



DO NO HARM

HEALTH, HUMAN RIGHTS
AND PEOPLE WHO USE DRUGS

CONTENTS

FOREWORD	1
INTRODUCTION	3
HIV AND PEOPLE WHO INJECT DRUGS: LACK OF GLOBAL PROGRESS	10
HARM REDUCTION	14
HEALTH CARE	27
STIGMA, DISCRIMINATION AND PUNISHMENT	33
PRISONS	42
REFORM AND EMPOWERMENT	48
CONCLUSION	56
COUNTRY PROFILES	59
Afghanistan	60
Australia	62
Azerbaijan	64
Belarus	66
Canada	68
China	70
Czech Republic	72
Egypt	74
France	76
Germany	78
India	80
Indonesia	82
Iran (Islamic Republic of)	84
Kazakhstan	86
Kenya	88
Kyrgyzstan	90
Malaysia	92
Mexico	94
Morocco	96
Myanmar	98
Nigeria	100
Pakistan	102
Philippines	104
Portugal	106
Republic Of Moldova	108
Russian Federation	110
South Africa	112
Thailand	114
Ukraine	116
United Republic of Tanzania	118
United States of America	120
Uzbekistan	122
Viet Nam	124
REFERENCES	126

PUTTING PEOPLE, HEALTH AND HUMAN RIGHTS AT THE CENTRE OF GLOBAL DRUG POLICY

The world is failing to protect the health and human rights of people who use drugs.

One result of this failure is an HIV response that has left behind people who inject drugs. Globally, there was no decline in new HIV infections among people who inject drugs between 2010 and 2014. This goes against the global trend of declining new HIV infections.

Evidence supports the need for a shift in the global approach to drug use. In this report, *Do no harm: health, human rights and people who use drugs*, UNAIDS shows what works to reduce the impact of HIV and other harms related to drug use. Countries that have moved away from laws and policies that are harmful to people who use drugs and that have increased investment in harm reduction have reduced new HIV infections and improved health outcomes. These policies also deliver broader social benefits, such as lower levels of drug-related crime and reduced pressure on health-care and criminal justice systems.

However, despite the large body of scientific evidence, these approaches are far from universal. Millions of people who use or inject drugs continue to be criminalized and marginalized. Stigma and discrimination prevent their access to health care, harm reduction and legal services. Levels of drug use remain unchanged.

In this report, UNAIDS calls for the global adoption of a people-centred, public health and human rights-based approach to drug use.

The world cannot continue to ignore the evidence. Over the coming months, the United Nations General Assembly will have two opportunities to reflect on this evidence-informed approach. The United Nations General Assembly Special Session on the World Drug Problem, being held from 19 to 21 April 2016, provides an opportunity to refocus international drug policies on their original goal—the health and well-being of humankind. Less than two months later, from 8 to 10 June, the General Assembly will meet again for the High-Level Meeting on Ending AIDS, where stronger commitments are needed to ensure that the AIDS response does not continue to leave behind people who inject drugs.

This is a unique opportunity to adopt a new course of action—to treat people who use drugs with dignity and respect; to provide them with equal access to health and social services; to greatly reduce the harms of drug use; and to contribute to the end of the AIDS epidemic and the achievement of the Sustainable Development Goals.

"IN FULL COMPLIANCE WITH HUMAN RIGHTS STANDARDS AND NORMS, THE UNITED NATIONS ADVOCATES A CAREFUL RE-BALANCING OF THE INTERNATIONAL POLICY ON CONTROLLED DRUGS. WE MUST CONSIDER ALTERNATIVES TO CRIMINALIZATION AND INCARCERATION OF PEOPLE WHO USE DRUGS AND FOCUS CRIMINAL JUSTICE EFFORTS ON THOSE INVOLVED IN SUPPLY. WE SHOULD INCREASE THE FOCUS ON PUBLIC HEALTH, PREVENTION, TREATMENT AND CARE, AS WELL AS ON ECONOMIC, SOCIAL AND CULTURAL STRATEGIES."

UNITED NATIONS SECRETARY-GENERAL BAN KI-MOON

26 JUNE 2015

INTRODUCTION

The maxim *primum non nocere*—“Above all, do no harm”—calls for careful consideration of the harms that may result from our actions (1).

Global efforts to control narcotic drugs and psychotropic substances are based on the premise that the misuse of these substances can lead to serious harm to the individual and society. As countries gather at the United Nations General Assembly Special Session (UNGASS) on the World Drug Problem on 19–21 April 2016, more than a half century after the Single Convention on Narcotic Drugs was agreed, the harms caused by international drug control to people who use drugs require much greater attention.

The vast majority of the 246 million people who use drugs have been criminalized by national legislation and marginalized by society (2). Many have been traumatized by violence, imprisoned for possession of small quantities of drugs for personal use or coerced to undergo drug dependence treatment. Women who use drugs have been forced to undergo sterilization or abortions, separated from their children and denied public housing and other benefits.

As a result, people who use drugs, especially those who inject drugs, have been isolated and often denied the means to protect themselves from HIV, hepatitis C virus, tuberculosis and other infectious diseases. Among the estimated 12 million people who inject drugs globally, 1 in 10 is living with HIV (3). Hundreds of thousands have been incarcerated in compulsory detention centres, including more than 455 000 in seven Asian countries (4).

The tools and strategies required to improve the health and lives of people who use drugs are well known and readily available. Needle-syringe programmes reduce the spread of HIV and other bloodborne viruses. Opioid substitution therapy and other evidence-informed forms of drug dependence treatment curb drug use, reduce vulnerability to infectious diseases and improve uptake of health and social services. Naloxone is an effective treatment for opioid drug overdoses and saves lives. Treatments for HIV, hepatitis C virus and tuberculosis greatly reduce morbidity and mortality. The United Nations Office on Drugs and Crime (UNODC), the World Health Organization (WHO) and UNAIDS recommend using these services within a comprehensive package of health interventions. Beyond the package, drug consumption rooms and heroin-assisted drug dependence treatment may deliver important benefits to the most marginalized and severely dependent people who inject drugs.

An overwhelming body of evidence shows that these harm reduction approaches reduce the health, social and economic harms of drug use to individuals, communities and societies, and they do not cause increases in drug use. Harm reduction is also cost effective. For example, each dollar spent on Australia’s needle–syringe programme returns up to US\$ 5.50 in averted health-care costs (5). By comparison, criminalization and incarceration appear expensive and ineffective. Criminalization has been shown to perpetuate risky forms of drug use, to increase the risk of illness (including HIV infection) among people who use drugs, to discourage people who use drugs from seeking health care, and to reinforce the marginalization by society of people who use drugs (6). In the United States of America, each dollar spent on incarceration of people who use drugs generates only US\$ 0.33 in public safety gains (7, 8).

Maximization of the coverage and effectiveness of harm reduction requires an enabling legal and policy environment and the dedication of sufficient financial resources. Countries that have decriminalized or relaxed criminal penalties for drug possession and use have increased enrolments into drug dependence treatment, reduced criminal justice costs and improved the health of people who use drugs. For example, Portugal’s depenalization of the purchase, possession and consumption of small amounts of narcotic drugs, and expansion of the availability of harm reduction services, have coincided with a 95% decrease in the number of people who inject drugs diagnosed with HIV each year (9). In the Czech Republic, decriminalization of possession and use of small quantities of drugs combined with a relatively high coverage of harm reduction have been credited with bringing about remarkably low rates of HIV among people who inject drugs (10). In China, the expansion of needle–syringe programmes and methadone maintenance therapy has seen the proportion of HIV infections acquired through injecting drug use plummet from nearly 50% to less than 1 in 10 (11).

Cost-effectiveness of harm reduction and incarceration of people who use drugs



Sources: Kwon J et al. Estimating the cost-effectiveness of needle–syringe programs in Australia. *AIDS* 2012;26:2201–2210.

Przybylski R. Correctional and sentencing reform for drug offenders: research findings on selected key issues. Lakewood, CO: RKC Group; 2009 (http://www.cjrc.org/wp-content/uploads/2016/02/Correctional_and_Sentencing_Reform_for_Drug_Offenders.pdf.)

State of Oregon, Criminal Justice Commission. Report to the legislature. January 2007. (<http://www.oregon.gov/v3replaced/docs/cjc2007reporttolegislature.pdf>)

These successes and others have fuelled a rising chorus for change. The International Narcotics Control Board has advised countries that international drug control conventions contain sufficient flexibilities for the scale-up of harm reduction within a balanced approach to drug control (12). WHO has called on countries to develop policies and laws that decriminalize drug use in order to reduce incarceration and improve coverage of harm reduction services (13). The United Nations Committee on Economic, Social and Cultural Rights, the United Nations Committee on the Rights of the Child, the United Nations High Commissioner for Human Rights and the Special Rapporteur on the Right to Health have all endorsed a harm reduction approach to drug use (14), and the United Nations General Assembly has stated that expansion of harm reduction will be critical to achieving international targets to reduce HIV infections among people who inject drugs (15).

Outside western Europe, North America and Oceania, however, few countries have achieved sufficient coverage of harm reduction services. In many middle-income countries with large populations of people who inject drugs, harm reduction is funded predominately by international donors and private foundations. This heavy reliance on donor resources, combined with the retention of policies that criminalize and penalize people who use drugs, limits scale-up and threatens the sustainability of existing services.

Globally, low coverage of harm reduction programmes has translated into a lack of progress. There was no decline in the annual number of new HIV infections among people who inject drugs from 2010 to 2014 (3). A global target to substantially reduce HIV transmission among people who inject drugs by 2015 has not been met.

The Sustainable Development Goals agreed by the United Nations General Assembly in 2015 include new targets to achieve universal health coverage, to end the epidemics of HIV and tuberculosis, to combat hepatitis, and to strengthen the prevention and treatment of drug dependence by 2030. The world will struggle to achieve these goals unless substantially greater investments are made in the health of marginalized populations such as people who use drugs.

UNAIDS has developed a 2016–2021 strategy to put the world on track to ending AIDS as a public health threat by 2030. A critical target within this Fast-Track approach is the expansion of a combination of HIV prevention and harm reduction services to reach 90% of people who inject drugs by 2020. Achieving this target would require annual investment in outreach, needle–syringe distribution and opioid substitution therapy in low- and middle-income countries to increase to US\$ 1.5 billion by 2020 (16).

Meanwhile, an estimated US\$ 100 billion is spent each year to reduce the supply and demand of narcotic drugs (17). Aggressive policing and punishment have had little or no impact on the number of people using drugs. Country data collected by UNODC show that the

percentage of people who use illicit drugs has remained stable—fluctuating between 4.6% and 5.2% of adults aged 15–64—since at least 2006 (2). Overly restrictive drug control policies also deny access to essential pain relief medicines to millions of women in labour, people with terminal cancer, people with late-stage AIDS and victims of violence and accidents.

The UNGASS on the World Drug Problem is an opportunity to refocus the international drug control system on its original goal—the health and well-being of humankind. UNAIDS calls on United Nations Member States to take on board five policy recommendations and 10 operational recommendations for a people-centred public health and human rights-based approach to drug use.

These recommendations are supported by the body of evidence contained within this report. They aim to treat people who use drugs with dignity and respect, to provide them with equal access to health and social services, to greatly reduce the harms of drug use, and to contribute to the end of the AIDS epidemic and the achievement of the Sustainable Development Goals.

FIVE POLICY RECOMMENDATIONS

1
RECOGNIZE THAT THE OVERARCHING PURPOSE OF DRUG CONTROL IS FIRST AND FOREMOST TO ENSURE THE HEALTH, WELL-BEING AND SECURITY OF INDIVIDUALS, WHILE RESPECTING THEIR AGENCY AND HUMAN RIGHTS AT ALL TIMES.

2
ENSURE ACCOUNTABILITY FOR THE DELIVERY OF HEALTH SERVICES FOR PEOPLE WHO USE DRUGS BY INCLUDING PUBLIC HEALTH AND HUMAN RIGHTS PILLARS IN THE FRAMEWORK OF THE UNGASS OUTCOME DOCUMENT THAT INCORPORATE CLEAR OBJECTIVES FOR REDUCING NEW HIV INFECTIONS AND PROTECT AND PROMOTE THE RIGHTS OF PEOPLE WHO INJECT DRUGS.

3
COMMIT TO FULLY IMPLEMENT HARM REDUCTION AND HIV SERVICES, AS OUTLINED IN THE WORLD HEALTH ORGANIZATION'S CONSOLIDATED GUIDELINES ON HIV PREVENTION, DIAGNOSIS, TREATMENT AND CARE FOR KEY POPULATIONS.

4
COMMIT TO TREATING PEOPLE WHO USE DRUGS WITH SUPPORT AND CARE, RATHER THAN PUNISHMENT. UNAIDS BELIEVES THAT THIS OBJECTIVE CAN BE ACHIEVED ONLY BY IMPLEMENTING ALTERNATIVES TO CRIMINALIZATION, SUCH AS DECRIMINALIZATION AND STOPPING INCARCERATION OF PEOPLE FOR THE CONSUMPTION AND POSSESSION OF DRUGS FOR PERSONAL USE.

5
ENSURE INTEGRATION OF HIV SERVICES WITH OTHER HEALTH AND SOCIAL PROTECTION SERVICES FOR PEOPLE WHO USE DRUGS.

TEN OPERATIONAL RECOMMENDATIONS

1.

Ensure that all people who inject drugs, including people in prisons and other closed settings, have access to harm reduction services to prevent HIV infection, including needle–syringe programmes, opioid substitution therapy and antiretroviral therapy.

2.

Ensure that all people who inject drugs and are living with HIV have access to life-saving antiretroviral therapy and other health services to manage tuberculosis, viral hepatitis and sexually transmitted infections.

In addition, ensure adequate availability and access to opioids for medical use to reduce pain and suffering.

3.

Ensure that all people who use drugs have access to non-coercive and evidence-informed drug dependence treatment consistent with international human rights standards and the Principles of Drug Dependence Treatment articulated by the United Nations Office on Drugs and Crime and the World Health Organization. All forms of compulsory drug and HIV testing and drug treatment should be replaced with voluntary schemes. The use of compulsory detention centres for people who use drugs should cease, and existing centres should be closed.

4.

Adapt and reform laws to ensure people who use drugs do not face punitive sanctions for the use of drugs or possession of drugs for personal use. Countries should consider taking a range of measures, including alternatives to criminalization, incarceration, penalization and other penalties based solely on drug use or possession of drugs for personal use. These measures include decriminalization, steps to reduce incarceration, removal of administrative penalties and depenalization.

5.

Ensure that the human rights of people who use drugs are not violated, by providing access to justice (including through legal services), prevention, treatment and other social services. Adopt smart policing measures to encourage people to access public health services.

6.

Recognize that stigma and discrimination impede access to HIV prevention, treatment and other health and development services, and ensure that all people who use drugs are not discriminated against while accessing health, legal, education, employment and other social protection services.

7.

Recognize that incarcerating people in prisons increases their risk of drug use, HIV infection and other health conditions and take steps to ensure that harm reduction and other health services are available in prisons in parallel with efforts to reduce the number of people being incarcerated for non-violent drug offences.

8.

Ensure widespread availability of naloxone among health workers, first responders, prison staff, enforcement officials and family members as a life-saving public health measure to enable timely and effective prevention of deaths from opioid overdose among people who use drugs.

9.

Support and empower community and civil society organizations, including organizations and networks of people who use drugs, in the design and delivery of HIV, health and social protection services.

10.

Undertake a rebalancing of investments in drug control to ensure that the resources needed for public health services are fully funded, including harm reduction for HIV infection, antiretroviral therapy, drug dependence treatment and treatment for hepatitis, tuberculosis and other health conditions.

HIV AND PEOPLE WHO INJECT DRUGS: LACK OF GLOBAL PROGRESS

In 2011, when the United Nations General Assembly gathered for a High-Level Meeting on AIDS, United Nations Member States recognized that HIV prevention efforts had been inadequately focused on key populations at higher risk of HIV infection, including people who inject drugs. The resulting Political Declaration on HIV and AIDS included 10 ambitious targets for 2015, including a pledge to reduce HIV transmission among people who inject drugs by 50% by 2015 (1).

Since the Political Declaration was agreed, the global AIDS response has achieved substantial progress, including increases in domestic and donor investment in the HIV responses in low- and middle-income countries, a rapid increase in the number of people living with HIV receiving antiretroviral therapy and substantial progress towards eliminating mother-to-child transmission of HIV, reducing the number of mothers dying from AIDS-related causes and reducing tuberculosis-related deaths among people living with HIV (2). These results inspired even greater ambition—the Sustainable Development Goals agreed by the General Assembly in 2015 include a commitment to end the AIDS epidemic by 2030.

People who inject drugs: estimated population size and incidence of HIV infection, by region, 2014

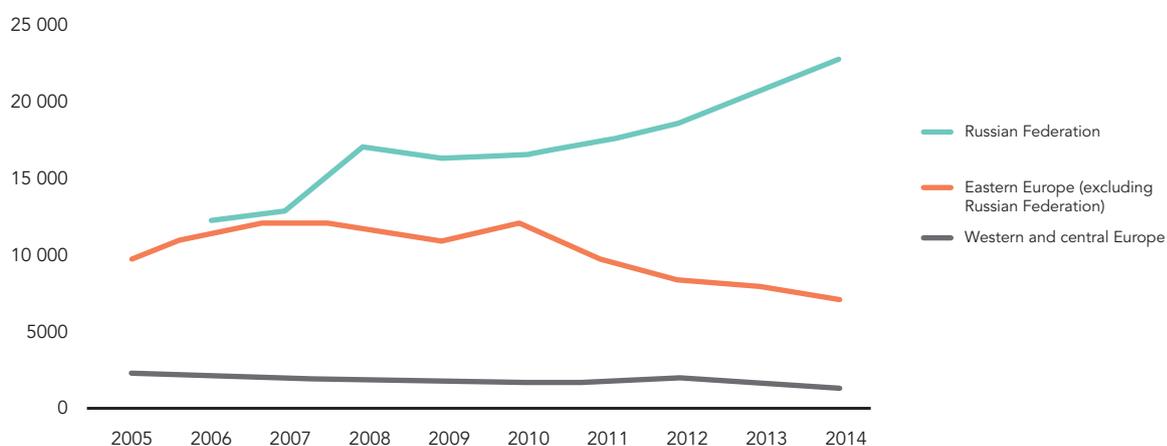
REGION	INCIDENCE PER YEAR	POPULATION SIZE ESTIMATE
Asia and the Pacific	1.4% [0.7–2.6%]	4 012 000 [2 796 000–5 302 000]
Latin America and the Caribbean	0.3% [0.1–0.7%]	721 000 [312 000–1 375 000]
Eastern and southern Africa	2.9% [1.0–19.5%]	333 000 [128 000–2 055 000]
Eastern Europe and central Asia	2.0% [1.1–3.8%]	3 159 000 [2 054 000–5 005 000]
Middle East and North Africa	1.2% [0.5–4.4%]	462 000 [299 000–1 128 000]
Western and central Africa	1.4% [0.3–15.0%]	155 000 [32 000–1 484 000]
Western and central Europe	0.8% [0.4–1.4%]	800 000 [719 000–914 000]
North America	0.3% [0.1–0.5%]	2 104 000 [1 819 000–2 413 000]

Source: UNAIDS, 2016.

However, global progress against HIV has left behind many people who inject drugs. UNAIDS estimates that 140 000 [112 000–168 000] people who inject drugs were newly infected with HIV globally in 2014, and people who inject drugs and their sexual partners accounted for about 30% of the people newly infected with HIV outside sub-Saharan Africa. Evidence available to UNAIDS suggests that there was no decline in the annual number of new HIV infections among people who inject drugs between 2010 and 2014. This lack of global progress obscures important differences among countries and regions.

These differences are most dramatic in Europe. In western and central Europe, where many countries have maintained high coverage of harm reduction programmes for more than a decade, the number of people who inject drugs newly diagnosed with HIV has steadily declined, from 2161 in 2005 to 1126 in 2014 (3). The annual number of HIV cases among people who inject drugs is much higher in eastern Europe, where trends are dominated by the Russian Federation. Available data suggests there are at least 1.5 million people who inject drugs in the Russian Federation—nearly half of the region’s 3.2 million people who inject drugs. In 2007, the number of newly reported HIV cases among people who inject drugs in the Russian Federation (12 538) was similar to the number in the rest of eastern Europe (12 026). Since then, the trends in case reporting have diverged dramatically. According to the European Centre for Disease Prevention and Control, the scaling up of harm reduction programmes in several eastern European countries coincided with stabilization in newly reported HIV cases among people who inject drugs, followed by a reduction to less than 7000 in 2014. In the Russian Federation, where access to sterile needles and syringes is low and opioid substitution therapy remains illegal and unavailable, the number of people who inject drugs newly infected with HIV climbed to nearly 22 500 in 2014 (4). In central Asia, data reported to UNAIDS suggest that Kyrgyzstan and Tajikistan are experiencing declines in the number of people who inject drugs newly infected with HIV, and the estimated infection rates in Azerbaijan and Kazakhstan are relatively stable.

Number of people who inject drugs reported to be newly diagnosed with HIV in Europe,* 2005–2014



* Subregional classification according to European Centre for Disease Control norms.

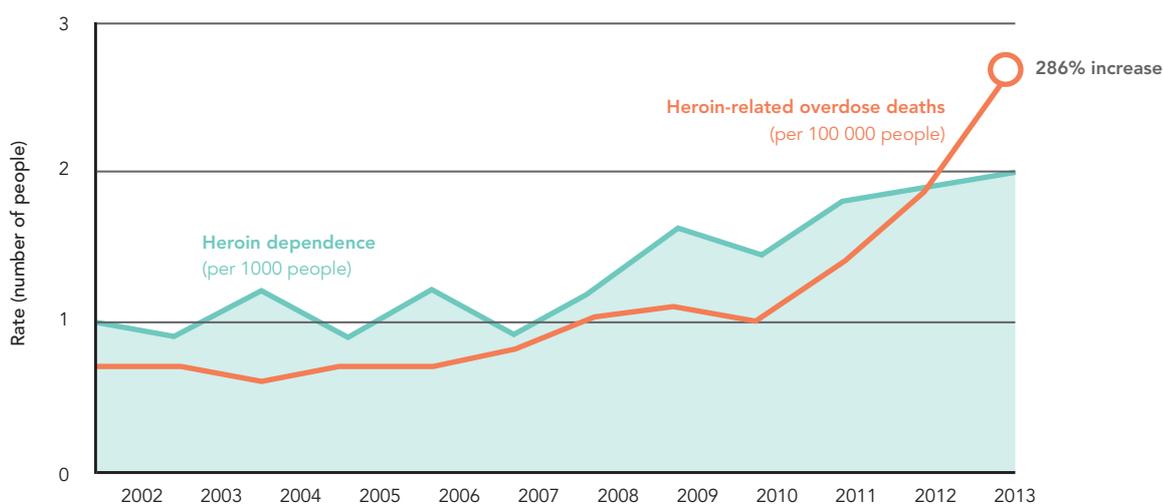
Sources: European Centre for Disease Control, Russian Federation AIDS Bureau.

UNAIDS estimates that more than 4 million people inject drugs in Asia and the Pacific, where HIV prevalence within this key population in 2014 was uniformly high, and eight of 19 countries reported that more than one in 10 people who inject drugs was living with HIV (5). In recent years, evidence of substantial reductions in the number of people newly infected with HIV in Bangladesh, Indonesia, Malaysia, Myanmar, Nepal and Viet Nam has been counterbalanced by a doubling new HIV infections among people who inject drugs in Pakistan and stable rates in Thailand. Data from India, where nearly 10% of the almost 2 million people who inject drugs are living with HIV (6), suggest that injecting drug use is spreading beyond regions where use is well known and documented (7). In China, where the HIV prevalence among an estimated 1.9 million people who inject drugs is 6% (8), a steep decline in the proportion of all new HIV infections attributable to injecting drug use between 2003 and 2013 (9) suggests a decline in the rate of new HIV infections.

The growing importance of sub-Saharan Africa as a transit area for heroin smuggling has coincided with an increase in injecting drug use. Heroin use and injecting drug use has spread south along the Swahili coast and subsequently moved inland, following transport routes along trans-African highways (10, 11). Kenya, Madagascar, Mauritius, Mozambique, Nigeria, Senegal, South Africa and the United Republic of Tanzania are all home to many people who inject drugs. There are also significant populations of people who inject drugs among the island countries of the Indian Ocean. Although limited in scope, surveys among people who inject drugs in sub-Saharan Africa suggest high HIV prevalence. In Kenya, where HIV prevalence among people who inject drugs is about 18% versus 5.6% in the general population, low condom use and safe injecting practices exacerbate transmission (12). Surveys in western Africa found the HIV prevalence among people who inject drugs to be 4.2% in Nigeria (13), 5.3% in Abidjan, Côte d'Ivoire (14) and 13.3% in Kinshasa, Democratic Republic of the Congo (15).

The United States of America is home to more than 90% of the estimated 2 million people who inject drugs in North America. Heroin use has increased among men and women in most age groups and across all income levels in the United States, leading to a 286% increase in heroin-related overdose deaths from 2002 to 2013 (16). The number of prescription opioid pain medications and overdose deaths attributed to these medications also quadrupled over a 15-year period (17). These trends have coincided with an increase in hepatitis C virus infections and new outbreaks of HIV associated with injecting drug use (18). Despite these worrying trends, annual diagnoses of HIV infection attributed to injecting drug use nationally fell from 2010 to 2014 among both men (2115 to 1590) and women (1455 to 1045) (19). In Canada, where comprehensive harm reduction programmes in major cities reach a large proportion of the estimated 112 900 [90 000–135 800] people who inject drugs (20), national health authorities estimate that the number of people who inject drugs newly infected with HIV declined from 531 [380–680] in 2011 to 270 [180–360] in 2014 (21).

Increases in heroin dependence and heroin-related overdose deaths in the United States of America, 2002–2013



Reproduced from: Today's heroin epidemic: more people at risk, multiple drugs abused. Atlanta: United States Centers for Disease Control and Prevention; 2015 (CDC Vital Signs).

Sources: National survey on drug use and health (NSDUH) 2002–2013; National Vital Statistics System, 2002–2013.

In Latin America and the Caribbean, there are limited data on people who inject drugs and HIV, and population size estimates in some countries may include substantial numbers of former injectors or people who use drugs but do not inject. Users of non-injecting drugs in the region appear to have higher HIV prevalence because of sexual risk behaviour. In Brazil, a 2011 survey of people who use drugs found low rates of low rates of condom use, as well as HIV testing and HIV prevalence of 5%—eight times higher than the general population (22). In Montevideo, Uruguay, 6.3% of people who smoke cocaine surveyed in 2012 were living with HIV; among the survey respondents who reported engaging in transactional sex within the last 12 months, HIV prevalence was 17.9% (23). In Argentina, the estimated proportion of new HIV infections among people who inject drugs decreased from 7.6% in 2005–2007 to 0.4% in 2011–2013 (24).

In the Middle East and North Africa, recent data on people who inject drugs are sparse. There is evidence of HIV epidemics among people who inject drugs in at least one third of the countries in the region, with HIV prevalence across the region estimated to be in the range of 10–15% (25). Data from North Africa are particularly concerning, with suggestions of steady incidence and rising prevalence in some settings (26). One of the highest rates of HIV prevalence in the world—87%—and hepatitis C virus prevalence of 94% were detected by a survey among 328 people who inject drugs in Tripoli, Libya, in 2010 (27).

Recent alarming outbreaks of HIV among populations of people who inject drugs have been detected across most regions—including Jalalpur Jattan, Pakistan (28); Indiana, United States (29); Kanpur, India (7); Athens, Greece (30); and Bucharest, Romania (31). This underscores the need to ensure access to comprehensive HIV prevention services, even in areas where the HIV prevalence among this key population is currently low.

HARM REDUCTION

Many of the 12 million people who inject drugs are unable or unwilling to stop, despite the many negative outcomes associated with drug use. The foundation of a rights-based, public-health approach to this reality is harm reduction: services, programmes and policies that seek to reduce the health, social and economic harms of drug use to individuals, communities and societies.

Elements of harm reduction have been documented as far back as the 1920s, when people treated for dependence on opioids in the United Kingdom were prescribed heroin or morphine to ease their withdrawal symptoms (1). Similar challenges led to the development of methadone maintenance therapy in the United States in the 1960s (2). The first needle–syringe programmes were launched in the 1970s when the role of sharing injecting equipment in the transmission of hepatitis B was first understood. The rampant spread of HIV among people who inject drugs in the 1980s convinced many high-income countries to greatly expand their needle–syringe programmes (2).

In too many countries with large populations of people who inject drugs, however, harm reduction has not expanded beyond small-scale pilot schemes funded by external donors. Detractors claim that harm reduction promotes drug use despite evidence to the contrary. Despite the many political and ideological barriers, harm reduction approaches have persisted due to an inexorable fact: harm reduction works. It reduces the spread of HIV and other bloodborne viruses, it reduces drug dependence and drug use and it prevents overdose deaths.

The overwhelming body of evidence on the effectiveness of harm reduction is the basis for a comprehensive package of interventions recommended by WHO, UNODC and UNAIDS for preventing the spread of HIV and reducing other harms associated with drug use.

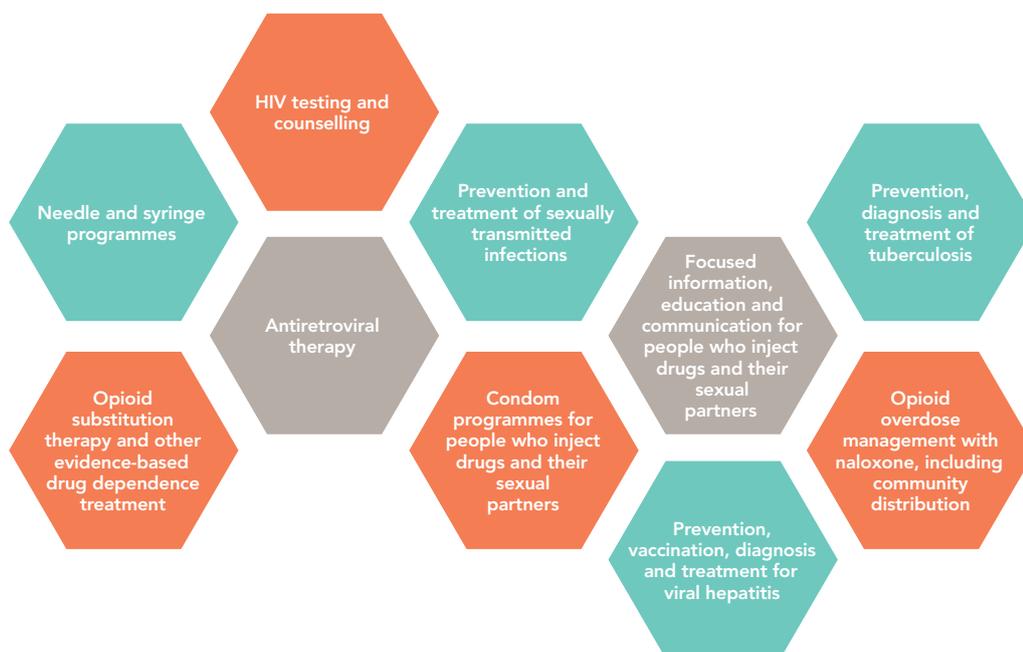
NEEDLE AND SYRINGE DISTRIBUTION

Needle–syringe programmes reduce the probability of transmission of HIV and other bloodborne diseases by lowering the rates of sharing of injecting equipment among people who inject drugs (3, 4). The provision of low dead-space syringes may also decrease HIV risk among injectors who continue to share needles (5). Well-designed needle–syringe programmes also provide information on and facilitate access to a range of services, including drug dependence treatment, health care and legal and social services.

Decades of experience within dozens of countries supports the effectiveness of needle–syringe programmes (1,6). Across eight countries in eastern Europe and central Asia, a tripling of needle–syringe programme coverage between 2005 and 2010 reduced risk behaviour related to HIV and hepatitis C virus and reduced new infections (7). Many individual programmes have achieved outstanding results. Ten years of needle–syringe programming in Australia reduced the number of cases of HIV by up to 70% and reduced the number of cases of hepatitis C by up to 43% (8). In New York, a sharp decrease in new HIV infections among people who inject drugs between 1992 and 2012 has been attributed to the implementation and expansion of syringe exchange since 1992 (9). In 2003 the New York City mayor publicly noted that harm reduction did not lead to increased drug use and drug-related crime, as opponents had warned. This political support led to further programme expansion (10).

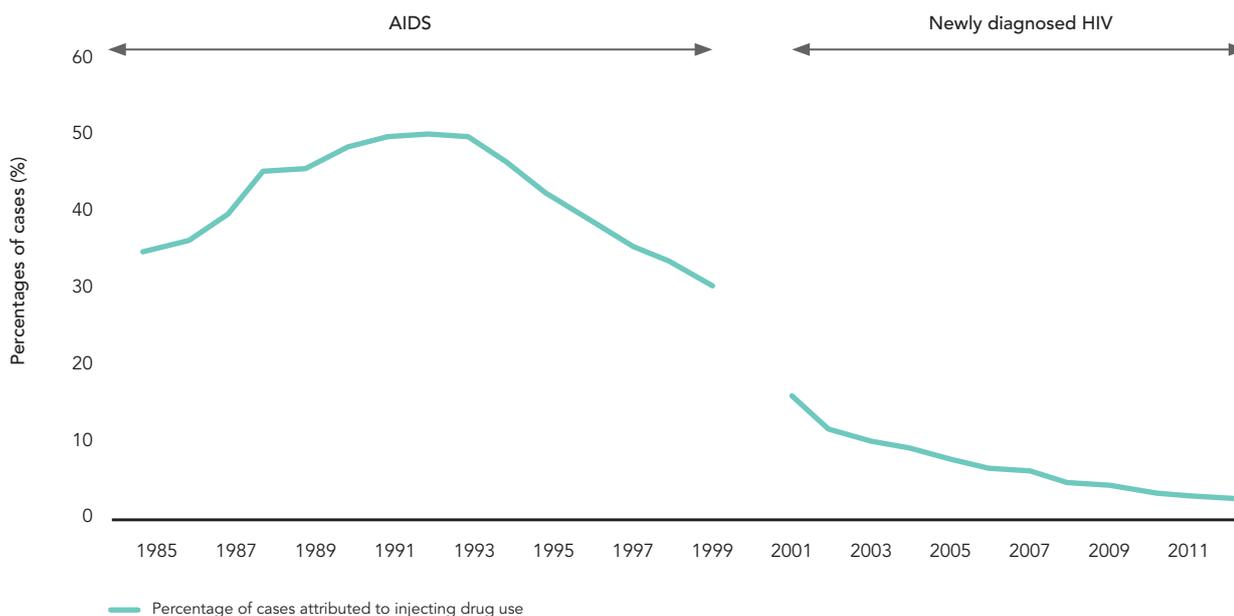
Costing US\$ 23–71 per person per year, needle–syringe programmes are relatively inexpensive to implement and are much more affordable than the lifetime health-care costs required to treat a person living with HIV (11). Cost-effectiveness is even higher if we consider the combined reduction of HIV and hepatitis C infections (12). For example, each dollar spent on Australia’s needle–syringe programme between 2000 and 2010 has an estimated lifetime return on investment of US\$ 1.30–5.50 in averted health-care costs (8). Conversely, the absence of needle–syringe programmes is a common feature in explosive and expensive increases in HIV incidence in communities that use drugs, for example in India, the Philippines, Thailand and the US state of Indiana (11, 13).

The comprehensive package for HIV prevention and reducing other harms associated with drug use*



* The first nine of these interventions are from: Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva: World Health Organization, United Nations Office on Drugs and Crime and Joint United Nations Programme on HIV/ AIDS; 2012. The tenth intervention was recommended in: Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2014.

Percentage of newly diagnosed HIV and AIDS cases attributed to injecting drug use, New York State, 1985–2012



Source: AIDS Institute, New York State Department of Health, 2014.

DRUG DEPENDENCE TREATMENT

People who are dependent on narcotic drugs and who want to reduce or completely stop their drug use can benefit from drug dependence treatment such as opioid substitution therapy. Treatment is neither quick nor simple. Drug dependence is a chronic health condition. As with other chronic conditions, long-term and continued treatment is often required; and the affected people remain vulnerable to relapse throughout their lifetime (14).

Despite these challenges, systematic reviews of opioid substitution therapy (mostly methadone or buprenorphine maintenance therapy) have demonstrated its effectiveness in the reduction or complete cessation of the use of heroin and other opioids (15,16). WHO placed methadone and buprenorphine on its Model List of Essential Drugs in 2005 (17), in 2009 urged countries to make maintenance therapy with these medicines the backbone of their treatment systems for opioid dependence (18).

Reducing injecting drug use through voluntary opioid substitution therapy yields individual and public health dividends. Methadone maintenance therapy has been associated with a 54% reduction in the risk of HIV infection within populations of people who inject drugs (19). It has been calculated that providing sufficient access to this critical component of harm reduction could prevent 130 000 new HIV infections outside sub-Saharan Africa every year (20).

Costs of needle–syringe programmes versus antiretroviral therapy



Source: Wilson DP, Donald B, Shattock AJ, Wilson D, Fraser-Hurt N. The cost-effectiveness of harm reduction. *Int J Drug Policy*. 2015;26:S5–11; Fast-Track update on investments needed in the AIDS response. Geneva: UNAIDS; 2016 (http://www.unaids.org/en/resources/documents/2016/unaids_fast-track_update_investments_needed, accessed 6 April 2016).

Substitution therapy has also been shown to decrease the risk of hepatitis C infection (21), to increase adherence to antiretroviral therapy for HIV (22), to lower out-of-pocket health expenditure (25) and to reduce opioid overdose risk by almost 90% (24). The scale-up of methadone maintenance therapy in diverse country contexts, including Portugal (25), Viet Nam (26) and New Zealand (27), has also been associated with a decrease in crimes committed by people who use drugs.

Opioid substitution therapy has been shown to be cost effective based solely on its ability to reduce HIV infections (19). Its cost-effectiveness substantially increases when its wider health, economic, psychological and social benefits, including reductions in the number and severity of relapses and reductions in crime and the costs of drug-related incarcerations, are considered (19).

The successful piloting of opioid substitution therapy in India led to the inclusion of the “management” of drug dependence and approval of the establishment of treatment centres in a 2014 amendment to the Narcotics Drugs and Psychotropic Substances Act (28). This policy change has facilitated the scaling up of the programme to more than 200 treatment centres serving about 22 500 people who inject drugs (29). Opioid substitution therapy is provided in both community settings and also through government health facilities in collaboration with nongovernmental organizations.

OVERDOSE TREATMENT

Opioid overdose claims the lives of an estimated 70 000–100 000 people each year (30). Naloxone is an extremely effective treatment for opioid drug overdose (31). Naloxone is relatively inexpensive, and using it may result in a life saved. In most countries, however, naloxone is accessible only by prescription or through hospitals and ambulance crews, who may not reach a person in need until it is too late. WHO recommends

that people likely to witness an opioid overdose should have access to naloxone and be instructed in its use for emergency management of suspected opioid overdose. An analysis of the cost-effectiveness of naloxone found that, even in a worst-case scenario, where very few overdoses were witnessed and naloxone was used only rarely, naloxone distribution to heroin users remained cost effective (32).

Scotland in the United Kingdom has been a world leader in the expansion of the availability of naloxone. In response to rising drug-related deaths, the Take Home Naloxone programme began in November 2010 by providing naloxone kits and training to people at risk of opioid overdose, including prisoners upon their release, and to their close friends and family (33). During the first four years of the programme, more than 20 000 naloxone kits were issued (34).

In the United States, heroin-related overdose deaths increased by 286% from 2002 to 2013 (35). By September 2015, 43 of 50 states had passed legislation to provide naloxone to people who are likely to witness an overdose, including family members and caregivers of people who use drugs (36). In 38 states, pharmacies can provide naloxone without a prescription (36). In 2015, the United States Food and Drug Administration approved nasal spray formulations of naloxone, which are easier to administer than an injection (37).

DRUG CONSUMPTION ROOMS AND HEROIN-ASSISTED DRUG DEPENDENCE TREATMENT

Other harm reduction approaches being used within a strong public health approach to drug use include drug consumption rooms and heroin-assisted dependence treatment. Drug consumption rooms in Copenhagen, Denmark, aim to reduce harms among the city's most marginalized and hard-to-reach people who use drugs, their families and the surrounding community, and to move their clients towards abstinence. One such facility, called The Cloud, provides booths for injecting and smoking.

Who should have access to Naloxone?

WHO recommends expanding naloxone access to



Source: Community management of opioid overdose. Geneva: World Health Organization; 2014 (http://www.who.int/substance_abuse/publications/management_opioid_overdose/en, accessed 6 April 2016).

Injecting booths include sterile needles and syringes, a vein finder and a waste bin. Police do not interfere with people using the facility, and medically trained personnel are on hand to attend to overdoses and accidental injuries. An evaluation of the programme found a decrease in theft, an 80% reduction in unsafe disposal of drug paraphernalia, and calls from the surrounding community for the facility to expand its opening hours, as disturbances and public drug-taking decreased during opening hours but remained prevalent when the facility was closed (38).

Evaluations of a similar drug consumption room in Vancouver, Canada, called Insite, found that it reduces needle sharing, overdose risk, public injecting, drug-related litter and violence against women who inject drugs; promotes health care and drug dependence treatment; and does not lead to increased drug use or increased crime (39). A cost-benefit and cost-effectiveness analysis of Insite found that it prevents an estimated 35 new cases of HIV and two to three deaths in the city per year, with a benefit to cost ratio of 5.12 to 1 (40).

Since the 1990s heroin-assisted drug dependence treatment has been piloted in several European countries and Canada as a second-line treatment for opioid-dependent people who have not responded to standard treatments such as methadone maintenance therapy (41). All injections are taken under direct medical or nursing supervision to ensure the person's safety and prevent diversion of the drug (41). A review of six randomized controlled trials by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) found that heroin-assisted treatment reduced criminal activity and the use of "street" heroin and other drugs and improved physical and mental health. Heroin-assisted treatment is more expensive than methadone maintenance therapy, however, and its users have more serious adverse events. On balance, EMCDDA has determined that heroin-assisted treatment successfully delivers important benefits to people with severe heroin dependence, their families and society (41).

COMBINATION APPROACH

Each individual approach, when implemented properly, reduces harms related to drug use and does not encourage illicit drug use. Reviews of these programmes have also found that delivering combined services of harm reduction and treatment is even more effective and cost effective than piecemeal approaches (11). For example, including condom provision within harm reduction programmes can help reduce the transmission of HIV from people who inject drugs to their sexual partners. New York City's integration of condom social marketing, methadone maintenance treatment and needle-syringe programmes has been associated with substantial decreases in sexual risk behaviour among people who inject drugs living with HIV (42). Routinely offering HIV testing to people who access needle-syringe services and drug dependence treatment services is essential to identify people living

with HIV as soon as possible after infection and then to offer immediate initiation of antiretroviral therapy. Numerous studies have shown that people living with HIV who inject drugs are more likely to remain on antiretroviral therapy if they access opioid substitution therapy (22, 43).

Countries that have adopted a comprehensive approach to harm reduction are delivering better health outcomes for people who inject drugs and more effective management of drug use and drug-related crime. China has made impressive progress in the scale-up of harm reduction services in recent years. Needle and syringe distribution has grown from a limited pilot in the early 2000s to a national programme that provided 180 needles and syringes per person who injects drugs per year in 2011, and to 204 needles and syringes per person who injects drugs per year in 2014 (44, 45). China's free voluntary methadone programme is among the largest in the world, serving more than 184 000 people—nearly 10% of people who inject drugs in China (46).

The impact of the programme has been dramatic. People who inject drugs accounted for less than 8% of people newly diagnosed with HIV in 2013, compared with 44% in 2003 (47).

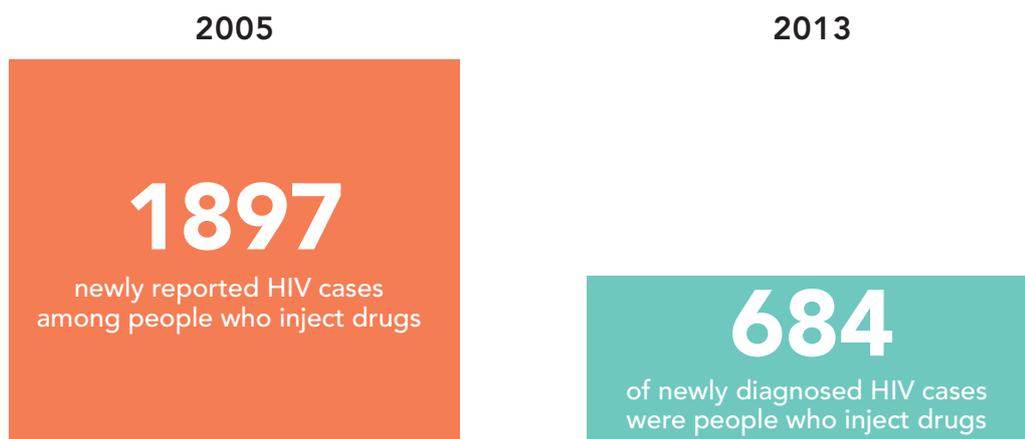
In the Islamic Republic of Iran, a tough anti-drug campaign was launched following the 1979 revolution. Individuals caught possessing drugs received fines, imprisonment and corporal punishment, and the death penalty was imposed for serious drug offences. Despite these measures, drug use and drug trafficking continued to increase. Growing recognition of the limits of enforcement, and the importance of the medical and social dimensions of drug use, resulted in improvements in drug dependence treatment and the expansion of needle–syringe distribution (48). Harm reduction programmes are implemented by both governmental and nongovernmental facilities. Nongovernmental organizations provide comprehensive harm reduction services through

Percentage of new HIV diagnoses attributed to injecting drug use, China, 2003 and 2013



Source: Halving HIV transmission among people who inject drugs. Geneva: UNAIDS; 2014 (http://www.unaids.org/sites/default/files/media_asset/20141125_Background_Note_Thematic_Segment_35PCB.pdf, accessed 6 April 2016)

Number of newly reported HIV cases among people who inject drugs, Islamic Republic of Iran, 2005 and 2013



Source: Islamic Republic of Iran AIDS progress report on monitoring of the United Nations General Assembly Special Session on HIV and AIDS. Tehran: National AIDS Committee Secretariat, Ministry of Health and Medical Education, Islamic Republic of Iran; 2015 (http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/IRN_narrative_report_2014_en.pdf, accessed 6 April 2016).

drop-in centres and referrals to public health-care facilities. Services include needle exchange, methadone maintenance, general medical care, voluntary counselling and testing for HIV, and the provision of food, clothes and other basic needs (49). In prisons, “triangular clinics” integrate services for treatment and prevention of sexually transmitted infections, injecting drug use and HIV (49). At the end of 2014, 81.5% of surveyed people who inject drugs reported the use of sterile injecting equipment the last time they injected (50). Newly reported HIV cases among people who inject drugs fell from a peak of 1897 in 2005 to 684 in 2013 (50).

BARRIERS TO HARM REDUCTION

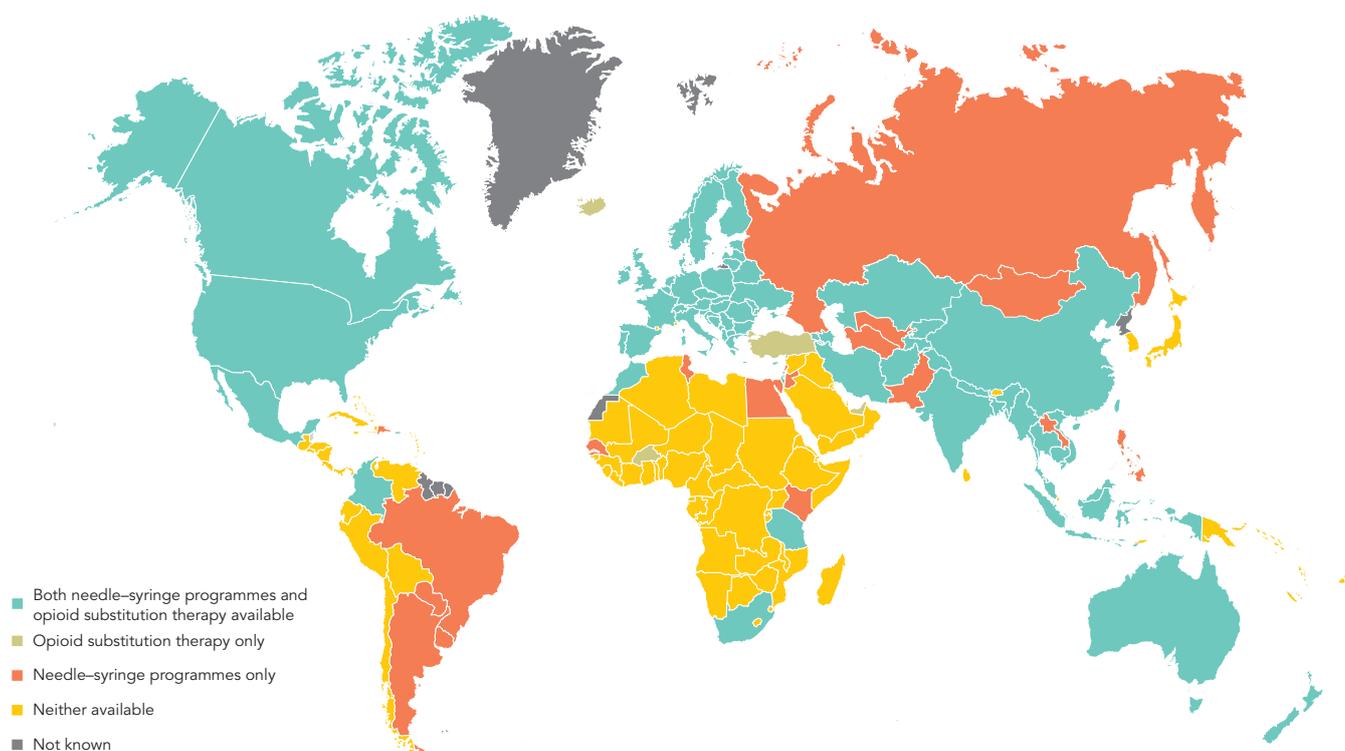
International drug control conventions contain sufficient flexibilities for the introduction of harm reduction within a balanced approach to drug use (51). The United Nations Committee on Economic, Social and Cultural Rights, the United Nations Committee on the Rights of the Child and the Special Rapporteur on the Right to Health have all endorsed the recommendations of WHO, UNAIDS and UNODC for a comprehensive harm reduction approach to drug use. The United Nations High Commissioner for Human Rights has recommended harm reduction approaches, the Human Rights Council has recognized the need for these programmes (52), and the United Nations General Assembly has called on countries to consider adopting and expanding harm reduction programmes in order to meet international targets to reduce the number of people who inject drugs newly infected with HIV (53). The Johns Hopkins–Lancet Commission on Drug Policy and Health has urged the General Assembly to ensure that harm reduction is explicitly named and endorsed as a central element of drug policy within the outcome document of its 2016 Special Session on the World Drug Problem (54).

Despite these endorsements and the availability of detailed guidelines for implementation, the provision of combination harm reduction programmes remains profoundly insufficient. In 2014 needle–syringe programmes were available in only 90 of the 158 countries where injecting drug use has been documented, and opioid substitution therapy was available in only 80 of these countries (14).

Where services exist, coverage is often low. The average number of syringes and needles distributed per person who injects drugs per year in most countries remains well below the internationally recommended 200. Only 15 countries report having met this coverage target for needle–syringe programmes at least once in the past four rounds of HIV response progress reporting to UNAIDS (55), and only 26 countries indicated high levels of coverage (more than 40%) of opioid substitution therapy in 2014 (56).

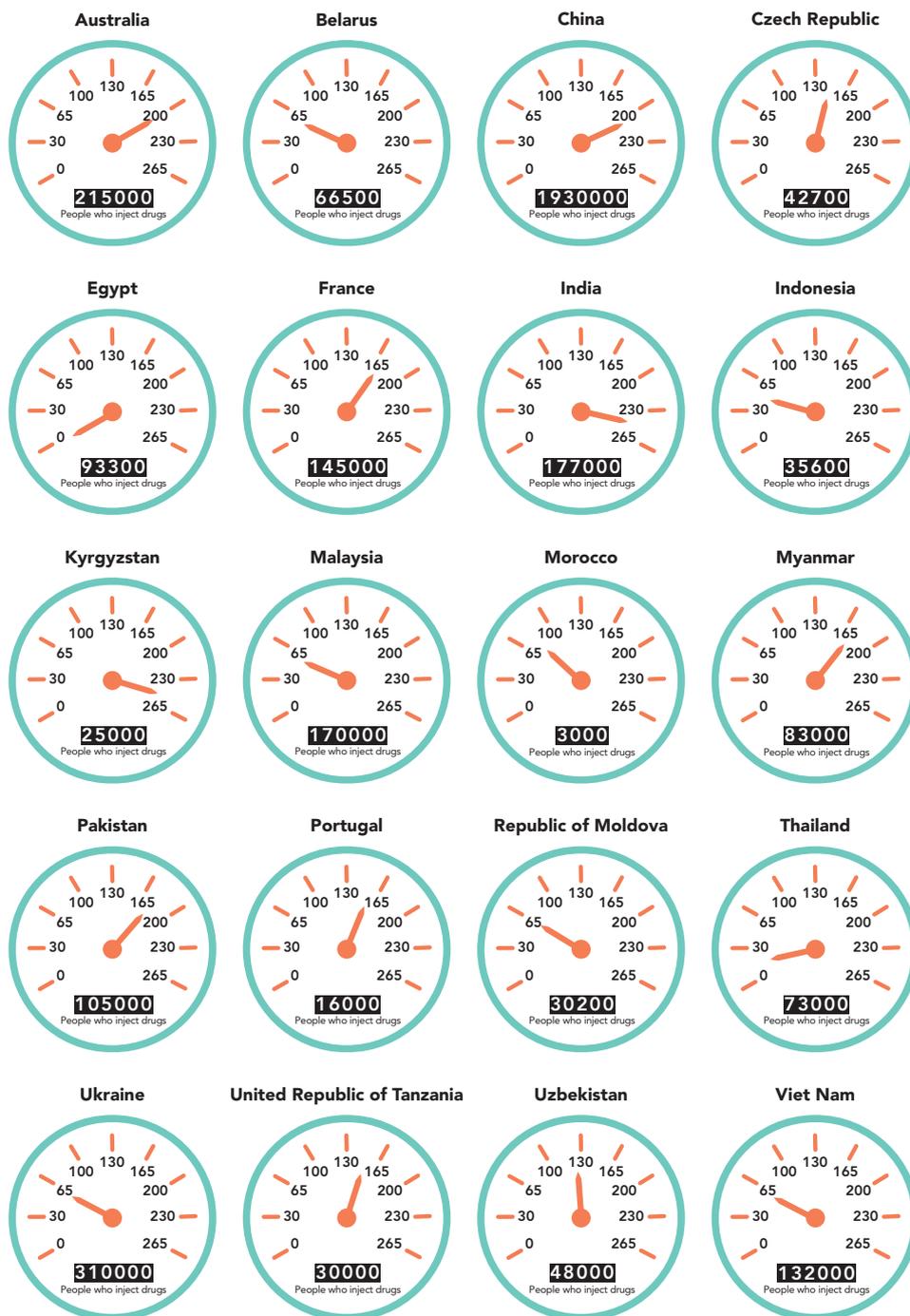
Women who inject drugs face particular challenges in accessing harm reduction services (57). Higher levels of stigma and discrimination and harmful gender norms translate to lower control over injecting and more frequently being “second on the needle” when injecting equipment is shared (58). Many women who inject drugs also engage in sex work, an overlap that is especially common in parts of eastern Europe and central Asia and is a growing concern in some Latin American countries, such as Mexico (57). Harm reduction programmes that tailor their services to meet women’s needs are rare (59).

Availability of needle–syringe exchange programmes and opioid substitution therapy, 2014



Source: The global state of harm reduction 2014. London: Harm Reduction International; 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>)

Needles and syringes distributed per person who injects drugs per year in selected countries, 2014 or latest year available



Source: various national data collected by UNAIDS country and regional offices. See country profiles for more detailed information.

Laws, policies and police practices restrict or prevent harm reduction scale-up in many countries. Criminal justice systems that use possession of drug paraphernalia or drug residue within injecting equipment as evidence of illegal drug possession or use are particularly disruptive to needle-syringe programmes (60). Syringe confiscation has been associated with increases in HIV infection among female sex workers who inject drugs (61). In parts of eastern Europe and central Asia,

nongovernmental organizations report that police may consider needle–syringe distribution as promotion of illegal drug use, which leads to a high rate of turnover among outreach workers who fear they may be arrested for carrying injecting equipment (62). Police crackdowns on drug use, random urine drug screens and police surveillance of health-care and harm reduction services providers discourage people who use drugs from accessing these services (60). During Thailand’s “war on drugs” campaign, health-care workers reported that police pressured them to identify people suspected of drug use, which discouraged people who use drugs from seeking HIV tests, antiretroviral therapy and other health care (63,64). Laws and policies with a disproportionate impact on women who use drugs include those that make drug use a criterion for loss of child custody, forced or coerced sterilization or abortion, and denial of public housing and other benefits (59, 65).

In some countries, opioid substitution therapy is unavailable or illegal. Substitution therapy using methadone and buprenorphine is forbidden by law in the Russian Federation, which has one of the highest rates of opioid use in the world (66). In some countries where opioid substitution therapy is available, police reportedly target people using such services for drug arrests (64, 67, 68).

In Myanmar, sections of a nearly 100-year-old excise act that had made possession of needles and syringes illegal were repealed in 2015 (69). The leadership of the national AIDS programme in Myanmar and local United Nations officials described the change as a major step forward in the expansion of harm reduction services within a country where more than one quarter of HIV infections are caused by the sharing of injecting equipment (70). Additional legal changes to end compulsory registration of people who use drugs and to reduce criminal penalties for possession and use of small amounts of drugs are under consideration (69).

INVESTING IN HARM REDUCTION

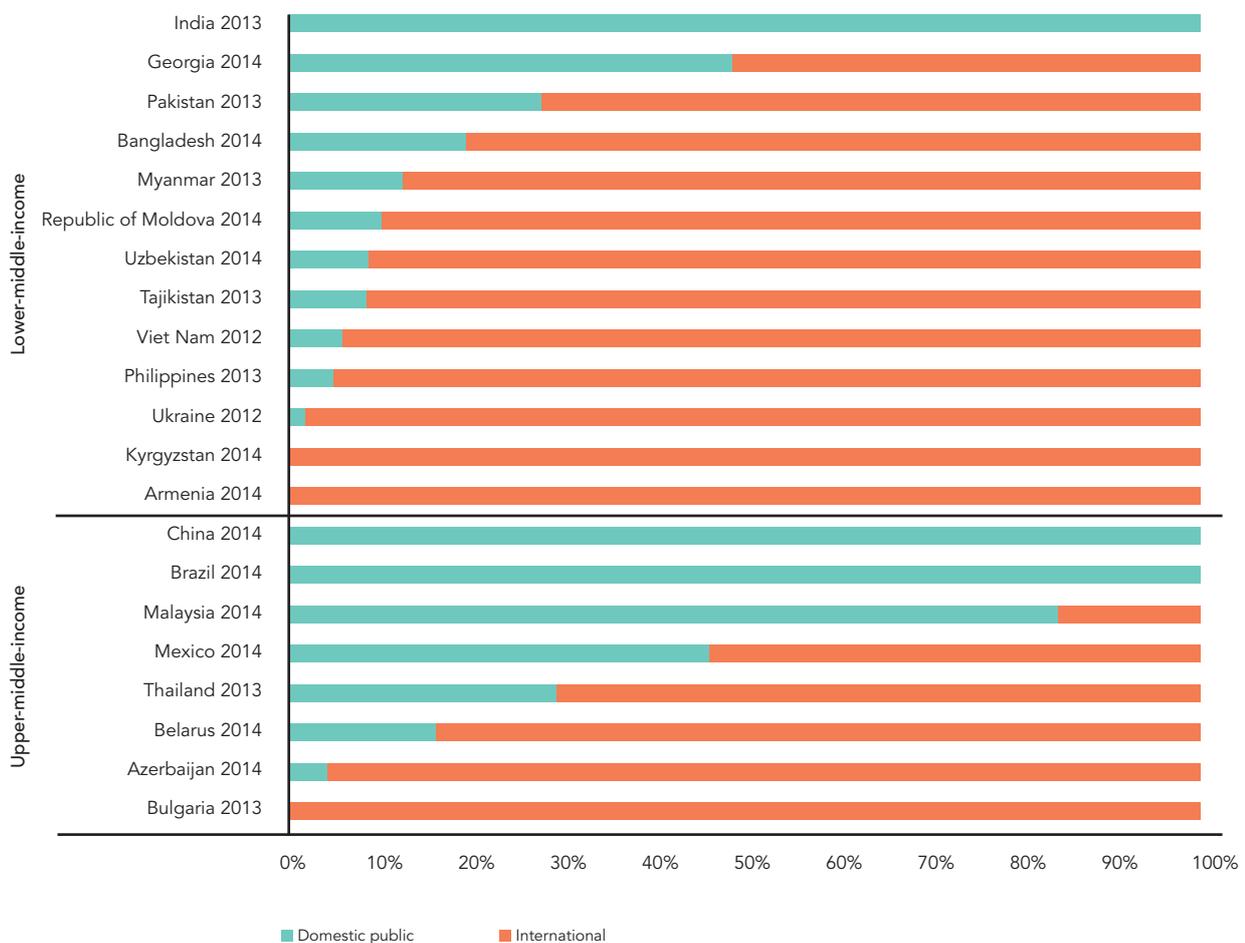
Reaching sufficient numbers of people who inject drugs with a comprehensive package of harm reduction services by 2020 is a critical component of wider efforts to achieve the end of the AIDS epidemic by 2030. The UNAIDS 2016–2021 Strategy calls on countries to reach 90% of people who inject drugs with a combination of HIV prevention and harm reduction services. Achieving this target would require annual investment in outreach, needle–syringe distribution and opioid substitution therapy in low- and middle-income countries to increase to US\$ 1.5 billion by 2020 (71). Meanwhile, an estimated US\$ 100 billion is spent each year to reduce the supply and demand of narcotic drugs (72).

Closing the financing gap will require far broader financial commitment, especially among middle-income countries with large populations of people who inject drugs. In many of these countries, harm reduction is

funded predominately by international donors and private foundations. Heavy reliance on donor sources limits potential for scale-up, threatens the sustainability of existing services, and is often a symptom of insufficient political and public support for harm reduction.

In Belarus, an upper-middle-income country where up to one quarter of people who inject drugs are living with HIV, the financing of harm reduction is being steadily transitioned from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) to domestic sources. The concept note for a 2016–2018 Global Fund grant pledges to increase Belarusian Government funding for HIV services from 35% in 2016 to 62% in 2018, followed by full Belarusian Government funding at the end of the grant (73). Within this transition, the Belarusian Government plans to use new social contracting mechanisms and local budgets to directly contract nongovernmental organizations to provide HIV services (73). The programme aims to expand HIV prevention services to 60% of people, including needle–syringe distribution to 45 000 people who inject drugs and opioid substitution therapy to 4900 people by the end of 2018 (73). The Eurasian Harm Reduction Network has praised the ambitious targets and the Belarusian Government’s commitment to fully fund harm reduction after 2018 (74).

Donor funding as percentage of total expenditure on harm reduction programmes for people inject drugs, 2012–2014



Source: UNAIDS Global AIDS Response Progress Reports from countries, 2013–2015.

ACTION AREAS

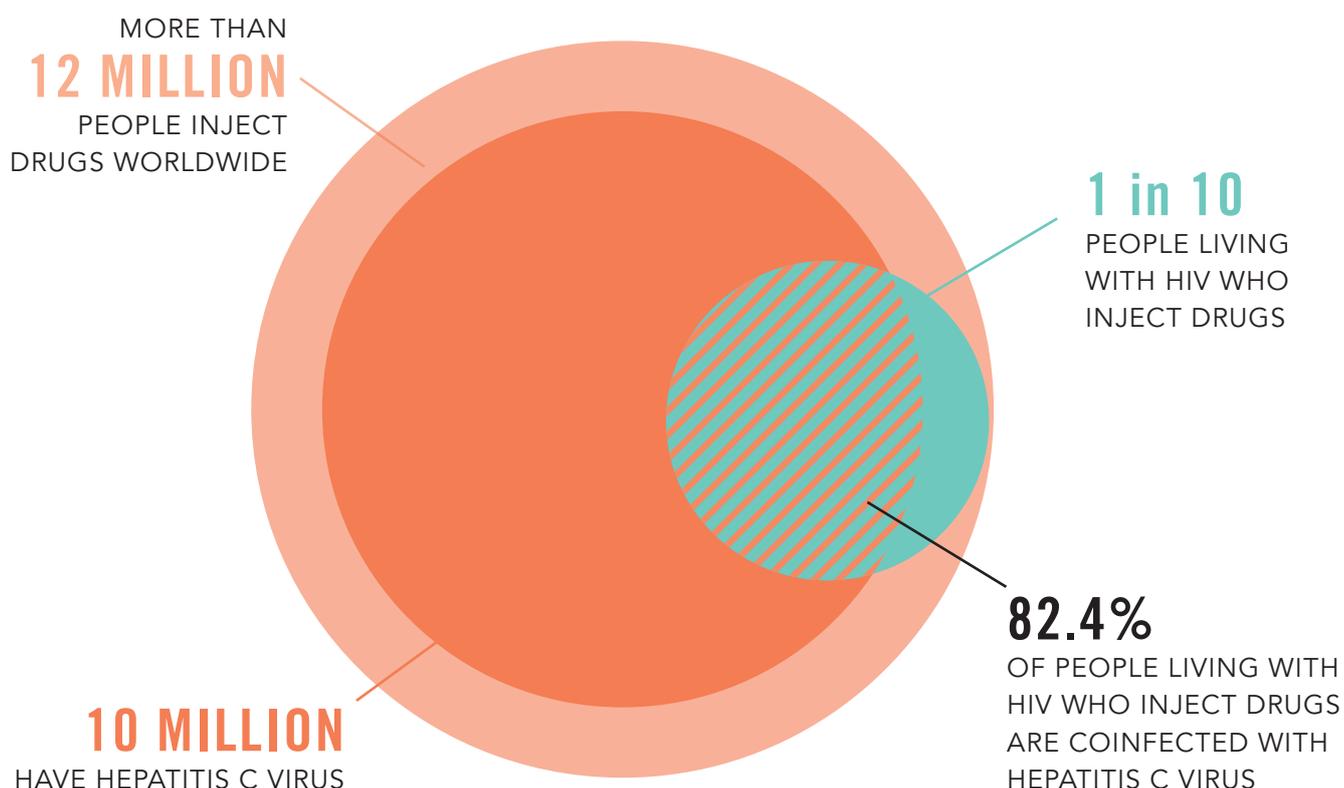
- Scale up comprehensive combination harm reduction to reach UNAIDS Fast-Track Targets by 2020.
 - Ensure harm reduction programmes make specific efforts to reach women who inject drugs.
 - Ensure naloxone is made available to people likely to witness an opioid overdose.
 - Explore the use of drug consumption rooms and heroin-assisted drug dependence treatment for people with severe dependence.
 - Remove legal and policy barriers to harm reduction, including the consideration of injecting equipment and other drug paraphernalia as evidence of drug use, police monitoring of health and harm reduction facilities, and bans on the use of methadone and buprenorphine for opioid substitution therapy.
 - Increase domestic financing of harm reduction in low- and middle-income countries.
-

HEALTH CARE

Millions of people who use drugs are vulnerable to HIV, tuberculosis, hepatitis C virus and sexually transmitted infections. Hepatitis C virus is more resilient than HIV and is capable of surviving on drug preparation and injecting equipment for several days to weeks (1). Hepatitis C virus is thus easier to transmit through the sharing of injecting equipment. An estimated 10 million people who inject drugs have chronic hepatitis C virus infection (2), and in some countries the majority of new and existing hepatitis C virus infections have occurred as a result of sharing injecting equipment (3). An estimated 82.4% of people who inject drugs living with HIV are coinfecting with hepatitis C virus (4).

Compared with the general population, tuberculosis is more prevalent in people who inject drugs or who use other drugs (5). People living with HIV who inject drugs, especially in prison, are at particularly high risk of tuberculosis (5). Sexually transmitted infections among people who use drugs, including syphilis, gonorrhoea and chlamydia, have been associated with incarceration, crack cocaine use, transactional sex, multiple sexual partners and HIV infection (6).

HIV and hepatitis C virus coinfection, globally, 2014



Despite the high disease burden and the availability of evidence-informed treatments, health systems rarely reach out to people who use drugs. Very low rates of HIV testing among people who inject drugs have been reported in Asia, the Pacific, sub-Saharan Africa, the Middle East and North Africa (7). Within the European Economic Area, 7 of 19 countries have HIV testing rates among people who inject drugs below 50% (8). The limited data available on antiretroviral therapy coverage among people living with HIV who inject drugs suggest that service uptake is much lower than among other people living with HIV. Among the countries that reported to UNODC in 2014, 22% described HIV treatment for people who inject drugs as unavailable or at low levels of coverage (9). In eastern Europe, people who inject drugs account for 80% of HIV infections but only 20% of people on antiretroviral therapy (10). In the Russian Federation, people who inject drugs are estimated to account for 40% of people living with hepatitis C, but only 1% of people being treated for hepatitis C virus inject drugs (11).

BARRIERS TO HEALTH CARE

Drug control laws and policies have been shown to be among the largest obstacles in many countries. Criminalization of drug use is the most frequently reported barrier to HIV testing among people who use drugs in the European Economic Area (8). Fear of arrest was cited as a reason for discontinuing tuberculosis treatment among people who use drugs in China (12). In Mexico, the proximity of a police station to a local tuberculosis clinic was found to be a barrier to treatment adherence (13).

Discriminatory attitudes among health-care workers and within entire health systems turn away people who use drugs from services. In China, health-care workers have expressed reluctance to treat people with tuberculosis with a history of drug use due to fears they may not adhere to treatment. Poor adherence would reduce their health facility's cure rate, which must meet a national target of 75% (12). People who inject drugs were initially excluded from hepatitis treatment due to concerns about adherence, increased susceptibility to side effects and reinfection (1). Analyses have since found that treatment of people who inject drugs for hepatitis C virus is both effective (13) and cost effective (14). WHO recommends focused hepatitis C virus screening for people who inject drugs, including repeated screening for people at ongoing risk of infection, and treatment combined with harm reduction for people found to have hepatitis C virus infection (15). WHO guidelines note that higher hepatitis C virus case-finding and treatment rates among people who use drugs would lead to greater population impacts and cost effectiveness (15).

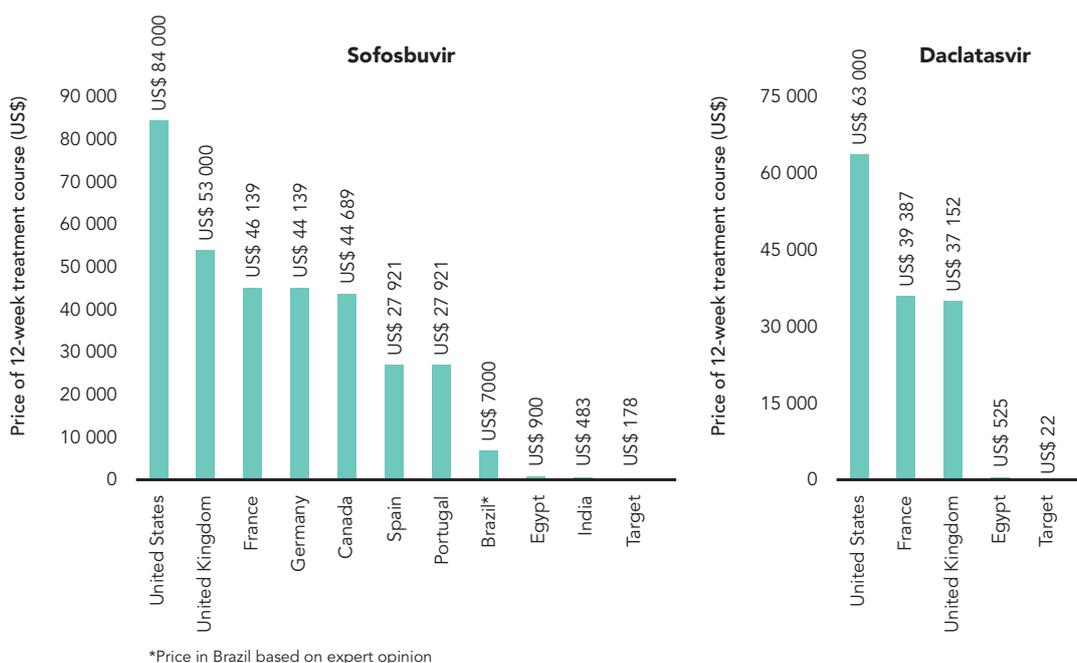
The high cost of hepatitis C virus diagnosis and treatment has been a large barrier to service expansion (11). In the United States, 12-week courses of the branded versions of two of the most effective antiviral medications, sofosbuvir and daclatasvir, cost US\$ 84 000 and US\$ 63 000, respectively (16). Major progress has been made in recent

years to reduce the price of hepatitis C medicines in low- and middle-income countries. Voluntary licensing agreements allow the production or import of generic versions of branded medicines to more than 100 low-income countries, and some middle-income countries with large numbers of hepatitis C infections have negotiated price reductions. For example, a course of sofosbuvir now costs US\$ 483 in India, and a course of daclatasvir costs US\$ 525 in Egypt (17). Costs vary globally. In Brazil a course of sofosbuvir is approximately US\$ 7000, in Spain and Portugal nearly US\$ 28 000, and in the United Kingdom US\$ 53 000 (17). Further and more widespread price reductions towards production costs for a sofosbuvir–daclatasvir combination estimated at US\$ 200 per patient would facilitate efforts to increase the number of people treated (17).

SERVICE INTEGRATION

Integration of services has consistently resulted in improved engagement, adherence and results. For example, people living with HIV who inject drugs and enrolled in methadone maintenance therapy are less likely to discontinue antiretroviral therapy and more likely to achieve viral suppression (18). People on opioid substitution therapy have also been shown to be highly adherent to hepatitis C virus treatment (19). Combining harm reduction services with hepatitis C virus treatment reduces the chance of hepatitis C virus reinfection (20). Service integration through co-location of interventions at a single site or through strong and coordinated linkage and referral between different service providers is recommended by WHO, UNODC and UNAIDS (21).

Costs of 12-week hepatitis C virus antiviral treatment courses in different countries, 2015



Source: Hill A et al. Rapid reductions in prices for generic sofosbuvir and daclatasvir to treat hepatitis C. *J Virus Erad* 2016;2:28–31.

In the United Republic of Tanzania, where HIV prevalence among people who inject drugs is quadruple the national rate and as high as 62% among women who inject drugs (22), the importance of integration was understood soon after the country's first methadone maintenance therapy clinic opened in 2011. An early methadone maintenance therapy patient at the Muhimbili National Hospital in Dar es Salaam died of tuberculosis, prompting concerns that led to establishment of an active tuberculosis case-finding programme and changes to the layout of the clinic to avoid transmission between patients and health-care workers. Among the first 150 methadone maintenance therapy patients, 4% had active pulmonary tuberculosis, which was roughly 23 times the national Tanzanian tuberculosis prevalence of 0.2% in 2011 (23). If passive case finding alone had continued, these people would have likely remained undiagnosed for a longer period of time, which may have led to additional tuberculosis infections and deaths (23).

In many settings, services are vertically organized, resourced and managed, and multidisciplinary care is lacking (24, 25). In 2010 less than a third of drug dependence treatment programmes in the United States offered HIV testing and counselling (26). In eastern Europe and central Asia, where cases of HIV among people who inject drugs continue to rise in many countries and multidrug-resistant tuberculosis rates are among the highest in the world, low coverage of opioid substitution therapy threatens efforts to integrate crucial health services and improve uptake (24).

In Estonia, where the rate of newly diagnosed HIV infections is among the highest in Europe (27), 60–80% of people on opioid substitution therapy in 2013 were living with HIV (28). Antiretroviral therapy is provided free of charge by the national health system, but in 2007 less than 12% of people living with HIV who inject drugs were on treatment (29). Integration of harm reduction and antiretroviral therapy services was identified as the key to ensuring the sustainability of the national HIV prevention strategy (30). The opioid substitution therapy programme at West Tallinn Central Hospital now provides directly supervised dispensing of antiretroviral medicines (28).

In Portugal, individual health programmes have worked together to achieve co-located delivery of treatment services in locations that are convenient to people who inject drugs, with outreach teams acting as mediators among the services. The approach has achieved high HIV testing coverage among people at drug dependence treatment centres, and most people with tuberculosis know their HIV status (31).

In São Paulo, Brazil, the Program De Braços Abertos (Open Arms programme) provides comprehensive support to people who use crack cocaine, including employment, food, shelter and comprehensive health care (32). Because an estimated 5% of people who use drugs in Brazil are living with HIV (33), health services include comprehensive HIV prevention, HIV testing and antiretroviral therapy. The use of fixed-dose-combination antiretrovirals has improved treatment adherence and health

outcomes. The success of this low-threshold, comprehensive approach has led to its replication in other Brazilian cities as part of the Ministry of Justice's National Policy on Drugs (32).

ACCESS TO ESSENTIAL CONTROLLED MEDICINES TO REDUCE PAIN AND SUFFERING

The Single Convention on Narcotic Drugs confirms that the medical use of narcotic drugs is "indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes". The United Nations Committee on Economic, Social and Cultural Rights has described the availability of essential medicines, including opioids, as an essential element of the right to health and has warned that states are obligated to provide access to these medications, regardless of resource constraints (34). Palliative care—the provision of pain and symptom relief for people facing life-limiting illnesses—has been described by the World Health Assembly as fundamental to improving the quality of life, well-being, comfort and human dignity of terminally ill people (35).

Efforts by countries to meet their obligations within international drug control conventions to prevent the diversion, trafficking and misuse of controlled substances have limited the availability of essential medicines used to reduce pain and suffering (36). Approximately 5.5 billion people, or three quarters of the world's population, have inadequate access to opioid analgesics (37). These drugs are simply unavailable to the vast majority of people outside high-income countries. For example, it has been estimated that 92% of the world's morphine is consumed by 17% of the world's population, primarily in North America, western Europe and Oceania (37).

As a result, every year tens of millions of people are not treated adequately for moderate or severe pain, including millions of women in labour, 5.5 million people with terminal cancer, 1 million people with late-stage AIDS and 800 000 victims of violence and accidents (38). At least 13 low- and middle-income countries—Burkina Faso, Burundi, Cambodia, Central African Republic, Chad, Côte d'Ivoire, Ethiopia, Haiti, Malawi, Mali, Niger, Nigeria and Rwanda—do not have sufficient supplies of opioids to treat 1% of their people with terminal cancer and people dying of AIDS-related diseases (39). Concerns over the diversion of methadone and other medicines used to treat dependence on heroin have also greatly limited the global expansion of opioid substitution therapy.

WHO has called on countries to ensure that national drug control policies recognize that controlled medicines, especially those on the WHO Model List of Essential Medicines, are necessary for medical and scientific purposes and that regulatory restrictions should be balanced with enabling policies that build the capacity of health professionals to manage proper use of these medicines, and to promote widespread

understanding of the therapeutic usefulness of controlled medicines and their responsible use, while preventing the development of drug use disorders and dependence associated with prescription drug use (36). The Johns Hopkins–Lancet Commission on Drug Policy and Health has called for WHO to be provided with sufficient resources to assist the International Narcotics Control Board in using the best science to determine the level of need for controlled drugs in all countries (40).

Colombia, Jordan, Romania, Uganda and Viet Nam have undertaken comprehensive reform programmes to improve access to palliative care (39). Leaders from the medical community in these countries worked with nongovernmental organizations and their own governments to assess what barriers exist to access to pain treatment, and to address these barriers through policy development, law reform, improving the education of health-care workers and strengthening drug supply systems (39).

UNODC has called for specific efforts to improve the ability of low- and middle-income countries to improve availability of opioid analgesics at affordable prices and to develop supervision systems that can detect illegal manufacture, over-prescription, unjustified sale or supply and diversion of controlled substances (41). WHO has stressed that finding the right balance between the control and access of opioid analgesics and other narcotic drugs will be critical to achieving public health targets within the Sustainable Development Goals (36).

ACTION AREAS

- Take specific steps to address discriminatory attitudes among health-care workers and remove structural barriers to the provision of health services to people who use drugs.
 - Ensure that treatments for HIV, tuberculosis and hepatitis C virus are affordable and readily available to people who use drugs.
 - Integrate health-care services with harm reduction services to improve engagement, adherence and results.
 - Ensure that opioid analgesics are affordable and available to all people who need them.
-

STIGMA, DISCRIMINATION AND PUNISHMENT

“... in many societies people who use drugs are invisible, stigmatized or demonized. And history teaches us that when this happens—when a group of people are invisible, stigmatized or demonized—widespread human rights abuse often follows.”

Paul Hunt, United Nations Special Rapporteur on the Right to the Highest Attainable Standard of Health, 2002–2008

MARGINALIZATION OF PEOPLE WHO USE DRUGS

The preamble of the Single Convention on Narcotic Drugs describes dependence on narcotic drugs as a “serious evil for the individual” and “fraught with social and economic danger to mankind”. Community advocacy organizations have denounced such language as emblematic of the demonization of people who use drugs and the stigma and discrimination they face in their daily lives (1).

The exclusion and marginalization of people who use drugs has been acknowledged as one of several unfortunate consequences of the international drug control system (2). Studies of public perceptions of people who use drugs confirm that negative attitudes towards people who use drugs have been established during decades of the global war on drugs. One survey in the United Kingdom found that nearly half of respondents felt that people with a history of drug dependence were a burden on society, more than 40% said they would not want a person who has been dependent on drugs to be their neighbour, and about a third said it would be foolish to enter into a serious personal relationship with a person who had been dependent on narcotic drugs, even if that person appeared to be fully recovered (3).

Civil society organizations of people who use drugs describe pejorative terms such as “junkie” and “addict” commonly used in news media as hate speech that dehumanizes and stereotypes them as unpredictable, violent and unable to exercise agency and self-determination (4). Such beliefs weaken human rights safeguards and create barriers to employment, health care and social services. These barriers are even larger when people who use drugs internalize societal stigma. Judgemental feelings among health-care providers have been linked to lower-quality health care and lower health outcomes (5, 6). Nearly one quarter of people who use drugs surveyed in the United States reported they had been prevented from obtaining medical care because of their drug use, and one third said they had been denied housing because other people knew about their drug use (7).

DISCRIMINATORY LAWS AND POLICIES

In many countries, laws, policies and other structural barriers facilitate discrimination of people with a history of drug use. In China, individuals determined by law enforcement to be dependent on heroin or other narcotic drugs are permanently registered in a Chinese Government tracking system, even if they successfully undergo drug dependence treatment. Registered people report being ostracized and shunned once their history of drug use is discovered by others, and they express little hope of establishing a non-stigmatized, non-drug-using identity, even after undergoing drug dependence treatment and achieving sustained abstinence (8). As a result, unregistered people who use drugs are reluctant to seek treatment at Chinese Government-sponsored facilities (8). Many countries in eastern Europe and central Asia maintain similar “narcological registers”.

In the United States, federal law calls for people with drug-related convictions, including for personal possession and use, to be denied housing assistance, nutritional support, cash transfers, and grants and loans for higher education (9). Individuals coming out of prison for drug-related crimes are thus denied social support services at a time when they may need it the most, increasing the likelihood that they will drop out of drug dependence treatment, struggle to find employment and suffer from food insecurity (10). Former prisoners who live in states that fully enforce the federal ban on nutritional support are more likely to report having gone an entire day without eating than those who live in states that do not enforce the ban. Furthermore, a study showed that people who did not eat for an entire day were more likely to engage in risky behaviour, such as using alcohol, heroin or cocaine before sex or exchanging sex for money (11). Similar legislation in Ontario, Canada, denying disability benefits to people dependent on drugs or alcohol was judged to be discriminatory and struck down by a court of appeals in 2010 (12).

DISCRIMINATION FACED BY WOMEN AND MINORITIES

Women who use drugs, especially those who inject drugs, face higher levels of stigma, discrimination and vulnerability to harm than their male counterparts (13). Hostile attitudes against women who use drugs and alcohol have been linked to higher rates of physical and sexual assault (14). In Georgia, more than 80% of women who use drugs reported experiencing violence in their own homes (15). A survey on violence against women in the Russian Federation found that 21% of respondents felt that a woman’s drug or alcohol addiction was a valid reason for her husband to beat her (16). Women who inject drugs and who have experienced sexual violence are more likely to be living with HIV than other women who inject drugs (17). Despite this, women who use drugs often have limited access to effective health and drug treatment services that take into account their specific needs and circumstances (18). Mothers with a history of drug use often fear to access health and social services due to legislation that may declare them unfit to parent. Pregnant women who use drugs may be pressured to have abortions or to give up their newborn infants (18).

“Because drugs, and people who use them, are criminalized, people who use drugs are dehumanized, are judged to be criminals, and are understood as dangerous, deviant and socially disruptive. It is these understandings that result in people who use drugs being endemically discriminated against, and it is these perceptions that inform systemic violence and human rights violations perpetrated against people who use drugs. Fear and hatred of people who use drugs—drug-user phobia—is rife, and is rarely challenged.”

International Network of People Who Use Drugs, submission to the Civil Society Task Force to UNGASS on the World Drug Problem 2016

Evidence suggests that racial minorities also face higher levels of stigma and discrimination, including disproportionate targeting by drug-related law enforcement. In the United States, African-American and Hispanic people are significantly more likely to be stopped and searched, arrested, prosecuted, convicted and incarcerated for drug offences, even though their rates of drug dealing and drug use are almost identical to those of the rest of the population (19). Americans of African descent are more than 10 times more likely than Americans of European descent to be imprisoned for a drug-related offence; similar overrepresentation of ethnic minorities in prisons has been documented in other countries, including Australia and Canada (20). As a result, legislation that limits access to social services by people convicted of drug-related offences has a greater impact on ethnic minorities (10).

The United Nations High Commissioner for Human Rights has described the increased vulnerability arising from a vicious circle of criminalization, discrimination and denial of social services as an important factor in some countries’ decisions to decriminalize or depenalize personal use and possession of drugs. Community advocates have called for the repeal of legislation that reinforces stigma and discrimination of people who use drugs, and for the establishment of programmes that facilitate interaction between recovering drug users and the communities where they live in order to foster more constructive perceptions (3, 21).

DISPROPORTIONATE DRUG ENFORCEMENT MEASURES

The decades-long effort to disrupt the sale and purchase of narcotic substances for recreational use has pushed this market underground, where it is controlled by highly organized criminal organizations and gangs that have contributed to rising levels of violence in many countries, including widespread killings and disappearances (2, 22). In response, drug-control legislation has grown increasingly severe, and anti-drug law enforcement has become increasingly militarized (23). People who use drugs are caught in the crossfire of this escalating war, and a disproportionate amount of the collateral damage is inflicted on women, children and ethnic minorities (24).

Efforts by some countries to get tough on drugs have included the imposition of stiff and sometimes mandatory minimum penalties

for drug-related crimes, including personal possession and use. For example, Tunisia imposes a minimum mandatory sentence of one year in prison on any person found guilty of use and possession of an illegal drug, including cannabis (25). Such legislation tends to have a particular impact on women and young people. Women are more likely to exist at the lower levels of the drug trade, working as drug cultivators, low-level dealers or couriers (26). People who use drugs and small-time street dealers are easier to find and apprehend than drug cartel kingpins. Young people arrested for drug possession have been pressured by police to act as confidential informants and to play roles in life-threatening “sting” operations (27).

Crackdowns on narcotic drug use are too often accompanied by police violence against people who use drugs (28). Among the worst cases are reports of extrajudicial killings during the height of Thailand’s war on drugs in 2003 (29). A recent study found that nearly half the people who inject drugs surveyed in Bangkok in 2011 reported having been beaten by the police (30). Civil society documentation of police violence and intimidation against women who use drugs in eastern Europe and central Asia in 2013 included sexual abuse, beatings, humiliation, torture, blackmail and extortion (31).

The huge numbers of people arrested and detained for possession or use of small amounts of drugs have put immense strain on criminal justice systems, in some countries resulting in prolonged pre-trial detention (21) and a compromised ability to adhere to minimum standards of due process (32). The United Nations Special Rapporteur on Torture has documented numerous cases of torture—including violence and the withholding of opioid substitution therapy—against people detained for drug-related offences to extract confessions or obtain information about other drug users or traffickers (33).

PRISONS OVERCROWDED WITH PEOPLE WHO USE DRUGS

Severe punishments for drug-related crimes have also contributed to a global rise in incarceration and the overcrowding of prisons in many countries, which can lead to violations of prisoners’ rights to be treated with humanity and dignity (21). The Working Group on Arbitrary Detention has called on countries to ensure that sentences for drug-related offences are proportionate to the nature of the crimes (24) and to remove legislation that denies people convicted of drug-related crimes the opportunities to be considered for suspended sentence, parole, pardon or amnesty that are available to people convicted of different crimes (34).

In some cases, being caught in possession of relatively small amounts of drugs leads to harsher punishments than those for murder, rape, kidnapping or bank robbery (21). In 2015, 33 countries or territories had laws prescribing the death penalty for drug-related offences, and since 2010 executions for drug offences occurred in at least seven

countries (35). For example, in Singapore, a 19-year-old man working as a courier for a drug dealer was sentenced to death in 2008 after being arrested with 47 grams of heroin in his possession. The death penalty is allowable under international law only for the “most serious crimes”, and the Human Rights Council has determined that drug-related offences do not meet this threshold (21). Following a high-profile legal challenge and advocacy from human rights groups, Singapore amended its Misuse of Drugs Act in 2012, and the sentence was reduced to life imprisonment (36).

Although the death penalty remains in force in Singapore for other drug-related offences, the change is part of a larger trend of countries stopping or reducing the use of the death penalty. Kyrgyzstan, the Philippines and Uzbekistan have abolished the death penalty for all offences, including drugs. Tajikistan limited the number of crimes punishable by death in 2004, removing drug offences from the list. Jordan has reduced the punishment for certain categories of drug crimes from the death penalty to life imprisonment (37).

COMPULSORY DETENTION AND TREATMENT

Approximately 27 million people who use drugs suffer from problem drug use, including drug-use disorders or drug dependence, and may benefit from treatment (38). More than 200 million other people who use drugs worldwide have no such need of treatment. Large numbers, however, are compelled to enter drug dependence treatment in ways that infringe on their human rights. A particularly grave concern is the hundreds of thousands of people who use drugs who are incarcerated in compulsory detention centres within at least 17 countries in Asia and Latin America (39, 40).

Compulsory or involuntary medical treatment of any kind is justified only as a last resort and for the shortest period of time necessary when strict criteria are met, including the presence of an immediate or imminent risk to the health of the patient or to the security of society (41). A set of principles issued jointly by WHO and UNODC stresses that drug dependence treatment, whether psychosocial or pharmacological, should not be forced on people (42).

In some countries, the decision-making process for sending people to compulsory drug detention facilities occurs outside the court system, a deprivation of liberty that violates the minimum standards of due process within the International Covenant on Civil and Political Rights (43). In other countries, courts give the accused a choice between a criminal conviction and a prison sentence, or a suspended sentence that will be dismissed if the individual completes a community drug dependence treatment programme. The United Nations High Commissioner for Human Rights has stated that the level of coercion within these “drug courts” may overstep an individual’s right to refuse medical treatment (21). The Working Group on Arbitrary Detention

has stated that such diversion into rehabilitation must not delay a determination of criminal responsibility (32), and that when the treatment option is undertaken under no circumstances may it extend beyond the period of the criminal sentence (21).

Long-term residential treatment of drug dependence without a person's consent is essentially a form of low-security imprisonment (41). Proponents of compulsory detention centres argue they are a response not only to an individual's drug dependence but also to a complex social problem that affects entire communities, and that the centres provide drug dependence treatment, educational programmes, job skills training programmes, physical exercise routines and opportunities for manual work in a safe, isolated environment (44).

The United Nations High Commissioner for Human Rights, the United Nations Special Rapporteur on Torture and the United Nations Special Rapporteur on the Right to Health have described numerous human rights concerns regarding the conditions within the centres and the drug dependence treatment provided. The treatment is not evidence-based and is conducted en masse, disregarding the need for individual informed consent and often provided without the aid or supervision of trained medical professionals. Centres typically subject detainees to long hours of physically strenuous exercise, physical and verbal abuse, beatings, solitary confinement and enforced labour (21). Former detainees have described specific accounts of ineffective treatment, forced labour, torture and other rights violations shortly after their release (45). Twelve United Nations organizations issued a joint statement in 2012 on compulsory drug detention and rehabilitation centres, calling for their closure and replacement with voluntary, evidence-informed and rights-based health and social services in the community.

Mounting concerns led to national policy reviews and transition plans in a number of Asian countries (46). Malaysia has been a pioneer of efforts to convert compulsory centres into facilities that provide voluntary, comprehensive and client-centred drug dependence treatment and support services, including methadone maintenance therapy (47). Health services at these "Cure and Care" centres include voluntary HIV counselling and testing, antiretroviral therapy, and testing and treatment for tuberculosis and hepatitis B and C (48). In Viet Nam, the Drug Rehabilitation Reform Plan commits to "gradually reducing compulsory treatment with an appropriate plan". Although there is no commitment to end compulsory detention within the Plan, there is acknowledgement of its shortcomings, and a clear path for scaling down this approach and scaling up evidence-based drug dependence treatment.

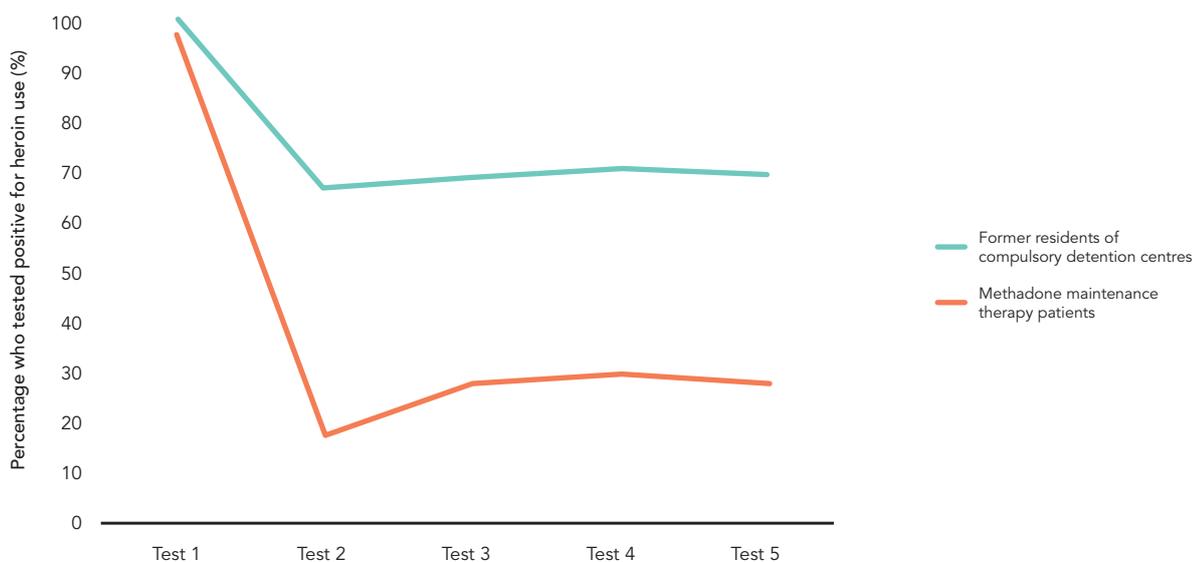
Comparative evaluations of compulsory and voluntary approaches make a strong case for accelerating the transition to voluntary drug dependence treatment. In Malaysia, a comparative study found that 50% of people in compulsory detention centres relapse within a month of release, and all relapse within a year, whereas less than 40% of people

treated in Cure and Care centres relapse within a year (49). In addition, Malaysia’s National Anti-Drugs Agency reported that the annual cost of detaining one person in a rehabilitation centre is more than four times higher than the annual cost of treating one voluntary patient at a Cure and Care centre (50).

In Viet Nam, the cost effectiveness of compulsory detention centres and community-based voluntary methadone maintenance therapy was compared using three years of programme data and patient surveys from the northern port city of Hai Phong. The study found that people who underwent compulsory detention and rehabilitation were three times more likely than people on methadone maintenance therapy to test positive for heroin use and 3.3 times more likely to report the use of other narcotic drugs. Former centre residents were 5.6 times more likely to engage in illegal activities and nearly 7 times more likely to report HIV-related risk behaviour compared with people on methadone maintenance therapy. The cost of detaining an individual in a compulsory centre was 2.5 times higher than the cost of one year of methadone maintenance therapy (51).

Despite the efforts of a few countries to experiment with alternatives to compulsory detention centres, none appears to be phasing out such institutions. Among seven countries in Asia with available data, 455 814 people who use drugs remained incarcerated in compulsory detention centres in 2014 (52). The number of detainees in these countries has decreased by just 4% since 2012, underscoring the urgent need for accelerating transition to voluntary community-based treatment and services.

Percentage of people who tested positive for heroin use* among former residents of compulsory detention centres and methadone maintenance therapy patients, Hai Phong, Viet Nam, 2009–2013



* based on urine screening

Source: Vuong TTH, Nguyen N, Le G, Ritter A, Shanahan M, Ali R et al. Economic evaluation comparing center-based compulsory drug rehabilitation (CCT) with community-based methadone maintenance treatment (MMT) in Hai Phong City, Vietnam: report on research findings. Durham, NC: FHI360 and Atlantic Philanthropies; 2015.

Number of people in compulsory detention centres for drug users in seven Asian countries, 2012–2014

COUNTRY	2012	2013	2014
Cambodia	2600	2713	3249
China	319 000	319 000	319 000
Lao People's Democratic Republic	3915	4718	5339
Malaysia	5473	5136	5753
Philippines	2744	3266	4392
Thailand	112 589	131 496	96 680
Viet Nam	27 920	29 273	21 401
Total	474 241	495 602	455 814

Source: Country presentations. Third Regional Consultation on Compulsory Centres for Drug Users in Asia and the Pacific, 21–23 September 2015, Manila, Philippines.

Outside Asia, several countries in Latin America—including Brazil, Ecuador, Guatemala, Peru, Uruguay and Mexico—use some form of compulsory drug rehabilitation or are reported to be considering such an approach (40). The Russian Federation is reportedly considering the establishment of labour camps for hundreds of thousands of people who use drugs who are normally sent to prison (53).

The slow progress towards rights-based and evidence-informed responses to drug use and drug dependence was acknowledged at the Third Regional Consultation on Compulsory Centres for Drug Users in Asia and the Pacific, held on 21–23 September 2015 in Manila. Countries struggling to build momentum for change have highlighted numerous challenges, including growing use of amphetamine-type stimulants, a lack of human resources trained in evidence-based approaches, and the poor quality of programme monitoring and evaluation systems to assess the progress of transition (46). Government delegations from nine countries in the region, civil society, technical experts and United Nations system agency representatives agreed on a set of recommendations to accelerate transition from compulsory centres to voluntary, community-based drug dependence treatment and services. These recommendations included the establishment within countries of multisectoral decision-making committees with participation of civil society and communities of people who use drugs; multisectoral and participatory reviews of existing legal and policy frameworks; development of national transition plans with clear objectives, activities and timelines; strengthening the capacities of key government sectors and civil society to scale up voluntary, community-based treatment and services; and annual monitoring and reporting of progress.

ACTION AREAS

- Repeal legislation that facilitates stigma and discrimination of people who use drugs and denies them public and social services based solely on their past or present drug use.
 - Ensure that drug-related laws and policies do not discriminate against women who use drugs and ethnic minorities.
 - End the use of the death penalty for drug-related offences.
 - End the practice of compulsory detention and treatment of people who use drugs.
 - Ensure that drug courts do not infringe on a person's rights to refuse medical treatment.
 - Incorporate human rights safeguards within drug control laws and drug-related law enforcement.
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PRISONS

The Basic Principles for the Treatment of Prisoners adopted by the United Nations General Assembly in 1990 state that all prisoners should have access to the equivalent health services available in the country without discrimination on the grounds of their legal situation. The “Nelson Mandela Rules” for treatment of people in prison agreed within the United Nations in 2015 emphasize that the provision of health care for prisoners is a governmental responsibility. They also clarify that health care for prisoners should be free of charge, provided without discrimination on the grounds of legal status, and organized in close cooperation with a country’s public health system in a way that ensures continuity of treatment and care for HIV, tuberculosis, other infectious diseases and drug dependence (1).

DRUG USE AND HARM REDUCTION IN PRISONS

UNODC estimates that one in three people in prison have used drugs at least once while incarcerated, with approximately one in eight reporting drug use during the previous month (2). An estimated 1 in 10 people in prison have used heroin at some point during their incarceration, and small-scale surveys of prisoners have found that between one fifth and one third have injected drugs while in prison (2).

Injecting drug use is much more common in prisons than among the general population. Paradoxically, the provision of harm reduction services in prisons is extremely rare. In 2013 there were only eight countries with needle–syringe programmes in prisons: Germany, Kyrgyzstan, Luxembourg, the Republic of Moldova, Romania, Spain, Switzerland and Tajikistan (3). Opioid substitution therapy in prisons and closed settings was available in only 43 countries (4).

The United Nations High Commissioner for Human Rights has stressed that health services for prisoners must include harm reduction (5). UNODC recommends a comprehensive package of 15 services to respond to HIV within closed settings:

1. Information, education and communication.
2. Condom programmes.
3. Prevention of sexual violence.
4. Drug dependence treatment, including opioid substitution therapy.
5. Needle–syringe programmes.

6. Prevention of transmission through medical or dental services.
7. Prevention of transmission through tattooing, piercing and other forms of skin penetration.
8. Post-exposure prophylaxis.
9. HIV testing and counselling.
10. HIV treatment, care and support.
11. Prevention, diagnosis and treatment of tuberculosis.
12. Prevention of mother-to-child transmission of HIV.
13. Prevention and treatment of sexually transmitted infections.
14. Vaccination, diagnosis and treatment of viral hepatitis.
15. Protecting staff from occupational hazards.

Many prison systems have expressed concerns that needle–syringe distribution could increase injecting drug use within prisons and that the presence of syringes and needles may create a more dangerous environment for staff and prisoners (3). Evaluations of needle–syringe distribution within European prisons have determined that these fears are unfounded. Programmes have successfully reduced needle sharing, syringes were not misused, disposal of used syringes was uncomplicated and neither drug use nor injecting drug use increased (6). Sharing of injecting equipment ceased after the implementation of most programmes, no new cases of HIV were found, and hepatitis C virus infections were greatly reduced (7).

Providing opioid substitution therapy during incarceration significantly reduces heroin use, injecting and syringe sharing within prison, encourages continuation of treatment after release, reduces risky behaviour and minimizes the risk of overdose (8). In a study of approaches to problem drug use and drug dependence within at least 12 countries, the United Kingdom Home Office found that prison-based drug dependence treatment programmes reduce the chances of a prisoner committing another crime following release (9). A review of the programmes in 15 European countries found variations in the quality and coverage of treatment, generally lower standards of care than outside of prisons, and a host of remaining challenges. Substitution therapy was nevertheless found to be an efficient harm reduction measure, positively associated with a reduction of overdoses both within prisons and after release, improved health care and better management of people dependent on opioids (10).

An evaluation of opioid substitution therapy in prisons in Kyrgyzstan found that prisoners who remained on treatment for more than three months showed improvements in health and quality of life; they also experienced

a marked reduction in injecting risk behaviour and heroin use (11). In the Islamic Republic of Iran, methadone maintenance therapy within prisons has been linked to lower narcotic drug use and reductions in HIV-related risk behaviour (12). Malaysia established a pilot methadone programme in two prisons in 2008 and 2009 that links prisoners to community-based treatment after release; among the first cohort of 57 patients who remained on treatment up until their release, nearly half were still on treatment 12 months later (13). The failure of many prison systems to adopt harm reduction programmes has left prisoners at extremely high risk of HIV and other infectious diseases. The prevalence of HIV, hepatitis and tuberculosis in prisons is typically 2–10 times as high as in the general population, and in exceptional cases it is up to 50 times higher (14).

PREVENTING SEXUAL TRANSMISSION OF HIV IN PRISONS

As well as the sharing of needles during injecting drug use, unprotected sex among men facilitates the spread of HIV within prisons. The prevalence of sexual activities within prisons has been difficult to measure, as prisoners may not admit to engaging in same-sex sexual activity for a range of reasons. Studies undertaken in a large number of countries confirm that consensual and forced sex does occur in prisons. Prevalence estimates vary from 1–2% to 4–10% or even higher (15). Opponents of condom provision have argued that access to condoms could encourage both consensual sex and rape, but a survey of more than 2000 prisoners in Australia found no evidence of this (16). No prison system allowing condoms has reversed its policy, and none has reported security problems or any other major negative consequences (17).

Prison systems that provide condoms and lubricant to prisoners include most systems in western Europe, Canada and Australia, some prisons in the United States, parts of eastern Europe and central Asia, Brazil, South Africa, the Islamic Republic of Iran and Indonesia (18). Availability of condoms in prisons globally remains low, however (4). A 2009 study by the AIDS and Rights Alliance of Southern Africa found that where same-sex conduct was criminalized, only one country in the region distributed condoms to prisoners (19).

COMPULSORY HIV TESTING AND SEGREGATION OF PRISONERS LIVING WITH HIV

Compulsory HIV testing of prisoners and segregation of prisoners living with HIV persists in some countries despite evidence showing these practices do not achieve superior management of HIV within prisons (17). WHO and UNAIDS have stressed that compulsory testing of prisoners for HIV is unethical and ineffective and should be prohibited (20).

Voluntary HIV testing and counselling of prisoners is recommended as a prevention component for people who engage in risky behaviour and as a gateway to antiretroviral therapy, care and support. Linkage of HIV testing and counselling with care and treatment is essential to encouraging prisoners to participate in voluntary HIV testing and counselling

programmes (17). The few data available on antiretroviral therapy among prisoners suggest that coverage is low (21)—an assumption reinforced by individual studies and reports of prisoners struggling to access HIV prevention, testing and treatment services in India (22, 23), Namibia (24), the Russian Federation (25) and Uganda (26).

THE REPUBLIC OF MOLDOVA: A COMPREHENSIVE APPROACH

The Republic of Moldova is one of only a few countries that provide nearly all 15 services in the UNODC-recommended comprehensive package. Condoms, HIV counselling and testing and antiretroviral therapy are available in 17 prisons in the Republic of Moldova. Needle, syringe and condom distribution programmes were initiated in 1999, and in 2014 the average number distributed annually reached 90 000 syringes and 35 000 condoms. Tuberculosis treatment has been provided since 2001, and opioid substitution therapy was launched in 2005 (27). The Moldovan prison-based syringe programme is largely run by prisoners, which enables prisoners to avail themselves of the service without having to reveal their drug use to prison staff (28). Coverage of antiretroviral therapy in Moldovan prisons increased from 2% in 2005 to 62% in 2013; deaths among people living with HIV in prisons fell by nearly two-thirds, from 23% in 2007 to 9% in 2013. The prevalence of hepatitis C decreased from 21% in 2007 to 4.6% in 2015, and incidence of tuberculosis declined fourfold, from 550 cases in 2006 to 127 cases in 2013 (29).

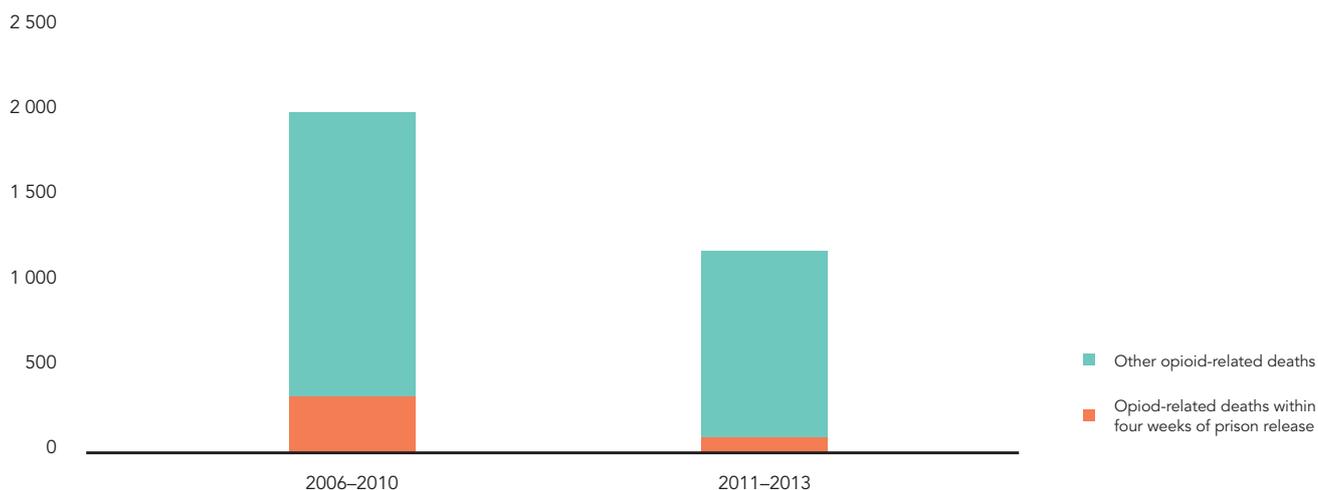
NALOXONE FOR NEWLY RELEASED PRISONERS

Prisoners with a history of drug use are at high risk of drug overdose and death in the weeks after their release. This is due to many factors, including decreased tolerance after a period of relative abstinence during imprisonment and the concurrent use of opioids with additional illicit drugs (30). Provision of naloxone kits upon release can reduce overdose deaths among ex-prisoners. In Scotland, United Kingdom, brief training of prisoners and the provision of naloxone kits have been associated with a 36% reduction in the proportion of opioid-related deaths in the four weeks following release from prison (31).

Globally the provision of naloxone to prisoners upon release is rare, especially outside western Europe. In the United States, the expansion of naloxone provision to counteract a rising trend in drug overdose deaths is leaving prisoners behind. Only a few prisons provide naloxone kits to at-risk prisoners upon release (32). In the state of Rhode Island, drug overdose is the leading cause of accidental death among adults (33), and in early 2014 the majority of people who died of a drug overdose had spent time in prison (32). In 2007 a pilot naloxone programme began providing overdose prevention training to prisoners before release, and in 2011 naloxone kits began being provided after release (34).

HEPATITIS C VIRUS AND TUBERCULOSIS IN PRISONS

Opioid-related deaths before (2006–2010) and after (2011–2013) naloxone, Scotland, United Kingdom



Source: Bird SM, McAuley A, Perry S, Hunter C. Effectiveness of Scotland's national naloxone programme for reducing opioid-related deaths: a before (2006–10) versus after (2011–13) comparison. *Addiction*. doi: 10.1111/add.13265.

The prevalence of hepatitis C virus ranges from 3.1% to 38% among prisoners and has been linked to sharing injecting equipment, tattooing and unprotected sexual intercourse (35). A high prevalence of HIV, overcrowding, poor ventilation, drug use and previous unhealthy lifestyles have been identified as contributors to the spread of tuberculosis within prisons (36). One study estimated that growth in the prison populations of 26 eastern European and central Asian countries accounted for a 20.5% increase in tuberculosis incidence from 1991 to 2002, or nearly four fifths of the average total increase in tuberculosis incidence in the countries studied (36). A systematic review found that improving tuberculosis control in prisons would significantly reduce a country's overall tuberculosis disease burden (37).

Despite the clear need, coverage of these essential health services remains low within the prison systems of many countries. Insufficient budgets are often cited as a barrier to providing appropriate health care to prisoners. Researchers estimated that providing hepatitis C treatment to all the prisoners in need in Rhode Island would cost nearly twice the entire annual health-care budget of the state's correctional system (38). The longer-term cost to the United States Government and the community of failing to provide that treatment is rarely assessed, however. Giving higher priority to prisoners' health is clearly required in many countries.

Courts around the world have described failure to provide people in prisons and other closed settings with the necessary medical care as inhumane and degrading treatment. The United Nations Special Rapporteur on the Right to Health has stressed that if harm reduction programmes and evidence-based treatments are made available to the general public but not to people in detention, it is a violation of the right to health (21). In South Africa, a landmark Constitutional Court ruling in 2012 found the South African prison system responsible for a prisoner's

tuberculosis infection (39). Since the ruling, there has been significant investment in the prison system's capacity to diagnose and treat tuberculosis, including systematic symptom screening coupled with the use of on-site Xpert MTB/RIF tests for people who are symptomatic. The country's TB/HIV Care Association is supporting 95 correctional facilities across the country. In Pollsmoor prison, where Nelson Mandela was once held, close to 90 000 prisoners have been screened for tuberculosis since 2013 and 915 were on treatment in 2015 (40). An early evaluation of the initiative found the scale-up of services effective and comparable in cost to other screening programmes (41).

Continuity of care is critical for people entering and leaving prisons and other closed settings, as interrupting treatments for HIV, tuberculosis or drug dependence has serious health consequences for the patients and the communities they are returning to. Multiple studies have shown that prisoners respond well to antiretroviral therapy and can achieve levels of adherence that are as high as or higher than those found in people in the community, but the gains in health status made in prison may be lost unless careful efforts are undertaken to link released prisoners to care within their communities (42). The spread of HIV and other infectious diseases in prisons is thus a wider public health issue (43).

Both linkage to HIV care after testing positive for HIV and retention in care after initiation of antiretroviral therapy are lower after release from prison in the United States, where less than 20% of prisons and jails provide services for the transition of released prisoners to community care as per national guidelines (44). To improve prison conditions and ensure prisoners receive the health care they need, UNODC and WHO have called for prison health services to be placed under the authority of ministries of health (45). France, Italy, Norway, the United Kingdom and parts of Switzerland and Spain are among the countries that have transferred responsibility of prison health to their health ministries (45).

ACTION AREAS

- Make UNODC's comprehensive package of 15 HIV services available to all prisoners.
 - Ensure the availability of essential health services, including tuberculosis and hepatitis C virus screening and treatment, to all prisoners.
 - End compulsory HIV testing and the segregation of prisoners living with HIV.
 - Ensure that naloxone kits are provided to prisoners with a history of drug use upon their release.
 - Ensure continuity of care for individuals entering and leaving prisons and other closed settings.
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REFORM AND EMPOWERMENT

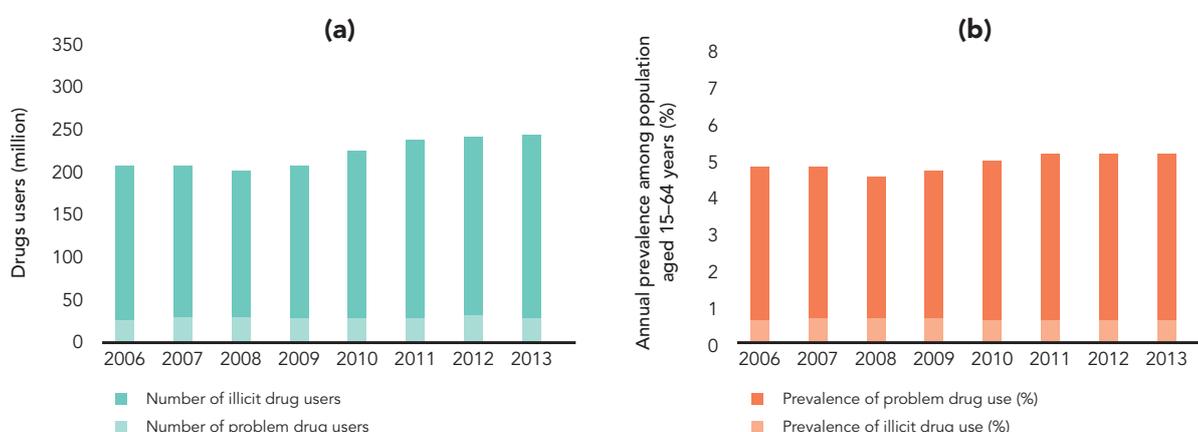
“A criminal record for a young person for a minor drug offence can be a far greater threat to their well-being than occasional drug use.”

Former United Nations Secretary-General Kofi Annan, 19 May 2015, speaking at the meeting “Strengthening a public health approach when addressing the world drug problem”

The 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances called on countries to include the possession of narcotic drugs and psychotropic substances for personal consumption as a criminal offence under their domestic law. International agreement to this provision coincided with a 30-year global increase in the criminalization of drug possession and use (1, 2). In 2011 offences related to drug possession comprised 83% of total global drug-related offences (2).

More aggressive policing and sanctioning have had little or no impact on the number of people using drugs. Country data collected by UNODC show that the percentage of people who use illicit drugs has remained stable, fluctuating between 4.6% and 5.2% of adults, since at least 2006 (3). Unsurprisingly, research has determined that the imprisonment of drug offenders is not cost effective. In the United States, the states of Washington, Oregon and New York separately calculated that they received, respectively, only US\$ 0.37, US\$ 0.35 and US\$ 0.29 in public safety benefits for every dollar invested in the incarceration of drug offenders, which means the costs were roughly three times more than the benefits (4, 5).

Global trends in (a) the estimated number of drug users^a and (b) prevalence of use^b, 2006–2013



^a Estimates percentage of people aged 15–64 years who used drugs in the past year

^b Estimates are for people aged 15–64 years in the past year

Source: World drug report 2015. Vienna: United Nations Office on Drugs and Crime; 2015.

Any benefits from the criminalization of drug use and the possession and sale of small amounts of drugs appear to be far outweighed by the increase in harms these policies create. Criminalization has been shown to perpetuate risky forms of drug use, to increase the risk of illness (including from HIV infection) among people who use drugs, to discourage people who use drugs from seeking health care, and to reinforce the marginalization by society of people who use drugs (6).

Criminalization has specific effects on women and their families. Globally, women are imprisoned for drug-related offences more than for any other crime (7). In some countries in the Americas, Europe and central Asia, 40–70% of women in prison are incarcerated for low-level, non-violent, drug-related offences (8), such as selling small quantities of drugs or serving as mules to carry drugs from one country to another (9). Many of these women are young, illiterate, impoverished single mothers who are struggling to take care of their children and other family members (9). In some countries, drug-related convictions can result in a woman losing custody of her children and forced or coerced sterilization or abortion (7). Children left behind are vulnerable to marginalization and may engage in criminal activity or problem drug use themselves as they struggle to cope with living on the streets, in institutions, in foster care or with relatives (10).

PEOPLE-FRIENDLY POLICING STRATEGIES

The incorporation of human rights safeguards within drug control laws and drug-related law enforcement is critical to the prevention of human rights abuses. As the human toll of punitive approaches mounts alongside persistent drug trafficking, drug use and drug-related crime, an increasing number of law enforcement agencies are buying into alternative, public health approaches to drug use.

In the United States city of Seattle, a coalition of law enforcement agencies, public officials and community groups collaborated to establish the Law Enforcement Assisted Diversion (LEAD) programme in 2011. Under this programme, police who would normally arrest and prosecute people caught in possession of drugs instead redirect them to community-based services, including drug dependence treatment. This diversion is done before an individual is officially booked for an offence, which avoids the costs and time entailed in booking, charging and requiring court appearances of an individual (11). A 2015 evaluation of the programme found a significantly lower level of criminal behaviour among beneficiaries of the programme compared with a control group. LEAD beneficiaries were 60% less likely to be arrested within their first six months in the programme, were 58% less likely to be arrested at all, and were 39% less likely to be charged with a felony crime (12). The costs of the programme (US\$ 899 per person per month at start-up, and US\$ 532 per person per month after several years of operation) were found to be similar to supportive programmes for homeless people, and there were substantial reductions in criminal justice and legal costs for LEAD beneficiaries compared with the control group (13).

The success of LEAD begs the question of whether criminalization of the possession and use of small amounts of narcotic drugs is an effective approach within drug control systems.

DEPENALIZATION AND DECRIMINALIZATION

A large body of evidence shows that alternatives to incarceration such as community-based drug dependence treatment are more cost effective at reducing health, social and economic harms of drug use (14). The United Nations Special Rapporteur on the Right to Health concluded in 2010 that decriminalization or depenalization of possession and use of drugs is an important step towards fulfilling the right to health, an analysis echoed by the United Nations High Commissioner for Human Rights in a 2015 study on the impact of the world drug problem on the enjoyment of human rights (7).

Several countries are moving away from criminalization of drug use. Armenia, Belgium, Chile, the Czech Republic, Estonia, Mexico and Portugal are among the countries that have adopted some form of decriminalization policy since 2000 (15). In the Netherlands and Germany, possession for personal use is illegal, but guidelines are established for police and prosecutors to avoid imposing punishment (15). In total, depending on the definition used, between 25 and 30 countries had decriminalized or depenalized drug possession and use by 2012 (15).

The Czech Republic's decriminalization of the use and possession of small quantities of drugs combined with relatively high coverage of needle-syringe programmes and opioid substitution therapy have been credited with the country's remarkably low rates of HIV among people who inject drugs, especially when compared with other countries in central and eastern Europe (16). Nearly 90% of people who inject drugs in the Czech Republic report using sterile injecting equipment the last time they injected, and HIV prevalence among people who inject drugs in 2012 was estimated to be 0.1% (17).

Among the best documented policy changes is Portugal's. In 2000, Portugal passed a new drug law that downgraded purchase, possession and consumption of small amounts of narcotic drugs from criminal to administrative offences. Under the law an individual can possess a 10-day supply of drugs before facing criminal charges as a drug dealer. The law also put in place a wide range of drug use prevention measures focused on high-risk groups and areas, and systematic application of harm reduction measures, including needle-syringe distribution and drug dependence treatment. Reintegration teams assist people undergoing drug treatment to return to education or employment and reintegrate into their communities, and actively work to dispel stigma and discrimination (6).

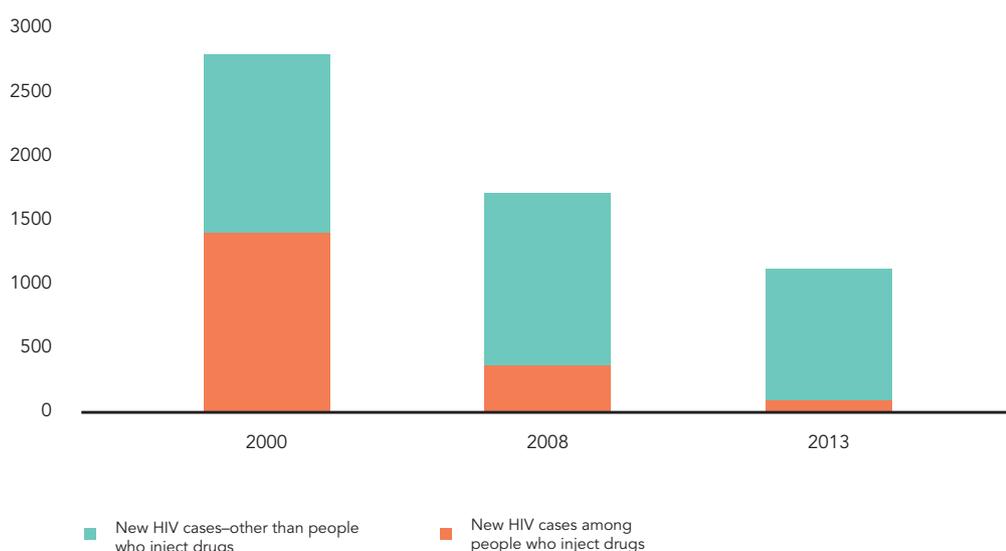
The 10 years after Portugal's law was enacted saw a decline in the rate of crimes related to drug consumption, especially petty thefts (18). Levels of drug use in Portugal have fluctuated since the policy change,

which has been the subject of intense debate between proponents and opponents of the policy. Contrary to the predictions of opponents of decriminalization, the policy change has not led to a dramatic increase in drug use, and drug use levels remain below the European average (19). There is evidence of reductions in problematic drug use, drug-related harms and criminal justice overcrowding (20), and the number of people entering drug dependence treatment programmes in Portugal increased from just over 5000 in 2008 to 40 000 in 2010 (18). The experience of Portugal reinforces multi-country analyses that have found little or no relationship between the strictness of national drug policies and illicit drug use (21, 22).

The public health benefits of Portugal’s drug policy are clear. Since 2000 there has been a steady decrease in the number of people who inject drugs newly infected with HIV, and a huge decrease in the percentage of people who inject drugs among new HIV infections (18). In 2013 a total of 78 new HIV cases were related to drug use, compared to 1430 in 2010 (23). A similar downward trend has been observed for hepatitis C and hepatitis B among people attending drug treatment centres, despite an increase in the number of people seeking treatment (19).

A review of countries that have decriminalized or relaxed criminal penalties for possession and use of small quantities of drugs found that these countries generally were able to direct more people who are drug dependent into dependence treatment; they also experienced a reduction in criminal justice costs. The review concluded that decriminalization coupled with investment in harm reduction can have a positive impact on individual drug users and society as a whole (15).

Numbers of people newly diagnosed with HIV in Portugal since the decriminalization of drug use, 2000–2013



Sources: Domosławski A. Drug policy in Portugal: the benefits of decriminalizing drug use. Warsaw: Open Society Foundations; 2011.

Relatório anual 2013: a situação do país em matéria de drogas e toxicodependências [Annual report 2013: state of the country in drugs and drug addiction]. Lisbon: Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências.

The growing body of evidence has fuelled a rising chorus for change. WHO has called on countries to work towards policies and laws that decriminalize injection and other uses of drugs to reduce incarceration and improve coverage of harm reduction services (24). The International Narcotics Control Board has increasingly stressed a need for a balanced approach to drug control “in which prevention, treatment and rehabilitation take a leading role”. A joint statement of experts following a UNODC scientific consultation in 2014 declared “an urgent need to realign harm reduction and law enforcement approaches to support prevention and treatment of HIV and hepatitis C among people who inject drugs”, and the Johns Hopkins–Lancet Commission on Drug Policy and Health has specifically called for the decriminalization of use, possession and petty sale of drugs, and the strengthening of health and social-sector alternatives to criminal sanctions (25).

The outgoing President of the International Narcotics Control Board, Lochan Naidoo, told the 58th session of the Commission on Narcotic Drugs in 2015 that “nothing in the [drug control] conventions requires states to incarcerate drug users” (26). During the same session, the Commission passed a resolution that called on public health and justice authorities to collaborate in the pursuit of “alternative measures to conviction or punishment for appropriate drug-related offences of a minor nature” (27). A few months later, the new President of the International Narcotics Control Board, Werner Sipp, described Portugal’s drug policy as “a model of best practices” that puts health and welfare at the centre of “a balanced, comprehensive and integrated approach, based on the principle of proportionality and the respect for human rights” (28).

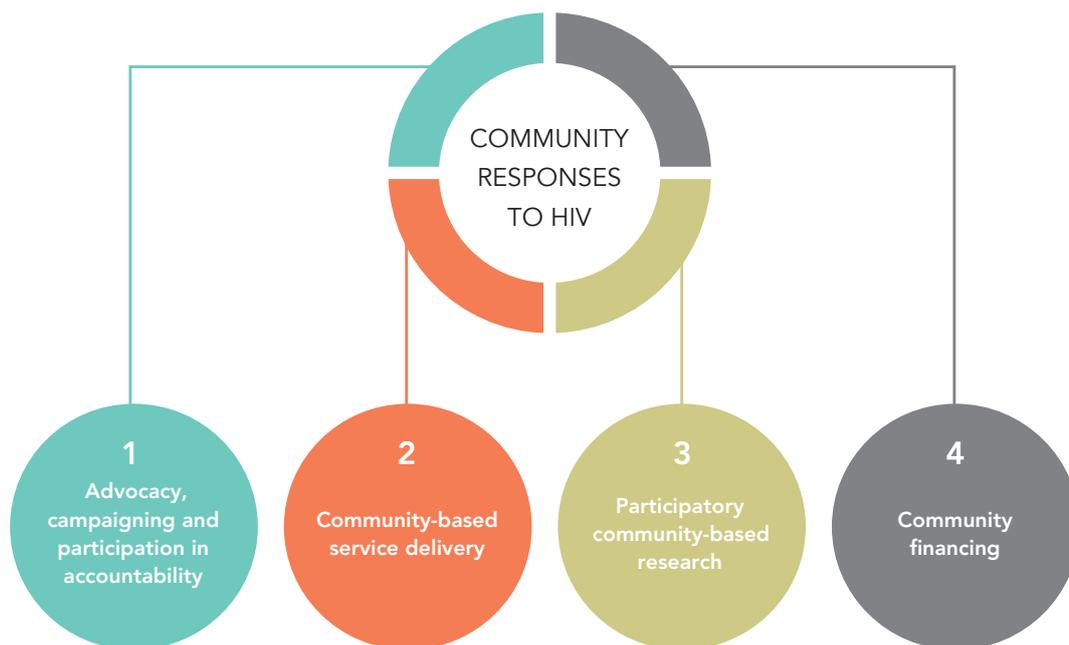
COMMUNITY EMPOWERMENT

“We are people from around the world who use drugs. We are people who have been marginalized and discriminated against; we have been killed, harmed unnecessarily, put in jail, depicted as evil, and stereotyped as dangerous and disposable. Now it is time to raise our voices as citizens, establish our rights and reclaim the right to be our own spokespersons striving for self-representation and self-empowerment...”

Vancouver Declaration–The International Activists who use Drugs, 30 April 2006 | Vancouver, Canada

Civil society’s unique role within the global HIV response for more than three decades has demonstrated the breadth of community contributions to efforts to improve health care and social justice for marginalized populations. A review by UNAIDS and the Stop AIDS Alliance in 2015 identified four components of community responses to HIV: advocacy, campaigning and participation in accountability; service delivery; research and evidence generation; and community financing. These components are also relevant to the participation of people who use drugs within efforts to develop more effective approaches to drug use.

Four components of community responses to HIV



Source: Communities deliver: UNAIDS, Stop AIDS Alliance. The critical role of communities in reaching global targets to end the AIDS epidemic. Geneva, 2015.

Community engagement in harm reduction dates back to at least the mid-1970s, when former users of heroin in Chicago were hired to reach hidden populations of people who inject drugs to encourage them to enter methadone maintenance therapy (29). Peer support is based on the belief that people who have faced, endured and overcome adversity can offer useful support, encouragement, hope and mentorship to other people facing similar situations (30). As outreach models spread, the power of peers was increasingly understood. By the late 1990s, enlisting active users of drugs was found to be more effective at providing entire networks of people who inject drugs with sterile injecting equipment, rather than only a few individuals (29). In 2004, WHO compiled the overwhelming evidence of the effectiveness of peer outreach in the prevention of HIV among people who inject drugs to assist countries to establish more effective HIV programmes (29). Peer support has also been shown to improve drug dependence treatment (31), and UNODC recommends the engagement of people who use drugs within community-based drug dependence treatment programmes (32).

In India, the Hridaya community-based harm reduction project has built partnerships between existing government health services and civil society organizations of the people who inject drugs within the states of Bihar, Haryana, Uttarakh and Manipur. The project provides a comprehensive range of harm reduction, health and social services to people who inject drugs and their sexual partners. Peers provide psychosocial support and enhance referral to external services. Of particular note is the engagement of female outreach workers to work with the sexual partners and families of people who inject drugs, and to recruit new clients into regular services. The Hridaya project has also facilitated the participation of people who use drugs in forums that influence state-level decision-making (33).

The experiences of countries with HIV epidemics predominantly among people who inject drugs were used to develop a harm reduction programme in Kenya, where a high-level HIV epidemic among the general population is in decline while HIV prevalence among people who inject drugs is approximately 18%. Many people who use drugs in Kenya avoid health services out of fear of discrimination, stigmatization and arrest. To address this, the Community Action on Harm Reduction project and the Kenyan AIDS NGOs Consortium used a peer outreach model to provide sterile injecting equipment to people who inject drugs and to link these people to HIV testing and treatment, sexual and reproductive health services, counselling, legal support, housing and income-generating activities. Over five years of implementation in Nairobi and four coastal towns (Mombasa, Malindi, Kilifi and Ukunda), the project provided services to almost 10 000 people who inject drugs (34). At the start of the project in 2011, 51.6% of the surveyed people who inject drugs had used a sterile syringe the last time they injected. In 2015, a follow-up survey found that 90% reported using sterile injecting equipment at last injection, greatly reducing their risk of HIV transmission (34).

CIVIL SOCIETY ADVOCACY FOR CHANGE

Over the past 25 years, small groups of peer outreach workers have bound together into communities with shared experiences, which have in turn established national organizations and international networks of people who use drugs. These civil society organizations have forged identities, self-respect and empowerment not only to provide support to community members but also to raise awareness and provoke change. Their experiences and insights must be recognized as critical contributions to the evolution of national drug laws and policies and the debate within the UNGASS on the World Drug Problem.

Civil society advocacy for sufficient, strategic and sustainable investments in harm reduction as HIV prevention in the region of eastern Europe and central Asia is being strengthened by the Eurasian Harm Reduction Network and the Global Fund (35). During its first year of implementation, the project conducted a financial analysis of harm reduction service costs and a community-led assessment of service quality in Belarus, Georgia, Kazakhstan, Lithuania, the Republic of Moldova and Tajikistan. The harm reduction funding and coverage gaps revealed by the assessments suggest that the region is far from achieving sustainable control of the spread of HIV. The Eurasian Harm Reduction Network and its partners have called on governments in the region to provide greater sustained state funding for harm reduction and to put in place policy reforms that will facilitate service delivery, such as the enactment of legislation to ensure possession of injecting equipment is not used by the criminal justice system as evidence of illegal drug use, and the recognition of opioid substitution therapy as a legitimate drug dependence treatment (36).

The International Network of People Who Use Drugs is one of several peer-based organizations that have engaged in the Civil Society Task Force and Civil Society Hearings for the UNGASS on the World Drug Problem. The formal submission of the International Network of People Who Use Drugs to the Task Force calls on United Nations Member States to recognize people who use drugs as experts on drug use who must be meaningfully engaged in the debate on the future of global drug policy (37). The Eurasian Harm Reduction Network and the Eurasian Network of People Who Use Drugs have urged governments in central and eastern Europe and central Asia to expand harm reduction in the region far beyond the small pilot schemes that are mostly funded by international donors (38).

The proponents of peer support describe the deep bonds that are established by mutual experience, and how the strength of a peer community can be leveraged to question previously held concepts and experiment with new behaviour (39). The shared experiences of countries struggling to control the global drug trade could be similarly leveraged to listen carefully to the advice of people who use drugs and to expand the use of alternative policy options that place people at the centre of a rights-based public health approach to drug use.

ACTION AREAS

- Use people-friendly policing strategies to reduce violence and the incarceration of people who use drugs.
 - Adapt and reform laws to ensure that people who use drugs do not face punitive sanctions for the use of drugs or possession of drugs for personal use.
 - Empower and finance communities of people who use drugs to advocate for their rights and participate in research and the delivery of services.
-

CONCLUSION

A struggle between an increasingly violent network of organized criminals and an increasingly militarized coalition of anti-narcotics police has dominated a half-century of efforts to control the production, sale and use of narcotic drugs and psychotropic substances. Caught in the crossfire are 246 million people who use drugs. They have been marginalized, denied health and social services, severely punished, forced to undergo unwanted medical tests and treatment, and exposed to HIV and a host of other harms. Hundreds of millions of additional people have been denied access to the medicines they need for pain relief.

The UNGASS on the World Drug Problem is an opportunity to refocus the international drug control system on its original goal—the health and well-being of humankind. The International Narcotics Control Board, United Nations System agencies and a growing body of scientific research have called for the scale-up of harm reduction within a balanced approach to drug control. Within this approach, UNAIDS has put forth five policy recommendations and 10 operational recommendations that can accelerate efforts to establish a people-centred public health and human rights-based approach to drug use.

FIVE POLICY RECOMMENDATIONS

1. Recognize that the overarching purpose of drug control is first and foremost to ensure the health, well-being and security of individuals, while respecting their agency and human rights at all times.
2. Ensure accountability for the delivery of health services for people who use drugs by including public health and human rights pillars in the framework of the UNGASS outcome document that incorporate clear objectives for reducing new HIV infections and protect and promote the rights of people who inject drugs.
3. Commit to fully implement harm reduction and HIV services, as outlined in the World Health Organization's consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations.
4. Commit to treating people who use drugs with support and care, rather than punishment. UNAIDS believes that this objective can be achieved only by implementing alternatives to criminalization, such as decriminalization and stopping incarceration of people for the consumption and possession of drugs for personal use.
5. Ensure integration of HIV services with other health and social protection services for people who use drugs.

TEN OPERATIONAL RECOMMENDATIONS

1. Ensure that all people who inject drugs, including people in prisons and other closed settings, have access to harm reduction services to prevent HIV infection, including needle–syringe programmes, opioid substitution therapy and antiretroviral therapy.
2. Ensure that all people who inject drugs and are living with HIV have access to life-saving antiretroviral therapy and other health services to manage tuberculosis, viral hepatitis and sexually transmitted infections. In addition, ensure adequate availability and access to opioids for medical use to reduce pain and suffering.
3. Ensure that all people who use drugs have access to non-coercive and evidence-informed drug dependence treatment consistent with international human rights standards and the Principles of Drug Dependence Treatment articulated by the United Nations Office on Drugs and Crime and the World Health Organization. All forms of compulsory drug and HIV testing and drug treatment should be replaced with voluntary schemes. The use of compulsory detention centres for people who use drugs should cease, and existing centres should be closed.
4. Adapt and reform laws to ensure that people who use drugs do not face punitive sanctions for the use of drugs or possession of drugs for personal use. Countries should consider taking a range of measures, including alternatives to criminalization, incarceration, penalization and other penalties based solely on drug use or possession of drugs for personal use. These measures include decriminalization, steps to reduce incarceration, removal of administrative penalties and depenalization.
5. Ensure that the human rights of people who use drugs are not violated, by providing access to justice (including through legal services), prevention, treatment and other social services. Adopt smart policing measures to encourage people to access public health services.
6. Recognize that stigma and discrimination impede access to HIV prevention, treatment and other health and development services, and ensure that all people who use drugs are not discriminated against while accessing health, legal, education, employment and other social protection services.
7. Recognize that incarcerating people in prisons increases their risk of drug use, HIV infection and other health conditions, and take steps to ensure that harm reduction and other health services are available in prisons in parallel with efforts to reduce the number of people being incarcerated for non-violent drug offences.

8. Ensure the widespread availability of naloxone among health workers, first responders, prison staff, enforcement officials and family members as a life-saving public health measure to enable timely and effective prevention of deaths from opioid overdose among people who use drugs.
9. Support and empower community and civil society organizations, including organizations and networks of people who use drugs, in the design and delivery of HIV, health and social protection services.
10. Undertake a rebalancing of investments in drug control to ensure that the resources needed for public health services are fully funded, including harm reduction for HIV infection, antiretroviral therapy, drug dependence treatment and treatment for hepatitis, tuberculosis and other health conditions.

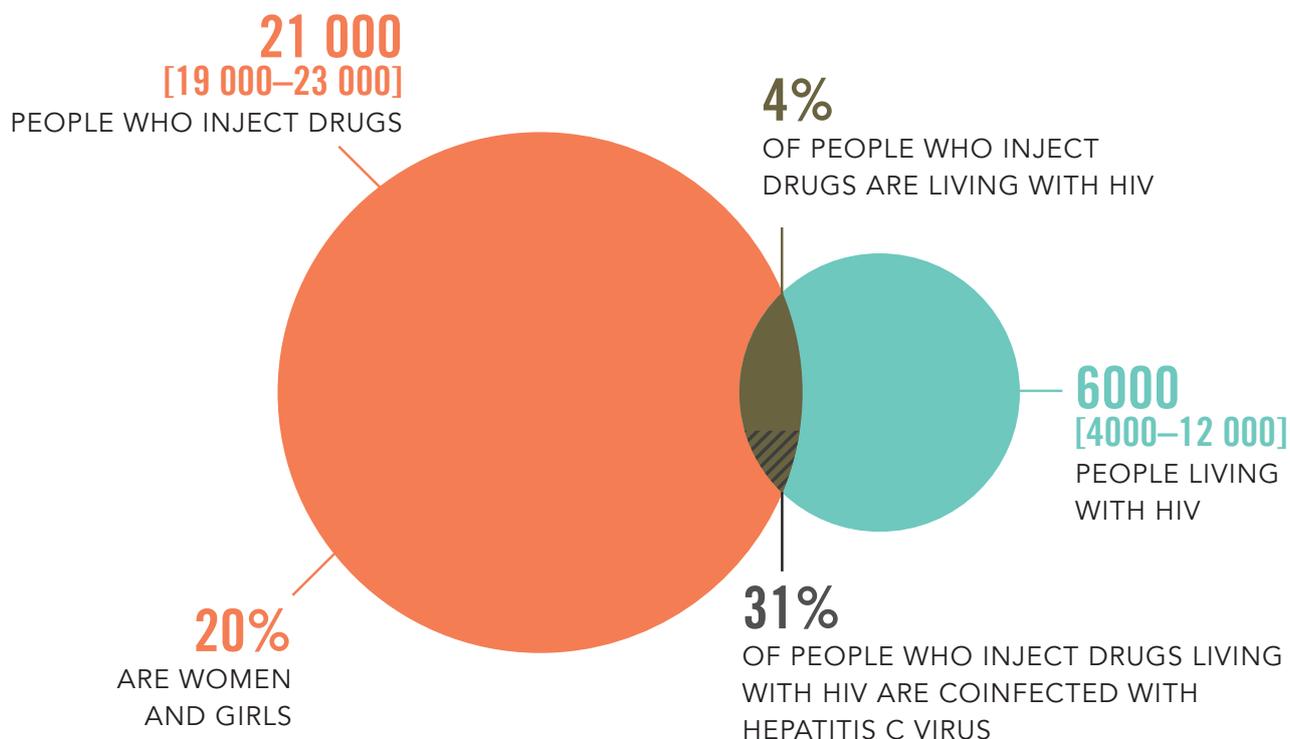
The preamble of the United Nations Charter places the international community's collective faith in fundamental human rights, in the dignity and worth of the human person, and in the equal rights of men and women and of nations large and small. It calls on Member States to ensure justice, to promote social progress and better standards of life, and to be tolerant of their neighbours. Establishing a people-centred public health and human rights-based approach to drug use will ensure that these core concepts established during the founding of the United Nations also apply to people who use drugs.

COUNTRY PROFILES

Thirty-two countries are home to approximately three quarters of the world's people who inject drugs.

AFGHANISTAN

HIV EPIDEMIC



Sources: National drug use survey: Afghanistan. Vienna: United Nations Office on Drugs and Crime; 2009 National programme data. Integrated biological and behavioural survey, Afghanistan, 2012.

LEGAL AND POLICY ENVIRONMENT

- +** **ENABLING NATIONAL POLICY**
The National Harm Reduction Policy guides the provision of needles and syringes, condoms and opioid substitution therapy.
- +** **POLICING**
There are no criminal penalties or other sanctions for the possession of needle/syringes and other drug paraphernalia.

Source: UNAIDS country office report, 2016.

HARM REDUCTION



159

syringes distributed per person who injects drugs per year



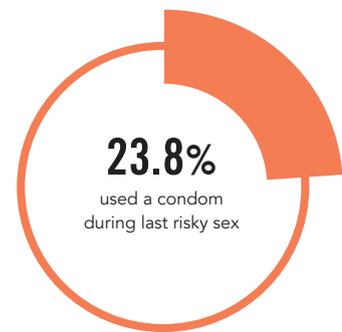
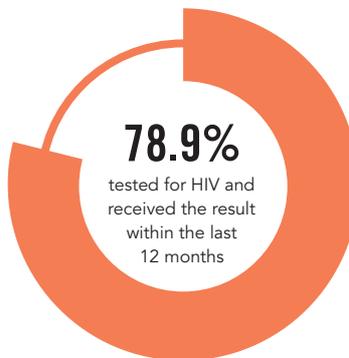
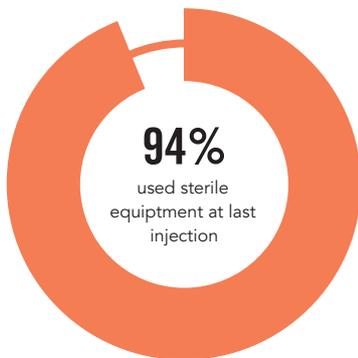
<1000

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: NACP, National programme data, 2015.

Integrated biological and behavioural survey, Afghanistan, 2012.

Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>).

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

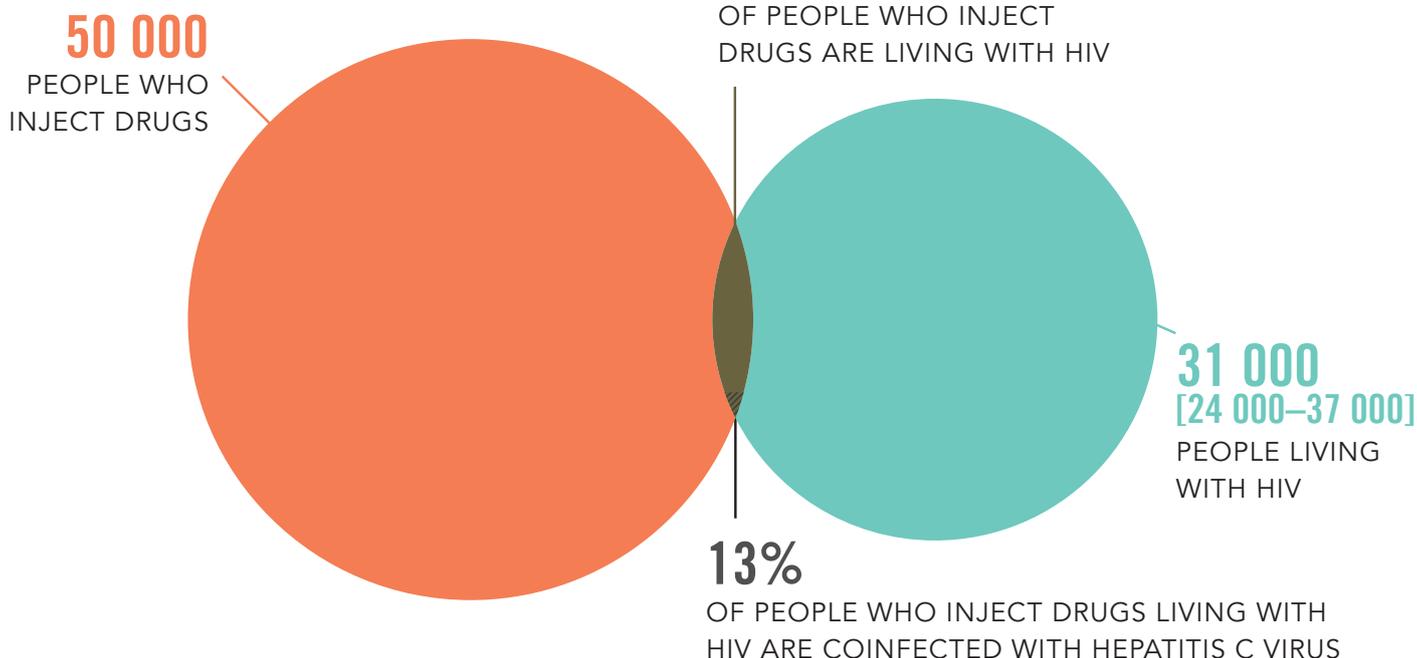


OPIOID SUBSTITUTION THERAPY

Source: The global state of harm reduction 2014. London: Harm Reduction International; 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>).

AUSTRALIA

HIV EPIDEMIC



Sources: Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>).
Dore, G. & Sasadeusz, J. (Eds) (2006). Co-infection: HIV & Viral hepatitis a guide for clinical management. ASHM.
Australian Institute of Health and Welfare 2014. National Drug Strategy Household Survey detailed report 2013. Drug statistics series no. 28. Cat. no. PHE 183. Canberra: AIHW.

LEGAL AND POLICY ENVIRONMENT

- + ENABLING NATIONAL POLICY**
Harm reduction features strongly in the national hepatitis C strategy and the national drug strategy.
- + POLICING**
There are no criminal penalties or other sanctions for the possession of needles, syringes or other drug paraphernalia.
- CRIMINALIZATION**
Possession of small quantities of drugs other than cannabis for personal use is a criminal offence punishable by a large fine and imprisonment (sentences vary by state).
- + OVERDOSE TREATMENT**
Naloxone is available without prescription to people likely to witness an overdose.

Source: Harm reduction, Australian Government Department of Health, 2008 (<http://www.health.gov.au/internet/publications/publishing.nsf/Content/phd-hepc-manual-toc~phd-hepc-manual-ch3~phd-hepc-manual-ch3-4>). Drug law in Australia, Australian Drug Foundation, 2015 (<http://www.druginfo.adf.org.au/topics/drug-law-in-australia#illegal>). Final decisions and reasons for decisions by a delegate of the Secretary to the Department of Health, Therapeutic Goods Administration, 2015.

HARM REDUCTION



203

syringes distributed per person
who inject drugs per year



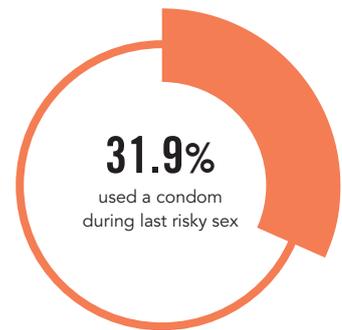
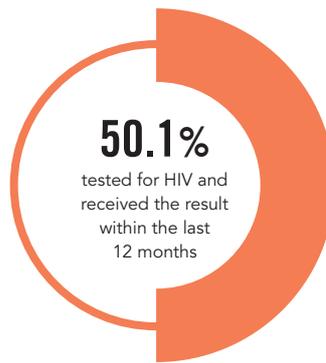
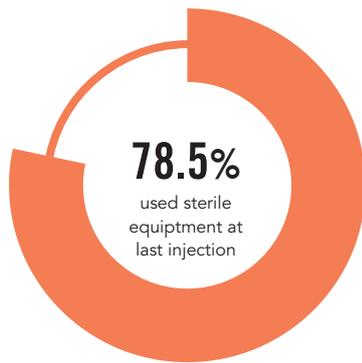
48 393

people enrolled in opioid
substitution therapy



1

safe injecting
facility



Sources: Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>).
The global state of harm reduction 2014. London: Harm Reduction International; 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>).
Australian Institute of Health and Welfare, Australian Government. National opioid pharmacotherapy statistics, 2014.

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

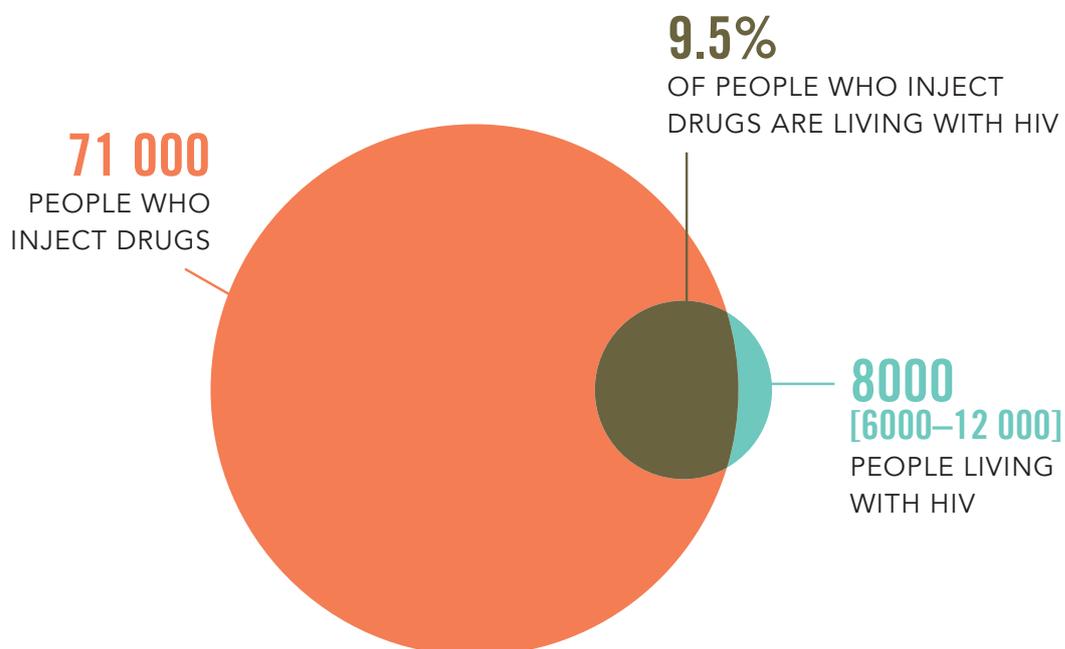


OPIOID SUBSTITUTION THERAPY

Sources: Australian Institute of Health and Welfare, Australian Government. The health of Australia's prisoners, 2012.
The global state of harm reduction 2014. London: Harm Reduction International; 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>).

AZERBAIJAN

HIV EPIDEMIC



Sources: Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>).

LEGAL AND POLICY ENVIRONMENT

- INSUFFICIENT ENABLING POLICY**
The country's policy framework does not have explicit supportive reference to harm reduction, but needle and syringe distribution and opioid substitution therapy are available.
- DOMESTIC INVESTMENT**
The financing of harm reduction in this lower-middle-income country is highly reliant on external funding, accounting for 96% of all funding in 2014.

Source: The global state of harm reduction 2014, London, Harm Reduction International, 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>); Global AIDS response progress report, Government of Azerbaijan, 2014.

HARM REDUCTION



78.5

syringes distributed per person who inject drugs per year



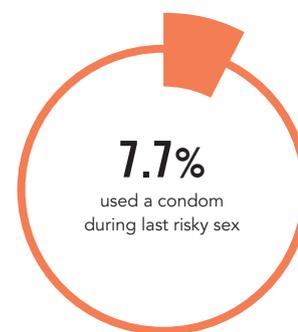
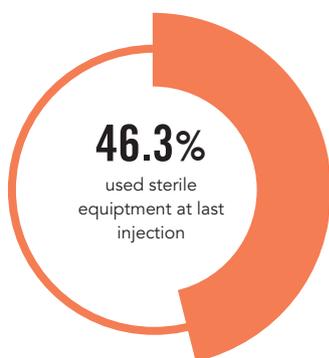
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people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>).

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

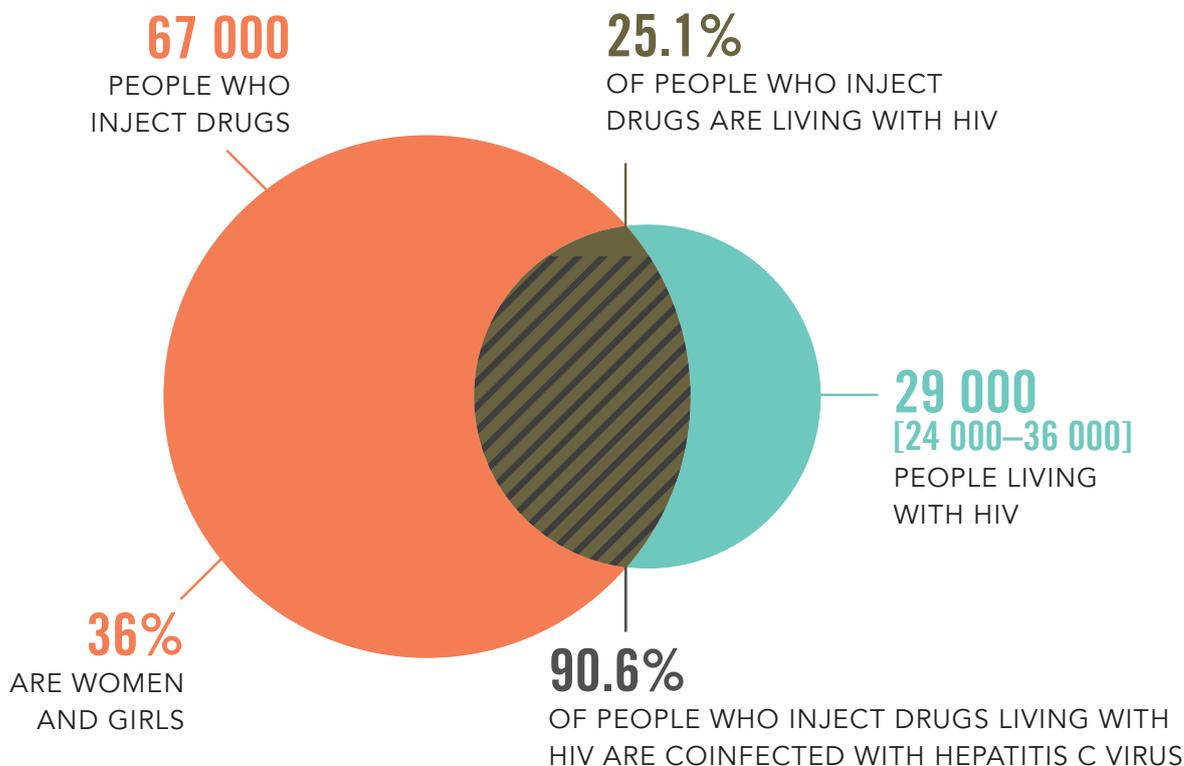


OPIOID SUBSTITUTION THERAPY

Source: The global state of harm reduction 2014. London: Harm Reduction International; 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>).

BELARUS

HIV EPIDEMIC



Source: Integrated biological and behavioural survey, Belarus, 2015.

LEGAL AND POLICY ENVIRONMENT

- REGISTRATION OF PEOPLE WHO USE DRUGS**
The Narcological Service of the Ministry of Health routinely registers known people who use or who are dependent on drugs. Since 2015 new registrations are routinely reported by health-care facilities to law enforcement agencies.
- CRIMINALIZATION**
A 2015 Presidential decree toughens criminal penalties for the production, transport and sale of illegal drugs and introduces administrative sanctions for drug use.
- DOMESTIC INVESTMENT**
The financing of harm reduction is being steadily transitioned from the Global Fund to Fight AIDS, Tuberculosis and Malaria to domestic sources. Opioid substitution therapy is almost completely funded by the state budget.

Source: UNAIDS country office report, 2016. EMCDDA, Country overview: Belarus.

HARM REDUCTION



56.7

syringes distributed per person who inject drugs per year



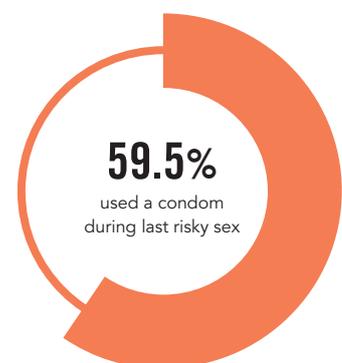
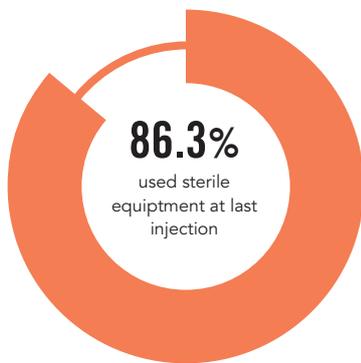
<1000

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: Integrated biological and behavioural survey, Belarus, 2015.
Ministry of Health report, 2015.

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

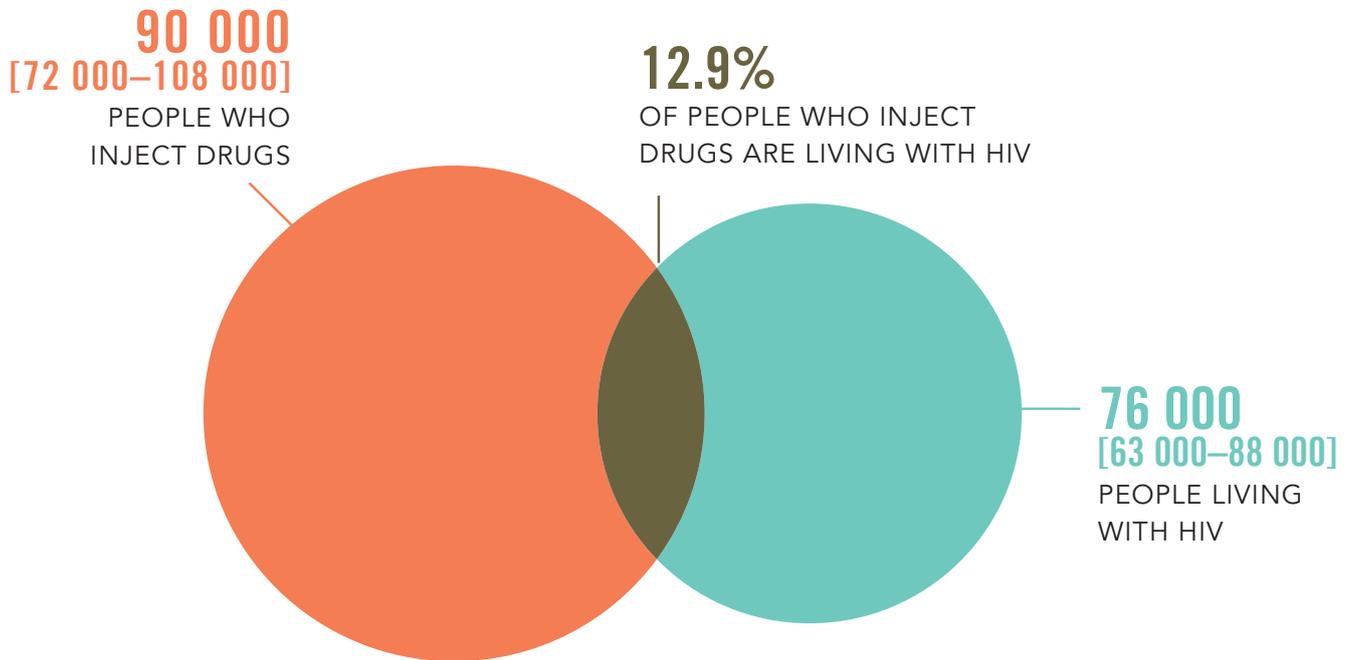


OPIOID SUBSTITUTION THERAPY

Source: The global state of harm reduction 2014. London: Harm Reduction International; 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>).

CANADA

HIV EPIDEMIC



Sources: Public Health Agency of Canada, revised estimate for 2014 estimation exercise.

LEGAL AND POLICY ENVIRONMENT

- + ENABLING NATIONAL POLICY**
A national harm reduction framework developed by the Canadian Government guides action to reduce the harms associated with alcohol and other drugs and substances from the national to the community level.
- + OVERDOSE TREATMENT**
Naloxone was delisted by national authorities in March 2016 to make it more easily available to people likely to witness an opioid overdose; it is up to individual provinces to make naloxone available without a prescription.
- + REACHING THE MOST MARGINALIZED**
Drug consumption rooms and heroin-assisted drug dependence treatment are available in cities with large populations of people who inject drugs.

Sources: National framework for action to reduce the harms associated with alcohol and other drugs and substances in Canada, Drug Strategy and Controlled Substances Programme and the Canadian Centre on Substance Abuse, 2005. Notice: Prescription Drug List (PDL): naloxone, Health Canada, 2016 (<http://www.hc-sc.gc.ca/dhp-mps/prodpharma/pdl-ord/pdl-ldo-noa-ad-naloxone-eng.php>). Insight into Insite, Vancouver, Urban Health Research Initiative, 2010 (<http://www.ohrdp.ca/wp-content/uploads/pdf/insite.pdf>). Strang J, Groshkova T, Metrebian N, New heroin-assisted treatment: recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond, Luxembourg, European Monitoring Centre for Drugs and Drug Addiction, 2012.

HARM REDUCTION



-

syringes distributed per person who inject drugs per year



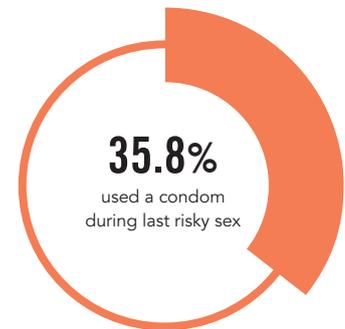
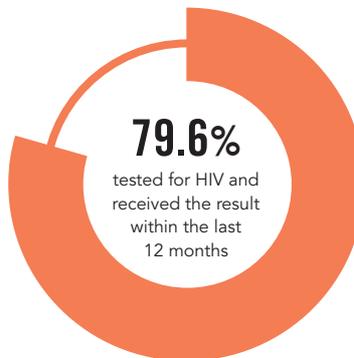
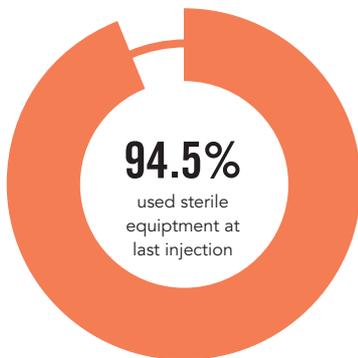
-

people enrolled in opioid substitution therapy



2

safe injecting facilities



Sources: Public Health Agency of Canada, I-Track Surveillance System, Phase 3 (2010–2012).
Public Health Agency of Canada, programme data reported to UNAIDS, 2016.

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

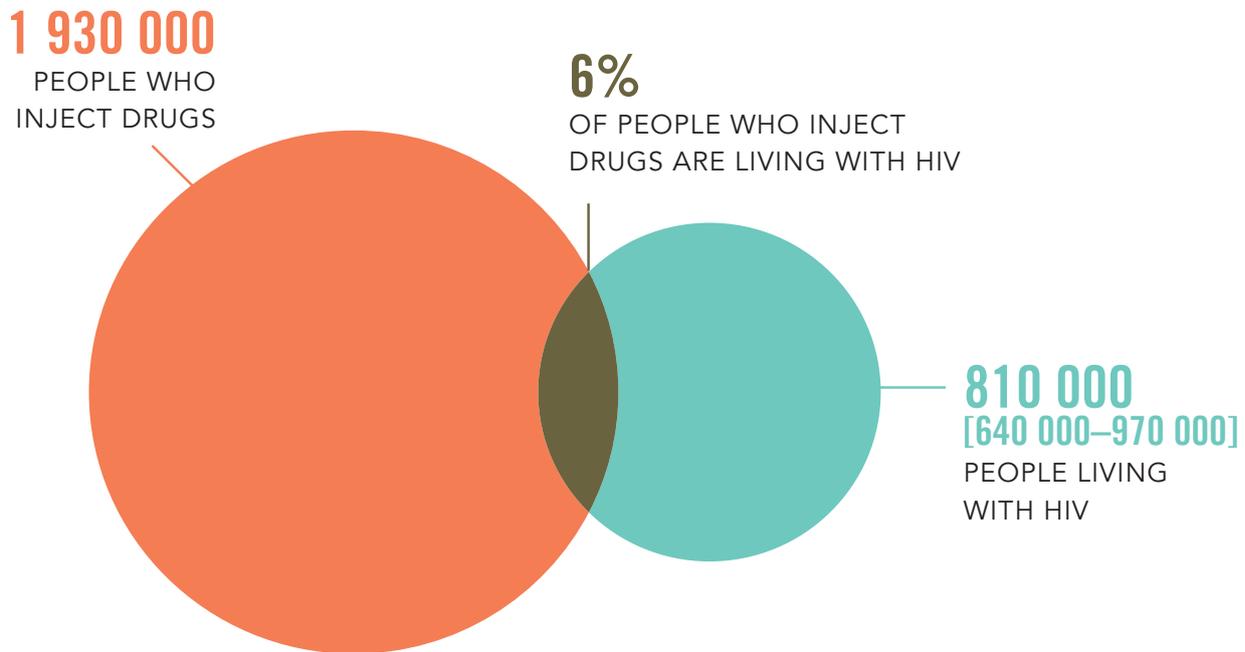


OPIOID SUBSTITUTION THERAPY

Source: Corrections Services Canada, programme data reported to UNAIDS, 2016.

CHINA

HIV EPIDEMIC



Sources: HIV estimation, China, 2013.
Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015
(<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>).

LEGAL AND POLICY ENVIRONMENT

- +** **ENABLING NATIONAL POLICY**
The National Health and Family Planning Commission, the Ministry of Public Security and the State Food and Drug Administration jointly formulated guidelines for methadone maintenance therapy that are guiding the expansion of one of the world's largest opioid substitution therapy programmes.
- **REGISTRATION OF PEOPLE WHO USE DRUGS**
Individuals dependent on heroin or other narcotic drugs are permanently registered in a government tracking system, even if they successfully undergo drug dependence treatment.
- **CRIMINALIZATION**
Possession of more than 200 grams of opium, 10 grams of methamphetamines and 10 grams of heroin can result in up to three years in prison.
- +** **POLICING**
There are no criminal penalties or other sanctions for the possession of needle/syringes and other drug paraphernalia.
- **COMPULSORY DETENTION**
In 2015, 264 000 people who use drugs were newly detained in compulsory detention centres.

Source: UNAIDS country office report, 2016. Kamarulzaman A, McBrayer J, Compulsory drug detention centers in East and Southeast Asia, *Int J Drug Policy* 2015;26:S33–S37.

HARM REDUCTION



204

syringes distributed per person who inject drugs per year



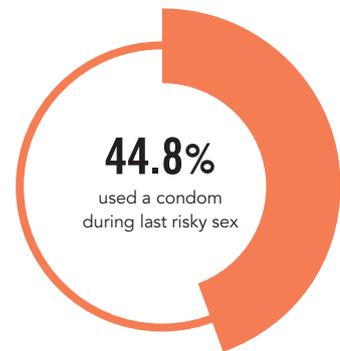
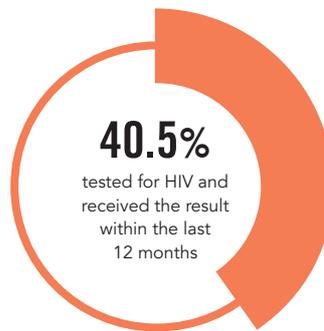
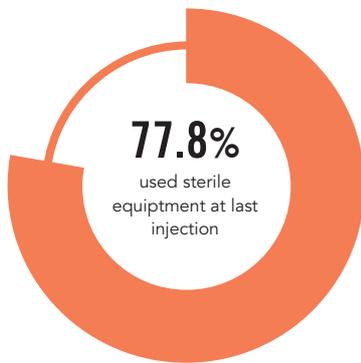
184 000

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>).

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

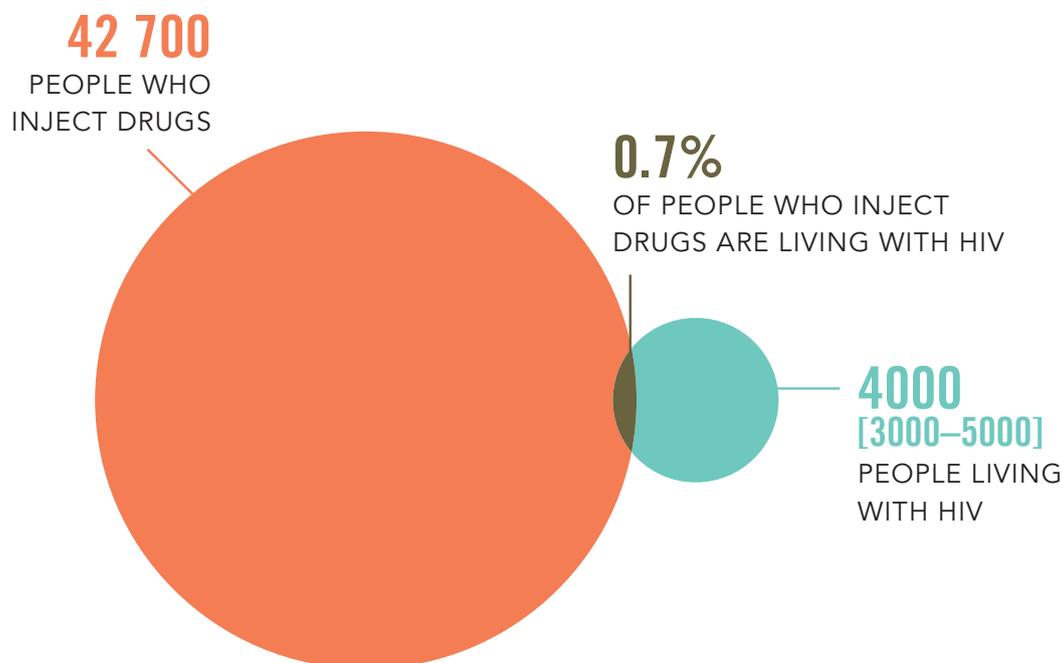


OPIOID SUBSTITUTION THERAPY

Source: National Center for AIDS/STD Control and Prevention, China.

CZECH REPUBLIC

HIV EPIDEMIC



Sources: National report: the Czech Republic 2013 drug situation. Prague: National Monitoring Centre for Drugs and Addiction; 2014 (http://www.emcdda.europa.eu/attachements.cfm/att_239732_EN_VZ_2013_EN_final.pdf). Treatment Demand Register and National Monitoring Centre for Drugs and Drug Addiction of the Czech Republic, 2012. UNODC, 2013.

LEGAL AND POLICY ENVIRONMENT

- +** **ENABLING NATIONAL POLICY**
Harm reduction has been a core part of the national drug policy since it was first established in 1992.
- +** **DECRIMINALIZATION**
Decriminalization of the use and possession of small quantities of drugs combined with relatively high coverage of needle–syringe programmes and opioid substitution therapy have been credited with the country’s remarkably low rates of HIV among people who inject drugs.
- +** **POLICING**
There are no criminal penalties or other sanctions for the possession of needle/syringes and other drug paraphernalia.

Source: EMCDDA, Country overview: Czech Republic. Office of the Government of the Czech Republic, Annual report: the Czech Republic—2010 drug situation. Csete J, A balancing act: policymaking on illicit drugs in the Czech Republic, Global Drug Policy Program, 2012.

HARM REDUCTION



138

syringes distributed per person who inject drugs per year



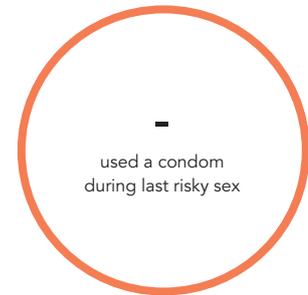
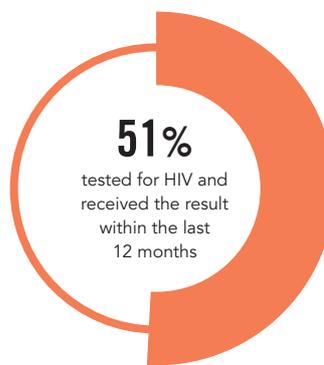
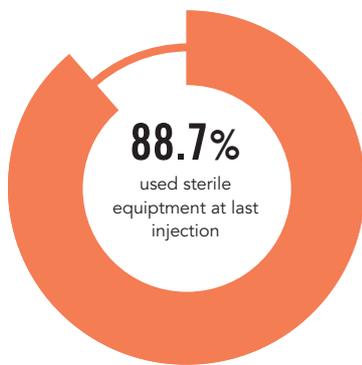
4000

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: Czech National Monitoring Centre for Drugs and Drug Addiction, unpublished data, 2016. Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>).

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

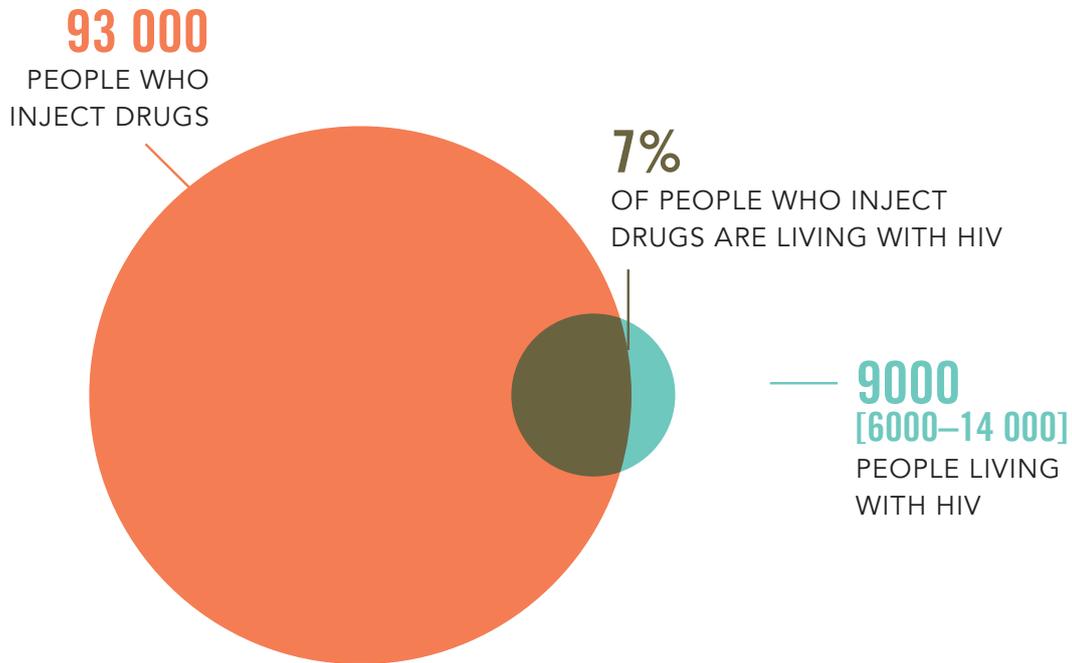


OPIOID SUBSTITUTION THERAPY

Source: National Monitoring Centre for Drugs and Addiction, Czech Republic, unpublished data, 2016.

EGYPT

HIV EPIDEMIC



Sources: Population size estimation, Egypt, 2015.
Integrated biological and behavioural survey, Egypt, 2010.

LEGAL AND POLICY ENVIRONMENT

- INSUFFICIENT ENABLING POLICY**
Needle and syringe distribution is limited to a network of nongovernmental organizations funded by international assistance and opioid substitution therapy is not among the drug dependence treatment options approved by health authorities.
- CRIMINALIZATION**
People caught in possession of small amounts of drugs for personal use face heavy fines and lengthy incarceration.
- POLICING**
Possession of needle/syringes and other drug paraphernalia can be considered evidence of drug use and drug dealing.

Source: UNAIDS country office report, 2016.
Egypt National AIDS Programme, National HIV programme situation and gap analysis, 2015; Oraby D, Harm reduction approach in Egypt: the insight of injecting drug users, Harm Reduct J, 2013;10:17.

HARM REDUCTION



1.3

syringes distributed per person who inject drugs per year



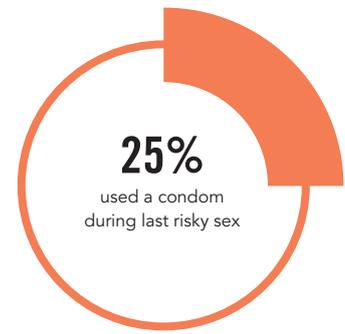
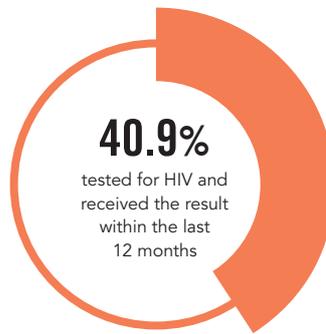
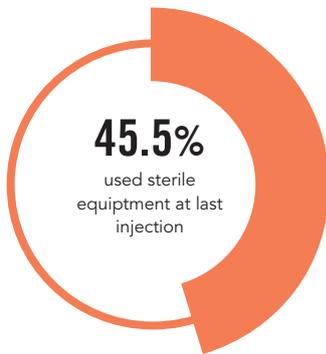
-

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: Integrated biological and behavioural survey, Egypt, 2010.
Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>).

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES



OPIOID SUBSTITUTION THERAPY

Source: The global state of harm reduction 2014. London: Harm Reduction International; 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>).

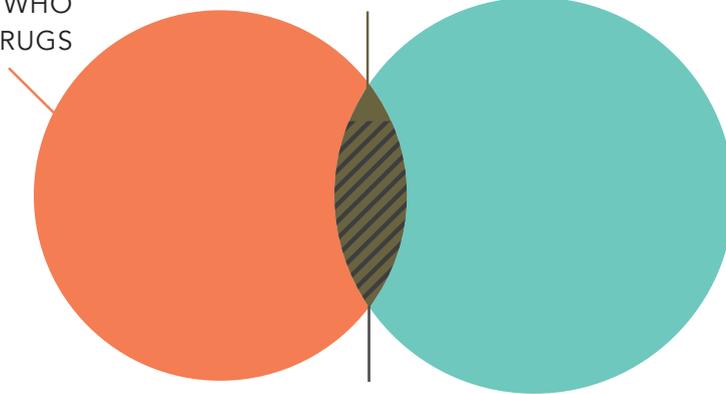
FRANCE

HIV EPIDEMIC

145 000
PEOPLE WHO
INJECT DRUGS

13%

OF PEOPLE WHO INJECT
DRUGS ARE LIVING WITH HIV



150 000
[143 000–156 000]
PEOPLE LIVING
WITH HIV

87%

OF PEOPLE WHO INJECT DRUGS LIVING WITH HIV
ARE COINFECTED WITH HEPATITIS C VIRUS

Sources: Costes et al. Prévalence de l'usage problématique de drogues en France - estimations 2006. 2009.

Weill-Barillet L et al. Hepatitis C virus and HIV seroprevalences, sociodemographic characteristics, behaviors and access to syringes among drug users, a comparison of geographical areas in France, ANRS-Coquelicot 2011 survey. Rev Epidemiol Sante Publique. 2016.

Supervie V, Koumavi Ekouevi D. Épidémiologie de l'infection par le VIH en France et dans le monde. Rev Prat 2014;64(8):1060-6.

Roux P. La co-infection par le virus de l'hépatite C chez les personnes infectées par le VIH : données de l'enquête ANRS-Vespa2, BEH (Bulletin Épidémiologique Hebdomadaire), N°26-27, 2013.

LEGAL AND POLICY ENVIRONMENT



ENABLING NATIONAL POLICY

Since 2004 harm reduction policies have been incorporated in public health regulations and state jurisdiction. A network of 154 low-threshold agencies receive funding directly from the social security system for needle and syringe distribution.



DEPENALIZATION

Use or possession of narcotic drugs is a criminal offence. Directives issued in 2008 and 2012 established depenalization measures, including cautions, compulsory drug awareness courses and court-ordered drug dependence treatment.



MOBILE METHADONE

Two buses provide mobile methadone maintenance therapy to improve access to opioid substitution therapy.



OVERDOSE PREVENTION

A nasal spray formulation of naloxone was approved in February 2015. A take-home naloxone programme will be launched in 2016.

Sources: EMCDDA. Harm reduction overview for France.

EMCDDA. Country overview: France.

François Beck, French Monitoring Centre for Drugs and Drug Addiction, personal communication, 6 April 2016.

HARM REDUCTION



170

syringes distributed per person who inject drugs per year



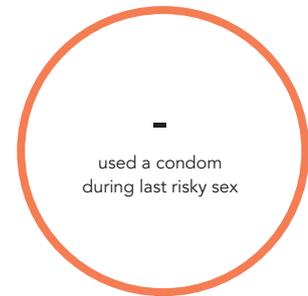
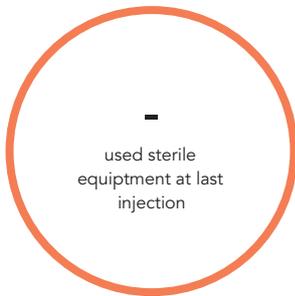
160 000

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: Workbook 3.4: harms and harm reduction. 2015 national report to the EMCDDA. Paris: Observatoire Français des Drogues et des Toxicomanies; 2015 (<http://en.ofdt.fr/BDD/publications/docs/natrep2015ENwb34.pdf>). Enquête ENA-CAARUD 2012.

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

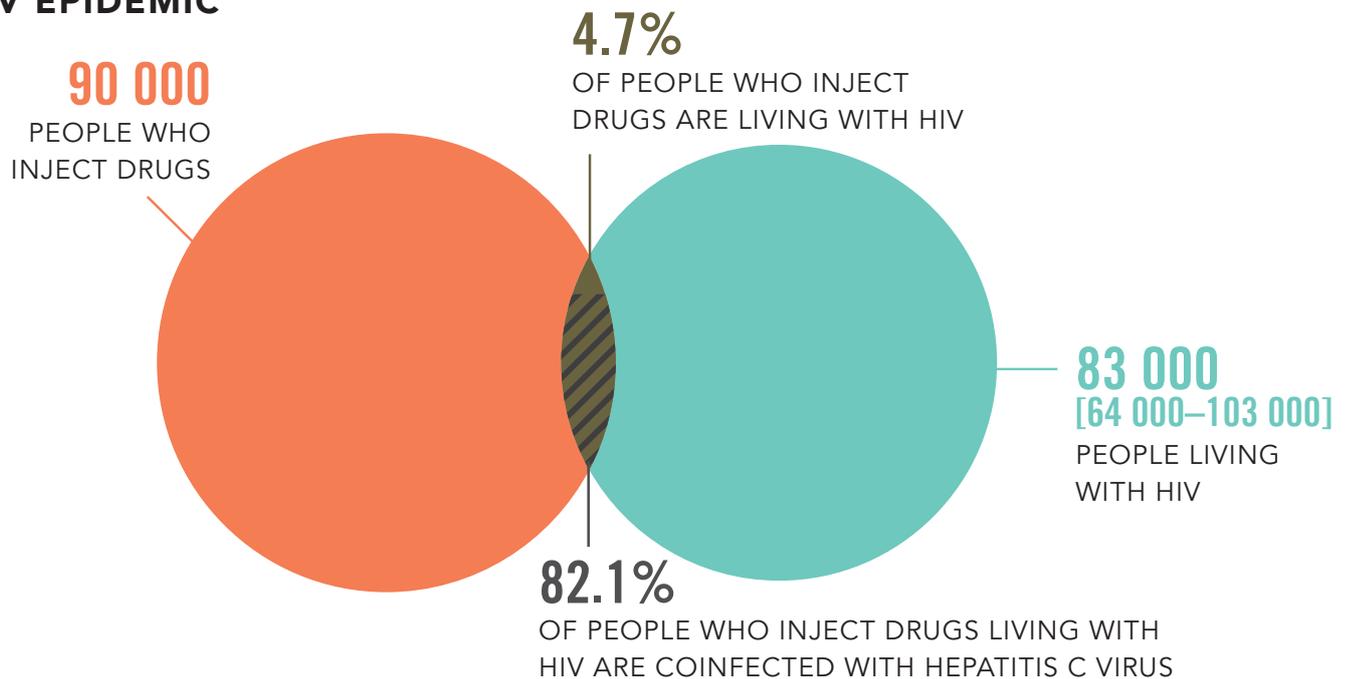


OPIOID SUBSTITUTION THERAPY

Source: Workbook 5.1: prison. National report 2015 to the EMCDDA. Paris: Observatoire Français des Drogues et des Toxicomanies; 2014 (<http://en.ofdt.fr/BDD/publications/docs/natrep2015ENwb51.pdf>).

GERMANY

HIV EPIDEMIC



Sources: Robert Koch Institute. PRESSURE study: drugs and chronic infectious diseases in Germany - results of the pilot phase of a sero-and behavioral surveys among injecting drug users. Epidemiol Bull. 2012;33.
Robert Koch Institute annual estimate (published in November 2011).
Backmund M, Meyer K, Henkel C, Reimer J, Wachtler M, Schutz CG. Risk Factors and predictors of human immunodeficiency virus infection among injection drug users. Eur Addict Res. 2005;11:138-144.
Robert Koch Institute. Epidemiologisches Bulletin. 9. November 2015 /Nr. 45.
Bundeskriminalamt (BKA) (Hrsg.) (2006). Bundeslagebild Rauschgift 2004. BKA, Wiesbaden.

LEGAL AND POLICY ENVIRONMENT

- ENABLING NATIONAL POLICY**
Needle and syringe programmes were legalized in 1992, and substitution-based drug dependence treatment has been nationally regulated since 2001. Harm reduction is one of the four pillars of the national drug strategy.
- DEPENALIZATION**
Drug use is not a criminal offense, and since 1992 public prosecutors have had the option to refrain from prosecuting individual caught in possession of small quantities of drugs for personal use.
- POLICING**
There are no criminal penalties or other sanctions for the possession of needle/syringes. Germany has the highest number of syringe vending machines in the world.

Source: EMCDDA, Country overview: Germany.

HARM REDUCTION



-

syringes distributed per person who inject drugs per year



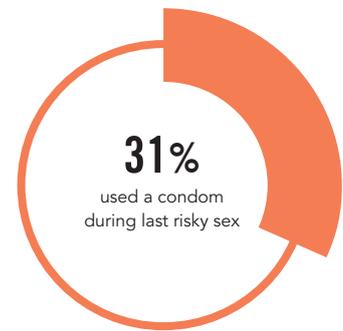
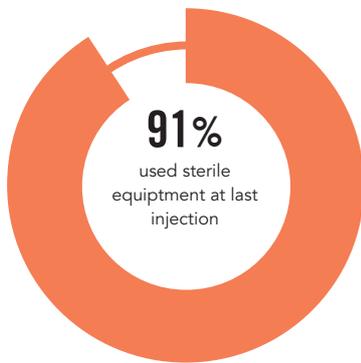
77 000

people enrolled in opioid substitution therapy



23

safe injecting facilities



Sources: German REITOX report 2015, Workbook Harms and Harm Reduction. REITOX Focal Point, 2014 National report to EMCDDA (2013 data). Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>).

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

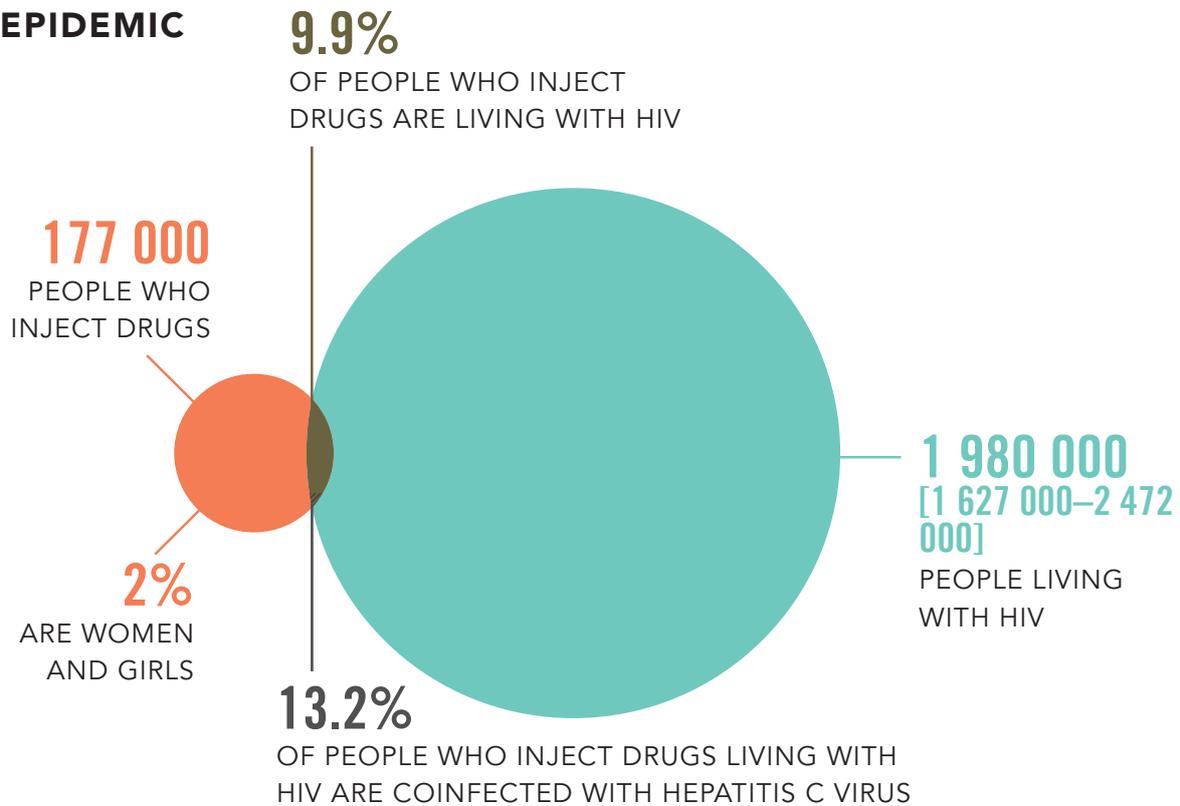


OPIOID SUBSTITUTION THERAPY

Source: Germany: 2015 national report (2014 data) to the EMCDDA by the Reitox National Focal Point. Workbook: prison. Hamm: Deutsche Hauptstelle für Suchtfragen; 2014 (http://www.dhs.de/fileadmin/user_upload/pdf/Reitox_Jahresberichte/WB09_Prison_2015_Germany_EN.pdf).

INDIA

HIV EPIDEMIC



Sources: Mapping and population size estimate, NACO, 2009.
HIV Sentinel Surveillance in India, 2010–11.
Integrated biological and behavioural survey, India, 2014–2015.

LEGAL AND POLICY ENVIRONMENT

- +** **ENABLING NATIONAL POLICY**
Amendments to the Narcotics Drug and Psychotropic Substance Act in 2014 enabled further scale-up of opioid substitution therapy, needle–syringe programmes and other harm reduction services.
- **CRIMINALIZATION**
Use of cannabis can result in up to six months of imprisonment, and use of heroin, morphine or cocaine can result in up to one year of imprisonment.
- +** **POLICING**
There are no criminal penalties or other sanctions for the possession of needle/syringes.

Source: UNAIDS country office report, 2016.

HARM REDUCTION



240

syringes distributed per person who inject drugs per year



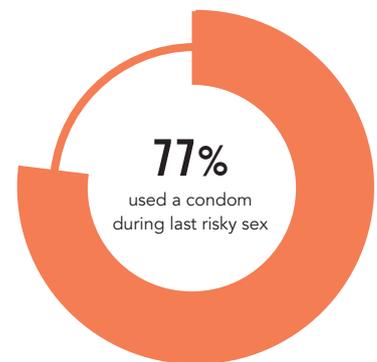
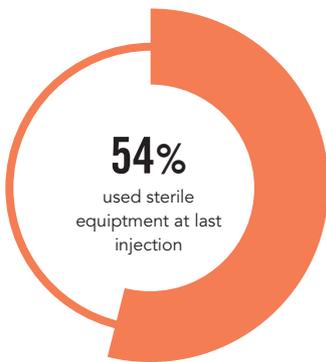
22 000

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: Integrated biological and behavioural survey, India, 2014–2015.
Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>)
National programme data, 2015.
NACO, unpublished calculations, based on integrated biological and behavioural survey, 2014–2015.

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

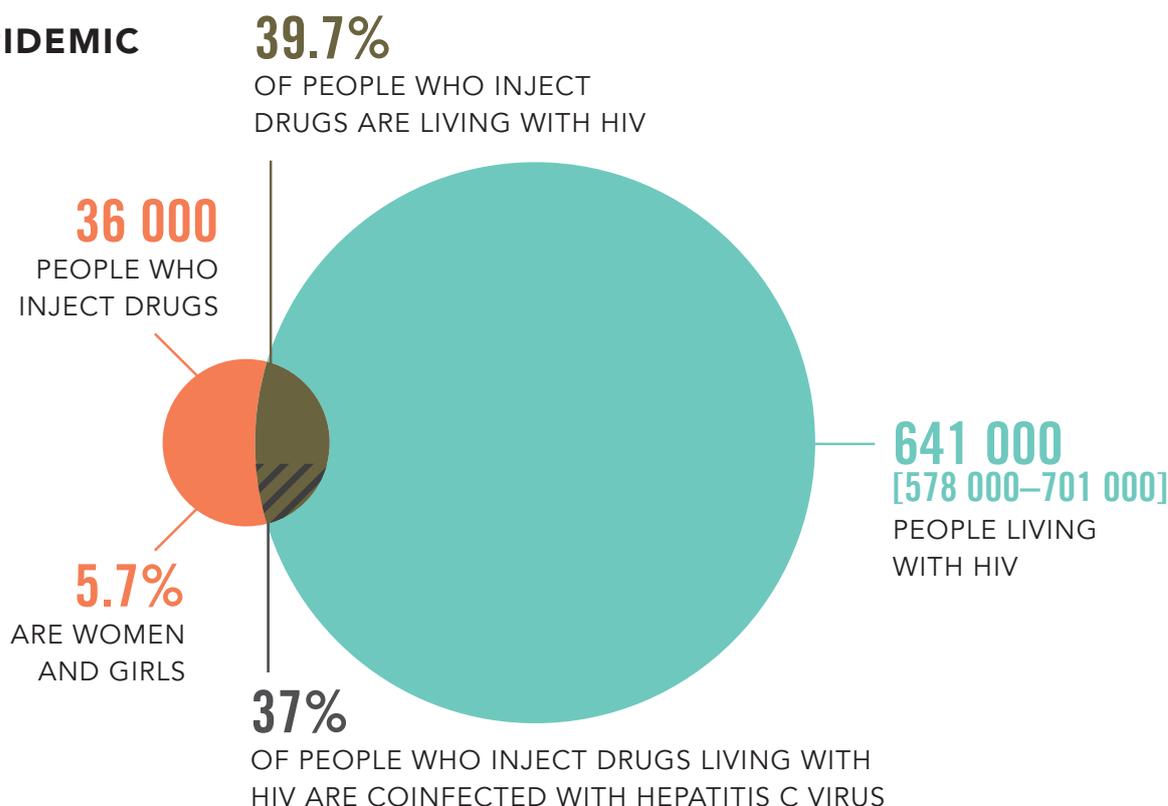


OPIOID SUBSTITUTION THERAPY

Sources: National commitments and policy instrument: part B - 2014 India.
Medical care and hospital administration. Delhi: Government of NCT of Delhi, India; 2014 (http://www.delhi.gov.in/wps/wcm/connect/lib_centraljail/Central+Jail/Home/Medical+Care+and+Hospital+Administration).

INDONESIA

HIV EPIDEMIC



Sources: Size estimation report, Ministry of Health, Indonesia, 2015.
HIV Mathematical Modeling, 2014.
Behavioural rapid survey among PWID (SCP Penasun 2014).
Integrated Rapid Behaviour Survey of IDU and Sentinel Surveillance in Tangerang, Denpasar and Makasar, 2014.

LEGAL AND POLICY ENVIRONMENT

- + ENABLING NATIONAL POLICY**
National-level legislation was enacted in 2011 in support of harm reduction, including regulations that facilitate the diversion of drug users into drug treatment.
- CRIMINALIZATION**
Possession of small quantities of drugs for personal use can result in heavy fines and lengthy prison sentences. Incarceration due to narcotics-related offences accounts for about 37% of the total prison population.
- HEALTH CARE**
Health insurance regulations consider drug use a “self-inflicted” condition that can disqualify an individual from receiving health insurance benefits. The estimated coverage of antiretroviral treatment among people who inject drugs is 6%.
- COMPULSORY DETENTION**
There are 1300 people who use drugs in compulsory detention centres.

Source: UNAIDS country office report, 2016.
Indonesia National AIDS Commission. Global AIDS response progress reporting: Indonesia country progress report 2014.
HIV mathematical modelling, 2014.

HARM REDUCTION



44

syringes distributed per person who inject drugs per year



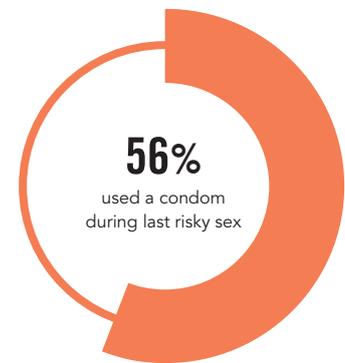
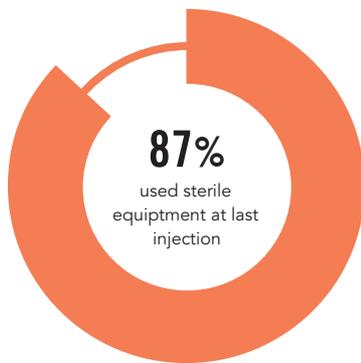
2000

people actively enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: Integrated biological and behavioural survey, Indonesia, 2011. Quarterly report. Jakarta: Ministry of Health, Indonesia; 2015.

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

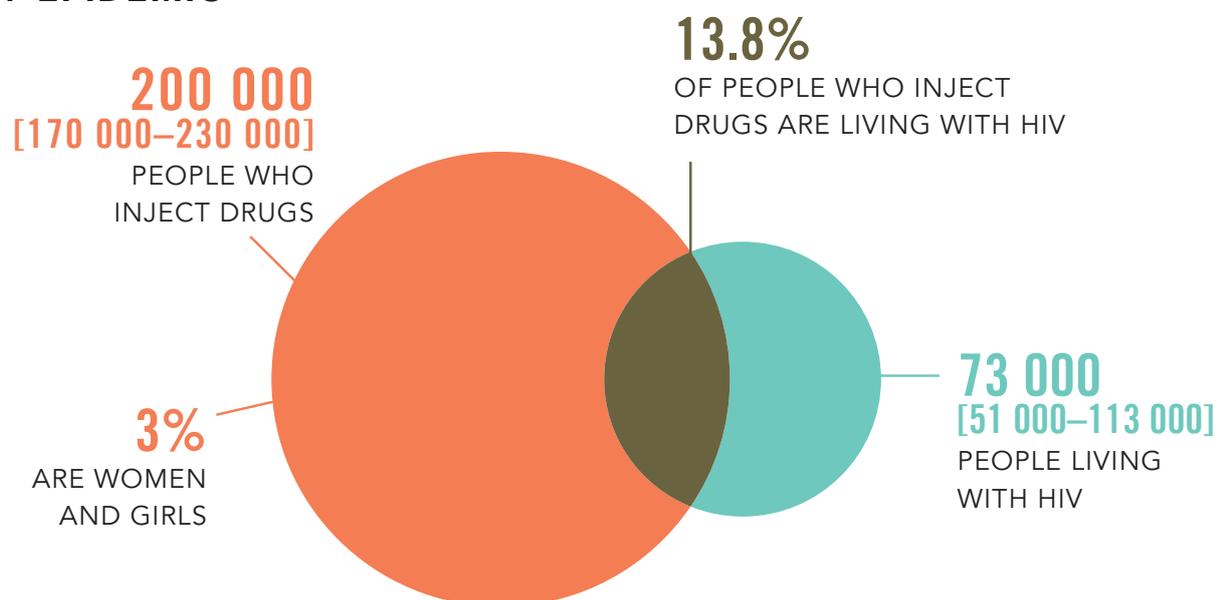


OPIOID SUBSTITUTION THERAPY

Sources: Global AIDS response progress reporting: Indonesia country progress report 2014. Jakarta: Indonesia National AIDS Commission, 2014. Ditjenpas routine data. Quarterly report. Jakarta: Ministry of Health, Indonesia; 2015.

IRAN (ISLAMIC REPUBLIC OF)

HIV EPIDEMIC



Sources: Rapid Situation Assessment, Iran, 2007.
Spectrum files, 2015.
Integrated biological and behavioural survey, Iran, 2014.
Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015.
J Pak Med Assoc. 2014;64:134-137.
Iran J Public Health. 2014;43:229-234.
Hepat Mon. 2012;12:442-447.
Med Glas (Zenica). 2012;9:299-303.
Hepat Mon. 2010;10:26-30.
Int J Infect Dis. 2010;14:e28-33.

LEGAL AND POLICY ENVIRONMENT

- ENABLING NATIONAL POLICY**
Ministry of Health guidelines for methadone maintenance therapy have been available since 2002; buprenorphine maintenance treatment is also offered; opium tincture solution maintenance treatment has been delivered as a pilot project.
- POLICING**
There are no criminal penalties or other sanctions for the possession of needles and syringes.

Source: UNAIDS country office report, 2016.
National AIDS Committee Secretariat, Ministry of Health and Medical Education, Islamic Republic of Iran AIDS progress report on monitoring of the United Nations General Assembly Special Session on HIV and AIDS, March 2015. Shahrabaki ME et al., Methadone treatment in Iranian opiate addicts: a preliminary report, Addict Health 2011;3:53-60.

HARM REDUCTION



44–60

syringes distributed per person who inject drugs per year



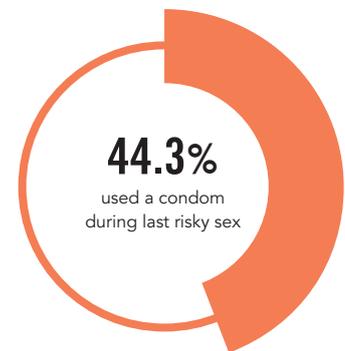
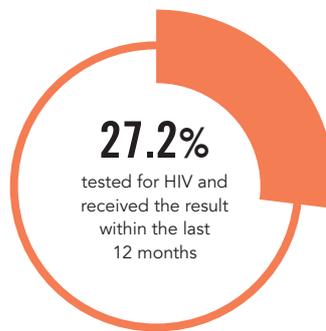
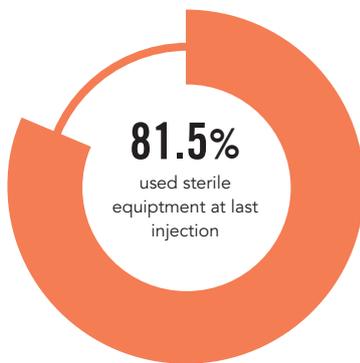
599 000

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>).

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

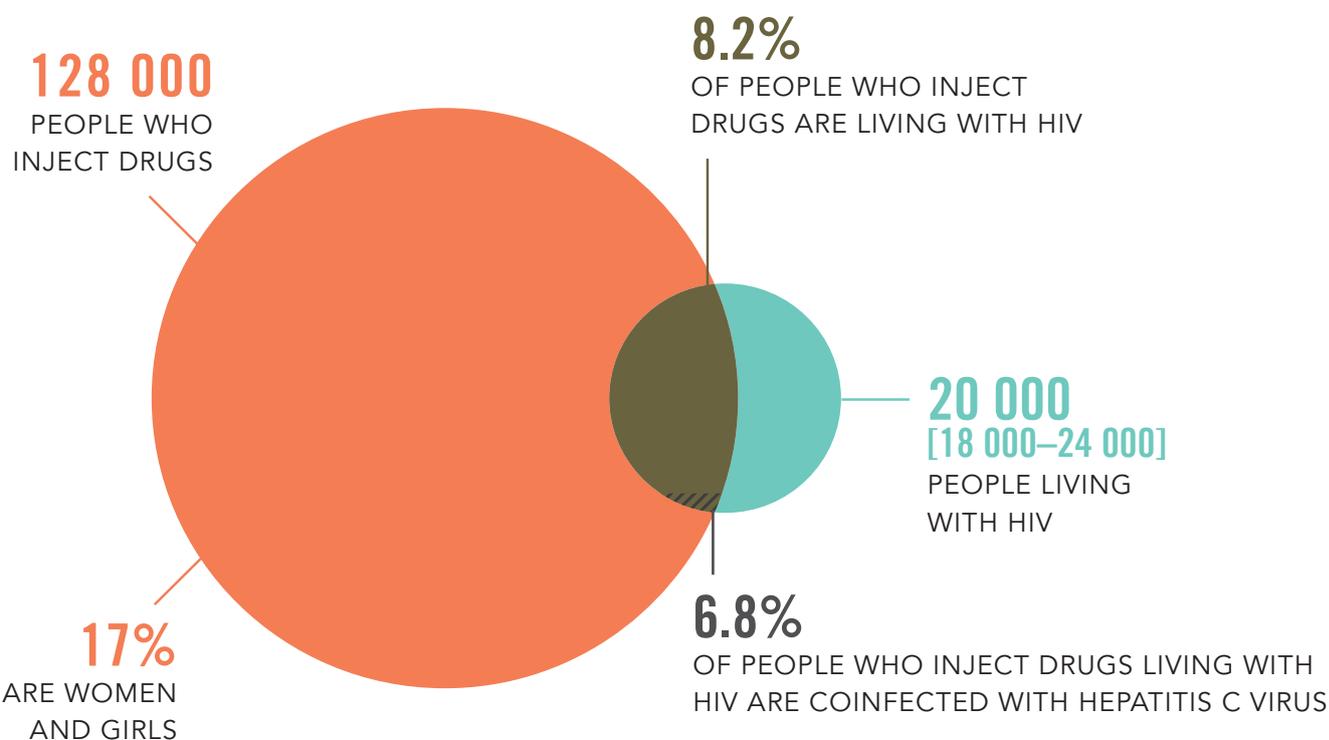


OPIOID SUBSTITUTION THERAPY

Source: DG health of IPO, Iran. 2015. The global state of harm reduction 2014. London: Harm Reduction International; 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>).

KAZAKHSTAN

HIV EPIDEMIC



Sources: Republican AIDS Centre M&E report, 2015.
Electronic HIV Case Management System, data of the Republican AIDS Centre, 2014–2015.
Integrated biological and behavioural survey, Kazakhstan, 2014.

LEGAL AND POLICY ENVIRONMENT

- + ENABLING NATIONAL POLICY**
A Republican AIDS Centre decree provides guidance on the delivery of a comprehensive package of HIV prevention, treatment and care of HIV for people who use drugs, including needle and syringe distribution; opioid substitution therapy remains a pilot programme.
- CRIMINALIZATION**
Non-medical use of narcotic drugs and psychotropic substances is punishable by fines, correctional labour and incarceration for 45 days.
- + DOMESTIC INVESTMENT**
The Government of Kazakhstan is gradually replacing donor funding with domestic funding.

Source: UNAIDS country office report, 2016.

HARM REDUCTION



264

syringes distributed per person who inject drugs per year



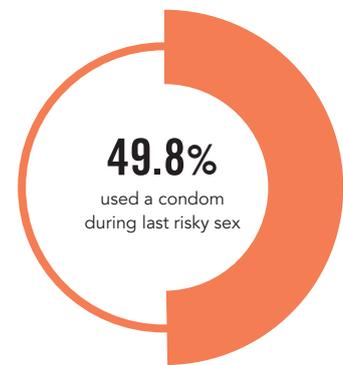
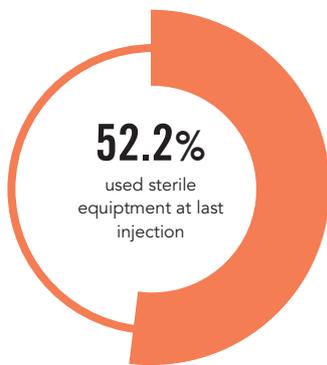
<1000

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: Republican AIDS Center M&E report, 2015.
Integrated biological and behavioural survey, Kazakhstan, 2014.
OST electronic register.

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

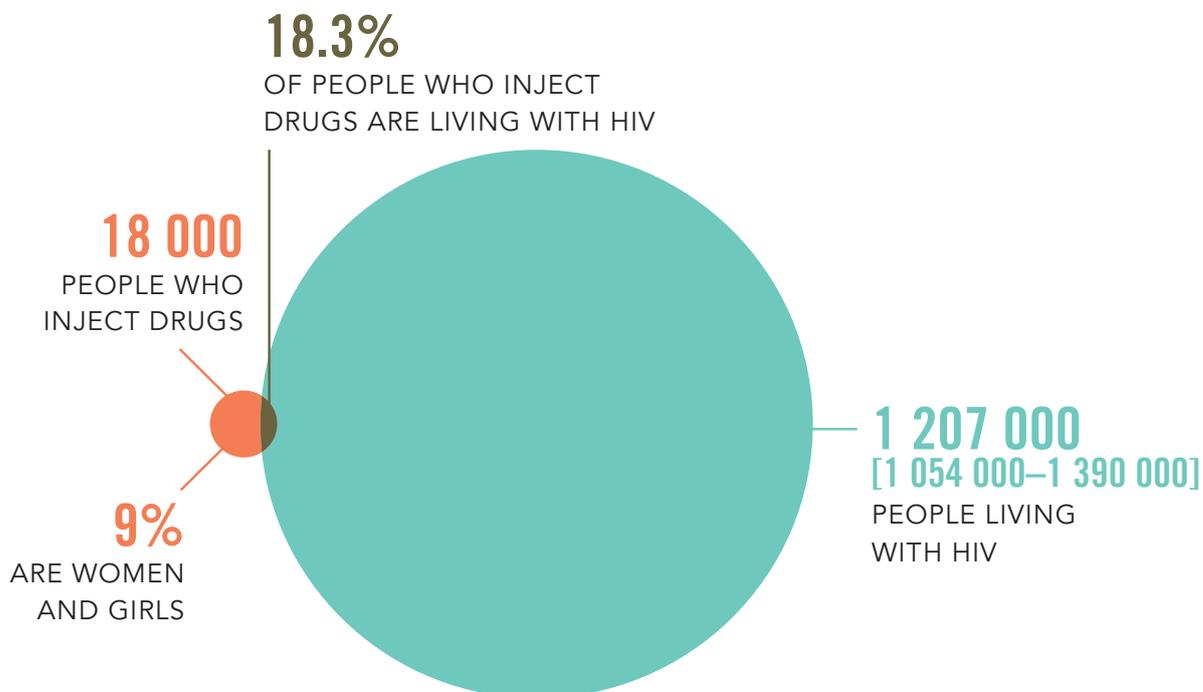


OPIOID SUBSTITUTION THERAPY

Source: The global state of harm reduction 2014. London: Harm Reduction International; 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>).

KENYA

HIV EPIDEMIC



Source: UNODC, 2012.
Rapid Situation Assessment for PWID, Kenya, 2012.

LEGAL AND POLICY ENVIRONMENT

- + ENABLING NATIONAL POLICY**
The Kenyan National AIDS Control Council introduced a harm reduction strategy in 2011, and the Kenya AIDS Strategic Framework for 2015–2020 promotes the comprehensive package for harm reduction recommended by WHO, UNODC and UNAIDS.
- POLICING**
Police have discretionary powers in favour of harm reduction, but many continue to arrest and prosecute people who use drugs for the possession of drug paraphernalia.
- CRIMINALIZATION**
Possession of any illicit narcotic or psychotropic substance is a criminal offence punishable by a fine and/or imprisonment.

Sources: Kageha E, Drug laws and human rights in Kenya: disharmony in the law and training recommendations to law enforcement, Mainline 2015.
UNAIDS country office report, 2016.

HARM REDUCTION



20

syringes distributed per person who inject drugs per year



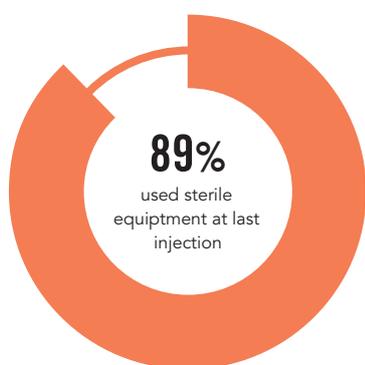
1100

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: NASCOP Polling Booth Survey, 2015.
National AIDS and STI Control Programme, programme data, 2014–2016.

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES



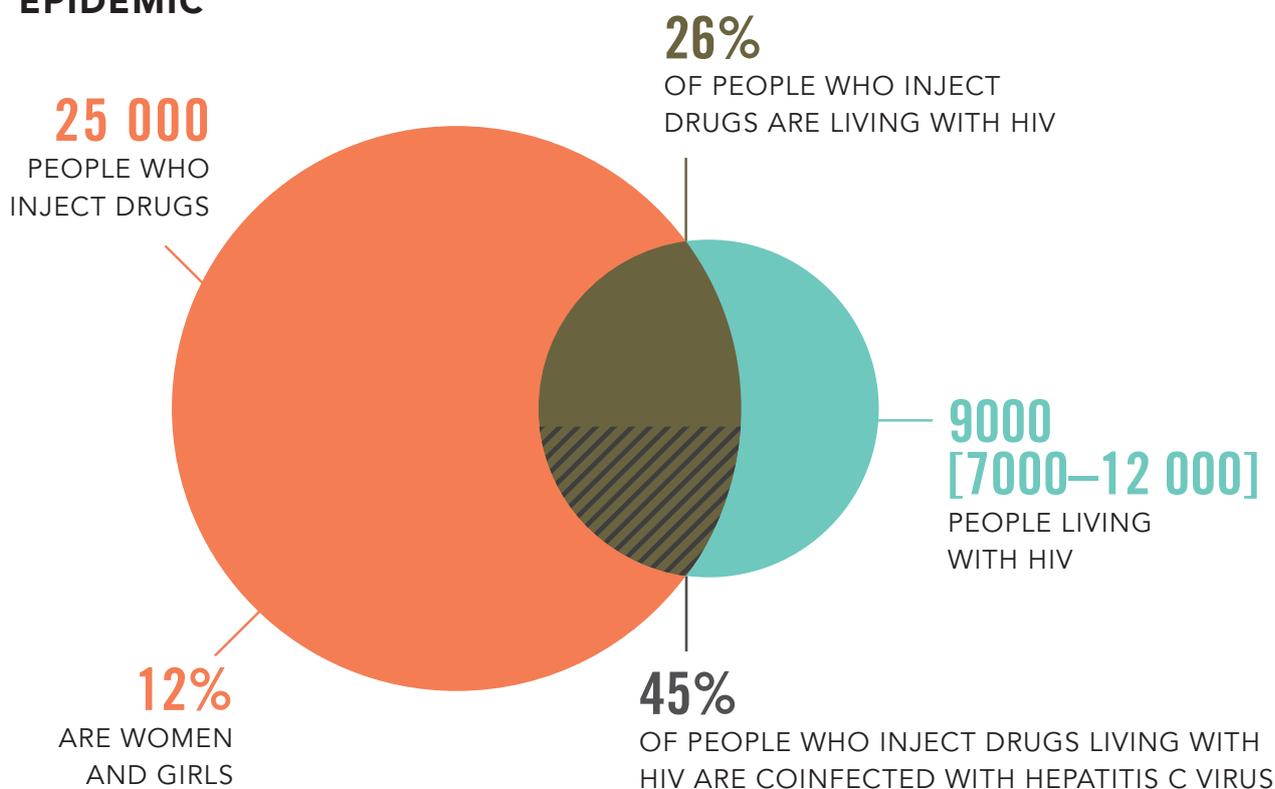
OPIOID SUBSTITUTION THERAPY*

* In some prisons, arrangements are made for people who use drugs who were enrolled in opioid substitution therapy before their incarceration to continue treatment through daily visits to the local clinic.

Sources: The global state of harm reduction 2014. London: Harm Reduction International; 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>).
UNAIDS country office report, 2016.

KYRGYZSTAN

HIV EPIDEMIC



Source: Size estimation report, Kyrgyzstan, 2013.
Integrated biological and behavioural survey, Kyrgyzstan, 2013.
Regional Advisory Committee, 2013.

LEGAL AND POLICY ENVIRONMENT

- + ENABLING NATIONAL POLICY**
Harm reduction has been part of the national drug strategy since 2011.
- CRIMINALIZATION**
Possession of more than 1 gram of a narcotic drug is a criminal offence punishable by a fine and up to two years in prison; the fines for drug possession have been increased in recent years.
- DOMESTIC INVESTMENT**
The financing of harm reduction in this lower-middle-income country is highly reliant on external funding; only 16% of expenditure for needle and syringe distribution and opioid substitution therapy came from domestic sources in 2013.

Source: UNAIDS country office report, 2016.

HARM REDUCTION



252

syringes distributed per person who inject drugs per year



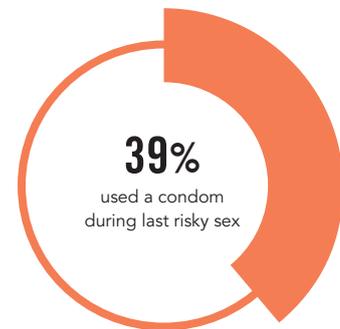
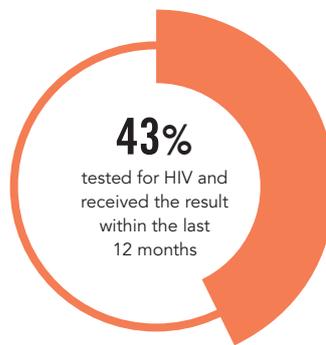
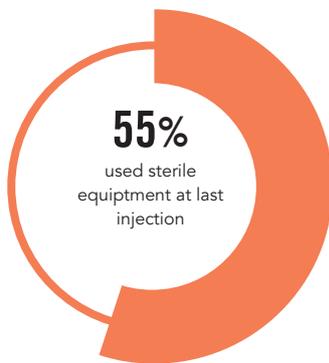
1227

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: Integrated biological and behavioural survey, Kyrgyzstan, 2013.
Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2014 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>).

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

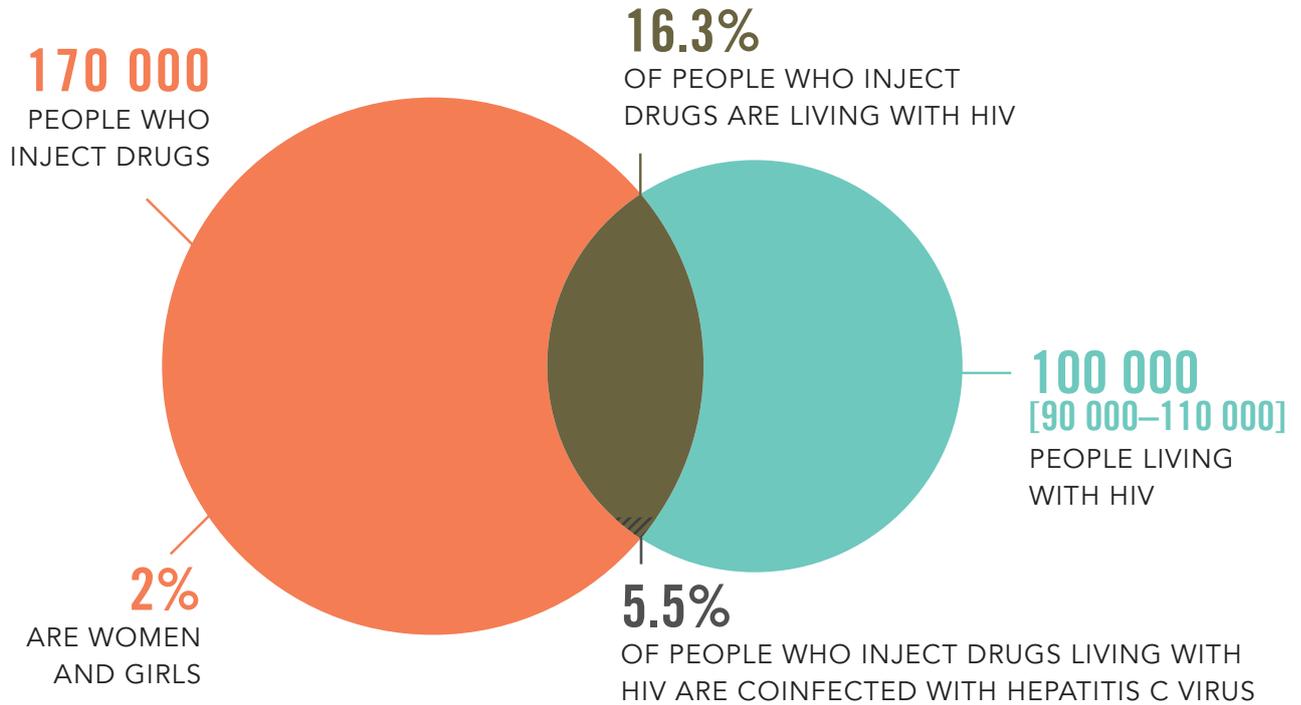


OPIOID SUBSTITUTION THERAPY

Source: Georg Fisher (GF) annual report, 2014.
Annual report, 2014. AIDS Foundation East-West; 2014.

MALAYSIA

HIV EPIDEMIC



Sources: EPP, 2014.

National monitoring and evaluation data, 1986–2014.

Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015.

Integrated biological and behavioural survey, Malaysia, 2014.

Survey among MMT clients, 2014.

LEGAL AND POLICY ENVIRONMENT

- + ENABLING NATIONAL POLICY**
The country's needle and syringe exchange programme and opioid substitution therapy are cornerstones of the national HIV prevention strategy.
- POLICING**
Section 37 of the Dangerous Drug Act 1952 states that possession of needles and syringes can result in up to two years in prison; a 2006 police standard operating procedure instructs police not to target needle and syringe exchange sites for arrest, but adherence to the standard operating procedure appears uneven.
- COMPULSORY DETENTION**
Under Malaysia's drug control laws, anybody with a positive urine screen for narcotic drugs can be deemed to be drug dependent by a government medical officer and sent to a detention centre for compulsory treatment followed by community supervision following release.

Source: UNAIDS country office report, 2016; Global AIDS response progress report Malaysia, Ministry of Health, Malaysia, 2015. Kamarulzaman A, McBrayer J, Compulsory drug detention centers in East and Southeast Asia, *Int J Drug Policy* 2015;26:S33–S37. Rahman F, Parasuraman G, Police knowledge of needle-and-syringe programs and harm reduction in Malaysia, Sixth Annual Conference of the International Society for the Study of Drug Policy, Canterbury 30–31 May 2012, (https://docs.google.com/file/d/0B62R_9AekiRXR1VQRW5JZzVEU00/edit?usp=sharing).

HARM REDUCTION



61

syringes distributed per person who inject drugs per year



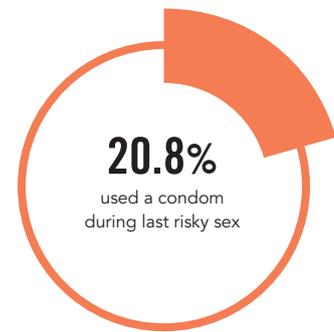
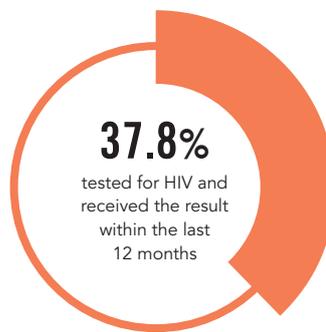
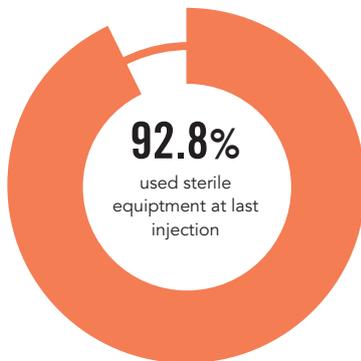
75 000

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: National programme monitoring and evaluation data, 1986–2014.
Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>).
Integrated biological and behavioural survey, Malaysia, 2014.

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

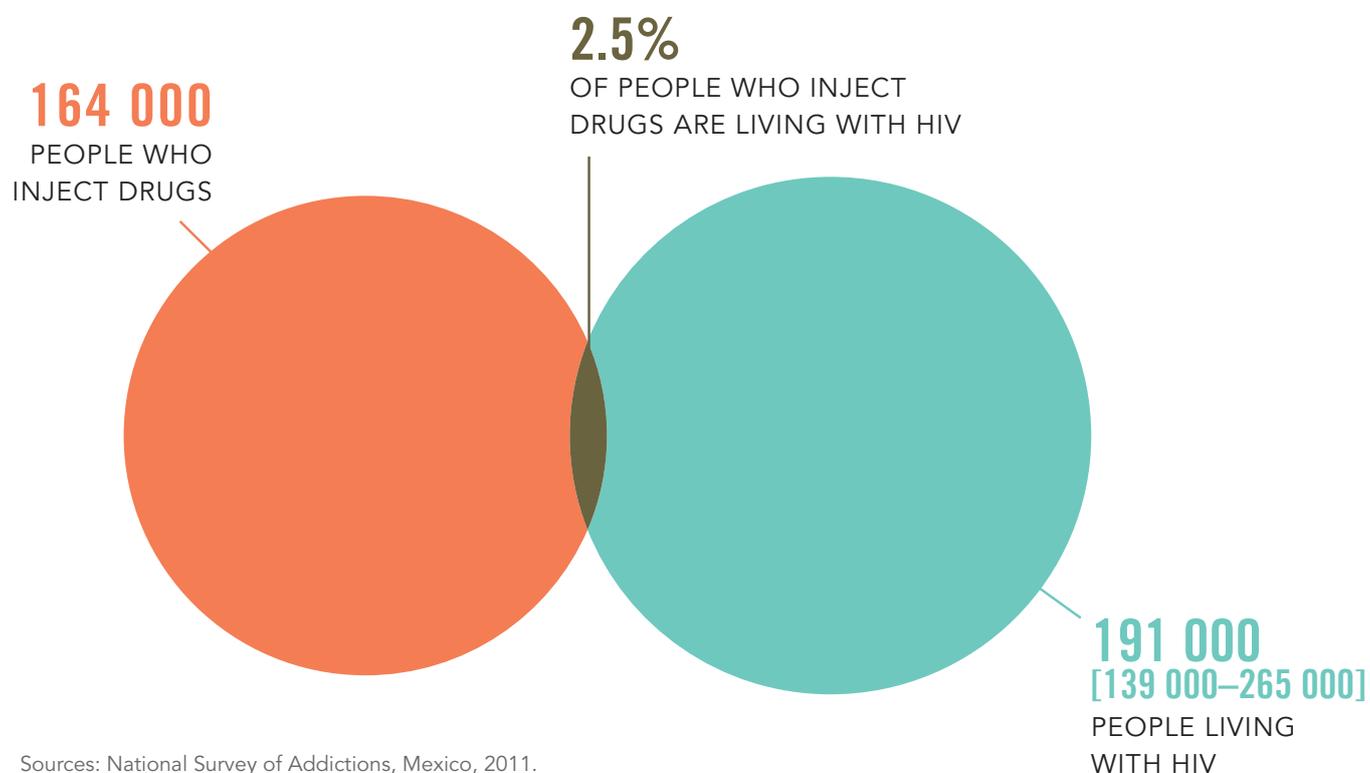


OPIOID SUBSTITUTION THERAPY

Source: Monitoring and evaluation data.

MEXICO

HIV EPIDEMIC



Sources: National Survey of Addictions, Mexico, 2011. CENSIDA website, 2013.

Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>).

LEGAL AND POLICY ENVIRONMENT

- +** **DECRIMINALIZATION**
In August 2009 Mexico's federal government partially decriminalized possession of small quantities of drugs such as cannabis, cocaine, amphetamines and heroin.
- **POLICING**
Policing practices such as crackdowns, targeted patrols of harm reduction services and syringe confiscation may reduce access to services and increase risky drug-related behaviours among people who inject drugs.

Source: Mexico's drug policy reform: cutting edge success or crisis in the making? *Int J Drug Policy* 2014;25:823–825.

HARM REDUCTION



3.9

syringes distributed per person who inject drugs per year



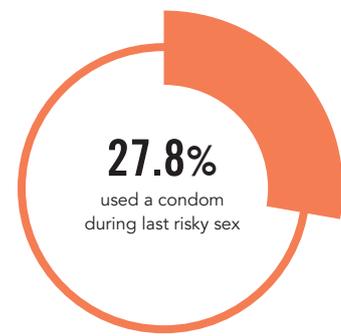
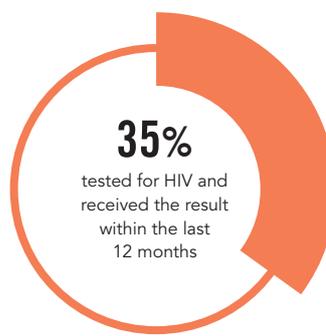
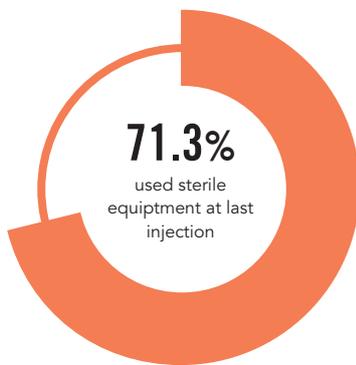
-

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>).

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

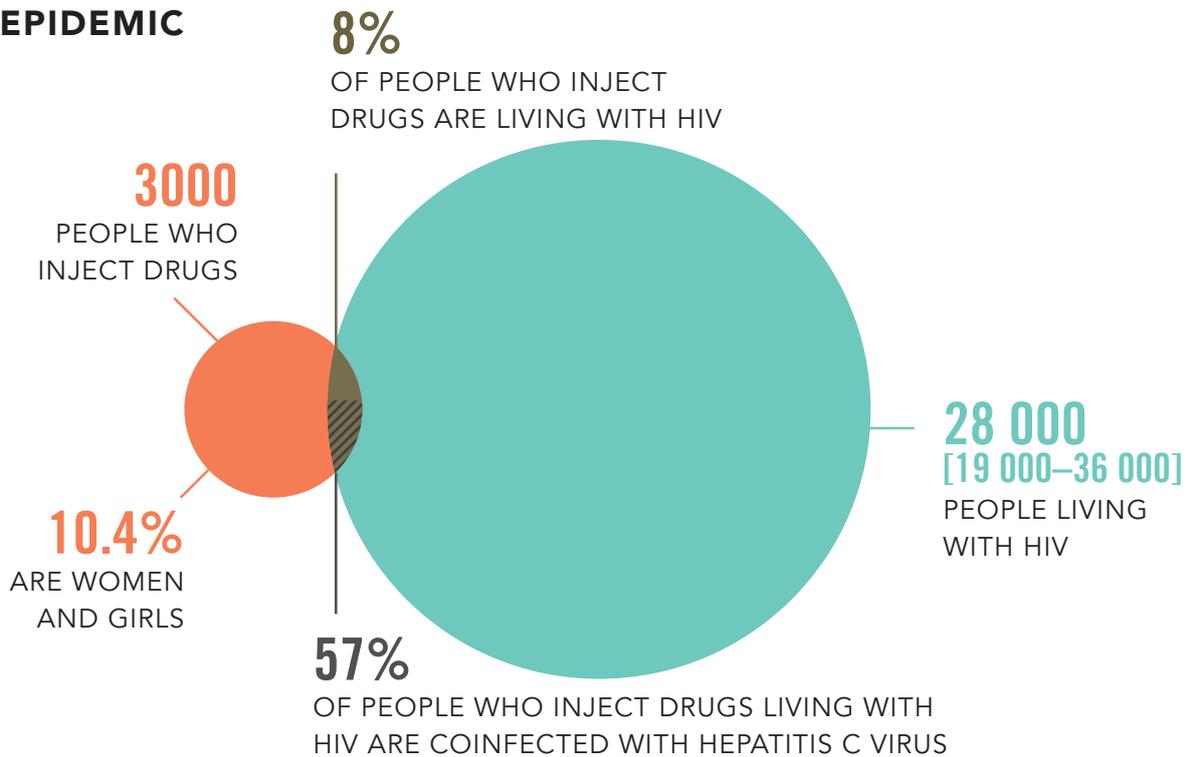


OPIOID SUBSTITUTION THERAPY

Source: <http://www.ihra.net/global-state-of-harm-reduction>.

MOROCCO

HIV EPIDEMIC



Sources: Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>). Modes of Transmission, Morocco, 2013. Spectrum files, 2014. Integrated biological and behavioural survey, Morocco, 2011–2012 and 2014–2015.

LEGAL AND POLICY ENVIRONMENT

- +** **ENABLING NATIONAL POLICY**
A national harm reduction plan guides implementation of needle and syringe distribution and opioid substitution therapy.
- **CRIMINALIZATION**
Possession of small quantities of drugs is a criminal offence that is strictly enforced, with penalties including fines and up to one year in prison.
- +** **POLICING**
There are no criminal penalties or other sanctions for the possession of needles, syringes or other drug paraphernalia.

Source: UNAIDS country office report, 2016; Himmich H, The rise of harm reduction in Morocco: successes and challenges, Middle East Institute, 23 February 2015.

HARM REDUCTION



88

syringes distributed per person who inject drugs per year



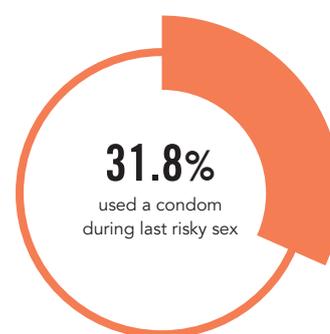
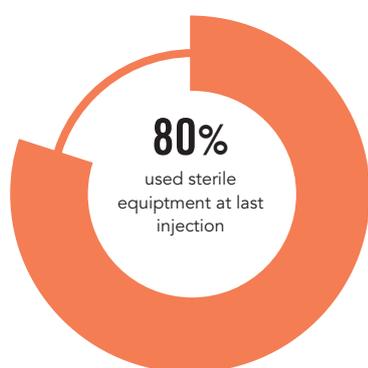
<1000

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>). National programme data, 2015.

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

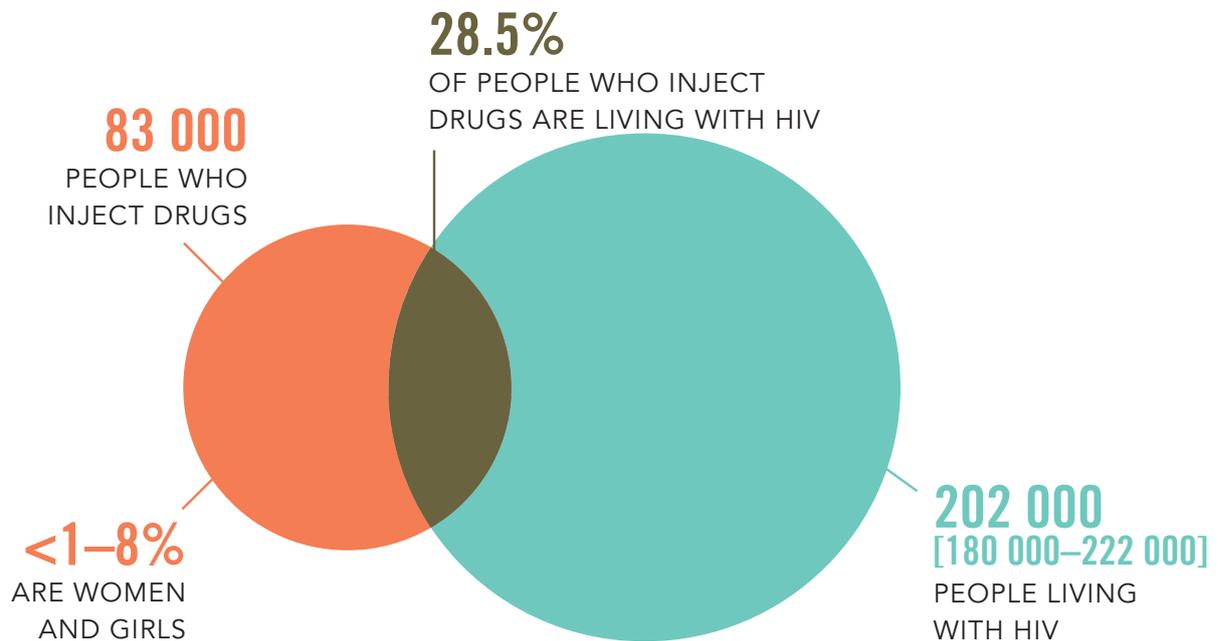


OPIOID SUBSTITUTION THERAPY

Source: The global state of harm reduction 2014. London: Harm Reduction International; 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>).

MYANMAR

HIV EPIDEMIC



Sources: Integrated biological and behavioural survey among people who inject drugs, Myanmar, 2014.

Population size estimation, Myanmar, 2014.

AIDS Epidemic Model, 2014.

Zaw SK et al. Prevalence of hepatitis C and B virus among patients infected with HIV: a cross-sectional analysis of a large HIV care programme in Myanmar. *Trop Doc.* 2013;43:113-115

LEGAL AND POLICY ENVIRONMENT

- + ENABLING NATIONAL POLICY**
Harm reduction is included in the national strategic plan for HIV developed by the national AIDS programme under the Ministry of Health.
- CRIMINALIZATION**
The Narcotic Drugs and Psychotropic Substances Law (1993) makes little distinction between drug users and traffickers; penalties are severe and sentences are not proportional to crimes (e.g. 3–5 years in prison for “small time offenders”).
- + POLICING**
Sections of a nearly 100-year-old excise act that made possession of needles and syringes illegal were repealed in 2015.
- REGISTRATION OF DRUG USERS**
The Narcotic Drugs and Psychotropic Substances Law (1993) establishes mandatory registration for drug treatment, undermining the strengthening of harm reduction interventions; failure to register for drug treatment can result in a prison sentence of up to five years.

Source: UNAIDS country office report, 2016.

HARM REDUCTION



168

syringes distributed per person who inject drugs per year



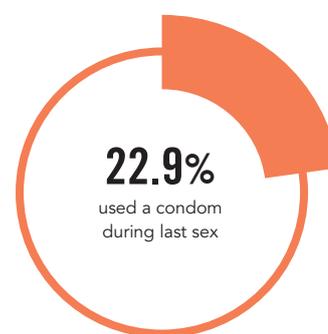
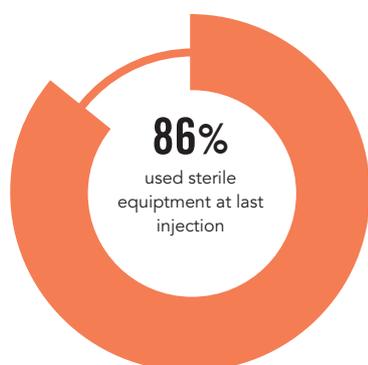
10 000

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: Integrated biological and behavioural survey among people who inject drugs, Myanmar, 2014. Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>). National Drug Abuse Control Programme, Ministry of Health, 2015.

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

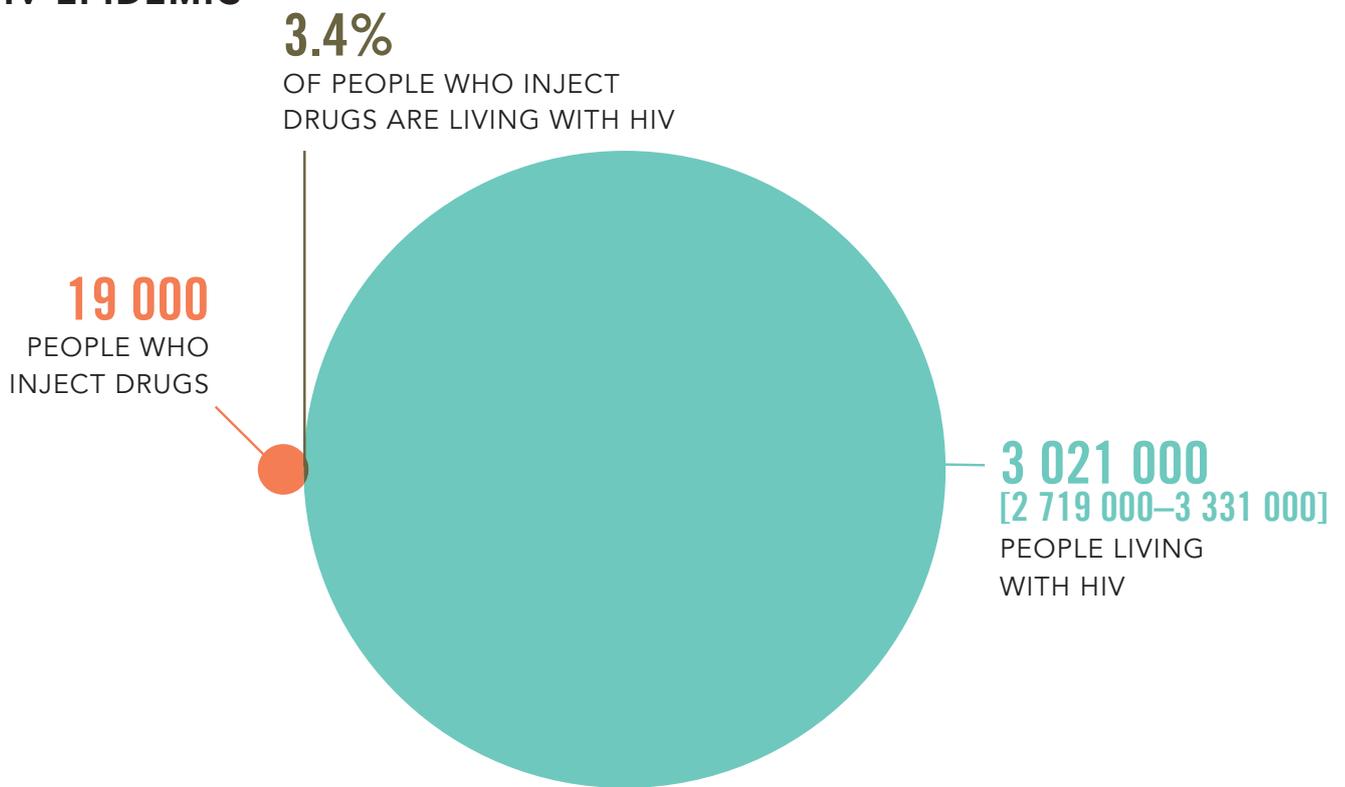


OPIOID SUBSTITUTION THERAPY

Source: The global state of harm reduction 2014. London: Harm Reduction International; 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>).

NIGERIA

HIV EPIDEMIC



Sources: Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>). Integrated Biological and Behavioral Surveys 2014. Federal Ministry of Health, Nigeria.

LEGAL AND POLICY ENVIRONMENT

- + ENABLING NATIONAL POLICY**
The National Policy for the Control of Viral Hepatitis in Nigeria, published in July 2015, calls for a combination approach to disease prevention among people who inject drugs, including needle–syringe exchange and opioid substitution therapy.
- LACK OF SERVICES**
There are currently no needle–syringe or opioid substitution therapy programmes in the country.

Sources: The global state of harm reduction 2014, London, Harm Reduction International, 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>). National HIV/AIDS & STI Control Programme, Federal Ministry of Health, Nigeria. National Policy for the Control of Viral Hepatitis in Nigeria, July 2015.

HARM REDUCTION



-

syringes distributed per person who inject drugs per year



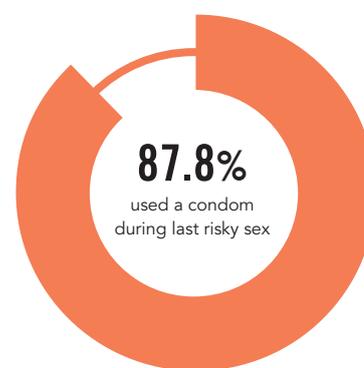
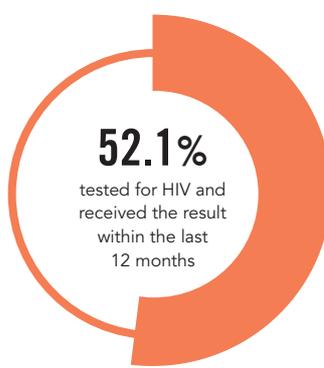
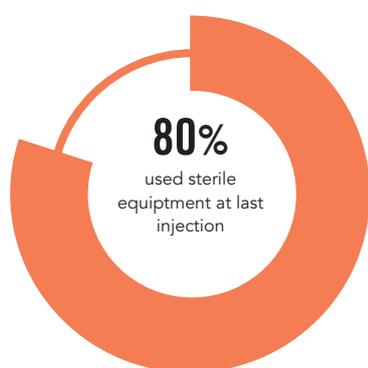
-

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: Integrated Biological and Behavioral Surveys 2014. Federal Ministry of Health, Nigeria.

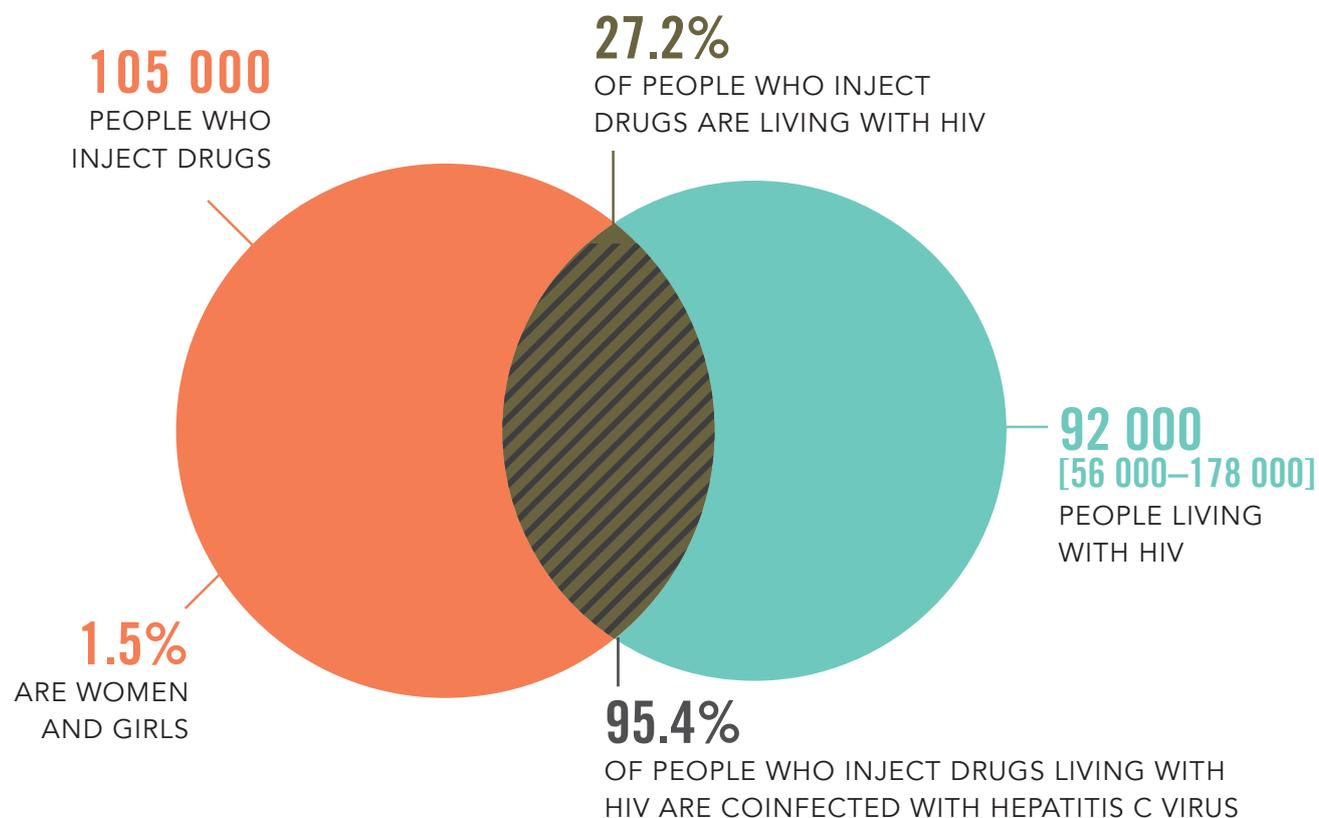
SERVICES AVAILABLE IN PRISONS

- HIV TESTING
- ANTIRETROVIRAL THERAPY
- CONDOMS
- NEEDLES AND SYRINGES
- OPIOID SUBSTITUTION THERAPY

Source: The global state of harm reduction 2014. London: Harm Reduction International; 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>).

PAKISTAN

HIV EPIDEMIC



Sources: UNODC, 2013.
Integrated biological and behavioural survey, Pakistan, 2011.

LEGAL AND POLICY ENVIRONMENT

- CRIMINALIZATION**
Under the Controlled Narcotic Substances Act, possession of less than 100 grams of narcotic drugs or psychotropic substances is punishable by fines and up to two years in prison.
- + POLICING**
The Controlled Narcotic Substances Act does not punish drug use per se, and the possession of needles and syringes or other drug paraphernalia is not objectionable.
- REGISTRATION OF DRUG USERS**
Provincial governments are required to register all people who use drugs within their respective jurisdictions.
- DOMESTIC INVESTMENT**
The financing of harm reduction in this lower-middle-income country is highly reliant on external funding, accounting for 72% of all funding in 2013.

Source: UNAIDS country office report, 2016.

HARM REDUCTION



178

syringes distributed per person who inject drugs per year



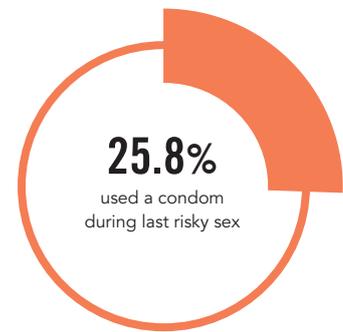
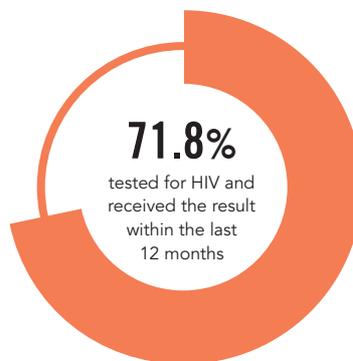
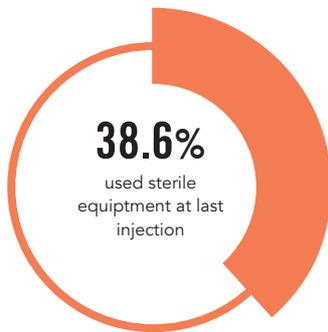
0

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: National AIDS Control Programme (NACP), Pakistan. Integrated biological and behavioural survey, Pakistan, 2011. Pakistan Global AIDS Response Progress Report (GARPR) 2015.

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

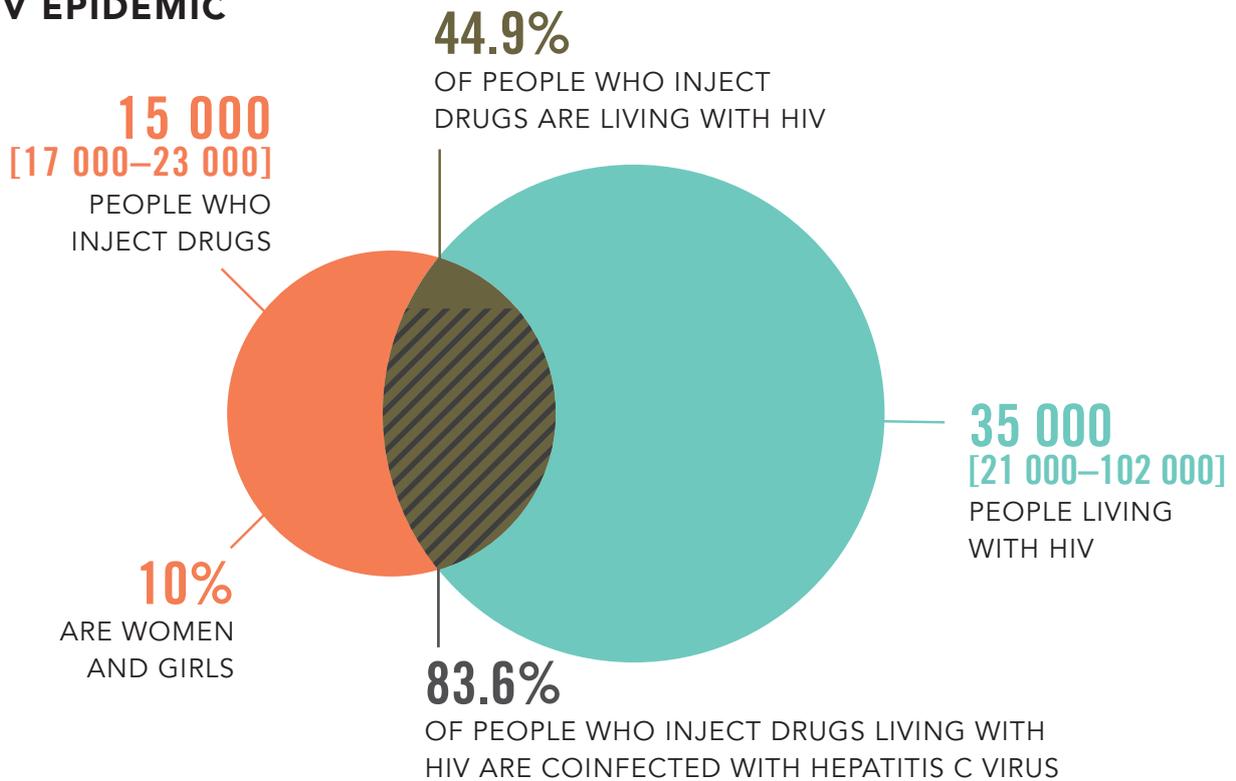


OPIOID SUBSTITUTION THERAPY

Source: The global state of harm reduction 2014. London: Harm Reduction International; 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>).

PHILIPPINES

HIV EPIDEMIC



Source: Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>). Presentation of EB (Partners Forum), 2015.

LEGAL AND POLICY ENVIRONMENT

- + ENABLING NATIONAL POLICY**
The Philippine AIDS Prevention and Control Act of 1998 supports harm reduction and the provision of health and social services to people who use drugs.
- CRIMINALIZATION**
Possession of narcotic drugs for personal use is punishable by fines or imprisonment.
- POLICING**
Possession of needles, syringes or other drug paraphernalia can result in a fine and up to one year in prison.
- COMPULSORY DETENTION**
Detention and coercive treatment is currently the dominant approach to drug use and drug dependence.

Sources: UNAIDS country office report, 2016. Transition from compulsory centres for drug users to voluntary community-based treatment and services, discussion paper for the Third Regional Consultation on Compulsory Centres for Drug Users in Asia and the Pacific, 21–23 September 2015. Republic Act 8504 of 1998 (AIDS Law); Republic Act 9165 of 2002 (Dangerous Drugs Act).

HARM REDUCTION



-

syringes distributed per person who inject drugs per year



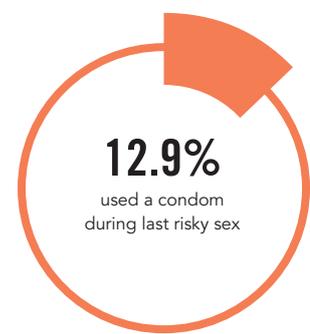
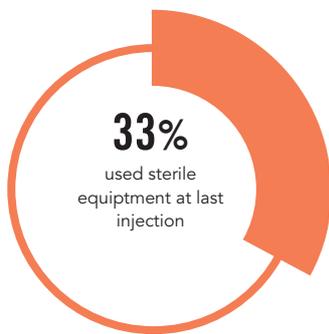
-

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>). Integrated biological and behavioural survey, Department of Health, Philippines, 2013.

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

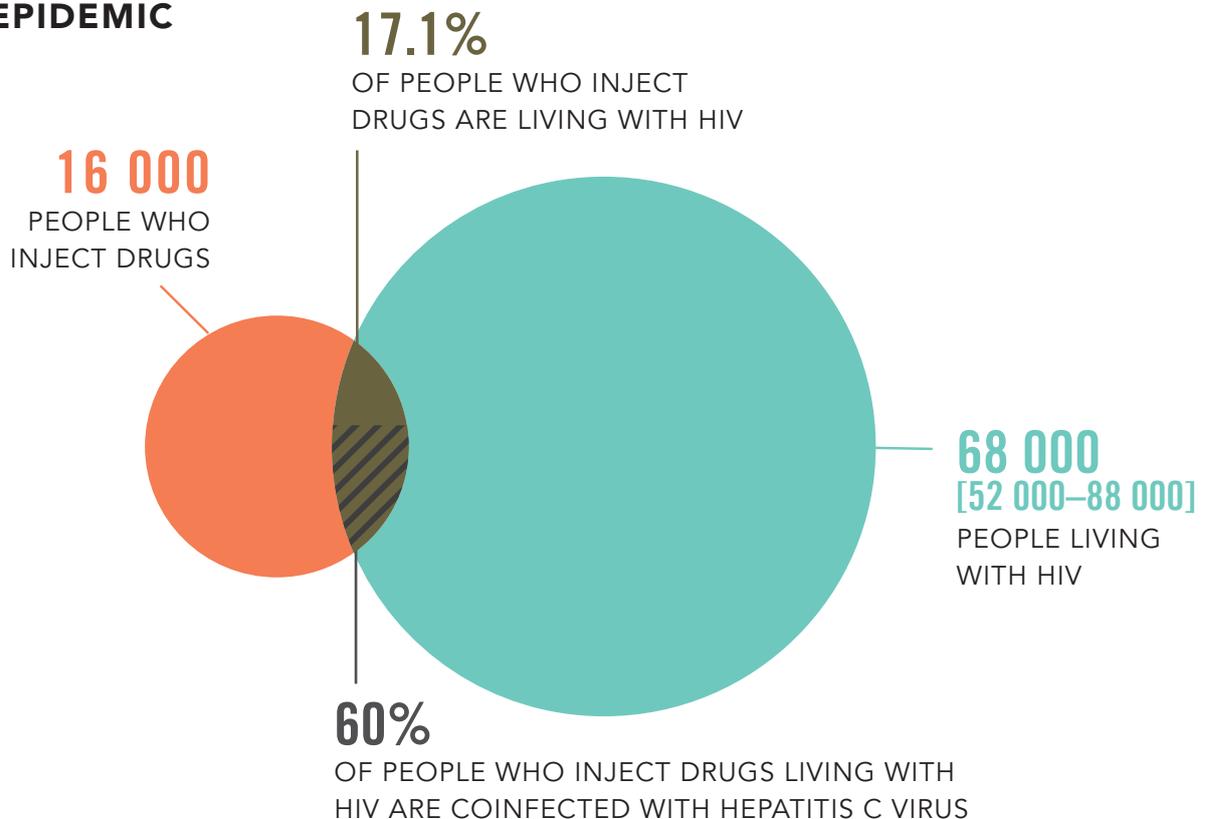


OPIOID SUBSTITUTION THERAPY

Source: Department of Health, Philippines, 2015.

PORTUGAL

HIV EPIDEMIC



Source: EMCDDA, 2013.

LEGAL AND POLICY ENVIRONMENT

- + ENABLING NATIONAL POLICY**
Risk and harm reduction is a pillar of the National Plan Against Drugs and Drug Addictions 2013–20; a network of comprehensive harm reduction programmes has been consolidated throughout the country in critical zones of intensive drug use.
- + DECRIMINALIZATION**
In 2000 Portugal passed a new drug law that downgraded the purchase, possession and consumption of small amounts of narcotic drugs from criminal to administrative offences; under the law an individual can possess a 10-day supply of drugs before facing criminal charges as a drug dealer.
- + POLICING**
There are no criminal penalties or other sanctions for the possession of needles and syringes.

Source: Country overview: Portugal, Lisbon, European Monitoring Centre for Drugs and Drug Addiction. Domosławski A, Drug policy in Portugal: the benefits of decriminalizing drug use, Warsaw, Open Society Foundations, 2011 (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>).

HARM REDUCTION



150

syringes distributed per person who inject drugs per year



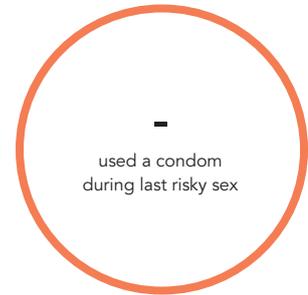
17 000

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: EMCDDA, 2013.

Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências (SICAD), 2013.

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

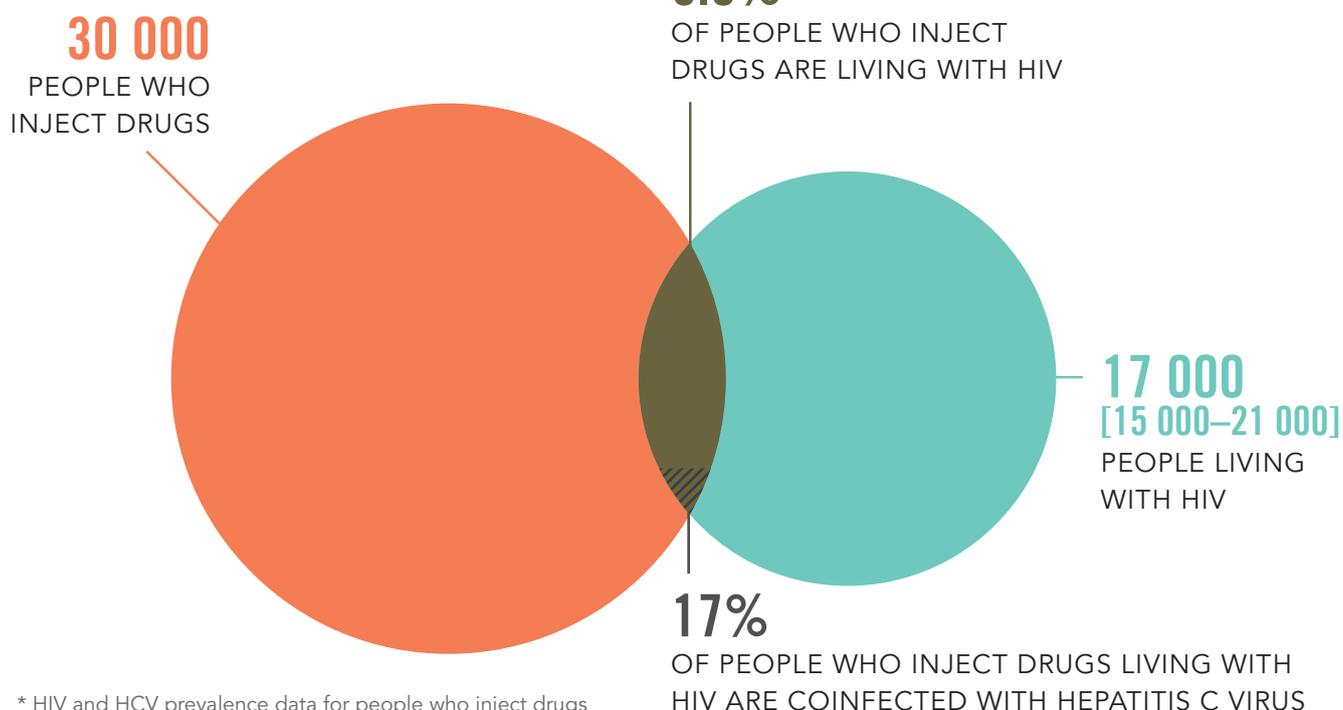


OPIOID SUBSTITUTION THERAPY

Sources: Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências (SICAD), 2013.

REPUBLIC OF MOLDOVA

HIV EPIDEMIC*



* HIV and HCV prevalence data for people who inject drugs in Chisinau, the capital of the Republic of Moldova.

Source: Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015. Investment case, Support to perform the HIV epidemiological situation analysis, Chisinau, 2015. Integrated biological and behavioural survey, Moldova, 2012.

LEGAL AND POLICY ENVIRONMENT

- + ENABLING NATIONAL POLICY**
A revised HIV law issued in 2012 contains specific clauses on harm reduction for people who use drugs in communities and prisons.
- + DECRIMINALIZATION**
Simple drug use is an administrative offence according to Article 85 of the Administrative Offences Code passed in 2008; under the code, purchase or possession of narcotic drugs or psychotropic substances in small amounts without the purpose of distribution, as well as their consumption without a medical prescription, is sanctioned with a fine.
- REGISTRATION OF PEOPLE WHO USE DRUGS**
A positive drug test conducted at the request of police or by an individual voluntarily accessing the health-care system can result in registration into a narcological register database.

Source: UNAIDS country office report, 2016. EMCDDA, Country overview: Moldova.

HARM REDUCTION*



67.5

syringes distributed per person who inject drugs per year



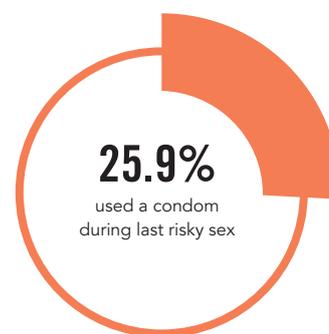
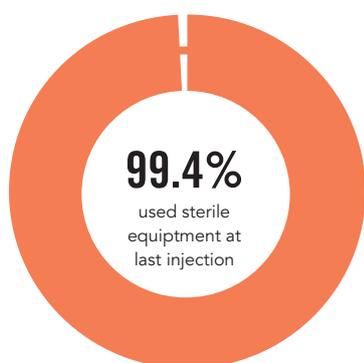
<1000

people enrolled in opioid substitution therapy



0

safe injecting facilities



* Behaviour data is for Chisinau, the capital of the Republic of Moldova.

Sources: Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>). Integrated biological and behavioural survey, Moldova, 2012.

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

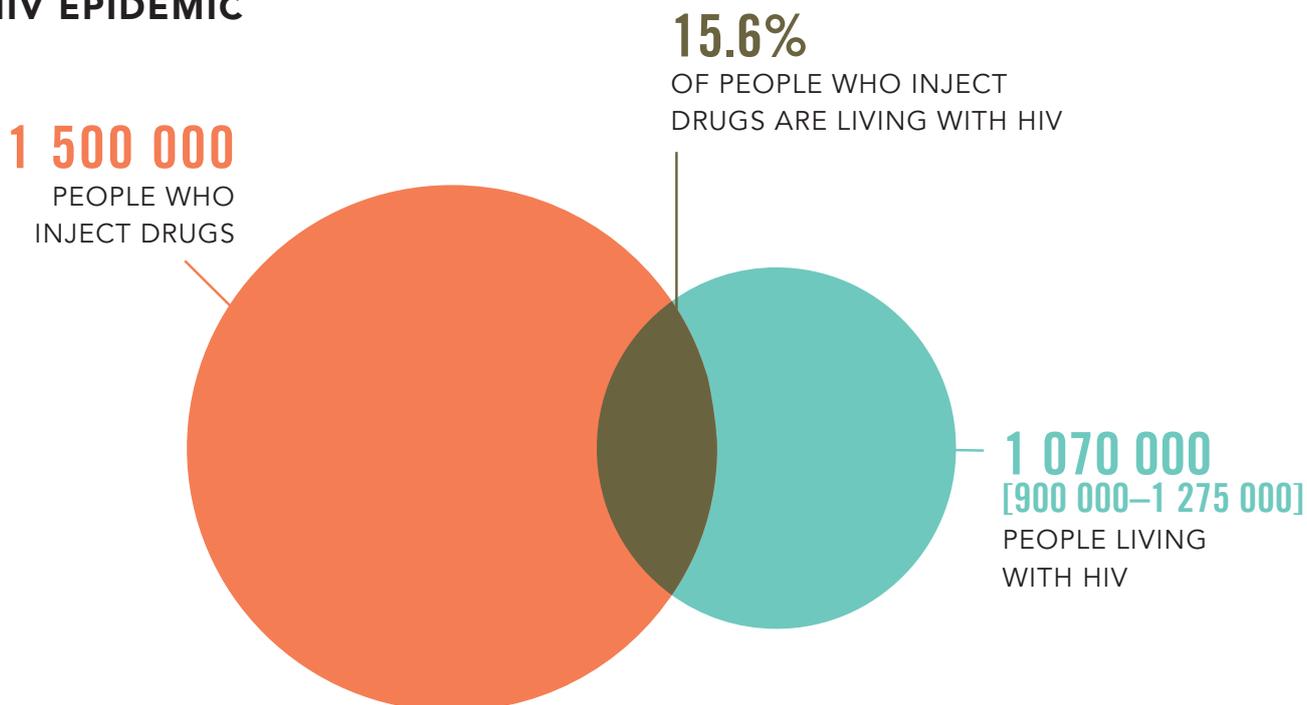


OPIOID SUBSTITUTION THERAPY

Source: The global state of harm reduction 2014. London: Harm Reduction International; 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>).

RUSSIAN FEDERATION

HIV EPIDEMIC



Source: Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>). Interview with the Chairman of the State Anti-Drug Committee, Federal Drug Control Service Director Viktor Ivanov, 28 December 2015. Federal Drug Control Service [website] (http://www.fskn.gov.ru/includes/periodics/events_right/2015/1228/142041939/detail.shtml, accessed 11 April 2016). UNODC/UNAIDS/WHO 2015 size estimates.

LEGAL AND POLICY ENVIRONMENT

- INSUFFICIENT ENABLING POLICY**
The country's policy framework does not have explicit supportive reference to harm reduction, and opioid substitution therapy is not available in the country.
- CRIMINALIZATION**
Drug use is an administrative offence punishable by a fine of 4000–5000 roubles or up to 15 days incarceration; possession of drugs can be an administrative or criminal offence depending on the amount in possession (Section 228 of the Criminal Code of the Russian Federation).
- POLICING**
Syringe possession is not illegal, and needle and syringe programmes exist; however, cases of arrests for possession of needles and syringes have been documented in some cities.

Sources: The global state of harm reduction 2014, London, Harm Reduction International, 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>). Lunze K, Raj A, Cheng DM, Quinn EK, Bridden C, Blokhina E, et al., Punitive policing and associated substance use risks among HIV-positive people in Russia who inject drugs, J Int AIDS Soc, 2014, 17, 19043; UNAIDS Regional Support Team report, 2016.

HARM REDUCTION



-

syringes distributed per person who inject drugs per year



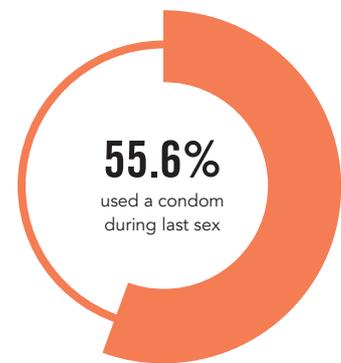
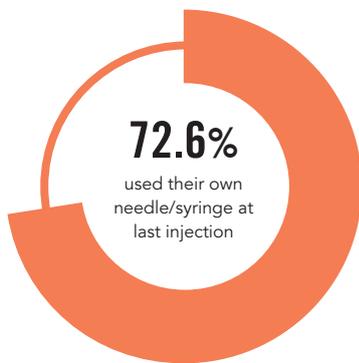
-

people enrolled in opioid substitution therapy



0

safe injecting facilities



Source: Yakovleva A. Evaluation of quality and effectiveness of regional low threshold harm reduction projects for IDUs, analytical report. ESVERO , 2014.

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

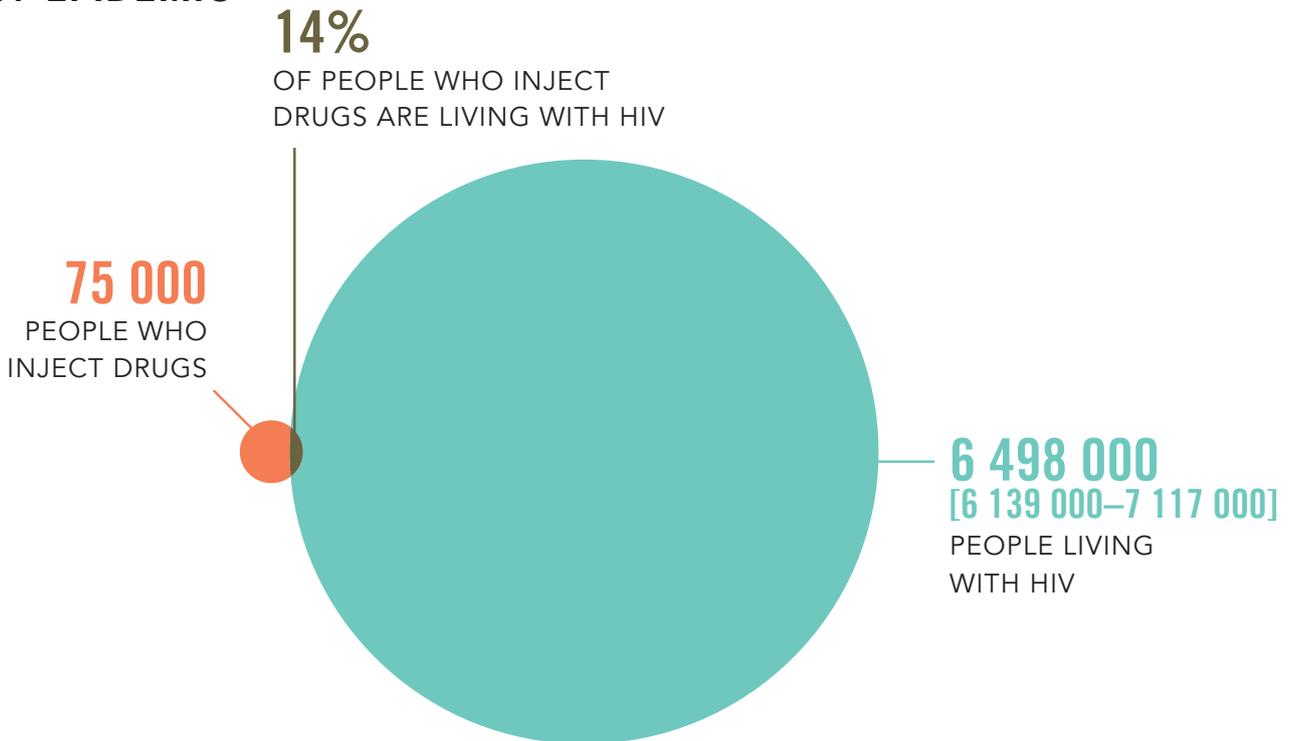


OPIOID SUBSTITUTION THERAPY

Source: UNAIDS Regional Support Team report, 2016.

SOUTH AFRICA

HIV EPIDEMIC



Sources: HIV positive drug users are harassed daily by police and gangsters. Times Live, 2016 (<http://www.timeslive.co.za/local/2016/02/03/HIV-positive-drug-users-are-harassed-daily-by-police-and-gangsters> accessed on 23/03/2016). Scheibe A, Makapela D, Brown B, dos Santos M, Hariga F, Virk H, et al. HIV prevalence and risk among people who inject drugs in five South African cities. Int J Drug Policy. 2016; <http://dx.doi.org/10.1016/j.drugpo.2016.01.004>.

LEGAL AND POLICY ENVIRONMENT

- CRIMINALIZATION**
Possession of narcotic drugs for personal use is punishable by fines or imprisonment.
- POLICING**
Awareness of harm reduction among law enforcement is low, leading to discouraging practices such as confiscation of needles and syringes; two thirds of people who inject drugs who were surveyed during a formative assessment in two metropolitan areas reported their engagement with law enforcement as being “abusive”.

Sources: National strategic plan on HIV, STIs and TB 2012–2016, Pretoria, South African National AIDS Council, 2011. Scheibe A et al., A long walk to freedom: towards health and rights for people who inject drugs in South Africa, TB/HIV Care Association, OUT LGBT Wellbeing, 2016 Lambert, A. Harm Reduction in South Africa. HIV and Drug Use Pre-Conference. Durban; TB/ HIV Care Association: 2015.

HARM REDUCTION



6

syringes distributed per person who inject drugs per year



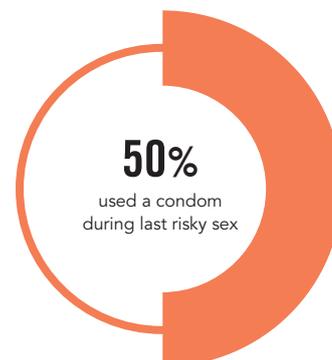
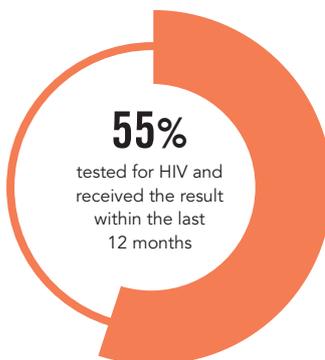
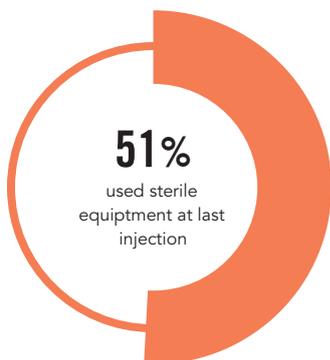
178

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: UNAIDS country office report, 2016.

United Nations Office on Drugs and Crime. (2015). Rapid assessment of HIV and related risk factors among people who inject drugs from five South African cities. Final report. Pretoria: UNODC.

<http://www.groundup.org.za/article/medicine-offers-hope-heroin-users-mitchells-plain/>.

Scheibe A, Makapela D, Brown B, dos Santos M, Hariga F, Virk H, et al. HIV prevalence and risk among people who inject drugs in five South African cities. Int J Drug Policy. 2016; <http://dx.doi.org/10.1016/j.drugpo.2016.01.004>.

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

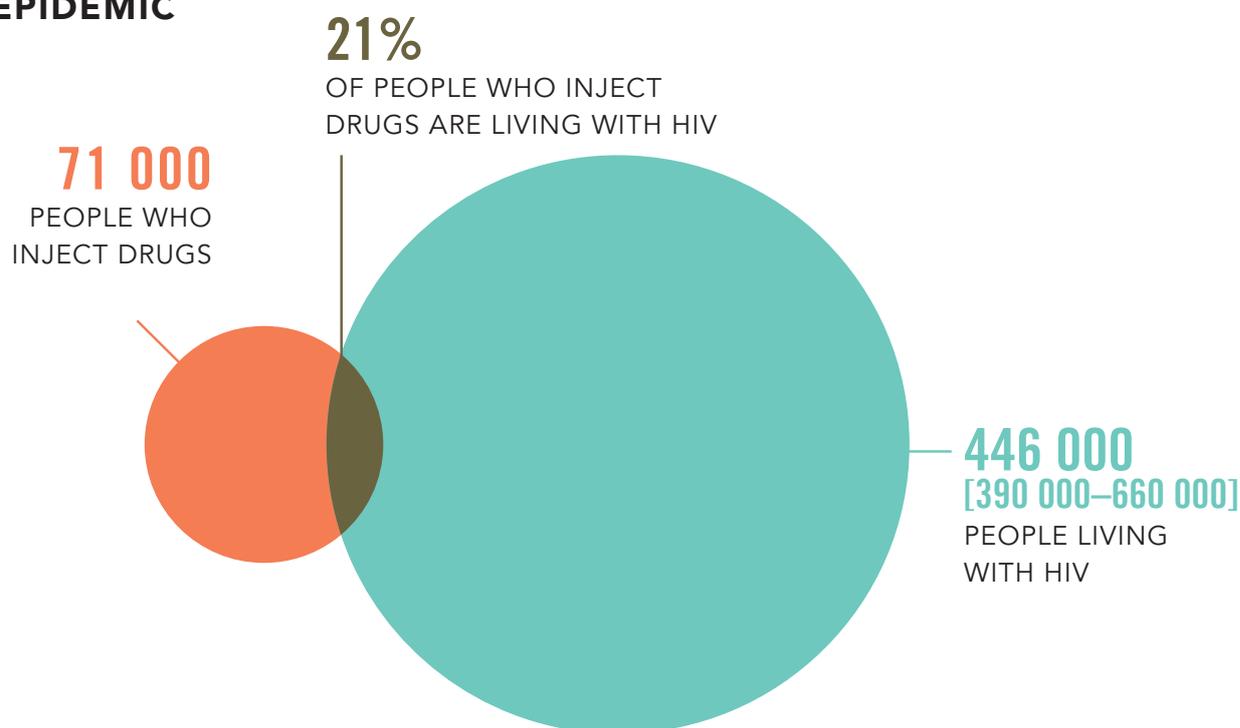


OPIOID SUBSTITUTION THERAPY

Source: The global state of harm reduction 2014. London: Harm Reduction International; 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>). UNAIDS country office report, 2016.

THAILAND

HIV EPIDEMIC



Sources: National Consensus Meeting: size estimation on PWID, National AIDS Management Centre, MOPH, September 2015. Minutes, AIDS Epidemic Model Meeting, 2015. Integrated biological and behavioural survey, Thailand, 2009/2010/2012/2014. AIDS Epidemic Model, 2010. Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>).

LEGAL AND POLICY ENVIRONMENT

- +** **ENABLING NATIONAL POLICY**
In 2014 the national narcotics control board launched a new harm reduction strategy that calls for collaboration between government agencies and civil society in the delivery of services, and the National AIDS Committee has endorsed the policy and strategies on harm reduction for drug use.
- **CRIMINALIZATION**
Under the 1979 Illicit Drug Act, substance use is a criminal offence; consumption of small amounts of type 1 substances, such as heroin, is punishable by fines and up to three years in prison.
- **POLICING**
Since 2003, there have been periodic police crackdowns on people who use drugs.
- **COMPULSORY DETENTION**
In 2014, 96 680 people arrested for drug use were placed in compulsory detention; a recent revision to the national drug policy (Order No. 108/2014) aims to enrol more people who use drugs in voluntary drug dependence treatment provided by public health services.

Source: UNAIDS country office report, 2016; Windle J, Drugs and drug policy and Thailand, Brookings Institution, Center for 21st Century Security and Intelligence, 2015. The Third Regional Consultation on Compulsory Centres for Drug Users (CCDUs) in Asia and the Pacific, 21-23 September 2015 Philippines, Office of the Narcotics Control Board (ONCB).

HARM REDUCTION



14

syringes distributed per person who inject drugs per year



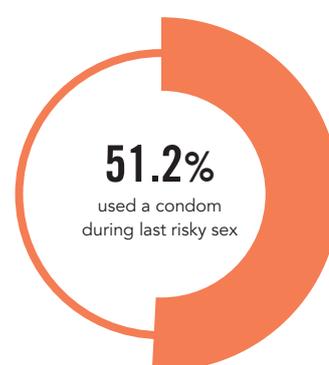
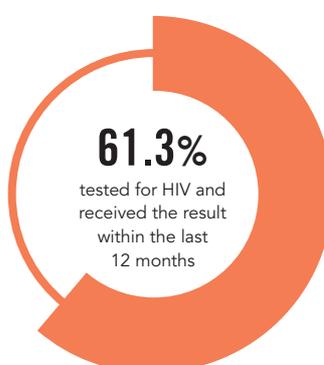
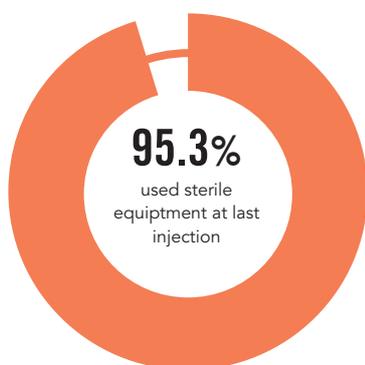
5956

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2016. (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>).

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES



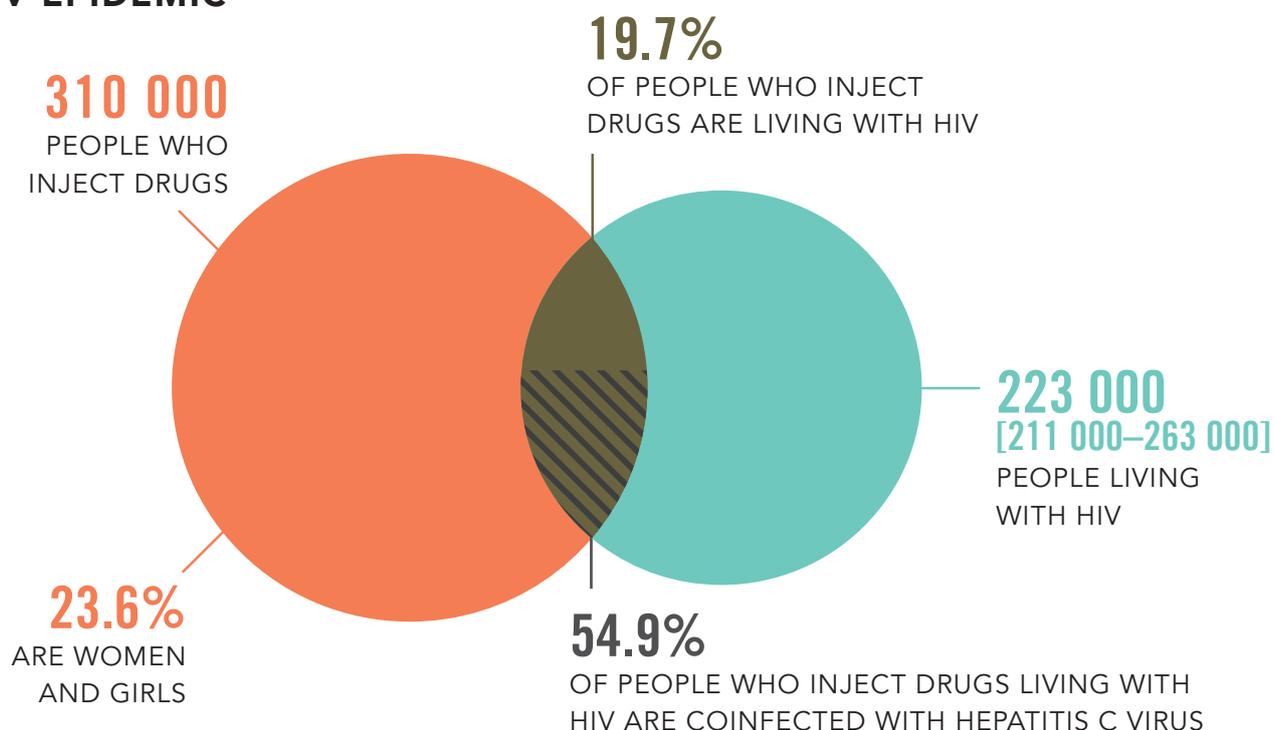
OPIOID SUBSTITUTION THERAPY

Source: Department of Correction, 2015.
Thailand NFM concept note, 2014.

Thailand national operation plan: accelerating ending AIDS (2015–2019). Nonthaburi: National AIDS Management Center; 2014.

UKRAINE

HIV EPIDEMIC



Sources: Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>). Integrated biological and behavioural survey, Ukraine, 2013. Ukrainian Centre for Dangerous Diseases Control, 2013–15.

LEGAL AND POLICY ENVIRONMENT

- + ENABLING NATIONAL POLICY**
Needle and syringe distribution and opioid substitution therapy are supported by the Law on the National AIDS Programme for 2014–2018.
- CRIMINALIZATION**
In 2010 the threshold amounts between administrative and criminal charges for opioid drug possession were lowered; nongovernmental organizations believe this intensified criminalization of small amounts of drugs negatively affects the performance of harm reduction programmes.
- + POLICING**
There are no criminal penalties or other sanctions for the possession of needles, syringes or other drug paraphernalia.
- DOMESTIC INVESTMENT**
The financing of harm reduction in this lower-middle-income country is almost completely reliant on international assistance.

Source: UNAIDS country office report, 2016; Country overview: Ukraine, European Monitoring Centre for Drugs and Drug Addiction.

HARM REDUCTION



66

syringes distributed per person who inject drugs per year



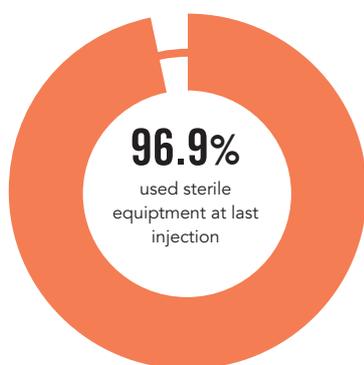
8407

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>). Integrated biological and behavioural survey, Ukraine, 2013. Ukrainian Center for Socially Dangerous Disease, Ministry of Health, Ukraine, 2013–2015.

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES



OPIOID SUBSTITUTION THERAPY

Source: The global state of harm reduction 2014. London: Harm Reduction International; 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>).

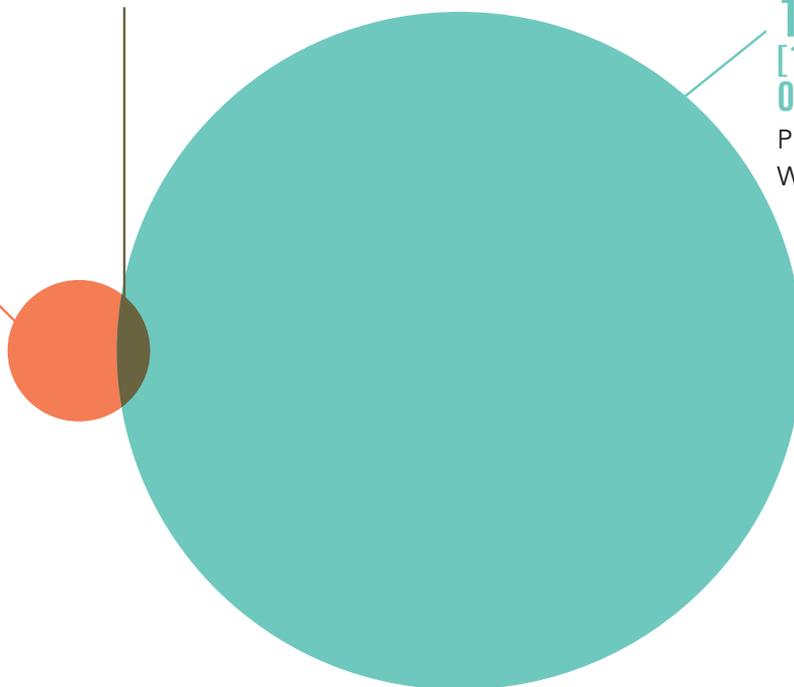
UNITED REPUBLIC OF TANZANIA

HIV EPIDEMIC

15.5%

OF PEOPLE WHO INJECT
DRUGS ARE LIVING WITH HIV

30 000
PEOPLE WHO
INJECT DRUGS



1 477 000
[1 211 000–1 779
000]
PEOPLE LIVING
WITH HIV

Sources: Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>).

LEGAL AND POLICY ENVIRONMENT



ENABLING NATIONAL POLICY

Small-scale harm reduction services such as syringe distribution, bleach kits for decontamination and methadone maintenance therapy are being implemented through the national AIDS response.

Source: Global AIDS response country progress report, Government of the United Republic of Tanzania, 2014.

HARM REDUCTION



155

syringes distributed per person who inject drugs per year



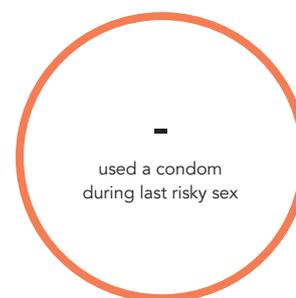
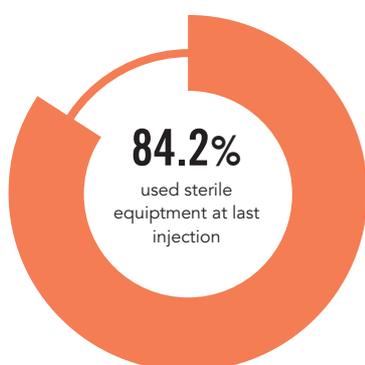
3376

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: UNAIDS country office report, 2016.
Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>).

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

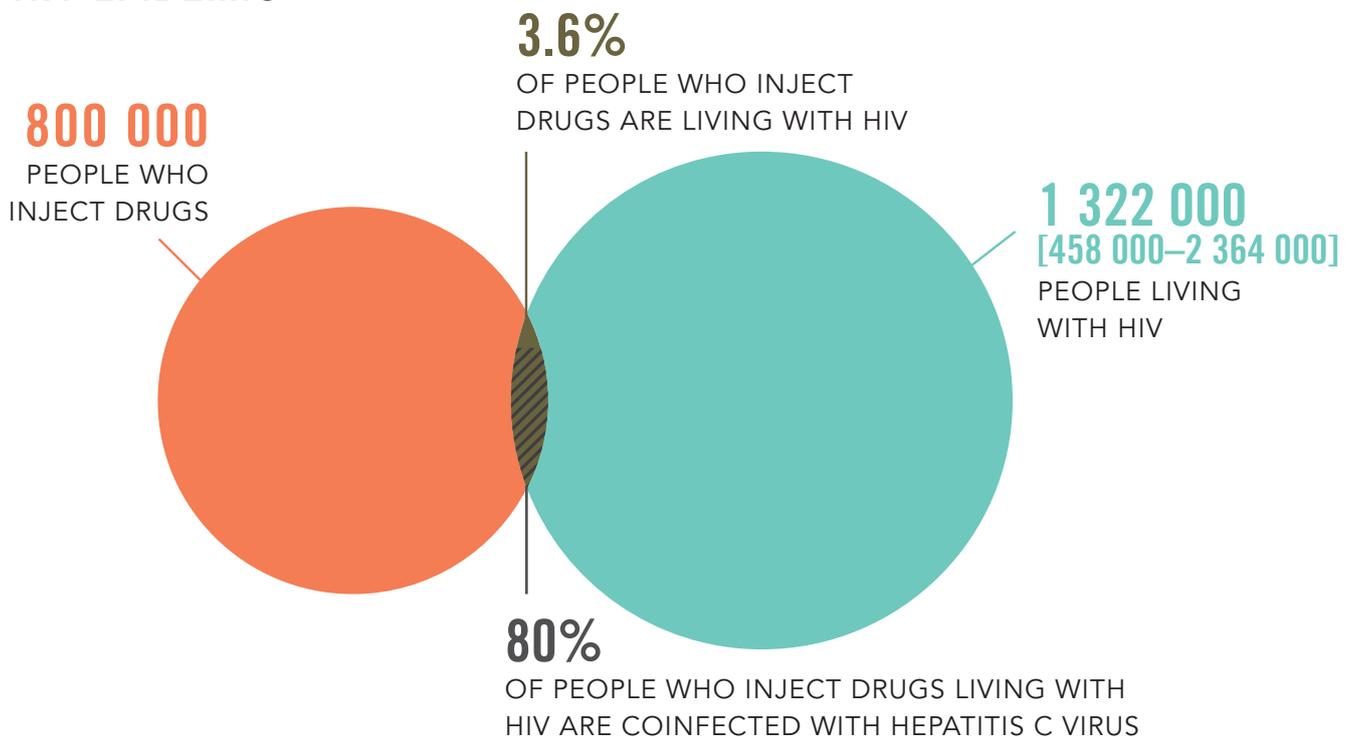


OPIOID SUBSTITUTION THERAPY

Source: The global state of harm reduction 2014. London: Harm Reduction International; 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>).

UNITED STATES OF AMERICA

HIV EPIDEMIC



Sources: Lansky A, Finlayson T, Johnson C, Hotzman D, Wejnert C, et al. Estimating the number of persons who inject drugs in the United States by meta-analysis to calculate national rates of HIV and hepatitis C virus infections. PLoS ONE.2014;9:e97596. CDC, HIV Monitoring Report, 2013. CDC, HIV and viral hepatitis fact sheet, March 2014.

LEGAL AND POLICY ENVIRONMENT

- + ENABLING NATIONAL POLICY**
The Consolidated Appropriations Act of 2016 gives states and local communities the opportunity to use federal funds to support certain components of needle-syringe programmes.
- CRIMINALIZATION**
Possession of narcotic drugs for personal use is often punishable by fines or imprisonment; penalties vary by state.
- + OVERDOSE TREATMENT**
By September 2015, 43 of 50 states had passed legislation to provide naloxone to people who are likely to witness an overdose, including family members and caregivers of people who use drugs.

Source: United States Congress, Consolidated Appropriations Act, 2016; Davis CS, Carr D, Legal changes to increase access to naloxone for opioid overdose reversal in the United States, Drug Alcohol Depend 2015, 157, 112–120.

HARM REDUCTION



59

syringes distributed per person who inject drugs per year



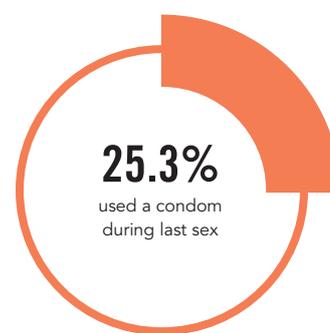
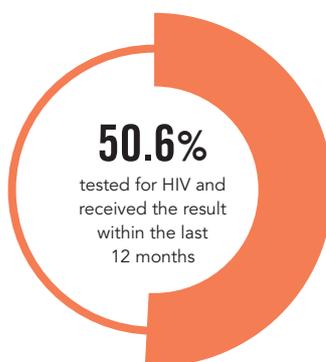
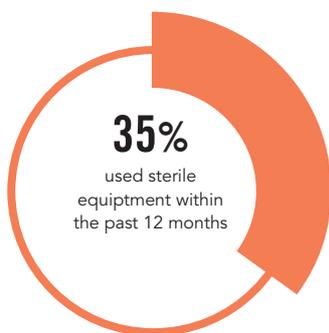
382 237

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: CDC HIV Monitoring Report, 2013.
CDC Morb Mortal Wkly Rep. 2013;64.
National HIV Behavioural Surveillance, USA, 2012.
National Behavioural Health Barometer, SAMHSA, 2015.
National Survey of Substance Abuse Treatment Services (N-SSATS), SAMHSA, 2013.

SERVICES AVAILABLE IN PRISONS*



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES



OPIOID SUBSTITUTION THERAPY

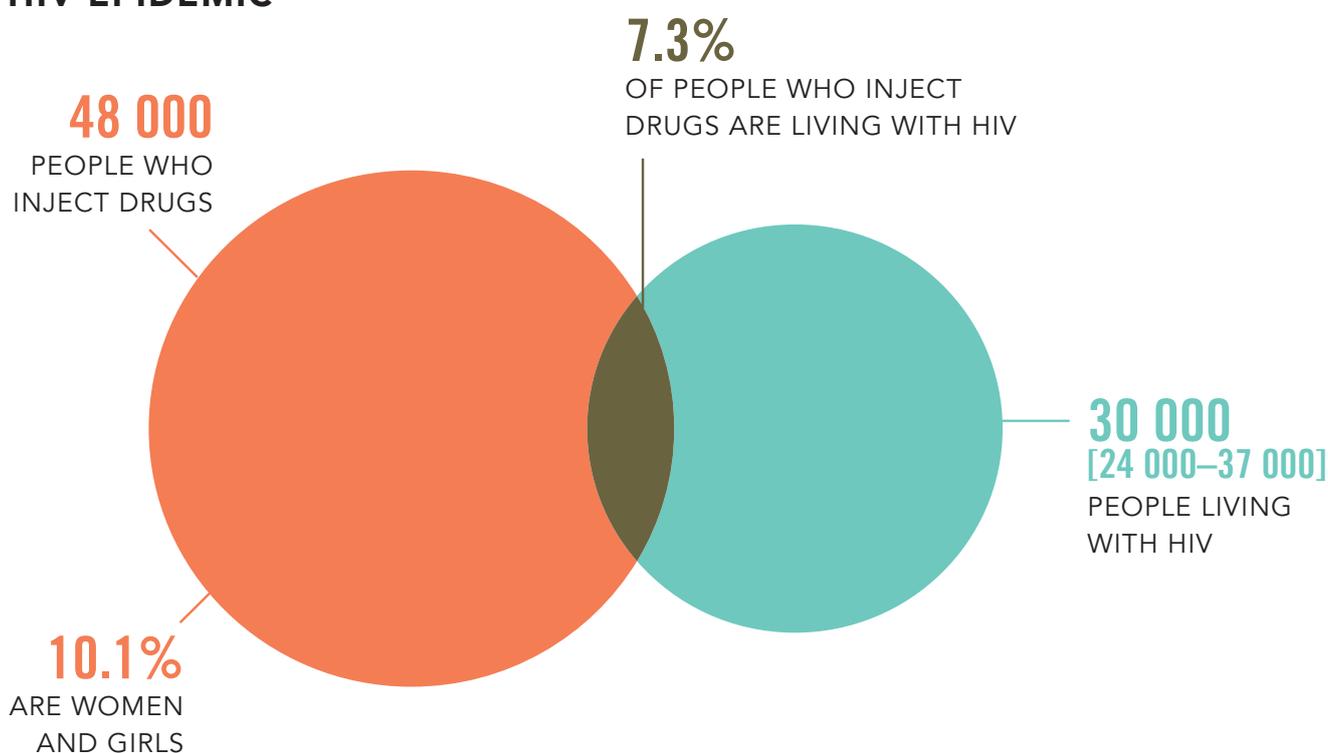
* Service availability is for federal prisons.

Source: Detoxification of chemically dependent inmates. Washington, DC: Federal Bureau of Prisons; 2014 (<https://www.bop.gov/resources/pdfs/detoxification.pdf>).

Management of HIV Infection, Federal Bureau of Prisons, Clinical Practice Guidelines, July 2013.

UZBEKISTAN

HIV EPIDEMIC



Sources: Most-at-risk population size estimation report, Uzbekistan, 2012. Integrated Bio Behavioural Survey, Uzbekistan, 2014. Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>).

LEGAL AND POLICY ENVIRONMENT

- + ENABLING NATIONAL POLICY**
There is explicit supportive reference to harm reduction in national policy documents, but opioid substitution therapy is unavailable.
- CRIMINALIZATION**
Possession of small quantities of drugs is punishable by fines and incarceration, starting from one to two times the minimum salary or 15 days of incarceration.
- REGISTRATION OF DRUG USERS**
Under a 2005 Ministry of Health order, people diagnosed with drug dependence are registered in a narcological register database; individuals are subject to regular medical check-ups and dynamic observation in outpatient substance abuse treatment units; exclusions apply to people who apply voluntarily for anonymous drug treatment.

Source: The global state of harm reduction 2014, London, Harm Reduction International, 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>). Country overview: Uzbekistan, European Monitoring Centre for Drugs and Drug Addiction. UNAIDS country office report, 2016.

HARM REDUCTION



127.5

syringes distributed per person who inject drugs per year



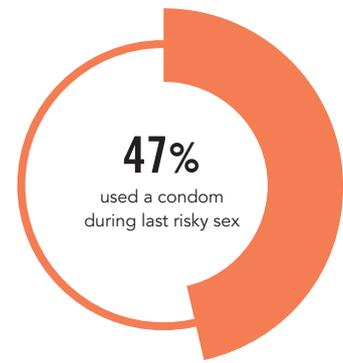
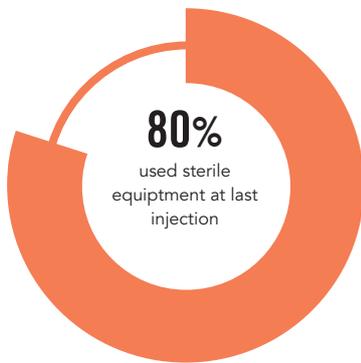
0

people enrolled in opioid substitution therapy



0

safe injecting facilities



Sources: Global AIDS response progress reporting. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>). Integrated biological and behavioural survey, Uzbekistan, 2014.

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES

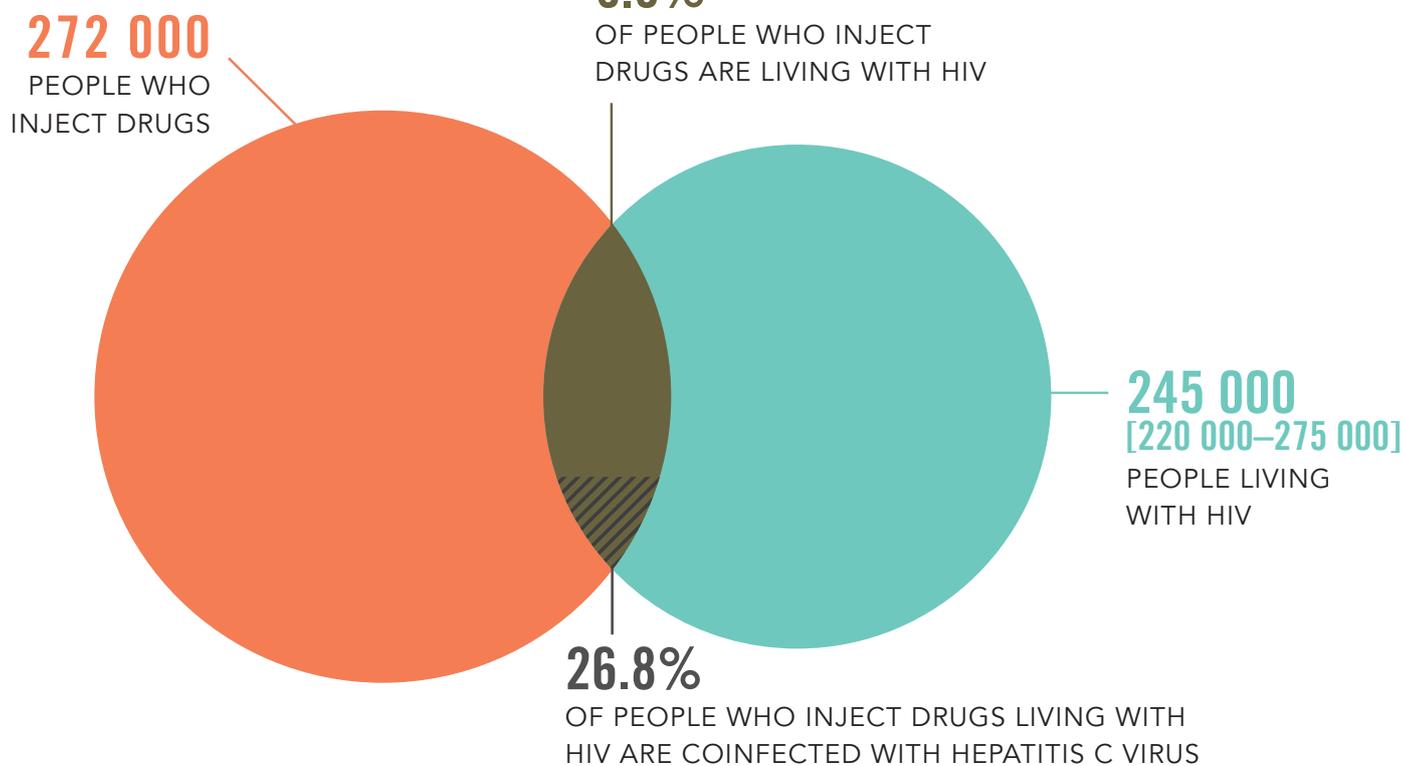


OPIOID SUBSTITUTION THERAPY

Source: The global state of harm reduction 2014. London: Harm Reduction International; 2014 (<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>).

VIET NAM

HIV EPIDEMIC



Source: AIDS Epidemic Model, Viet Nam, 2014.
Integrated biological and behavioural survey, Viet Nam, 2009.
HIV sentinel surveillance, Viet Nam, 2015.

LEGAL AND POLICY ENVIRONMENT

- + ENABLING NATIONAL POLICY**
The Law on HIV/AIDS Prevention and Control authorizes harm reduction, including the provision of needles and syringes, peer outreach support and methadone maintenance therapy.
- + POLICING**
There are no criminal penalties or other sanctions for the possession of needles, syringes or other drug paraphernalia.
- CRIMINALIZATION**
Possession of small quantities of drugs for personal use is a criminal offence punishable by up to five years in prison.
- COMPULSORY DETENTION**
For most of the past 20 years, the primary approach to drug dependence treatment has been compulsory detention within centres, which has raised serious human rights concerns; in recent years, as methadone maintenance therapy has scaled up, the number of people in compulsory detention has decreased.

Source: UNAIDS country office report, 2016.

HARM REDUCTION



62

syringes distributed per person
who inject drugs per year



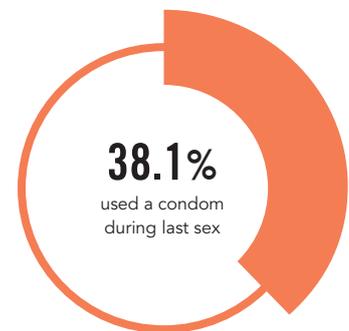
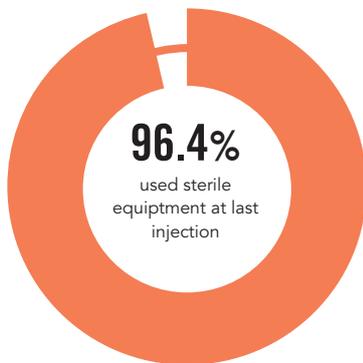
44 000

people enrolled in opioid
substitution therapy



0

safe injecting
facilities



Sources: National programme data, 2015.
HIV sentinel surveillance plus behavioural survey (HSS+), Viet Nam, 2015.

SERVICES AVAILABLE IN PRISONS



HIV TESTING



ANTIRETROVIRAL THERAPY



CONDOMS



NEEDLES AND SYRINGES



OPIOID SUBSTITUTION THERAPY

Source: VAAC's report on HIV/AIDS activities in 2015 and key tasks in 2016.

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HIV AND PEOPLE WHO INJECT DRUGS: LACK OF GLOBAL PROGRESS

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2. Ten targets: 2011 United Nations Political Declaration on HIV and AIDS. Global progress and lessons learned, 2011–2015. Geneva: UNAIDS; 2015 (http://www.unaids.org/en/resources/documents/2015/ten_targets, accessed 6 April 2016).
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4. Pokrovsky VV, Ladnaya NN, Tushino OI, EV Buratsova. [HIV infection: newsletter No. 40.] Moscow: Federal Scientific and Methodological Center for Prevention and Control of AIDS; 2015.
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