmission than men. HIV prevalence rates among women injecting drugs were found to be particularly high in Zanzibar (40%),³¹ Tanzania (65% in Dar es Salaam),⁴¹ Nigeria²⁰ and Kenya (where six out of every seven female injectors are living with HIV).⁴²

Many studies also report that a large proportion of women who use drugs engage in sex work. In a recent South African study, female sex workers reported engaging in sex work in order to support their drug use, but they also engaged in drug use in order to cope with sex work. A number of the women reported injecting drugs. Female sex workers who reported using drugs were also found to be at risk of sexual violence, further increasing their risk of HIV.⁴³

While the response to drug use and HIV must target all those affected, particular attention must be paid to women and the interplay between drug use, sex work and HIV transmission in Sub-Saharan Africa.

Increasingly, studies are linking HIV transmission with non-injecting drug use in this region.^{44,45} For example, HIV prevalence is elevated among people who use drugs and alcohol in Malawi (25.5%), where the most common drug use includes alcohol (including traditional brews such as 'chibuku' and 'kachasu') and cannabis, known locally as 'chamba'.⁴⁶ In Kenya and Zanzibar, HIV prevalence was found to be 6.3% and 4.1% respectively among non-injecting drug users.^{2,13}



Map 9.4: HCV prevalence among people who inject drugs in Sub-Saharan Africa

A meta-analysis of twenty African studies found an association between alcohol use and positive HIV serostatus.⁴⁷ In Zimbabwe, where approximately one-quarter of the adult population is living with HIV, drinking in 'beerhalls' was associated with unprotected sex.⁴⁸ Researchers are also beginning to investigate the potential link between methamphetamine use (known locally as 'tik') and HIV transmission in South Africa.⁴⁹

The existing evidence on non-injecting drug use and HIV transmission is explored further in section 3 of this report.

Hepatitis C virus (HCV)

According to WHO data in 1999, national HCV prevalence was high in the Central African Republic (4.5%), Chad (4.8%), the Democratic Republic of the Congo (6.4%), Gabon (6.5%) and Zimbabwe (7.7%). Very high estimates were reported in Guinea (10.7%), Burundi (11.1%) and Cameroon (12.5%).

There is very limited information available on HCV among people who inject drugs in the region. In Mombasa, Kenya, HCV prevalence is reported at 70% among people who inject drugs.⁴² In Zanzibar, HCV prevalence was found to be elevated among both people who inject drugs (22%) and those who use non-injecting drugs (15%). Rates were also higher overall among females using drugs (21.7%) than among males (15.1%). The same study found HIV and HCV co-infection among 40% of people who use drugs (both injecting and non-injecting).¹³

Drug use and its related harms in prisons

UNODC estimates that 668,000 people are incarcerated in the region, with female prisoners making up between 1 and 6% of the total prison population.⁵⁰ Botswana and South Africa have the highest imprisonment rates in the region at 329 and 342 per 100,000 in the adult population respectively.⁵¹ South Africa has the largest reported prison population in the region at between 157,402 and 159,961 people.⁵⁰

Two countries, Sudan and the Democratic Republic of the Congo, have the death penalty for drug offences in their legislation. Although the majority of countries in the region have mandatory sentencing for drug offences, in some Southern African countries there are alternatives to incarceration, including diversion programmes (Botswana, Malawi, Namibia and South Africa) and fines (Namibia and Swaziland). Compulsory drug treatment is in place in several Southern African countries (Angola, Lesotho, Namibia, South Africa and Swaziland).

Conditions in most African prisons are extremely poor, with severe overcrowding, poor maintenance and living conditions, poor nutrition and lack of health care.⁵⁰ Although there is a lack of available data on the history of drug use among prison populations, a recent UNODC report indicated that injecting in prisons is likely to be rising in several countries (Cape Verde, Côte d'Ivoire, Guinea, Kenya, Mauritius, Nigeria, Senegal and Tanzania).⁵⁰

A review of HIV prevalence among prisoners found only five countries had data available on injecting drug use in prisons, reporting it to be either very limited (Cote D'Ivoire and Zambia) or non-existent (Mozambique, Niger and South Africa).⁵² Despite this, existing data suggest high prevalence rates among African prisoners compared to the general adult populations. A review of HIV in prisons found prevalence rates higher than 10% in the national prison populations of South Africa and Zambia, as well as

in some prisons in Burkina Faso, Cameroon, Cote D'Ivoire, Gabon, Malawi and Rwanda.⁵² Nearly one-third of new HIV infections in Mauritius in 2005 were among prisoners.⁵

Table 9.2 consolidates the available data, some of which is over ten years old and most of which is taken from random sampling and therefore may not be representative of the national prison population. This exemplifies the lack of recent and reliable information in this area.

Table 9.2: HIV prevalence rates in prisons in Sub-Saharan Africa

Country	HIV prevalence rate among prisoners ⁵⁰	Year
Burkina Faso	11%	1999
Cameroon	12%	2005
Cote D'Ivoire	28%	1993
Djibouti	6.1% ⁵²	n/a
Malawi	60–75% ⁴⁶	n/a
Nigeria	9%	2004
Rwanda	14%	1993
Senegal	2.7%	1997
South Africa	45%	2006
Uganda	8%	2002
Zambia	27% ⁵³	1999

n/a = not available

There are no available data on HCV prevalence rates in prisons.

THE RESPONSE

Harm reduction services

Needle and syringe exchange programmes (NSPs)

The only country with an official NSP is Mauritius, where, since 2006, three NSP sites have been operating and distributing injecting equipment via community-based outreach. There are plans to increase the number and coverage of NSPs in Mauritius,⁵ but a lack of human resources and funds make this a challenge.²⁴ In addition, while the possession of injecting equipment without a prescription is still illegal, fear of arrest will continue to be a significant barrier to people accessing this service.

In at least thirteen countries in the region* sterile injecting equipment can be purchased from pharmacies. In South Africa, bleach and alcohol swabs are also available at pharmacies.⁵⁴ However, even in cases where it is affordable, pharmacists may not be willing to sell syringes to people they suspect of injecting drugs. In South Africa, where pharmacy sales are more widespread than most other countries, problems are associated with the judgmental attitude of pharmacists towards 'heroin junkies', as well as the difficulties of accessing equipment late at night.⁵⁵ In Malindi, Kenya, non-governmental organisations (NGOs) worked

* Angola, Botswana, Burkina Faso, Kenya, Lesotho, Malawi, Mozambique, Namibia, the Seychelles, South Africa, Swaziland, Tanzania (including Zanzibar) and Uganda.

with pharmacists to ensure that they would not refuse sales of injecting equipment to people injecting drugs.⁵⁶ In Nigeria, one study found that 70% of people who inject drugs reported being able to obtain sterile syringes, mostly from pharmacies but also from friends and drug dealers.²⁰

There are several hurdles to overcome in order to introduce or increase NSPs in communities where injecting occurs. There is a need for increased surveillance to add to existing information on the extent and nature of injecting drug use in the region. All sectors must recognise the importance of early intervention in order to mitigate the impact of injecting. Lessons must be learnt from other resource-limited settings in which NSPs are available. In addition, support from relevant bodies on the development of new, as well as the reform of existing, legislation and policy is required.^{24,27}

Treatment for drug dependence

In general, opioid substitution therapy (OST) is not available in Sub-Saharan Africa. Mauritius and South Africa are the only two countries in which OST is prescribed for maintenance therapy. In Mauritius, the volume of OST prescribing has steadily increased since the initiation of the programme, and there are now reported to be 400 people receiving OST from seven sites.⁶ South Africa is the only other country where OST is available for maintenance therapy, but this is not widely accessible and there is currently no legislation to accommodate OST provision.⁵⁷ A few private facilities provide OST, many of which are inaccessible to people who use opiates due to prohibitive expense.²⁷

In general, the provision of OST in Sub-Saharan Africa is impeded by legislation prohibiting the prescription of methadone and buprenorphine, a lack of political will, as well as weakened health-care systems in many countries.

A small number of countries provide OST for detoxification purposes, including Uganda,²⁴ Somalia,³⁵ Botswana (mostly used for alcohol detox) and South Africa.²⁷ In South Africa, methadone and buprenorphine are both available for detoxification. However, methadone is only available as a syrup (Physeptone), which has high sugar content, contains alcohol and must be taken in large quantities. Buprenorphine is a preferred option, but is expensive and therefore not accessible to everyone.⁵⁷ Detoxification involves three to seven days of OST prescription from standalone outpatient units, such as 'K-TOX' in Cape Town.⁵⁸ Other opiate detoxification units are housed in government hospitals in Cape Town, Pretoria and Johannesburg.⁵⁹ In Kenya, tranquilisers and painkillers are used to relieve withdrawal symptoms during detoxification.

Other (non-OST) drug treatment is available in several countries to varying extents. South Africa and Kenya appear to have the most extensive treatment provision, with 9,412 people accessing 72 sites in South Africa, and Kenya being reported as the country with the most drug treatment services in East Africa. In Nigeria, a broad range of drug treatment is available, including treatments that are religious-based and those offered by traditional healers. However, a study in Lagos highlighted that people who used drugs had difficulties accessing these due to prohibitive cost.²⁰ Mauritius, Uganda and Zanzibar also offer treatment for drug use.

Throughout the rest of the region, there are very few dedicated drug treatment or rehabilitation services outside of psychiatric services. There is also a great amount of stigma associated with being a drug user and accessing these services. Most countries

have fewer than ten drug treatment sites. In Namibia, for example, in 2004, only fifty-four people in the country received drug treatment.

In Uganda, a 32-bed drug treatment centre has been established within the national mental hospital but, in general, drug treatment is limited.²⁴ Somalia has one outpatient treatment centre and Sudan has three psychiatric wards providing drug treatment.⁶⁰ Limited drug treatment is available in Burkina Faso and to a lesser extent in Liberia, where a rehabilitation centre that was destroyed during the fifteen-year civil war has not yet been renovated and there is a lack of trained staff to work on drug treatment. In Swaziland, it is reported that there is no dedicated drug treatment or rehabilitation centre but some provision for drug treatment is offered in psychiatry services.⁶¹

Aside from the obvious lack of coverage of OST and non-OST drug treatment services, a number of further barriers are reported for people who inject drugs in accessing these services. These include prohibitive cost of treatment or travel, inappropriateness of services (for example those targeted at alcohol use rather than injecting drug use) and stigma and discrimination. The predominant view is that people who use drugs are criminals and not necessarily in need of, or deserving of, treatment. While the recent Kenyan country progress report highlighted the need for de-stigmatisation of 'rehabilitated drug users' and support for them to find work by issuing 'certificates of good conduct' after a period being clean, increased efforts are necessary to reduce stigma that affects people currently using drugs.⁶²

Targeted HIV prevention, treatment and care

Throughout the region, civil society, government and international organisations are involved in the provision of HIV prevention, treatment and care. Although far from reaching the target of 'universal access', HIV interventions in the region have increased dramatically in recent years, with considerable support from international donors. As HIV transmission is predominantly via heterosexual sex, the response has not traditionally been targeted towards those who inject drugs. Data on the extent to which people who inject drugs have access to HIV services are very limited.

Interventions targeting people who inject drugs with HIV prevention, treatment and care are reported in at least five countries (Burkina Faso, Mauritius, Mozambique, Kenya and South Africa). In Mauritius, it is reported that 10% of people who inject drugs accessed voluntary HIV counselling and testing (VCT) in the last twelve months. Many received information on HIV and AIDS through radio and television and participated in a seminar on HIV and AIDS. Condom distribution is also reported to have recently increased.⁶

In South Africa, information and awareness programmes run by government and civil society that address the link between drug use and HIV are in the early stages of implementation.⁶³ PEPFAR has also provided the Medical Research Council in South Africa with funding for an international rapid assessment response and evaluation. The target populations are people who use drugs (injecting and non-injecting), including sex workers and men who have sex with men (MSM). The project involves research which will inform an intervention phase working with various NGO/CBO service providers in the field of drug treatment and HIV services to build capacity, strengthen networks and facilitate community outreach to increase the reach and competency of services.⁶⁴

In Mozambique, one NGO works on increasing access to HIV services for people who inject drugs. In Burkina Faso, there are reported to be some programmes reaching people who inject drugs with STI prevention, limited condom distribution, and information, education and communication (IEC) programmes.

In 2004, a PEPFAR grant allowed the UNODC to support the implementation of community-based outreach programmes for people who inject drugs in Kenya.⁶⁵ There is now a national Working Group on Prevention of HIV among Drug Users guiding policy and programming on HIV and drug use,⁶⁶ and significant efforts are being made to increase uptake of VCT among people who use drugs. NGOs in Nairobi and in several coastal towns offer psychosocial and peer support outreach, self-help groups, harm reduction education and VCT, and refer clients to antiretroviral treatment (ART) clinics and other services.²⁴

There are no data available to indicate the numbers of people who inject drugs that are receiving ART, although it is reported that some provision is occurring in South Africa.

Several barriers exist that impede the access of people who inject drugs to essential HIV services. In many countries, for example Lesotho, Malawi, Swaziland and Zimbabwe, access to VCT, ART and other services is limited in general, and is likely to be even less available to marginalised groups. Surveillance systems are few, and as such there is a lack of evidence on the extent of injecting drug use and HIV, discouraging many countries, for example, Mozambique, Namibia and Swaziland, from prioritising this during service design and delivery. Further barriers include a lack of awareness of HIV risk behaviours, harm reduction and drug treatment services, distance to services and cost of transport, severe stigma and discrimination associated with both drug use and HIV, fear of arrest or harassment, and a lack of confidentiality at both HIV and drug treatment services.

A consultation with people who inject drugs in Kenya revealed that few VCT sites are 'drug-user friendly', and that IEC materials for people who use drugs are 'inadequate'.⁶² In South Africa, interviews with people who use drugs (including those who inject, MSM and sex workers) indicated that access to VCT was problematic due to their lack of knowledge of VCT sites, long waiting times and cancellation of appointments in public centres, and the expense associated with private facilities. People who use drugs also felt stigmatised.⁶⁷

In several countries the provision of ART is still limited, for example in Djibouti (600 people), the Seychelles (199 people), Somalia (200 people) and Sudan (800 people). Even in countries such as Zambia and Zimbabwe where ART is more available, in practice it is easier for some groups (for example government officials, teachers, mothers and civil servants) to gain access to the treatment than others. In South Africa, while ART is provided, recent studies show that vulnerable people who use drugs have limited knowledge about the treatment.⁶⁷

A country progress report from Kenya's National AIDS Control Commission admitted that people who inject drugs had been 'neglected' in the national response to HIV, along with MSM and migrant populations. The report highlights the intention to respond to HIV among people who use drugs in 2008, stating that they, along with other marginalised, criminalised groups had 'been excluded from care, treatment and prevention strategies, policy and programmes'.⁶²

Targeted HCV prevention, treatment and care

Information on the availability of HCV prevention, treatment and care programmes for people who inject drugs is very scarce. South Africa was the only country found to have HCV testing and treatment in place, which in theory could be accessed by people who inject drugs, although there is no information to illustrate the extent to which this is occurring.

Harm reduction in prisons

In general, prison health care in Sub-Saharan Africa is very limited. There are no prisoners in the region with access to either prison needle and syringe exchange (PNEP) or OST. HIV prevention, care and treatment services are very limited in prisons throughout the region.

VCT is available in prisons in at least ten countries (Botswana, Kenya, Lesotho, Malawi, Mauritius, the Seychelles, South Africa, Tanzania, Uganda and Zambia) but to varying extents. For example in Botswana and Mauritius, VCT is available to most prisoners. However in Malawi, there is just one pilot VCT site operating in Zomba Central prison.⁴⁶

The availability of condoms also varies widely. For example, they are available in some prisons in Lesotho and the majority of prisons in South Africa, but distribution is prohibited in Botswana as it is believed they would promote sexual behaviour in the prisons (condoms are only distributed to prisoners upon release from prison or parole).⁶⁸

ART is available in some prisons in at least eight countries: Botswana (302 people are receiving ART), Kenya, Lesotho, the Seychelles, South Africa (2,323 people receiving ART), Tanzania, Uganda (100 people receiving ART) and Zambia. Prevention of mother-to-child transmission (PMTCT) and STI testing and treatment are also reported to be available in Botswana's prisons.²⁷ Treatment of opportunistic infections is reported to be available in a small number of Ugandan prisons.²³

In Zambia, a number of NGOs support HIV prevention and care programmes in prisons.⁵³ In South Africa, NGOs and research initiatives focus on HIV within prisons and provide harm reduction information for prisoners using drugs.⁶⁹ Information on the availability of HCV testing and treatment within prisons is unavailable for most countries in the region. As HCV services are very rarely in place outside prisons across the region (with the exception of South Africa), it is unlikely that prisoners will have access to them.

Policies for harm reduction

Until recently, HIV policy and practice mainly focused on sexual and vertical (mother-to-child) HIV transmission, as these are the main routes of transmission in the region. However, a number of policies have been developed in recent years which prioritise, or make reference to, responding to HIV and drug use.

For example, Zanzibar has a Five-year National Strategic Plan on Substance Use and HIV and AIDS (2007–2011), and the Tanzanian National Drug Control Policy (2007) identifies responding to HIV infection among people who use drugs as critical to the response.¹⁰ In addition, the Mauritian National Multisectoral HIV/AIDS Strategic Framework (NSF) 2007–2011 includes two objectives on reducing HIV transmission among people who inject drugs and prisoners. It sets targets of 80% of people who inject drugs and all prisoners having access to HIV prevention services by 2011.

Many HIV action frameworks in the region (Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe) include mention of human rights, and those in South Africa, Zambia and Zimbabwe also include mention of injecting drug use. However, South Africa has the only drug policy in the region which includes mention of a specific harm reduction intervention, in this case OST.

In some countries, policies have become redundant following years of conflict (for example in Liberia) and in others, further investigation is needed to ascertain whether policies are in place and to establish their content.

At the regional level, the recently released African Union Plan of Action on Drug Control and Crime Prevention (2007–2012) prioritises within it 'Regional and National capacity building and training to enhance prevention and care of substance abuse and related HIV and AIDS' as well as requiring 'Member States to conduct training in harm reduction, drug abuse treatment and rehabilitation, and provide services for drug dependent individuals, including street children and child soldiers'.⁷⁰

In October 2007, the Sub-Saharan African Harm Reduction Network (SAHRN) was formed. A meeting held in Nairobi, Kenya brought together NGOs, researchers and UN representatives from eleven African countries to discuss drug use and the reduction of its related harms in the region. During the meeting, the lack of appropriate policies, and/or the political will to create and implement them, were cited as significant barriers to promoting harm reduction in the region.

The overarching objective of SAHRN is to create a conducive environment for harm reduction in Sub-Saharan Africa, through advocacy, information sharing and networking. An initial scoping report revealed that there are very few civil society organisations in the region currently focusing on harm reduction policy and advocacy at the national level. Current data suggest that these are limited to Cameroon, Liberia, Mauritius, Nigeria, South Africa and Zambia. However, it is hoped that the formation of SAHRN will bring new opportunities for researchers and NGOs to engage in harm reduction policy at the regional and international levels.

Multilateral support for harm reduction

There are clearly numerous challenges to the establishment of harm reduction interventions such as OST and NSP in the resource-poor countries of Sub-Saharan Africa, where poverty affects the majority of the population and health system infrastructures are often already struggling to cope with numerous health issues, including generalised HIV epidemics. Support from both international donors and multilateral agencies will be integral to the response in this region. Currently, few, if any, multilateral agencies support or actively contribute to the initiation or scaling up of NSP or OST services in the region. However, a number have some focus on increasing access to drug treatment as well as HIV prevention, care and treatment for people who use drugs and for prisoners.

With the exception of South Africa, there are no drug user organisations in the region. In South Africa, the drug user organisation was established in the early 1990s and is currently less active than it has been in the past. Drug use remains greatly hidden within communities and people who use drugs are often deterred from accessing any health services for fear of being stigmatised and, in some countries, arrested. This stigma also stifles the voices of people who use drugs in the region. They are not empowered to advocate for better access to services, or to be involved in the planning, implementation and monitoring of treatment provision to ensure their needs are met.

The UNODC has three offices covering Sub-Saharan Africa: one each in West/Central Africa, East Africa and Southern Africa. In 2001, a UNODC Africa-wide initiative was launched to develop national capacity in drug demand reduction and treatment. In Kenya, a PEPFAR grant allowed UNODC to support the development of community-based outreach for people who use drugs. The UNODC has also had an increased focus on HIV within prisons in Sub-Saharan Africa, releasing a report on the issue and hosting a regional meeting in Mombasa, Kenya in 2007.⁵⁰

In addition, funding from the World Bank has enabled the Tanzanian government to establish a programme focusing on HIV and drug use.¹⁰ Other technical and financial support for programmes on HIV and drug use comes from UNAIDS, WHO and UNICEF.

While recognising the importance of these initiatives, multilateral agencies are failing to promote, or provide support for, harm reduction approaches such as NSP and OST in the region. There is now increasing evidence of the contribution of injecting drug use to HIV and HCV epidemics in the region and experiences from elsewhere illustrate the importance of timely intervention to mitigate the rapid escalation of epidemics among key populations and the wider population. In Sub-Saharan Africa, injecting drug use could exacerbate epidemics in countries where HIV prevalence is already very high, as well as rapidly expanding epidemics in countries which have so far remained relatively less affected.

An increased focus from multilateral agencies is necessary in order to provide government and civil society with the necessary support and guidance on how to respond to the challenges faced. This will perhaps require different approaches to those used in other settings. For example a recent article suggested that supporting and expanding community-based efforts would be paramount to an effective response.³⁸ Efforts to curb injecting among people who use drugs in the region may also be part of the harm reduction response to reduce the 'potential for drug driven HIV to exacerbate the heterosexual epidemic'.²¹

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Section 3: Key Issues

The human right to harm reduction

‘There will be no equitable progress in HIV prevention so long as some parts of the population are marginalized and denied basic health and human rights – people living with HIV, sex workers, men who have sex with men, and injecting drug users.’

Ban Ki Moon

United Nations Secretary-General¹

‘Harm reduction is not an option. It is a must.’

Anan Pun

Chairperson, International Network of People who Use Drugs²

In March 2008, UNODC Executive Director Antonio Maria Costa opened the 51st session of the Commission on Narcotic Drugs (CND) with a call for a greater focus on harm reduction and human rights in the context of international drug control. This speech builds on a number of recent statements emanating from UNODC which focus on health, harm reduction and human rights. But questions still need to be asked about the connection between human rights and harm reduction, and what that means for the status of harm reduction in international law.

International drug control and health organisations, including UNODC, WHO and UNAIDS, have expressed clear support for harm reduction interventions. The UNDCP’s Legal Affairs Section and the International Narcotics Control Board (INCB) have made it clear that harm reduction services do not contravene the international drug control conventions. However, merely stating that harm reduction services are not prohibited by the drug conventions falls far short of acknowledging that such measures are critical to ensuring that the fundamental human rights of people who use drugs are respected, protected and fulfilled.

Harm reduction and the international drug control conventions

The international drug control regime is based on three UN treaties: the Single Convention on Narcotic Drugs 1961 (as amended by the 1972 Protocol to the Single Convention), the Convention on Psychotropic Substances 1971 and the Convention Against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988. All three treaties have considerable international support, with over 180 countries agreeing to be bound by each.

The 1961 and 1971 conventions pre-date the HIV epidemic and the discovery of hepatitis C. The 1988 convention makes no mention of HIV, despite the fact that HIV was an issue of considerable international concern during the negotiation of that treaty and had already been connected to injecting drug use. Nonetheless, the debate among drug control agencies and some member states about the legality of harm reduction measures has centred almost exclusively on these three instruments.

In 2002, the Legal Affairs Section at the UNDCP issued a legal opinion on harm reduction. Its view was that harm reduction services – including needle and syringe exchange, opioid substitution treatment and safer injecting sites – do not contravene the terms of the three international drug control conventions.³

The INCB, although recently reviewing its position on harm reduction,⁴ has consistently ignored the UNDCP legal opinion

on safer injecting sites, maintaining that they are illegal under the treaties.⁵ In its 2007 annual report, and in contradiction to its recent support for needle exchange, the INCB also condemned the distribution of ‘safer crack use kits’ in Canada as being contrary to the provisions of the drug control conventions.⁶

Despite the UNDCP legal opinion to the contrary, the drug conventions are consistently used as a basis to deny harm reduction services in countries around the world.⁷ In Russia, for example, where the use of methadone or buprenorphine for treating drug-dependent persons is prohibited by law,⁸ the 1961 Single Convention has been cited by top health-care officials as justification for the ban.⁹

Assertions of the legality of harm reduction measures under the drug control conventions are clearly insufficient to ensure access to these essential services. Under the drug control treaties, and without reference to competing legal obligations, it appears as though harm reduction is optional. But the drug control system does not operate in a legal vacuum.

Harm reduction and international human rights law

All human rights are universal, indivisible, interdependent and interrelated.¹⁰ HIV, drug policy and harm reduction cut across a wide range of protections. Economic, social and cultural rights such as the rights to health and social security have the clearest connections. But they cannot be implemented alone. Such rights are often unattainable in places where civil and political rights such as the rights to life, freedom from torture, access to information and the due process of law are violated. In areas where the right to non-discrimination is not respected, it is the most marginalised and those in need of special care and assistance who face the greatest violations of their rights. All too often this includes people who use drugs.

Harm reduction and the right to health

The right to health is enshrined in Article 25 of the Universal Declaration of Human Rights, Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) and a number of other international human rights instruments.¹¹ Article 12 of the ICESCR specifically binds states to take measures to prevent, treat and control epidemic diseases.

Individuals who use drugs do not forfeit the right to the highest attainable standard of health. The prohibited legal status of the drug(s) in question does not remove from states parties their obligations to respect, protect and fulfil this right for all persons within their jurisdiction, including people who use illegal drugs.

Increasingly, UN human rights monitors have begun to interpret the provision of harm reduction interventions as necessary for states to be compliant with the right to health. In 2006, the UN Committee on Economic, Social and Cultural Rights expressed concern at ‘the rapid spread of HIV’ in Tajikistan, ‘in particular among drug users, prisoners, and sex workers’. The Committee called upon the Tajikistan government, in the context of the right to health, to ‘establish time-bound targets for extending the provision of free... harm reduction services to all parts of the country’.¹²

In 2007, the Committee raised concerns relating to opioid substitution therapy in its report on the Ukraine, stating it was ‘gravely concerned about the high prevalence of HIV/AIDS... and

the limited access by drug users to substitution therapy'.¹³ The Committee recommended that the Ukrainian government 'make drug substitution therapy and other HIV prevention services more accessible for drug users'.¹⁴

The Committee has also made clear the importance of access to accurate information as one of the 'underlying determinants of health'. This includes 'the right to seek, receive and impart information and ideas concerning health issues' and the obligation of the state to support people 'in making informed choices about their health'.¹⁵

One of the strongest statements in support of a human right to harm reduction was made by the UN Special Rapporteur on the Right to Health, Professor Paul Hunt, following his mission to Sweden in 2007. In his report, the Special Rapporteur stated that harm reduction is not only an essential public health intervention, but that it also 'enhances the right to health' of people who inject drugs. Describing the provision of harm reduction programmes as 'an important human rights issue', Professor Hunt emphasised the Swedish government's 'responsibility to ensure the implementation, throughout Sweden and as a matter of priority, of a comprehensive harm reduction policy, including counselling, advice on sexual and reproductive health, and clean needles and syringes'.¹⁶

Harm reduction and the rights to life and to freedom from torture, inhuman or degrading treatment and arbitrary detention

Harm reduction is intended to enhance the right to health of people who use drugs not only by preventing the transmission of HIV and other blood-borne viruses, but also by bringing people who use drugs into contact with essential health and other services. However, fear of ill-treatment at the hands of police, coercive drug treatment and other disproportionate measures that violate human rights can have the effect of driving people who inject drugs underground and away from such essential services, thereby increasing their vulnerability to HIV infection. A number of specific human rights violations may be identified in this regard.

The 2003 'War on Drugs' in Thailand, which resulted in the extrajudicial killings of over 2,800 people,¹⁷ has had a lasting impact on whether people who use drugs access fundamental health care services.¹⁸ Studies report a significant decline in the number of people seeking treatment for drug use during the 'War on Drugs', and find that a significant percentage of people who had formerly attended drug treatment centres went into hiding, in some cases sharing syringes because sterile syringes were difficult to obtain.¹⁹ Researchers have also found that the government crackdown on drug use was likely to discourage people who use drugs from accessing voluntary HIV counselling and testing and other medical services.²⁰

The death penalty for drug offences is a violation of the right to life in international human rights law, yet more than thirty countries retain capital punishment for drugs.²¹ Approximately one hundred people are executed by firing squad in Vietnam each year, mostly for drug-related offences. In recent years, China has used the UN's International Day Against Drug Abuse and Illicit Drug Trafficking (26 June) to conduct public executions of drug offenders. A recent study of HIV prevention efforts along the border between these two countries indicated that 'crackdowns and elevated enforcement activities from late 2003 into 2004 resulted in arrest

of many people who inject drugs... and drove others underground or prompted them to leave the area at least temporarily'.²²

Detention of people who use drugs without trial violates basic principles of human rights law, yet this violation has been documented in many states. For example, coercive drug treatment is employed in a number of countries, often under the guise of rehabilitation. In China, those arrested for drug possession and use can be consigned to forced detoxification centres without trial. Investigations have uncovered extreme ill-treatment in the name of rehabilitation, such as the administering of electric shocks to 'patients' while they view pictures of drug use.²³ A 2004 survey found that 9% of 3,213 Chinese heroin users had taken extreme steps, such as swallowing glass, to gain a medical exemption from forced treatment.²⁴

International law unequivocally forbids the use of torture and other cruel, inhuman or degrading treatments or punishments. Yet police in some countries have been known to use drug dependency as a tool to coerce incriminating testimony from people who use drugs. In the Ukraine, for example, it has been reported that police intentionally use withdrawal as an investigative tool to coerce incriminating testimony from people who use drugs, and to extort money by threatening to detain them.²⁵

Harm reduction and the right to non-discrimination

While many other rights are central to this issue, key among them is the right to non-discrimination, common to all nine of the core human rights treaties, the Universal Declaration and the Charter of the United Nations. International human rights law protects every human being from discrimination based on a variety of grounds including health status (which, in turn, includes HIV status).²⁶ This prohibited form of discrimination is clearly of specific relevance to people who use drugs, who are particularly vulnerable to HIV and other blood-borne viruses as well as many other health-related problems.

An important element of the right to non-discrimination is the obligation of states to identify those groups and individuals in need of special care and assistance to ensure that their rights are guaranteed.²⁷ Nearly twenty years ago, the UN Human Rights Committee noted that 'the principle of equality sometimes requires states parties to take affirmative action in order to diminish or eliminate conditions which cause or help to perpetuate discrimination prohibited by the Covenant on Civil and Political Rights'.²⁸

In relation to HIV prevention, UNAIDS has stated that any laws enacted to prevent discrimination against people living with HIV 'should also protect groups made more vulnerable to HIV/AIDS due to the discrimination they face'.²⁹ However, national drug control efforts often stigmatise people who use drugs by focusing overwhelmingly on criminalisation. Such approaches, rather than identifying and assisting those in need, may well help to 'perpetuate' those conditions that lead to discrimination.

Harm reduction, on the other hand, is specifically aimed at ensuring that the rights of people who use drugs, as a specific and vulnerable group, are guaranteed. This includes the right to health, but also the many other rights that are violated through disproportionately punitive and coercive policies.

The primacy of human rights law

The primacy of human rights over drug control in international law is clear and unambiguous.³⁰ That the drug conventions have received widespread state support in no way diminishes overriding human rights obligations.

‘Human rights’ appears no less than seven times in the Charter of the United Nations, from the preamble, to the purposes of the UN, to the mandates of the General Assembly and Economic and Social Council of the United Nations. Drug control is not mentioned at all. Article 103 of the Charter specifically states that if there is a conflict between the Charter and any other international treaty, which includes the drug conventions, state obligations under the Charter, and therefore the human rights obligations it contains, shall prevail.

The Universal Declaration, which gives expression to the human rights obligations contained in the Charter,³¹ forms the bedrock of international human rights norms. No less than nine UN human rights treaties (two of which have yet to enter into force) add further specific content to the norms set out in the Universal Declaration.

Human rights is one of the ‘three pillars’ of the UN system, standing alongside security and development. In terms of political support for human rights, the Vienna Declaration and Programme of Action, agreed in 1993 by over 170 states, affirms that the protection of human rights is ‘the first responsibility of states’ and that the universal nature of human rights ‘is beyond question’.³² In the Declaration of Commitment on HIV/AIDS, adopted during the 2001 UN General Assembly Special Session (UNGASS) on HIV/AIDS, the General Assembly reaffirmed that ‘the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic’ and ‘reduces vulnerability to HIV/AIDS’.³³

In the specific context of drug control, the General Assembly, in the Political Declaration adopted during the 1998 UNGASS on drugs, and in repeated resolutions since then, has stated categorically that drug control must be carried out in full conformity with human rights.³⁴ At the 51st session of the Commission on Narcotic Drugs in 2008, this requirement was finally reflected in a CND resolution.³⁵

The question, therefore, is not just what drug control conventions have to say about harm reduction, but what human rights law, as the primary body of law in the international system, requires from states in order to guarantee the rights of people who use drugs. And in human rights law, harm reduction is not an option: it is a must.

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Beyond injecting drug use: The overlap between HIV and non-injecting drug use

It is estimated that 200 million people use illegal drugs¹ and two billion people use alcohol.² The number of people who inject drugs is approximately 11.6 million,* a small proportion of the overall number of people who use psychoactive substances. Yet, in the two decades since they first began, harm reduction projects have focused almost exclusively on reducing the risk of HIV transmission posed by injecting drug use. Such initiatives are integral to the response, particularly where injecting drug use is driving HIV epidemics, however the numerous potential health risks related to non-injecting drug use (NIDU) make it another key issue when considering the global state of harm reduction.

Cocaine and crack cocaine

In many parts of the world, rates of cocaine and/or crack cocaine ('crack') use are significant. Researchers have found crack use to be associated with increased sexual risk behaviour, sex work and HIV transmission.³ Smoking crack can also cause wounds, burns and cuts to the mouth and lips, which can serve as transmission sites for HIV and other blood-borne viruses, whether through oral sex or the sharing of paraphernalia.⁴

Associations between crack use and HIV are documented in published reports from across the Caribbean, a region where injecting drug use is relatively uncommon. In Trinidad, for example, a study of attendees at a sexually transmitted infection (STI) clinic found that crack use was a significant predictor of HIV infection among men.⁵ Similar results have been found in research from the Bahamas^{6,7} and Saint Lucia.⁸ In South America, there is a growing body of literature on the role of NIDU in the HIV epidemic, particularly from Argentina⁹ and Brazil.¹⁰ In the US, a study of non-injecting cocaine users reported that 'young smokers of crack cocaine, particularly women who have sex in exchange for money or drugs, are at high risk for HIV infection. Crack use promotes the heterosexual transmission of HIV'.¹¹

Indeed, sex work has been highlighted as an important factor in the association between drug use and HIV transmission. Several studies, from sub-Saharan Africa to Asia, have found that HIV prevalence rates among people who both use drugs and engage in sex work are higher than among those who only use drugs or only engage in sex work (see regional overviews in this report). These studies indicate that the combination of sex work and drug use, including cocaine use, increases vulnerability to HIV transmission.

While a lack of comparable data makes it difficult to assess the full epidemiological impact of non-injecting cocaine use globally or regionally, existing research suggests that it is an important driver in HIV epidemics. It is widely acknowledged that further research is needed on this topic in order to build a global evidence base and to develop and evaluate targeted harm reduction interventions.

Amphetamine-type stimulants (ATS)

According to global estimates, amphetamine-type stimulants (ATS) are the second most commonly used illicit drugs in the world (after cannabis), and are regularly used by over 26 million people.¹² ATS use can play an important role in increasing sexual risks associated with HIV and STI transmission.

Much of the research in this area has focused on men who have sex with men (MSM), particularly in the US, where ATS are often used in the context of sexual activity.¹³ In the US, the prevalence of ATS use is estimated to be twenty times higher among MSM than among the general population.^{14,15} Several studies have found that ATS use increases sexual risk-taking behaviour,^{16,17} which can in turn increase vulnerability to HIV and sexually transmitted infections for MSM and other ATS users.^{18,19}

There is a need for further research on ATS use within other populations, such as those involved in sex work and people using ATS in other areas of the world. Use of various ATS is reported to be widespread in some Asian countries, including Cambodia, China and PDR Laos (see regional overviews in this report).

Methamphetamine smoking, known locally as 'tik', is also reported to be common amongst young people in South Africa. Researchers have begun to investigate the relationship between 'tik' use and HIV transmission, and they warn that this potential new 'HIV transmission vector' could have significant implications for a country which already has high HIV prevalence.¹²

Alcohol

Alcohol is the world's most commonly used psychoactive drug and 'the association between alcohol use, reduced sexual inhibitions, HIV transmission and individual behaviour has been demonstrated... in both the developed and developing world'.²⁰ Given the effect of alcohol on the immune system, its use is also associated with a higher incidence of AIDS diagnoses among people who are already living with HIV,²¹ and 'likely plays a pivotal, but incompletely defined, role in HIV viral replication, disease progression... and increased frequency of adverse medical events from treatment'.²²

In Africa, numerous studies document the overlap of alcohol use and HIV infection, including epidemiological data from the Central African Republic, Kenya, Tanzania, Zambia, Zimbabwe²³ and Uganda.^{24,25} In 2007, a meta-analysis of twenty African studies concluded that 'Alcohol drinkers were more apt to be HIV+ than nondrinkers'.^{26,27} In India, a large-scale study found elevated prevalence rates of HIV and STIs among patrons of local 'wine shops', leading the researchers to conclude that this 'may play an important role in expanding the Indian epidemic'.^{28,29}

Conclusion

There is a clear need for further research into the global contribution to HIV epidemics made by use of the three types of substance reviewed here, as well as other NIDU. This research should, in turn, generate increased attention from the HIV and harm reduction sectors internationally, amongst whom this issue has been somewhat overlooked until recent years.

In response to growing concerns about alcohol use and HIV in Africa, the US held a meeting in 2005 to inform PEPFAR (President's Emergency Plan for AIDS Relief) programming. The meeting concluded that 'the relationship between alcohol misuse and the transmission of HIV must be addressed programmatically'.³⁰ In addition, the World Health Organization recently conducted an international, cross-cultural study on alcohol use and sexual risk behaviours intended to 'inform preventive initiatives'.²⁵ The Caribbean Regional Strategic Framework for HIV/AIDS has also included cocaine and HIV research as a priority for 2008 to 2012 in a draft strategy.⁸ However, alcohol use barely receives a mention

* based on data gathered for this report

on the UNAIDS website and NIDU is not yet on the agenda of HIV departments of key bilateral donors such as the UK's Department for International Development.

There are examples of good practice at the grassroots level, in terms of both HIV prevention amongst MSM and the distribution of sterile, single-use paraphernalia for drug smoking such as 'safer crack kits'. There is also some promising evidence from trials of pharmacological interventions for ATS dependence³¹ and other interventions to reduce ATS use and corresponding risk behaviours.^{32,33} However, these examples do not yet form integral components of comprehensive harm reduction packages.

Non-injecting drug use is highly prevalent around the world and the harm reduction community must respond to the challenges that this creates. HIV and harm reduction policies and practices need to be expanded to include NIDU, especially cocaine, ATS and alcohol. This is an issue that must be addressed in order for harm reduction to move forward and become a truly global approach for all psychoactive drugs.

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Civil society engagement: Connecting the local with the global

'If only those with power... would listen and incorporate the experience of those who have first hand knowledge of the reality of the situation on the ground – the results would transform the ideas of leadership and decision-making'.

Mary Robinson

Former UN High Commissioner for Human Rights¹

Civil society engagement in international processes should not be seen as a token gesture or an empty entitlement. People working at the local level and with affected communities are often best placed to assess the situation on the ground, and to help develop targeted and specific strategies to respond to the issues they face. Connecting this local experience to international decision-making is crucial in ensuring that international policy is informed by evidence, experience and the pragmatism that underpins community-based responses.

In responding to the global HIV pandemic, significant improvements have been made in many areas. The involvement of people living with HIV and of non-governmental organisations (NGOs) is included at even the highest levels of governance in some multilateral agencies. Yet, civil society engagement in international drug policy, and in particular the involvement of people who use drugs, lags far behind.

There are many opportunities for civil society engagement at the international level in the context of drug control, harm reduction and human rights. It is up to civil society and people who use drugs, as much as international agencies and bodies, to ensure that they are represented and heard.

UN civil society relations in drug policy

In 2003, then UN Secretary-General Kofi Annan commissioned a high-level panel to investigate methods of improving civil society engagement throughout the UN system. In its report,² the panel concluded that the most compelling reason for 'enhancing dialogue and cooperation with civil society is that doing so will make the United Nations more effective'.³ The report produced a series of practical recommendations to achieve this outcome. Central to these proposals was the need to 'connect the local with the global'⁴ so that UN deliberations, decisions and policies 'become richer and more diverse, yet grounded in reality'.⁵

These comments are of considerable relevance to global drug policy and have important implications for decision-makers at the international level. However, while there is little doubt that civil society engagement with the UN has improved over the years, it is equally true that this improvement has not been uniform. Civil society remains seriously under-represented in international drug policy when compared to other areas of the UN system.

Commission on Narcotic Drugs (CND)

The CND is a 'functional commission' of the Economic and Social Council of the UN (ECOSOC), yet its practices in relation to civil society fall far behind many of its sister commissions. While the level and quality of civil society engagement at the Commission on the Status of Women and the Commission on Sustainable Development, for example, are considerable,⁶ the same may not be said of the CND.

Civil society representation at the CND is generally minimal, with limited entitlements to participate. Indeed, NGOs are excluded from informal negotiations, and may be excluded from open sessions at the request of any member state. There is no civil society liaison, and there are no online instructions explaining how NGOs may contribute.

Due to the efforts of NGOs, however, this situation is improving. Over one hundred NGO and civil society representatives attended the 51st session of the CND in 2008. NGO statements in favour of harm reduction and human rights made during the plenary sessions were greater in number than in previous years.⁷

International Narcotics Control Board (INCB)

The INCB is the independent committee responsible for monitoring the implementation of the international drug control treaties. It refuses to engage in any way with civil society. This refusal stands in stark contrast to the UN human rights treaty bodies, which monitor the implementation of the UN human rights conventions and which specifically encourage civil society to become involved in their work. At the 2008 CND session, many member states made statements calling on the INCB to involve civil society in its work.⁸

United Nations Office on Drug and Crime (UNODC)

Civil society engagement with UNODC is significantly better than with either the CND or the INCB. NGOs have assisted UNODC in the planning and implementation of projects worldwide, and UNODC funds civil-society-led projects in many countries. UNODC is also assisting NGOs to become more involved in policy.

The 'Beyond 2008' project, for example, is a joint initiative of the Vienna and New York NGO Committees on Narcotic Drugs, in partnership with UNODC. The objective of this process is to highlight NGO achievements, review best practice and develop recommendations for the CND in the lead up to the 2008–2009 high-level meeting on drugs.⁹

Nevertheless, the level of engagement in other UN agencies, funds and programmes is arguably more developed. For example, formalised policies and guidelines on civil society engagement have been developed by WHO,¹⁰ UNDP¹¹ and UNAIDS¹². In terms of policy development, NGOs may enter into official relations with the executive boards of WHO and UNICEF, and may observe and make statements at board meetings. UNDP facilitates 'structured dialogues' between its board and an advisory committee made up of fourteen civil society representatives. Five NGO representatives sit on the Programme Coordinating Board of UNAIDS, including representatives living with HIV and from harm reduction networks.

Similar arrangements apply in other international bodies, for example the Global Fund allows full voting rights to the three civil society representatives on its board.

In terms of assisting NGOs to participate, WHO, UNAIDS and the Office of the High Commissioner for Human Rights (OHCHR) all have established civil society liaison units. The OHCHR's civil society unit has a key role in assisting NGOs to participate at the Human Rights Council, a level of support that is severely lacking at the CND, and which should be provided by UNODC.

Greater involvement of people who use drugs

People who use drugs are perceived as a 'problem community' or even 'socially evil',¹³ an attitude which fuels discrimination and limits their capacity to be involved as equal partners in the response to HIV and drugs. The demands of people who use drugs for a voice in decision-making processes are often not met. The experiences of people who use drugs, essential for the effective design and implementation of policies and programmes that affect them, remain under-utilised. Despite this, the number of drug user organisations involved in a wide range of initiatives is growing, as is the capacity of those organisations to become involved in advocacy at both national and international levels.

The International Network of People who Use Drugs (INPUD) became a legally established entity in 2007 with support from IHRA and the International Harm Reduction Development Programme of the Open Society Institute. A regional subsidiary, INPUD Asia-Pacific, was launched at the 8th International Congress on AIDS in Asia and the Pacific (ICAAP), and is the first regional network for people who use drugs. People who use drugs are also mobilising and organising in some of the most challenging environments. Black Sheep, for example, is a local drug user network formed recently in Myanmar to provide peer-to-peer support.

In 2007, research conducted by INPUD and the Correlation Network found that the work carried out by drug user organisations was extremely broad, ranging from harm reduction, peer support and counselling to media work, advocacy and conference organisation.¹⁴ The research also found, however, that networking and advocacy at the international level were weak among drug user organisations. INPUD and regional networks of people who use drugs will have a central role to play in increasing that engagement in the coming years.

In its first year of operation, INPUD has represented people who use drugs in international forums such as the EU Civil Society Forum on Drugs, the CND and the Civil Society Task Force for the 2008 UNGASS on HIV and AIDS.

Seizing opportunities

There is clearly a momentum developing in the engagement of civil society, and in particular people who use drugs, in drug policy. This development must be reinforced not only by promoting better practices within the drug control entities, but also by taking advantage of existing avenues and processes. Some opportunities include:

- a) Networking through partnerships such as the International Drug Policy Consortium (IDPC), and sharing ECOSOC accreditation to increase civil society representation.
- b) Promoting policy coherence within UN governance structures – UNAIDS Programme Coordinating Board (PCB), CND, ECOSOC, General Assembly, Human Rights Council. For example, at the 51st session of the CND in 2008, a resolution was passed calling for greater co-ordination between the CND and the UNAIDS PCB on HIV transmission.
- c) Linking civil society advocacy at the 2008–2009 high-level meeting on drugs with that taking place around the 2008 UNGASS on HIV/AIDS. Such links should include sharing expertise and experiences across specific content areas (drugs, HIV etc.) for mutual capacity-building and network cross-fertilisation.

Opportunities to expand the meaningful involvement of people who use drugs can be promoted, particularly through the UN human rights bodies. For example:

- a) The Human Rights Council, which is a new and senior political body in the UN reporting directly to the General Assembly.
- b) The Office of the High Commissioner for Human Rights, which sits alongside UNODC as a department of the UN secretariat and is charged with mainstreaming human rights throughout the UN system.¹⁵
- c) The UN human rights treaty bodies, which oversee the implementation of the human rights treaties through periodic reports submitted by governments. In 2007, IHRA and the Swedish Drug Users' Union used this process to submit a 'shadow report' on Sweden's obligations under the International Covenant on Economic, Social and Cultural Rights, and the state's failure to implement comprehensive harm reduction services as part of the obligation to fulfil the right to health.¹⁶

Civil society engagement at the UN level brings to life the concept of 'We, the Peoples,' in whose name the Charter of the United Nations was written.¹⁷ Time and again, political declarations stemming from UN special sessions and high-level meetings reaffirm the importance of civil society input and the involvement of affected communities in meeting international challenges. Reducing the impact of drug-related harms, responding to HIV transmission among people who inject drugs and campaigning for the rights of people who use drugs should not be treated any differently. People who use drugs are part of the solution, not the problem.

While there is little doubt that the level of civil society engagement in international drug policy must improve, this is not solely the responsibility of the UN, its agencies and programmes. While those bodies have the obligation to improve their own processes, NGOs and drug user organisations must also attempt to seek out and utilise the many existing avenues at national, regional and international levels if valuable local experience and expertise is to be incorporated into international policy-making. Meaningful civil society engagement, after all, requires engaged civil society.

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- 3 *ibid.* p 8.
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- 6 See UN Non-Governmental Liaison Service (2008) *UN–Civil Society Engagement: Year in Review 2007*. New York and Geneva: UN-NGLS.
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