THE GLOBAL STATE OF HARM REDUCTION 2022

8TH
EDITION

HARM REDUCTION INTERNATIONAL

ACKNOWLEDGEMENTS

AUTHORS

ASIA

Gideon Lasco is senior lecturer at the University of the Philippines Diliman's Department of Anthropology, affiliate faculty at the UP College of Medicine's Social Medicine Unit, research fellow at the Ateneo de Manila University's Development Studies Program, and honorary fellow at Hong Kong University's Centre for Criminology.

EASTERN AND SOUTHERN AFRICA

Wangari Kimemia is a Kenyan consultant in research, training and advocacy in harm reduction and drug policy. She holds Bachelor of Education (English and Literature), Master of Arts (Sociology) and is pursuing PhD (Sociology). She is the Advocacy and Capacity Building Officer with Women and Harm Reduction International Network (WHRIN).

EURASIA

Anya (Ganna) Dovbakh is the Executive Director at the Eurasian Harm Reduction Association. She has 25 years of experience of work in HIV/AIDS and public health areas and social care services development for key affected populations in Eastern Europe and Central Asia and builds systems and programs for harm reduction organizations and leaders from 28 countries of the EECA region.

Maria Plotko is the Senior Program Officer with the Eurasian Harm Reduction. She leads grants management, research and human rights related activities. Her main areas of expertise are women who use drugs, quality of harm reduction services, community led monitoring, and human rights.

LATIN AMERICA AND THE CARIBBEAN

Carolina Ahumada is the Project Coordinator and technical assistant at Intercambios Civil Association and Project Manager at Youth RISE. She has a degree in Sociology from the University of Buenos Aires 2021 and was a Fall Intern at WOLA Washington Office on Latin America for Women and Incarceration and Drug Policy programs.

Jorgelina Di Iorio, PhD is the Intervention coordinator of Intercambios Civil Association Researcher of the National Council of Scientific and Technical Research of Argentina (CONICET) Professor of Social Psychology, School of Psychology, University of Buenos Aires. Co-coordinator of research projects focusing on inequalities and public health, particularly with people who use drugs and homelessness. She was a Fulbright Visiting Scholar 2019-2020 Department of Population Health/Division of Epidemiology, New York University.

MIDDLE EAST AND NORTH AFRICA

Mr. Elie Aaraj is the Founder and Former Director of the SIDC Association in Lebanon. Founding President of the Order of Nurses. Co-Founder and ED of MENAHRA. Former President RANAA. Holder of "Medaille Marcelle Hochar" Award (2005) from the LRC Nursing Association, the National Rolleston Award (2011) from HRI. The "Kim Mo IM"

Award -International Council of Nursing (2019).

Sandra Hajal Hanna is a nurse and a public health consultant with more than 15 years of experience in the fields of substance use and mental health. Sandra has been involved in different types of projects related to mental health, substance use, harm reduction, sexual health, nursing education, and public health. She has a wide experience in conducting research assessments, project and service evaluations, training material development and delivery in addition to many others. Sandra has previously worked in clinical settings, NGOs, iNGOs, and governmental agencies in Lebanon and the MENA region.

OCEANIA

Michala Kowalski is a Scientia PhD candidate at the UNSW Sydney's Social Policy Research Centre. Michala joined the Drug Policy Modelling Program as a research officer in 2017 and is a member of the Global Cannabis Cultivation Research Consortium. Research interests include drug and alcohol policy, technological innovations, and harm reduction.

NORTH AMERICA

Derek T. Frasure is a Ph.D. candidate in English Language and Literature at the University of Michigan, Ann Arbor. He is also the regional research consultant and author of the North America chapter of Harm Reduction International's 2022 Global State of Harm Reduction report, as well as a peer reviewer for Springer Nature's Harm Reduction Journal. Additionally, Derek serves as Policy Director for Students for Sensible Drug Policy at the University of Michigan.

Sam Shirley-Beavan is a consultant for the Public Health and Social Policy team with Harm Reduction International, which conducts original research and analysis into harm reduction trends around the world. Sam holds an MA in Conflict, Governance and International Development from the University of East Anglia and a BA in Politics and Spanish from the University of Bath. He is a member of the Correlation European Harm Reduction Network Expert Group on Monitoring.

WEST AND CENTRAL AFRICA

Kunal Naik has been involved in advocacy focusing on Harm Reduction, Drug Policy Reform, HIV, and Key populations for the past 10 years both locally and internationally. As an addictologist he is interested in the development of effective evidence-based drug policy, and therapy embracing harm reduction principles. He is the Sub-Saharan Africa representative on the Members Advisory Council (MAC) of the International Drug Policy Consortium.

WESTERN EUROPE

Robert Csák is a sociologist holding a PhD in Health Science. He did research on the risk environment affecting people who inject drugs, decreasing coverage of NSPs in Budapest and Belgrade, NPS use in marginalised communities. Robert led the GSHR 2020 and has worked in NSPs, done community outreach, HIV and HCV testing and counselling for over ten years.

CONTRIBUTORS

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ASIA

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NORTH AMERICA

Sam Shirley-Beavan, Harm Reduction International; Daniel Wolfe, Expert Consultant; Sandra Ka Hon Chu, HIV Legal Network; Roxanne Saucier, MPH, Harm Reduction and Drug Policy Consultant; Matt Curtis, California Department of Public Health, Office of AIDS; Annette Hubbard and Sarah Spencer, Megan's Place, Homer Exchange; Barbie Zabielski, Virginia Harm Reduction Coalition; Bryce Pardo, RAND Corporation; Cameron Murphy, Kentucky Harm Reduction Coalition; Carl Phillips;

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OCEANIA

Michala Kowalski, University of New South Wales; Lisa Maher, University of New South Wales (Kirby Institute); John Ryan; Alison Ritter, Drug Policy Modelling Program, Social Policy Research Centre, UNSW Sydney; Amy Peacock, National Drug and Alcohol Research Centre, UNSW Sydney; Annie Madden, Harm Reduction Australia; Anna Conway, Kirby Institute, UNSW Sydney; Ashley Koning, Te Pou; Baillee Farah, Chloe Span, Students for Sensible Drug Policy; Charlie Lay, Australia Injecting & Illicit Drug Users League (AIVL); Chris Gough, Canberra Alliance for Harm Minimisation & Advocacy (CAHMA); Geoff Noller, Needle Exchange Services Trust & New Zealand Needle Exchange Program; Jason George, New Zealand Needle Exchange Program; Rachel Sutherland, National Drug and Alcohol Research Centre, UNSW Sydney; Sarah Hiley, North Richmond Community Health.

MIDDLE EAST AND NORTH AFRICA

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EASTERN AND SOUTHERN AFRICA

Wangari Kimemia, Harm Reduction and Drug Policy Consultant; Joanne Csete, Columbia University; Julie MacDonnell, TB HIV Care; Angela McBride, South African Network of People Who Use Drugs; Allan Maleche, Kelin; Timothy Tumahole, Captive Eye; Bhekizitha Sithole, FHI 360; Tibebu Getachew Esuendale, Organization for Social Services, Health and Development; Bernice Apondi, VOCAL Kenya; Catherine Mwangi, Women Nest; John Kimani, Kenya Network of People Who Use Drugs; Undule Mwakasungula, Drug Policy and Harm Reduction

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FOREWORD

BY
WINNIE BYANYIMA

The *Global State of Harm Reduction 2022* shows the positive changes that communities and civil society are making among people who use drugs through evidence- and rights-based harm reduction services. The good news is that change is possible and within reach, as long as governments and donors invest in community-led solutions that work. It is not only the right thing to do, it is their duty. Access to healthcare is a human right for all of us.

The risk of acquiring HIV is 35 times higher among people who inject drugs than among adults who do not. Yet globally, harm reduction services are not available at the level and scale required to end AIDS, with fewer than 1% of people who inject drugs living in countries with the UN-recommended levels of coverage of needles, syringes, and opioid substitution therapy. In too many countries, there are no harm reduction services at all.

What's more, in low- and middle-income countries, we have an ongoing funding crisis for harm reduction. Governments and donors have invested just 5% of the funds needed for an effective response. If we are serious about ending the AIDS crisis and guaranteeing human rights for all – commitments made by governments at the UN through the 2021 Political Declaration on HIV/AIDS – we need to scale up investment now in community-led responses. These responses must take into account the legal, policy, and social barriers facing people accessing HIV and harm reduction services and the multiple and intersecting forms of structural inequalities and discrimination faced by women who use drugs.

"Change is possible and within reach, as long as governments and donors invest in community-led solutions that work"

It is time for laws that criminalise drug use and possession for personal use to come to an end. As long as countries continue to criminalise drug possession for personal use, we will not end AIDS for people who use drugs and their partners. That number of countries crimimalising drug use or possession for personal use was 115 out of 128 reporting countries at the last count. Countries that have either decriminalised drug use or have effective diversion policies in place developed in collaboration with communities, are testament to what can happen when countries invest in non-judgmental health-based programmes. In Czechia and the Netherlands, fewer than twelve people who injected drugs acquired HIV annually from 2009-2018.

The Global AIDS Strategy 2021-2026 calls for an end to all laws that criminalize drug use and possession, along with action to reduce stigma, discrimination and violence against people who use drugs. Because until people who use drugs have access to HIV and harm reduction services, we will not end AIDS among people who use drugs. We will not end AIDS at all.

Thanks to progress on societal enablers and with community-led organisations in the design, implementation and delivery of programmes, across the world, women, young people, indigenous people, LGBTQI people, people in prison, and more are accessing life-saving harm reduction services. These programmes show those who are serious about ending the AIDS pandemic how it can be done, at the grassroots, with the grassroots.

Winnie Byanyima
Executive Director, The Joint United Nations Programme on HIV and AIDS (UNAIDS)

FOREWORD

BY
ANTON BASENKO

On 24 February 2022, Russia invaded my country, Ukraine, and our lives were changed overnight. As someone who lives with HIV and has been a drug user for over 20 years, I was afraid, and I still am.

I remember the events that followed the annexation of Crimea in 2014-2015 and the occupation of parts of the Donbas region of Ukraine. We witnessed the complete closure of harm reduction services, including sites that provided opioid agonist therapy such as methadone and buprenorphine to those that needed it. Many years ago, these very services saved my life. Harm reduction programmes, and the non-judgemental approach that guides them, have saved many lives. Russia has consistently opposed the adoption of harm reduction at the international level, despite decades of evidence showing its effectiveness at helping people who use drugs live full lives and helping to curb the spread of infectious diseases like HIV. So when Russia invaded my country earlier this year, we didn't know what would happen. But the response from civil society and communities of people who use drugs that followed has been nothing short of extraordinary.

I have seen firsthand the incredible strength and resilience of people who use drugs. We have a long history of forming networks and communities to take care of each other, in the face of stigmatisation and criminalisation; of mobilising for change; and of adopting innovative public health solutions, even with a lack of resources and when laws and policies didn't allow for it. When the war in Ukraine began, harm reduction networks and networks of people of who use drugs responded at astonishing speed. We used the lessons we have learnt over the years to respond to HIV, the overdose epidemic and other crises, and applied them to the current moment, even in the face of unspeakable horrors.

The story of a woman I know from one of the eastern regions of Ukraine, who uses drugs, is an illustration of the strength and solidarity in our community. She witnessed unimaginable pain when her husband died after being blown to pieces in front of her eyes because of a Russian missile strike. She was left to care for her child, who suffered from cerebral palsy. But through networks of people who use drugs with whom she was connected with, she was evacuated from the dangerous place she was in, and was guided from city to city, from one harm reduction organisation to another, until she made her way through central and western Europe to a country in which she was able to safely reside. At every stage of her journey, she and her child received extraordinary support from local networks of people who use drugs and harm reduction organisations; they meet her at the railway/bus station, helped her find accommodation and access to food and opioid agonist therapy.

"When the war in Ukraine began, harm reduction networks and networks of people of who use drugs responded at astonishing speed. We used the lessons we have learnt over the years to respond to HIV, the overdose epidemic and other crises, and applied them to the current moment, even in the face of unspeakable horrors."

She now lives in safety, has gained protective status and social support, and can work peacefully, with access to quality harm reduction programmes which allow her to live happily and care for her child. So many people came together to help her but it was not chaotic; it was an organised and coordinated effort among people with shared values, who are committed to ensuring access to harm reduction services.

Her story is one among many of networks of people who use drugs helping each other. Despite the number of facilities destroyed and the displacement of people who use drugs due to the war, I am proud to say that our global harm reduction family is irrepressible and our desire to help each other is so strong that we can only move forward.

This report, the *Global State of Harm Reduction 2022*, shows just how resilient we are. Even in the midst of a war and a global pandemic, we were able to mobilise to ensure that our loved ones stay alive and that people who use drugs could access the services they needed.

The report shows where we are today, colourfully and clearly, with facts and evidence. It shows the world we can create when people who use drugs, people who work in non-governmental organisations, people who make laws and policies at the national and local level come together; a world of mutual respect which supports diversity, health, rights and freedom, and one that is free of judgment and stigma.

Harm reduction saves lives. It saved mine and those of so many I love. My hope is that donors and governments recognise this and step up to provide the resources and support we need to continue doing the work we do. Like so many of those who have preceded us in the harm reduction movement, we have shown the power of community-led efforts. It is time that we get the recognition we deserve, so we can continue our fight against discrimination, against HIV, tuberculosis, overdose and so we can prevent unnecessary suffering and death.

Anton Basenko

Ukrainian Network of People who Use Drugs (PUD.UA/VOLNA), Chair and Founding Member;

International Network of People who Use Drugs (INPUD), Board Member;

The Global Fund to Fight AIDS, Tuberculosis and Malaria, Board Communities Delegation, member;

European AIDS Treatment Group (EATG), Programme Manager;

Alliance for Public Health, Communities, Rights and Gender Adviser;

Ukraine Cabinet of Minister's National Council on HIV/TB, people who use drugs representative.

INTRODUCTION AND METHODOLOGY

INTRODUCTION

This is the eighth edition of the *Global State of Harm Reduction*. Every two years since 2008, Harm Reduction International (HRI) has mapped responses to drug-related health harms around the world, including HIV and viral hepatitis. The report has become a key publication for researchers, policymakers, civil society organisations, advocates and United Nations' agencies interested in mapping harm reduction policy adoption and programme implementation globally.

The *Global State of Harm Reduction* has always been produced through a collaborative effort between community and civil society representatives and researchers. This year, we have expanded this collaboration, as all nine regional chapters are authored by regional experts. We hope that the involvement of these additional regional experts and harm reduction organisations has resulted in a more comprehensive, thorough analysis in the *Global State of Harm Reduction 2022*.

In this year's report, dedicated chapters pay special attention to viral hepatitis and the ongoing impact of the COVID-19 pandemic. In addition, we now report on Eastern and Southern Africa and West and Central Africa separately, reflecting the growth of harm reduction across Africa. We have also expanded our attention to include harm reduction for non-injected drugs and stimulants, for the first time collecting quantitative data on the availability of safer smoking kits and stimulant pharmacotherapy.

In all our work, Harm Reduction International defers to and respects local and regional terminology preferences, and is committed to the use of non-stigmatising, accurate language. In this regard, we take our lead from the INPUD and ANPUD Language Statement and Reference Guide.[a] Furthermore, we are committed to being inclusive and anti-racist. We capitalise Black when used in a racial, ethnic or cultural sense, and Indigenous when referring to the original inhabitants of a place.

This report and other *Global State of Harm Reduction* resources can be found at www.hri.global.

METHODS

The information presented in the *Global State of Harm Reduction 2022* has been gathered using two primary research strategies.

Firstly, Harm Reduction International – in collaboration with regional partners – disseminated an extensive survey to community and civil society organisations and other national and regional experts. This survey sought quantitative and qualitative information on the harm reduction services available in each country, region or territory. In 2022, this effort led to contributions from 192 people in 87 countries.

Secondly, researchers undertook an extensive review of research papers and reports from intergovernmental organisations, multilateral agencies, international non-governmental organisations, academics, civil society, harm reduction organisations and networks of people who use drugs.

Epidemiological data in many of the regional chapters has been sourced from two global systematic reviews, supplemented by national or regional published data and experts. These reviews identified the prevalence of injecting drug use, the sociodemographic characteristics of, and risk factors for, people who inject drugs, the prevalence of blood-borne viruses[b], and coverage of needle and syringe programmes (NSP), opioid agonist therapy (OAT), drug consumption rooms (DCRs), HIV testing, antiretroviral treatment (ART) and condom programmes[c].

Figures published through international reporting systems, such as those undertaken by the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Office on Drugs and Crime (UNODC) and the World Health Organization (WHO), may differ from those collated here. This is due to variations in the scopes of monitoring surveys, reliability criteria and regional classifications.

There are still significant gaps in the data, which serve as an important reminder of the need for a greatly improved monitoring and data reporting system on HIV and drug use around the world. A particular concern is the lack of data disaggregated by gender.

Regions have been largely defined using the coverage of regional harm reduction networks. Accordingly, this report examines Asia, Eastern and Southern Africa, Eurasia, Western Europe, Latin America and the Caribbean, North America, Oceania, the Middle East and North Africa, and West and Central Africa. All regional updates have been peer reviewed by experts in the field (see: Acknowledgements).

LIMITATIONS

The report aims to provide a global snapshot of harm reduction policies and programmes; as such it has limitations. It does not comprehensively evaluate the quality of the services in place, although where possible it does highlight areas of concern.

While the *Global State of Harm Reduction 2022* aims to cover important areas for harm reduction, primarily it focuses on public health aspects of the response to drug use. The report does not document all the social and legal harms people who use drugs face, nor does it cover all the health harms related to legal or illegal substance use.

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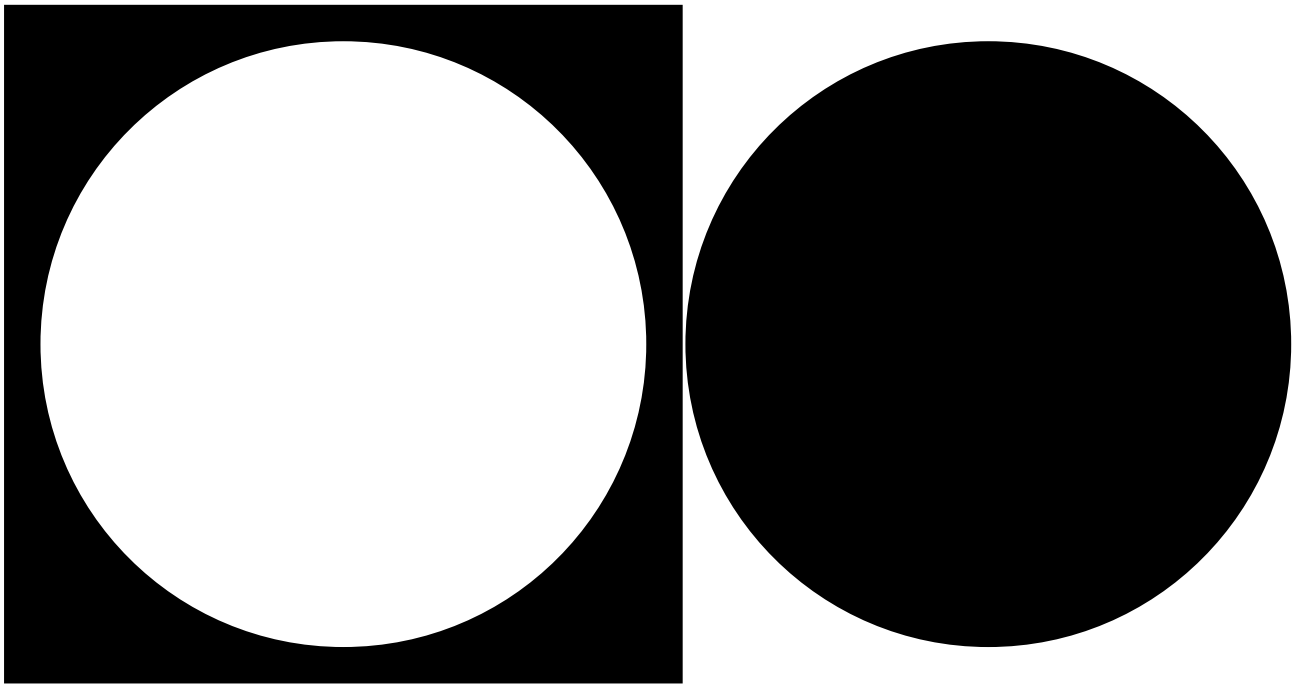

GLOBAL OVERVIEW

HARM REDUCTION INTERNATIONAL

TABLE 1 COUNTRIES OR TERRITORIES EMPLOYING A HARM REDUCTION APPROACH IN POLICY OR PRACTICE

Country/territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room operational	Take home naloxone available	At least one naloxone peer distribution programme operational	At least one safer smoking kit distribution programme	Stimulant prescription available	NSP in at least one prison	OAT in at least one prison
ASIA										
Bangladesh	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Bhutan	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Brunei Darussalam	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Cambodia	✗	✓	✓	✗	✗	✗	✗	✗	✗	✗
China	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Hong Kong	✗	✗	✓	✗	✗	✗	✗	✗	✗	✗
India	✓	✓	✓	✗	✓	✓	✗	✗	✗	✓
Indonesia	✓	✓	✓	✗	✗	✗	✓	✗	✗	✓
Japan	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Laos	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Macau	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Malaysia	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Maldives	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗
Mongolia	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Myanmar	✓	✓	✓	✗	✓	✓	✗	✗	✗	✗
Nepal	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
North Korea	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Philippines	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Singapore	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
South Korea	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Sri Lanka	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Taiwan	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Thailand	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Vietnam	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
EASTERN AND SOUTHERN AFRICA										
Angola	nd	nd	nd	✗	nd	nd	nd	nd	nd	nd
Botswana	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Comoros	nd	nd	nd	✗	nd	nd	nd	nd	nd	nd
Eritrea	nd	nd	nd	✗	nd	nd	nd	nd	nd	nd
Eswatini	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Ethiopia	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Kenya	✓	✓	✓	✗	✓	✓	✗	✗	✗	✓
Lesotho	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Madagascar	nd	nd	nd	✗	nd	nd	nd	nd	nd	nd
Malawi	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗

Country/territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room operational	Take home naloxone available	At least one naloxone peer distribution programme operational	At least one safer smoking kit distribution programme	Stimulant prescription available	NSP in at least one prison	OAT in at least one prison
Mauritius	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Mozambique	✗	✓	✓	✗	✓	✗	✗	✗	✗	✗
Namibia	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Rwanda	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Seychelles	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
South Africa	✓	✓	✓	✗	✓	✓	✗	✗	✗	✗
South Sudan	nd	nd	nd	✗	nd	nd	nd	nd	nd	nd
Uganda	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
United Republic of Tanzania	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Zambia	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Zimbabwe	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
EURASIA										
Albania	✓	✓	✓	✗	✓	✗	✗	✗	✗	✓
Armenia	✓	✓	✓	✗	✗	✗	✗	✗	✓	✓
Azerbaijan	✗	✓	✓	✗	✗	✗	✗	✗	✗	✗
Belarus	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Bosnia and Herzegovina	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Bulgaria	✓	✗	✓	✗	✗	✗	✗	✗	✗	✓
Croatia	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Czechia	✓	✓	✓	✗	✓	✗	✓	✓	✗	✓
Estonia	✓	✓	✓	✗	✓	✗	✓	✗	✗	✓
Georgia	✓	✓	✓	✗	✓	✓	✗	✗	✗	✗
Hungary	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Kazakhstan	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Kosovo	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Kyrgyzstan	✓	✓	✓	✗	✓	✓	✗	✗	✓	✓
Latvia	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Lithuania	✓	✓	✓	✗	✓	✗	✗	✗	✗	✓
Moldova	✓	✓	✓	✗	✓	✗	✓	✗	✓	✓
Montenegro	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
North Macedonia	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Poland	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Romania	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Russia	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗
Serbia	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Slovakia	✓	✓	✓	✗	✗	✗	✓	✗	✗	✗

Country/territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room operational	Take home naloxone available	At least one naloxone peer distribution programme operational	At least one safer smoking kit distribution programme	Stimulant prescription available	NSP in at least one prison	OAT in at least one prison
Slovenia	✓	✓	✓	✗	✓	✓	✓	✗	✗	✓
Tajikistan	✓	✓	✓	✗	✓	✓	✗	✗	✓	✓
Turkmenistan	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Ukraine	✓	✓	✓	✗	✓	✗	✗	✗	✗	✓
Uzbekistan	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
LATIN AMERICA AND THE CARIBBEAN										
Antigua and Barbuda	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Argentina	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗
Bahamas	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Barbados	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Belize	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Bolivia	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Brazil	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗
Chile	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Colombia	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Costa Rica	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Cuba	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Dominican Republic	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
Dominica	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Ecuador	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
El Salvador	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Grenada	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Guatemala	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Guyana	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Haiti	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Honduras	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Jamaica	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Mexico	✓	✓	✓	✓	✓	✓	✗	✗	✗	✗
Nicaragua	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Panama	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Paraguay	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Peru	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Puerto Rico	✓	✓	✓	✗	✓	✓	✗	✗	✗	✗
Saint Kitts and Nevis	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Saint Lucia	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗

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Saint Vincent and the Grenadines	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Suriname	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Trinidad and Tobago	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Uruguay	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Venezuela	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
MIDDLE EAST AND NORTH AFRICA										
Afghanistan	✓	✓	✓	✗	✓	✓	✗	✗	✗	✓
Algeria	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Bahrain	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Djibouti	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Egypt	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
Iran	✓	✓	✓	✗	✓	✓	✗	✗	✗	✓
Iraq	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Israel	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Jordan	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Kuwait	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Lebanon	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Libya	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Morocco	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Oman	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Pakistan	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
Palestine	✓	✗	✓	✗	✗	✗	✗	✗	✗	✓
Qatar	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Saudi Arabia	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Somalia	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Sudan	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Syria	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Tunisia	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
United Arab Emirates	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Yemen	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
NORTH AMERICA										
Canada	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
United States of America	✓	✓	✓	✓	✓	✓	✓	✗	✗	✓

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OCEANIA										
Aotearoa-New Zealand	✓	✓	✓	✗	✓	✓	✗	✗	✗	✓
Australia	✓	✓	✓	✓	✓	✓	✗	✗	✗	✓
Federated States of Micronesia	✗	nd	✗	✗	nd	nd	nd	nd	nd	nd
Fiji	✗	nd	✗	✗	nd	nd	nd	nd	nd	nd
Kiribati	✗	nd	✗	✗	nd	nd	nd	nd	nd	nd
Marshall Islands	✗	nd	✗	✗	nd	nd	nd	nd	nd	nd
Nauru	✗	nd	✗	✗	nd	nd	nd	nd	nd	nd
Palau	✗	nd	✗	✗	nd	nd	nd	nd	nd	nd
Papua New Guinea	✗	nd	✗	✗	nd	nd	nd	nd	nd	nd
Samoa	✓	nd	✗	✗	nd	nd	nd	nd	nd	nd
Solomon Islands	✗	nd	✗	✗	nd	nd	nd	nd	nd	nd
Timor Leste	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Tonga	✗	nd	✗	✗	nd	nd	nd	nd	nd	nd
Tuvalu	✗	nd	✗	✗	nd	nd	nd	nd	nd	nd
Vanuatu	✓	nd	✗	✗	nd	nd	nd	nd	nd	nd
WEST AND CENTRAL AFRICA										
Benin	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
Burkina Faso	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Burundi	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Cameroon	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Cape Verde	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Central African Republic	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Chad	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Congo	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Cote d'Ivoire	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Democratic Republic of the Congo	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Equatorial Guinea	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Gabon	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Gambia	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Ghana	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Guinea	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
Guinea-Bissau	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Liberia	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗

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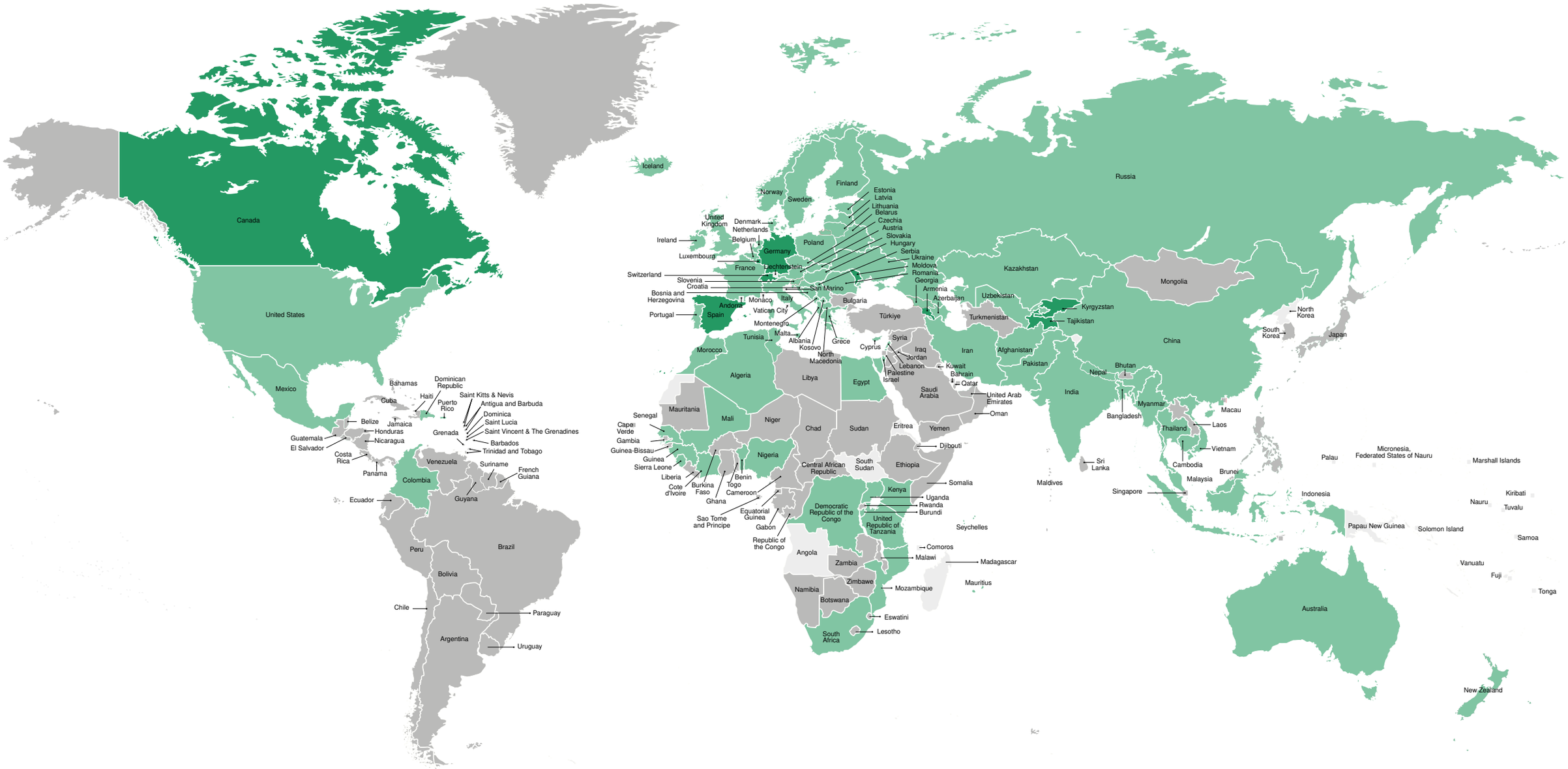
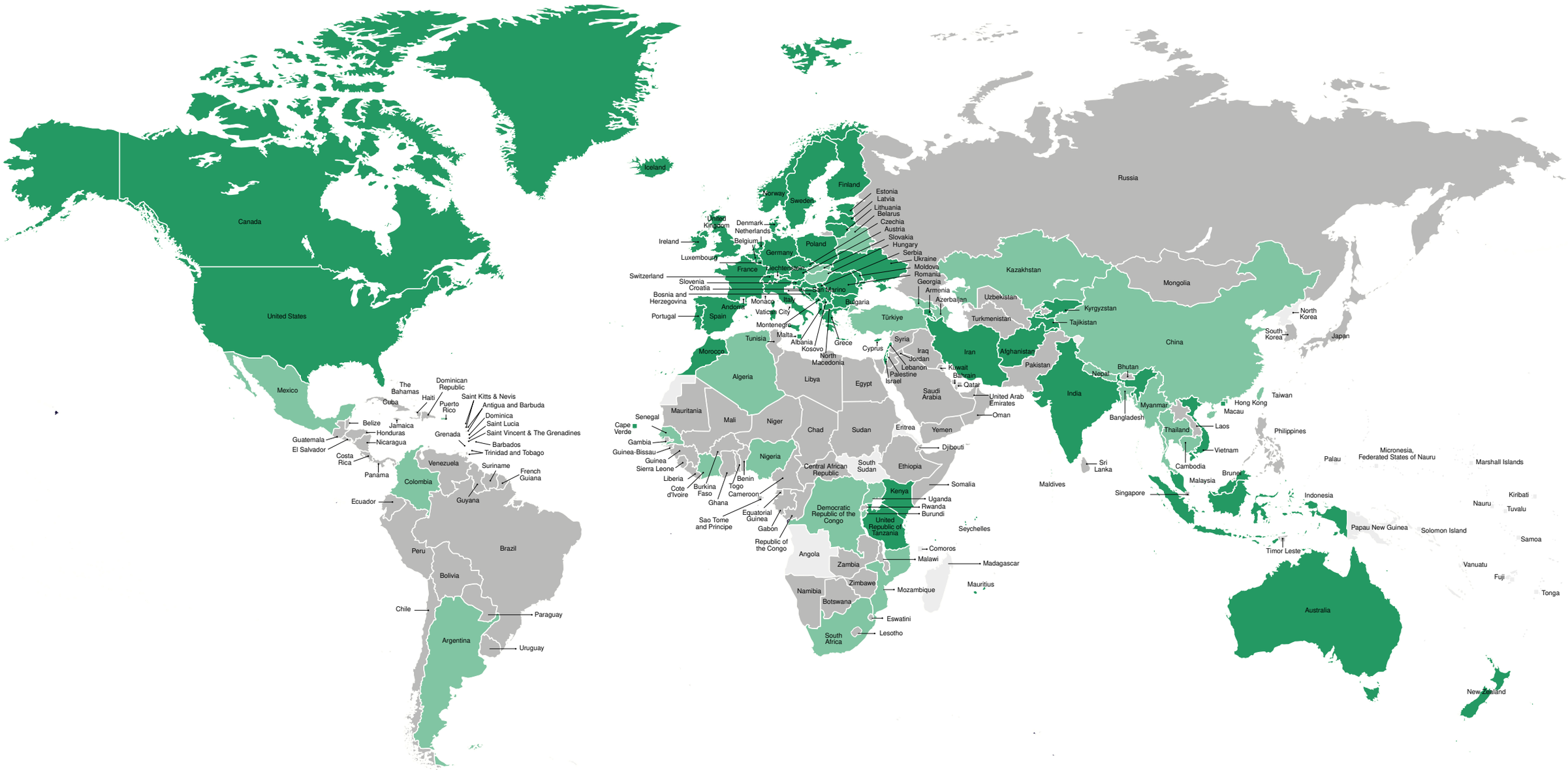
Mali	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
Mauritania	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Niger	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Nigeria	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Sao Tome and Principe	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Senegal	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Sierra Leone	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
Togo	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
WESTERN EUROPE										
Andorra	nd	nd	nd	✗	nd	nd	nd	nd	nd	nd
Austria	✓	✓	✓	✗	✓	✓	✓	✗	✗	✓
Belgium	✓	✓	✓	✓	✗	✗	✓	✗	✗	✓
Cyprus	✓	✓	✓	✗	✓	✗	nd	✗	✗	✓
Denmark	✓	✓	✓	✓	✓	✗	nd	✗	✗	✓
Finland	✓	✓	✓	✗	✗	✗	nd	✗	✗	✓
France	✓	✓	✓	✓	✓	✗	✓	✗	✗	✓
Germany	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
Greece	✓	✓	✓	✓	✗	✗	nd	✗	✗	✓
Iceland	✓	✓	✓	✓	✗	✗	nd	✗	✗	✓
Ireland	✓	✓	✓	✗	✓	✗	nd	✗	✗	✓
Italy	✓	✓	✓	✗	✓	✓	✓	✗	✗	✓
Liechtenstein	nd	nd	nd	✗	nd	nd	nd	nd	nd	nd
Luxembourg	✓	✓	✓	✓	✗	✗	nd	✗	✓	✓
Malta	✓	✓	✓	✗	✗	✗	nd	✗	✗	✓
Monaco	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Netherlands	✓	✓	✓	✓	✗	✗	✓	✗	✗	✓
Norway	✓	✓	✓	✓	✓	✗	nd	✗	✗	✓
Portugal	✓	✓	✓	✓	✓	✓	✓	✗	✗	✓
San Marino	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Spain	✓	✓	✓	✓	✓	✗	✓	✗	✓	✓
Sweden	✓	✓	✓	✗	✓	✗	nd	✗	✗	✓
Switzerland	✓	✓	✓	✓	✗	✗	✓	✗	✓	✓
Türkiye	✗	✗	✓	✗	✗	✗	nd	✗	✗	✗
United Kingdom	✓	✓	✓	✗	✓	✓	✓	✗	✗	✓
GLOBAL TOTAL	**104**	**92**	**87**	**16**	**35**	**21**	**19**	**2**	**9**	**59**

M1.1 GLOBAL AVAILABILITY OF NEEDLE AND SYRINGE PROGRAMMES (NSPs) IN THE COMMUNITY AND IN PRISONS



- NSP available in the community
- NSP available in the community and prison
- NSP not available

M1.2 GLOBAL AVAILABILITY OF OPIOID AGONIST THERAPY (OAT) IN THE COMMUNITY AND IN PRISONS

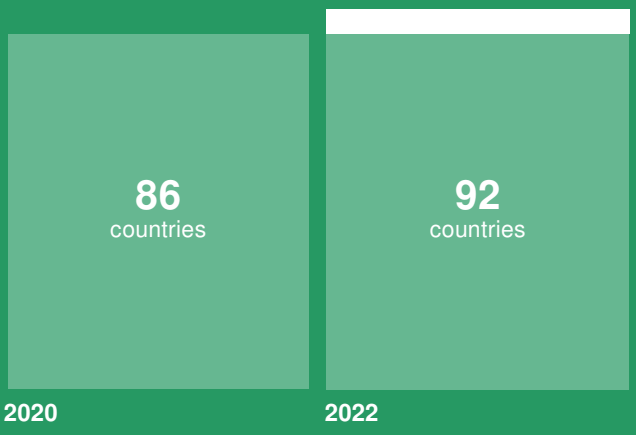


- OAT available in the community
- OAT available in the community and prison
- OAT not available

HARM REDUCTION INTERVENTIONS FROM 2020 TO 2022

NEEDLE AND SYRINGE PROGRAMMES (NSPs)

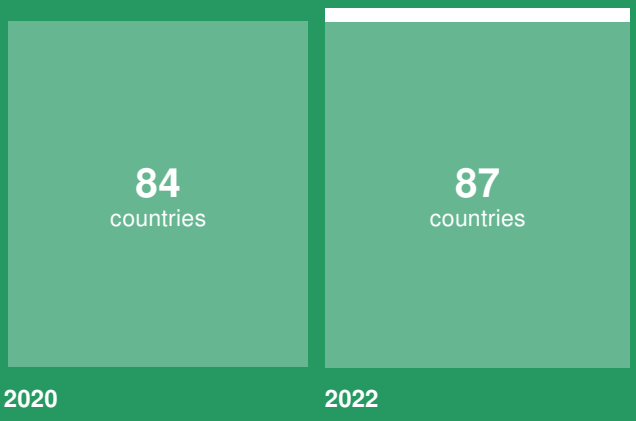
92 countries with at least one NSP in 2022



*Additionally, in Seychelles NSP has been available since 2016, but this was unreported in previous editions of the *Global State of Harm Reduction.*

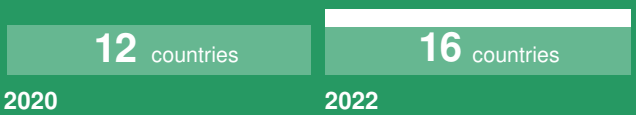
OPIOID AGONIST THERAPY (OAT)

87 countries with at least one OAT programme in 2022



DRUG CONSUMPTION ROOMS (DCRs)

16 countries with legal and operational DCRs in 2022



HARM REDUCTION IS STRONGER THAN IN 2020

The period from 2020 to 2022 has seen increased uptake of harm reduction interventions. For the first time since 2014, the *Global State of Harm Reduction* has found an increase in the number of countries implementing key harm reduction services.

This growth has been driven by new needle and syringe programmes (NSPs) opening in five African countries as well as four new countries having officially sanctioned drug consumption rooms (DCRs).[a] This includes a site in Mexico that had been operating without formal approval since 2018 but now has approval from local authorities. Three countries have introduced opioid agonist therapy (OAT) for the first time.

No country has stopped the implementation of NSP, OAT or DCRs since 2020.

In 2022, we identified:

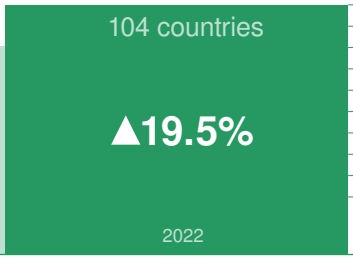
- 92 countries implementing at least one NSP (up from 86 in 2020)
- 87 countries with at least one OAT programme (up from 84 in 2020)
- 16 countries with legal and operational DCRs (up from 12 in 2020).

The number of countries providing naloxone on a take-home basis and through peer-distribution models has also increased. Changes in definitions and research strategies make year-on-year comparisons difficult, but the *Global State of Harm Reduction 2022* finds there are 35 countries where take-home naloxone is available, and 21 countries operating peer-distribution naloxone programmes. However, these programmes are often on a very small scale and highly vulnerable to regulatory or funding changes, especially those in low- and middle-income countries such as Iran, Kenya and South Africa.

An unprecedented 104 countries are now reported to include supportive references to harm reduction in national policy documents, compared with 87 in 2020.

The overall increase in the commitment to and implementation of harm reduction is a testament to the dedication, resilience and strength of community, civil society and international organisations, which have successfully advocated for a health and human rights-based approach to drug use despite extremely limited resources.

Supportive references to harm reduction in national policy documents



EASTERN AND SOUTHERN AFRICA	9
WESTERN AND CENTRAL AFRICA	11
ASIA	13
EURASIA	26
LATIN AMERICA AND THE CARIBBEAN	5
MIDDLE EAST AND NORTH AFRICA	15
NORTH AMERICA	2
OCEANIA	4
WESTERN EUROPE	19
Total	**104**

a The legal status of DCRs varies globally. The *Global State of Harm Reduction* includes in its count those facilities that have official backing from state authorities at either the national, sub-national or city level.

"The overall increase in the commitment to and implementation of harm reduction is a testament to the dedication, resilience and strength of community, civil society and international organisations, which have successfully advocated for a health and human rights-based approach to drug use despite extremely limited resources."

UNEQUAL RESOURCES, UNEQUAL PROGRESS

Nevertheless, the harm reduction movement cannot be complacent. The coverage and scale of harm reduction is still limited, and great inequalities remain within and between regions and countries in terms of access.

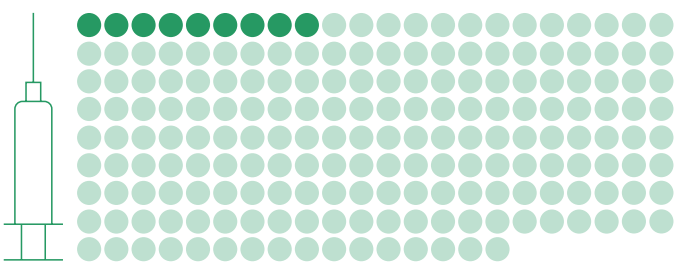
While the vast majority of countries in Eurasia, North America and Western Europe implement both NSP and OAT, these programmes are more absent than they are present in all regions of Africa, Latin America and the Caribbean, and the Middle East. Only North America, Oceania, Western Europe, and Mexico have officially sanctioned DCRs, and even in these countries support may be from local or state government rather than at the national level.

Even in countries where harm reduction programmes are implemented, availability, accessibility and quality remain significant issues. Services are unevenly distributed in most countries. People living in rural areas or outside capital cities, for example, are often poorly served.

Around the world, people who use drugs continue to face criminalisation, stigma and discrimination that prevents access to services. Certain populations experience these barriers particularly acutely; most notably, women, LGBTQI+ people, people who are migrants or refugees, young people, and Black, Brown, and Indigenous people, all of whom face a lack of services tailored to their needs.

"Around the world, people who use drugs continue to face criminalisation, stigma and discrimination that prevents access to services. Certain populations experience these barriers particularly acutely; most notably, women, LGBTQI+ people, people who are migrants or refugees, young people, and Black, Brown, and Indigenous people, all of whom face a lack of services tailored to their needs."

Needle and syringe programmes (NSPs) in prisons



EURASIA Kyrgyzstan, Moldova, Armenia, Tajikistan	4
NORTH AMERICA Canada	1
WESTERN EUROPE Germany, Luxembourg, Spain and Switzerland	4
Total	**9**

b In 2018 and 2020, the *Global State of Harm Reduction* reported the existence of prison NSP in North Macedonia. However, new reports from national civil society organisations show that prison NSP never been meaningfully implemented in the country.

Harm reduction in prisons has seen little expansion since 2020. Still, only 9 countries operate NSPs in prisons: Armenia, Canada, Germany, Kyrgyzstan, Luxembourg, Moldova, Spain, Switzerland and Tajikistan.[b] Canada has the world's only prison based DCR. The number of countries providing OAT in prisons is unchanged at 59. While OAT programmes are now operating in prisons in Kosovo, Macau, and Tanzania, this is balanced by new data indicating that prisons in Georgia, Hungary and Jordan only offer opioid agonists for detoxification.

HARM REDUCTION IN TIMES OF CRISIS

Since 2020, the world has experienced several acute crises which have tested the resilience of harm reduction services. The COVID-19 pandemic has continued to have a dramatic impact on harm reduction and public health. Many services were forced to close or reduce their operations during the worst of the pandemic, while lockdown orders and emergency powers resulted in the securitisation and militarisation of public health, which had a heavy impact on people who use drugs.[1,2] Nevertheless, harm reduction services, particularly those led by the community of people who use drugs and civil society, adapted to ensure they could still operate throughout the COVID-19 pandemic, for example, by increasing access to take-home OAT and naloxone (see the COVID-19 chapter, page 33). It is essential that community and civil society – which in many cases were the frontline of the COVID-19 response – are included in international conversations and decision making about pandemic preparedness, notably the proposed Pandemic Treaty.[3]

Economic, political, humanitarian, and environmental crises have also put harm reduction at risk. In Afghanistan, the Taliban retook control of the country in August 2021, which has had a significant impact on harm reduction service provision (see Spotlight: Afghanistan, page 105). Russia's invasion of Ukraine in February 2022 has caused Europe's largest movement of refugees since the Second World War[4] and put harm reduction services in Ukraine and neighbouring countries under immense pressure. Community and civil society organisations have continued to provide harm reduction services during this economic and humanitarian crisis (see Spotlight: Ukraine, page 80). In Lebanon, the COVID-19 pandemic and a major explosion in the port of Beirut led to an economic crisis and shortages of essential OAT medications in 2021. A coalition of national, regional and global civil society and community-led organisations reached an agreement with pharmaceuticals company Ethypharm and the Lebanese government to import a donation of buprenorphine to mitigate the impact of the shortage (see Spotlight: Lebanon's OAT Shortage, page 103).[5] In Sri Lanka, economic and political crises resulted in shortages of essential medicines and limited the operations of essential health services, including harm reduction.[6] Climate crisis and extreme weather, including flooding, wildfires, droughts and heatwaves, have created acute public health disasters across the globe which have affected vulnerable populations, including people who use drugs, people in prison and detention and people experiencing homelessness.[7,8,9,10]

Since May 2022, the world faced another public health challenge in the form of an ongoing outbreak of monkeypox. The outbreak has particularly affected gay men and other men who have sex with men. Within days of the outbreak being confirmed, the harm reduction movement and LGBTQI+ communities were already responding with advice on harm reduction and avoiding infection.[11,12]

The community and civil society organisations that make up the harm reduction movement have met all of these crises with compassion, dedication and resilience. With or without the support of the state, civil society and peer support groups have mobilised to ensure that as many people as possible continue to access lifesaving and life-enhancing harm reduction services.

"The community and civil society organisations that make up the harm reduction movement have met all of these crises with compassion, dedication and resilience. With or without the support of the state, civil society and peer support groups have mobilised to ensure that as many people as possible continue to access lifesaving and life-enhancing harm reduction services."

DECOLONISING DRUG POLICY AND BUILDING AN ANTI-RACIST HARM REDUCTION MOVEMENT

In the *Global State of Harm Reduction 2020* we reported on the wave of reflection on racism and colonialism that followed the murder of George Floyd by a police officer in Minneapolis, United States. These shifts have continued to influence thinking about drug policy and harm reduction globally.[13,14,15,16,17]

In November 2021, a group of advocates and academics published a paper detailing the ways in which drug policy has been used to uphold colonial and racist power structures around the world.[15] Over recent years, this has been a theme of advocacy and research carried out by many organisations in different countries, including Bolivia, Brazil, Indonesia, South Africa and the United States.[13,14,18,19,20,21,22]

The implementation of harm reduction continues to be affected by racism and colonial structures. Black, Brown and Indigenous people who use drugs have less access to harm reduction services.[15] Direct and structural racism makes it harder for Black, Brown and Indigenous people to access services, it results in Black, Brown and Indigenous communities being targeted by drug law enforcement agencies and disproportionately detained or imprisoned, and means the needs of these communities are often deprioritised or ignored.[23] People who are migrants or refugees face particular challenges, to the extent that experiencing migration can be a major detriment to a person's health.[24]

There are strong examples of harm reduction organisations leading the way on providing actively anti-racist services. For example, the Canberra Alliance for Harm Minimisation and Advocacy in Australia provides harm reduction services specifically tailored to the needs and practices of Indigenous communities.[25]

REACHING UNDERSERVED COMMUNITIES

The movement to build an anti-racist harm reduction movement is just one example of the efforts documented in this report to reach people who have historically been underserved by harm reduction.

For the first time, the *Global State of Harm Reduction 2022* has collected country-by-country data on the provision of safer smoking kits and pharmacotherapy for people who smoke drugs and use stimulants. Our research has found that safer smoking kits are distributed in 19 countries around the world[f], and 2 countries (Canada and Czechia) have nascent stimulant pharmacotherapy programmes.

The needs of women who use drugs remain gravely under-addressed in most contexts. As reported in every regional chapter of this report, community and civil society actors observe that women who use drugs face consistently higher

c These are Austria, Belgium, Brazil, Canada, Czechia, Estonia, France, Germany, Italy, Indonesia, Moldova, the Netherlands, Portugal, Slovakia, Slovenia, Spain, Switzerland, the United Kingdom and the United States.

barriers to harm reduction services than men, and that there is a lack of services specifically tailored to women's needs. Pregnant and parenting people face particularly acute stigma and discrimination when accessing harm reduction services, despite all evidence indicating that parental substance use is best addressed by harm reduction.[26,27] People engaged in sex work, despite being formally prioritised as a key population in global policy documents, face criminalisation which hinders access to health and harm reduction practices and services.[28] The efforts of global networks, such as the Women and Harm Reduction International Network and Women4GlobalFund, have been important in raising awareness of these inequities.

"Women who use drugs face consistently higher barriers to harm reduction services than men, and there is a lack of services specifically tailored to women's needs. Pregnant and parenting people face particularly acute stigma and discrimination when accessing harm reduction services, despite all evidence indicating that parental substance use is best addressed by harm reduction"

FAILURE TO FUND: THE CONTINUED CRISIS FOR HARM REDUCTION

Harm Reduction International has been monitoring investment in harm reduction for more than a decade[d]. Findings have been consistently dire, and this remains the case in the latest research. Still, only a few international donors fund harm reduction, and their investment appears to be shrinking. In low- and middle-income countries, funding for harm reduction is only 5% of the level needed to meet the estimated service needs for people who inject drugs by 2025. Sadly, the gap between the funding that is required and the funding that is available has only grown wider in recent years.[29]

In September 2022, the seventh replenishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) took place. The replenishment raised USD 14.25 billion, falling short of the target of USD 18 billion.[30] Nineteen donors[e] increased their pledge by 30%, including the European Union and Germany – a testament to sustained civil society advocacy. There was outstanding leadership from 13 African governments,[f] which together pledged more than USD 50 million. With 60% of harm reduction funding in low- and middle-income countries coming from the Global Fund, it is essential that harm reduction funding is protected from the shortfall in the replenishment.[31]

The funding gap for harm reduction in low- and middle-income countries is widening

Funding for harm reduction is only 5% of the level required in low- and middle-income countries

d For more information on funding for harm reduction, see Harm Reduction International's 2021 funding report, *Failure to Fund: The continued crisis for harm reduction in low- and middle-income countries,* available at www.hri.global/failure-to-fund.

e These were Belgium, Burkina Faso, Cote d'Ivoire, European Commission, Germany, Ireland, Kenya, South Korea, Kuwait, Portugal, Rwanda, Saudi Arabia, South Africa, Spain, Togo, Uganda, CIFF (Children Investment Fund Foundation), Rotary Australia World Community Service and Rotarians Against Malaria.

f These were Burkina Faso, Central African Republic, Côte d'Ivoire, Malawi, Zimbabwe, Tanzania, Uganda, Nigeria, Eswatini, South Africa, Togo, Rwanda and Kenya.

Research by Harm Reduction International in 2016 found that fully funding an effective harm reduction response would be achievable by redirecting just 7.5% of the funds spent on drug law enforcement towards harm reduction.[32,33] Six years later, funding for drug law enforcement still dwarfs investment in harm reduction. Globally, USD 100 billion is spent on drug law enforcement, and just USD 131 million is spent on harm reduction.[29,32]

Of particular concern is the shrinking investment in advocacy for harm reduction. Community-led advocacy is particularly underfunded. Opportunities for funding of harm reduction advocacy via multi-country grants from the Global Fund have significantly reduced, despite their positive impact.[34] Without advocacy for national investment in harm reduction, services in low- and middle-income countries will continue to be reliant on a shrinking pool of international funding. Adding to this, Open Society Foundations, a key funder of drug policy reform and harm reduction advocacy, has undergone structural and organisational changes which could have implications for its funding in this area.

Some donors have slightly increased their funding for harm reduction. These include the Elton John AIDS Foundation, the Robert Carr Fund and ViiV Healthcare Positive Action.[35,36]

HUMAN RIGHTS AND HARM REDUCTION

Harm reduction is a human right. It is recognised as a vital component of the right to the highest attainable standard of health for people who use drugs.[37] Denial of access to harm reduction, including in detention settings, violates the prohibition of torture and other cruel, inhuman and degrading treatment.[38,39]

In her May 2022 report on human rights and HIV, the United Nations High Commissioner for Human Rights, Michelle Bachelet, noted the barriers to harm reduction access created by the criminalisation, stigmatisation and marginalisation of people who use drugs.[40] The report highlights the human rights violations faced by women and trans people who use drugs; notably physical and sexual violence, which exacerbate both groups' vulnerability to HIV. This theme was also addressed by 18 human rights and harm reduction organisations in a joint statement to the 50th Session of the Human Rights Council (2022), which highlighted the disproportionate impact of the COVID-19 pandemic and government responses on the rights of marginalised and criminalised populations, including people who use drugs, people who sell sex and LGBTQI+ people.[41]

In June 2022, UN human rights experts[g] called for an end to the 'war on drugs', stating: 'Data and experience accumulated by UN experts have shown that the "war on drugs" undermines health and social wellbeing and wastes public resources while failing to eradicate the demand for illegal drugs and the illegal drug market.' The statement also emphasised the responsibility of the UN system, the international community and individual UN member states to reverse the devastation.[42]

Human rights violations continue to be committed worldwide in the name of drug control. These include, among many others, the denial of access to harm reduction services, including through the criminalisation of drug paraphernalia (such as syringes and pipes), the prohibition of OAT (for example, in Russia), and discrimination against people who use drugs in the provision of HIV and viral hepatitis care.[43]

g The statement was issued jointly by the Working Group on Arbitrary Detention, the Working Group on discrimination against women and girls, the Special Rapporteur on the Right to Health, the Special Rapporteur on the right to adequate housing, the Working Group of Experts on People of African Descent, the Special Rapporteur on the rights to freedom of peaceful assembly and of association, the Special Rapporteur on the implications for human rights of the environmentally sound management and disposal of hazardous substances and wastes, the Independent Expert on the enjoyment of all human rights by older persons, the Special Rapporteur on contemporary forms of slavery including its causes and consequences, the Special Rapporteur on the situation of human rights in the Islamic Republic of Iran, the Special Rapporteur on trafficking in persons, especially women and children, the Special Rapporteur on extrajudicial, summary or arbitrary executions, and the Special Rapporteur on violence against women.

As of 2021, 35 countries retained the death penalty for drug offences. At least 131 people were executed for drug offences in 2021. Due to a lack of transparency, and even censorship, this figure is likely to represent only a fraction of all drug-related executions. There was an 11% increase in known death sentences for drug offences from 2020 to 2021, with at least 237 death sentences handed down in 16 countries. Roughly 10% of all drug-related death sentences confirmed in 2021 were handed to foreign nationals, raising significant fair trial and human rights concerns.[44] Despite the progress towards abolishing the death penalty for drug offences that some countries have made (such as in Malaysia),[45] it remains a tool of drug control in many others. Indeed, in some countries, there are ongoing national-level discussions to reinstate or introduce the death penalty for drug offences (such as in the Philippines and Tonga).[44,46,47]

POLITICS AND POLICY

Since 2020, there have been significant policy and political developments at the national and international level that may have implications for harm reduction implementation.

At the national level, elections in Colombia and the United States saw the inauguration of presidents who have made commitments in favour of a health-based approach to drug use. In the Philippines, Rodrigo Duterte was ineligible to stand for election due to the country's single-term limit, thus ending a presidency that had waged a drug war responsible for up to 30,000 extrajudicial killings.[48] However, human rights abuses against people who use drugs and people involved in the drug trade continue in the country.[49]

THE GLOBAL DRUG POLICY INDEX (GDPI)

In 2021, a consortium of harm reduction organisations launched the Global Drug Policy Index (GDPI).[h] The GDPI is the world's first accountability and evaluation mechanism to assess national drug policies. Its aim is to promote and measure countries' alignment with United Nations' recommendations on health, human rights and development.

The 2021 index evaluated 30 countries around the world. It is composed of 75 indicators across five dimensions: (1) absence of extreme responses, (2) proportionality and criminal justice, (3) harm reduction, (4) access to medicines, (5) development. Of the 30 countries, Norway, New Zealand and Portugal received the highest average scores across all dimensions, while Indonesia, Uganda and Brazil received the lowest scores of the 30 countries included in the index.

In the harm reduction dimension, Norway, Portugal and the United Kingdom scored highest, and Brazil, Ghana and Uganda scored lowest, among the 30 countries.

h This consortium consisted of the Eurasian Harm Reduction Association, the Eurasian Network of People who Use Drugs, the European Network of People who Use Drugs, the Global Drug Policy Observatory, Harm Reduction International, the International Drug Policy Consortium, the Middle East and North Africa Harm Reduction Association, the West African Drug Policy Network, the Women and Harm Reduction International Network and Youth Rise. The consortium was funded by the Robert Carr Fund.

The Russian government has continued to be an obstacle to evidence-based, rights-based drug policy at the international level, most notably at the United Nations Commission on Narcotic Drugs (CND), the governing body of the United Nations Office on Drugs and Crime (UNODC). Following the Russian invasion of Ukraine, Latvia challenged Russia's nomination to represent the Eastern European Group in the working group responsible for overseeing UNODC's finances and governance ('FINGOV'). The Latvian Ambassador stated: "I believe that a representative of a country that is being more and more isolated because of its aggression against Ukraine would not be the best adviser on implementation of regional and global programmes." In response, the Russian delegation forced a vote on the issue. This represented an extraordinary break with the longstanding consensus that has governed the CND's procedures and caused unprecedented friction between member states' delegations, which may have long-term implications on the governance of drug policy at CND.[50] Russia has also continued to block harm reduction civil society organisations from gaining Special Consultative Status with the Economic and Social Council of the United Nations.[36]

Elsewhere at the United Nations, in 2021, the Joint United Nations Programme on HIV and AIDS (UNAIDS) launched the *Global AIDS Strategy 2021-2026: End Inequalities. End AIDS.* The strategy focuses on closing gaps in the accessibility of HIV prevention, treatment and care, drawing attention to the needs of key populations (including people who use drugs) and regions where resources and political will are inadequate for an effective response to HIV.[51] In addition, to mark International Drug Users' Day in November 2021, UNAIDS issued a statement reaffirming its commitment to the decriminalisation of people who use drugs and the promotion of community-led services.[52]

At the World Health Organization (WHO), the 2022 session of the World Health Assembly (WHA) passed a resolution to ensure the WHO Director General continues to report to the WHA every two years on how the WHO is addressing the public health dimensions of drug use.[53] The WHO also launched the new *Global Health Sector Strategies (2022-2030)* on HIV, viral hepatitis and sexually transmitted infections, which include commitments to harm reduction for people who use or inject drugs and tailored interventions for people who use stimulants.[54]

In 2022, the Global Fund also launched a new strategy for 2023 to 2028. Notably, the strategy explicitly commits the Global Fund to the engagement and leadership of key populations to broaden and improve service provision.[55] However, the Global Fund Advocates Network has criticised the strategy as it does not include a goal for funding services that fit this commitment.[56]

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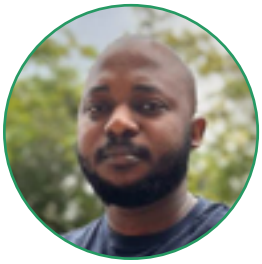
COVID-19

BY
TEMITOPE SALAMI



OVERVIEW

The COVID-19 pandemic has continued to put a strain on the health and lives of people who use drugs and on harm reduction service delivery.[1] The Global State of Harm Reduction 2020 documented the ways in which the COVID-19 pandemic created new challenges for harm reduction services and people who use drugs, while also reporting on the innovation and flexibility of community and civil society organisations in responding to these challenges.[2] Harm reduction services have now had time to shift and institutionalise adaptations to service provision (such as mobile and online outreach programmes, telehealth services, take-home treatment options and 24 hour needle and syringe dispensaries). Yet more work is required to ease the unintended consequences of the COVID-19 pandemic on social and healthcare service provision for people who use drugs, particularly in low-income countries.

Despite improvements in harm reduction services in some regions, the challenges that the COVID-19 pandemic has brought still exist in many countries. Lack of information, and the spread of misinformation, has undermined confidence in the safety of COVID-19 vaccines, and vaccine hesitancy has contributed to low uptake of the COVID-19 vaccine among people who use drugs.[3–5] Other challenges include stigma, structural barriers to health and global inequity in vaccine availability.[1,6] When it comes to vaccine equity, there is an overall disparity between regions. Data from the United Nations Development Programme (UNDP) indicates that approximately 72% of people in high-income countries (or 3 in 4) have been vaccinated with at least one dose, but in low-income countries only 24% of people (or 1 in 4) have been vaccinated (as of September 2022).[7] Around the world, the COVID-19 pandemic's impact on new patterns of drug use is now recognised. For example, the risk of overdose has increased due to social isolation and physical distancing,[6,8,9] and women who use drugs have been disproportionately affected by the pandemic's negative consequences.[6,10–13] But there have also been positive effects, such as the emergence of innovative adaptations in harm reduction service provision.[3]

Despite the wave of disruptions to essential community care caused by the COVID-19 pandemic, many service providers, especially peer-led services, demonstrated resilient leadership by responding quickly and adapting service delivery. Innovative service options were provided to clients, such as online support and take-home doses of opioid agonist therapy (OAT) and naloxone. These actions ensured many people continued to access essential harm reduction interventions.

During a special session held in December 2021, the World Health Assembly (WHA) agreed upon the development of an international instrument on pandemic preparedness. The pandemic treaty, which is still under development, will set binding rules for the international community on preventing, responding to and recovering from future pandemics. However, community and civil society groups have had limited opportunities to meaningfully engage with policymakers at all levels of decision-making on the issue of better pandemic preparedness. Recognising the essential role that community and civil society played in the response to the COVID-19 pandemic, and the lessons learned from

this, a broad range of health-focused civil society (including communities and civil society from the harm reduction movement) are actively engaged in, and advocating for, the meaningful participation of community and civil society in the pandemic treaty drafting process.[14]

To build on gains made in harm reduction since 2020, countries must categorise harm reduction as an essential public health service during crises;[15] community-led organisations must be involved at the highest levels of decision-making, and governments must safeguard and improve funding for low-threshold harm reduction programmes. Research and development of guidelines on the effectiveness of take-home medications or other adaptations in OAT, needle and syringe programmes (NSPs) and naloxone delivery should be sustained and advanced. Integration of information on COVID-19, prevention and vaccine access into harm reduction programming and ongoing community guidance is critical to sustain progress in harm reduction provision.

In many countries, a lack of both transparency and resources hinders the collection and publication of accurate data on the state of COVID-19 vaccinations in prisons. Prison vaccination plans vary significantly; as of September 2021, only 20 countries had enabled 80% (or more) of people in prison to receive at least one dose of a COVID-19 vaccine.[16]

"To build on gains made in harm reduction since 2020, countries must categorise harm reduction as an essential public health service during crises"

ASIA

Overall, COVID-19 has led to major setbacks for harm reduction programmes in Asia, with NSP and OAT services incapable of meeting demand due to government restrictions, staff and equipment shortages, and inadequate funding for harm reduction.[17]

In Bangladesh, India, Indonesia, Malaysia, Myanmar, Nepal, Pakistan, Philippines, Thailand and Vietnam, many drop-in centres offering NSPs have remained closed long after lockdown measures eased due to lack of funding.[17–19] In India, COVID-19-related containment measures caused supply chain disruptions in OAT provision, resulting in massive delays to meeting demand and restarting services.[17] Despite the suspension of face-to-face services, peer educators in Bangladesh, Myanmar and Nepal initiated secondary distribution of needles and syringes to people who were unable to access NSPs. In Myanmar, peer-led programmes ensured people were provided with sufficient take-home doses of OAT. In Nepal, the success of peer-led, take-home OAT has led to new guidelines being developed for future programming.[18–20]

Still, many people who use drugs do not have the same level of access to COVID-19 prevention, testing, treatment and care. Due to abstinence requirements in many countries, people experiencing homelessness who also use drugs cannot access housing unless they stop using drugs. In Macau, availability of public housing is critical for accessing COVID-19 services in state-led programmes as people need to provide an address for contact-tracing and treatment.[21] Where people who use drugs can access COVID-19 services, uptake is often low due to stigma and fear of incarceration. Recent reports suggest vaccinations are available in some prisons in Sri Lanka and Nepal,[19,22] but are not available in most prisons across the region.

EASTERN AND SOUTHERN AFRICA

The pandemic has had far-reaching consequences for harm reduction service availability in the region. In South Africa, limited coverage in NSP and OAT provision continued into 2021;[23,24] access to methadone was nearly impossible outside dispensaries and treatment centres, meaning most people were unable to get their medication.[23] During Mauritius' lockdown, in certain regions civil society advocacy led to the ban being lifted on NSPs and the secondary distribution of syringes by peers.[25] The COVID-19 pandemic has had a debilitating impact on HIV and harm reduction services for women who use drugs in Kenya, as limited operating hours, fewer outreach programmes and economic challenges resulted in poorer access to services and increased risk-taking, including engaging in sex work. Other clients have been displaced into rural areas where services are unavailable.[11,13]

Nevertheless, in Eastern and Southern Africa, the realities of the COVID-19 pandemic catalysed service adaptations and advanced the debate around take-home OAT doses. Indeed, the provision of take-home OAT increased substantially in the region between 2020 and 2022.[13,23–25] Advocacy from community and civil society groups led to the NSP programme in eThekwini (Durban), South Africa being reinstated after 18 months of COVID-19-related suspension.[24]

There are also examples of effective, low-threshold service adaptations implemented during the COVID-19 pandemic being continued after the acute phase of the crisis had passed.[3] This includes services at the Bellhaven Harm Reduction Centre, a low-threshold community space in Durban, South Africa which provide a range of evidence-based HIV, harm reduction and health-related services, including an NSP and OAT. In 2020, Bellhaven served up to 175 people per day.

In Kenya, the Kenyan Network of People Who Use Drugs' (KenPUD) peer-to-peer model, which focuses on supporting groups of women who use drugs, has integrated COVID-19-related information and support into broader programming. KenPUD offers evidence-based information about COVID-19 vaccines, with tailored messages in Kiswahili and English, at the beginning and end of peer support meetings.

EURASIA

The impact of the COVID-19 pandemic on harm reduction services in the region was dwarfed by Russia's invasion of Ukraine in February 2022, which caused unthinkable death and damage and has displaced at least 14 million people.[26] Despite the best efforts of community and civil society, many people lack access to health services (e.g. support, NSPs and HIV prevention). Antiretroviral therapy (ART) and OAT provision is less available for displaced people and people who have sought refuge in neighbouring countries (with the exception of Poland and Romania where these medicines are available, but there are concerns about continuity due to limited funding), although the majority of the 17,000 people receiving OAT in Ukraine before the invasion were men,[27] and men are not allowed to leave the country.[28] Many HIV and harm reduction services have been re-established in Lviv, in Western Ukraine (see Spotlight: Ukraine, page 80).[29–31]

As in other regions, the COVID-19 pandemic has caused both positive and negative changes in Eurasia. Among positive developments, the digitisation of harm reduction information and services has expanded the pool of clients and made services more accessible.[34] In Czechia, more harm reduction programmes have been introduced, including stimulant pharmacotherapy[a] for people who use methylphenidate.[32] In Slovakia, civil society organisations were able to forge better ties with government during the COVID-19 pandemic to

a This refers to people who use stimulants being prescribed a stimulant by a medical professional with the aim of reducing harmful health and social effects of their stimulant use.

emphasise the need for harm reduction services, for example, cooperation improved between the city of Bratislava government and service providers. In addition, take-home OAT has been introduced in Slovakia, meaning people receiving methadone now only need to attend a clinic twice a week.[33]

COVID-19 vaccination, prevention and treatment is available in many countries in the region, but the majority of countries have rules that easily exclude people who use drugs.[32,33] In Slovakia, Odyseus, a community harm reduction service provider, runs a vaccination programme specifically for people who use drugs,[33] but these examples are rare.

LATIN AMERICA AND THE CARIBBEAN

Latin America and the Caribbean has experienced some of the biggest impacts of the COVID-19 pandemic. Increasing social inequity has limited access to NSP and OAT services and treatment for vulnerable groups, such as people who use drugs and LGBTQI+ people.[35] The COVID-19 pandemic has compounded the challenges presented by donor withdrawal over recent years; availability and coverage of programmes continue to decline, with harm reduction service providers and community groups unable to adequately fund their operations. Domestic funding for harm reduction is equally strained; in Argentina, Brazil, Bolivia, Colombia, Mexico and Peru there are reports that the COVID-19 response has been prioritised, leading to budget cuts to other health services.[36,37]

People who have been in prison face an increased risk of contracting COVID-19, as detention facilities are often overcrowded. Although governments in the region introduced measures to decongest prisons to reduce overcrowding - Brazil, Costa Rica, El Salvador and Panama continue to have the highest rates of incarceration negatively affecting prison health and causing exposure to COVID-19 virus, including for people who use drugs.[36,38,39]

MIDDLE EAST AND NORTH AFRICA

The COVID-19 pandemic continues to negatively affect the lives of people who use drugs and people living with HIV, hepatitis C and tuberculosis in the Middle East and North Africa region.[1] Stay-at-home orders and restrictions on mobility often prevented OAT and NSP services from being delivered throughout the region.[40–42] In Lebanon and Morocco, people experienced great difficulty accessing OAT dispensaries as they needed to obtain special permits to leave their homes.[41–43] In Morocco, service providers struggled to adequately support clients who remained in active programmes due to inadequate funding and staff shortages.[43]

It is unclear whether the COVID-19 vaccine is available (on a voluntary basis) in prisons across the region, although it is available in Pakistan, Algeria and Morocco according to civil society reports.[43–45] Compulsory COVID-19 testing for people in prison is practiced in Algeria and Pakistan,[44,45] while in Morocco, people's age and health condition, and the availability of vaccines, determine eligibility for COVID-19 testing, treatment and care.[43] In Egypt, vaccination is a requirement for accessing harm reduction services in prison.[40] Barriers to accessing COVID-19 services, such as stigma, discrimination, threat of incarceration and forced treatment, still exist for people who use drugs.

NORTH AMERICA

Overdoses in North America increased drastically during the COVID-19 pandemic, from a level that was already unprecedentedly high. The upsurge in overdose deaths has focused public attention on the need to expand drug checking services to mitigate the impact of a toxic drug supply.[46–50]

In many ways, the challenges posed by the COVID-19 pandemic remain significant for harm reduction services in North America. The availability of short-term, restricted funding[46,51–56] for the COVID-19 response[57–60] has accelerated the implementation of harm reduction programmes (e.g. drug consumption

rooms, new federal funding in the United States, and increased safer supply in Canada through prescribing regimes), although major disparities in progress have been recorded across the United States (see North America chapter, page 110)

Public health guidance issued by the United States during the COVID-19 pandemic led to some NSP and OAT services closing, either temporarily while restrictions were in place or permanently.[53,54,61–64] Innovation and expansion of telehealth, mail order and mobile services[51,65–67] resulted in increased participation in some services[47] and a decrease in others.[61,68,69] This increased isolation for some people, who lost touch with their services and were unsure of whether and where services were operational.[62,70]

The situation in Canada is similar, with lockdown restrictions leading to forced closures of facilities or reduced opening hours.[48,71–74] The requirement to be vaccinated against COVID-19 reduced access for some, given significant vaccine hesitancy among people who use drugs.[75,76] The loss of social bonds and service providers' connection with clients[49,71] increased syringe sharing.[77] Some provincial services rose to the challenge, despite these difficulties. For example, in Manitoba, NSPs were recognised as an essential service and have remained open throughout the COVID-19 pandemic[78] and community-led organisations greatly increased their outreach services.[72,73] In both Canada and the United States, there have been changes in the adoption of drug consumption rooms (DCRs) (also referred to as overdose prevention centres or supervised injection sites).[b] DCRs were not universally categorised as essential health services in Canada,[74] leading to closures and reduced operations in many areas.[74,79]

Supply chain issues caused naloxone shortages, which led to higher prices.[47,67,80,81] But an increase in the use of mail order improved access to naloxone, particularly for people in rural areas of the United States.[54,68] In Canada, greater integration of naloxone with other services (such as homeless shelters) improved access.[74]

Preliminary evidence suggests people in prison have access to voluntary COVID-19 vaccinations in both Canada and the United States. Nonetheless, it is unclear if vaccination is a requirement for accessing harm reduction services. In both countries, drug checking and safer smoking services were significantly impacted by supply chain issues during the COVID-19 pandemic (e.g. there was a shortage of safer smoking equipment, such as crack pipes and drug checking equipment), which negatively affected service availability and coverage.[46,60,65,74,79]

OCEANIA

In Aotearoa-New Zealand and Australia, compared to the general population, there has been a marginal improvement in the availability and accessibility of COVID-19 prevention, testing, treatment and vaccination for people who use drugs.[82–86] The New Zealand Needle Exchange Programme (NZNEP) recently received funding for community access to COVID-19 testing for people who inject drugs, for example.[83]

There have been considerable gains in NSP and OAT delivery in Aotearoa-New Zealand and Australia, notwithstanding COVID-19-related difficulties in access and distribution (including stretched services, COVID-19-related staff shortages, and the closure of some sites and limited operating hours in others).[82,85–88] In both countries, NSPs and OAT were classified as essential services and remained open, albeit with variations across jurisdictions.[83,88]

Access to OAT was maintained through an increase in take-home doses, including long-acting injectable options (such as depot buprenorphine). In Australia,

b The increase in opioid overdoses during the COVID-19 pandemic may have facilitated the opening of two centres in New York City. [65,66] In Canada, some jurisdictions allowed for more flexible models which more adequately met client needs (e.g. on-site safer consumption provision in isolation shelters), which were not available before COVID-19.[74]

increased access to depot buprenorphine in prisons enabled more people to receive treatment. A study conducted in Sydney, Australia found that 24-69% of people on OAT had access to take-home doses and telehealth services.[86–89] Aotearoa-New Zealand adopted less draconian monitoring and increased flexibility in OAT service delivery by dispensing extra take-home options. Civil society sources report that this did not result in an increase in overdoses.[85]

In Australia, at the start of the COVID-19 pandemic, the New South Wales Users and AIDS Association (NUAA) moved to online service delivery of NSP, putting in place protocols and training to ensure the programme would remain open. It incorporated COVID-19 prevention measures (including physical distancing, wearing masks and hand-washing), and throughout the lockdowns worked to prevent both overdoses and COVID-19. For three months, under state-wide lockdown conditions, NUAA provided needle and syringe supplies in specific areas of Sydney where need was greatest as well as in public housing blocks with COVID-19 outbreaks and homeless shelters. Drawing on its longstanding relationships with government health clinics, NUAA was able to offer COVID-19 vaccines at its services, one of only a few examples of fully integrated COVID-19 vaccines and harm reduction services.[3] Prison health for people who use drugs is accessible in the region, based on certain criteria (such as age, pre-existing conditions, mental health, ethnicity and drug use).[82] A prison COVID-19 protection framework (a traffic light system) was introduced in Aotearoa-New Zealand in March 2020 to prioritise which populations received the vaccine.[83] Vaccination against COVID-19 is a requirement to access harm reduction services in Timor Leste.[90]

WEST AND CENTRAL AFRICA

In West and Central Africa, lockdown measures affected harm reduction programmes with service providers experiencing severe shortages of vaccines, equipment and staff, and difficulties reaching clients.[91–93]

Poor access to COVID-19 vaccines in Africa has limited their availability in prisons.[11,24,91,94–96] In Liberia, where vaccines are available in prison, vaccination is a requirement to access harm reduction services.[92] Barriers to COVID-19 prevention, testing and treatment continue to exist, especially for people who do not have access to harm reduction services.[23,93,97]

Lockdown measures negatively affected the supply of syringes to service providers in Cote d'Ivoire,[91] Liberia[92] and Sierra Leonne. However, in Sierra Leone, peer networks where able to deliver needles and syringes through secondary distribution channels.[93]

WESTERN EUROPE

To contain the negative consequences of the COVID-19 pandemic on the gains made in drug policy and harm reduction service delivery in Western Europe, conscious efforts were made to adapt services and foster information sharing and knowledge exchange among experts and service providers.[1]

Limited operational capacities and mobility restrictions due to lockdowns created significant barriers to accessing harm reduction services across the region. In Austria, the United Kingdom and Switzerland, low threshold facilities experienced staff shortages and had to limit the distribution of sterile needles and syringes, with many sites operating on an appointment-only basis.[98–101] Supply shortages (e.g. of syringes, citric acid and solvents) significantly reduced the availability of NSPs, while the temporary closure of drop-in centres reduced daily staff contacts with clients in Italy, Germany and Portugal.[102–104] In many cases, harm reduction services were not prioritised, which meant communities of people who use drugs were neglected. In turn, this increased the risks associated with minimal access to treatment, such as social isolation and overdose.[105] In Portugal, for example, harm reduction health workers were assigned to other services as a matter of urgency.[104]

In Belgium, the 12-month closure of the DCR in Liege (between September 2020 – August 2021) denied people access to an essential service. The DCR in Brussels opened in May 2021.[106] The shutdown of fixed-site services and limited capacity of mobile DCRs, including in Portugal and Switzerland, meant that people who use drugs faced major barriers to health and treatment during the COVID-19 pandemic.[101,104]

Like in some other regions, delivery of naloxone, safer smoking and drug checking were significantly hampered due to insufficient peer-to-peer distribution channels and outreach services, the unavailability of nasal naloxone and the increased cost of materials (such as pipes). This resulted in overdoses increasing in Italy, Germany and the United Kingdom (Scotland).[99,102,107,108] In addition, drug checking was limited in Italy, Spain and Austria (linked to restrictions on the parties and nightclubs where drug checking services usually operate).[102,105,109]

Notwithstanding the challenges of the past three years, harm reduction practitioners report adaptations of services and some positive developments since 2020. For example, in Bath, United Kingdom, peer-to-peer provision of NSP and home deliveries of naloxone have been successfully piloted.[100,107] Due to the increase in smoking as a mode of consumption, NSPs increased provision of inhalation and smoking equipment in Wallonia, Belgium. In Brussels, sample analysis for monitoring purposes is back to normal levels, following a 39% drop during lockdown.[106] Extended opening hours and closer collaboration with social services have increased clients' access to DCRs in Germany,[108] while innovations in NSP and OAT delivery have increased service uptake across the region.

Peer networks have been critical in implementing adaptations.[99,100,102,107,108] Underscoring the resourcefulness of service providers and peer networks, the adoption of low-threshold services, take-home dispensing, the use of telemedicine, peer-to-peer relationships (secondary syringe distribution), and rural mail order all improved service access for people who use drugs (despite the challenges of unevenly distributed services and the lack of appropriate coverage in the region's rural and remote areas). Other innovative solutions include the utilisation of needle and syringe vending machines in shelters for after-hours provision (in Scotland), click-and-collect options, and other mobile outreach services.

"Peer networks have been critical in implementing adaptations. Underscoring the resourcefulness of service providers and peer networks, the adoption of low-threshold services, take-home dispensing, the use of telemedicine, peer-to-peer relationships (secondary syringe distribution), and rural mail order all improved service access for people who use drugs."

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VIRAL HEPATITIS

BY
COLLEEN DANIELS

OVERVIEW

Hepatitis B and C are preventable and treatable, with services that can be delivered easily and cheaply within primary healthcare and at harm reduction sites. However, most countries are still not on track to meet the World Health Organization (WHO) target to eliminate hepatitis C and B as a public health threat by 2030. In many cases, the exclusion of people who use drugs from national programmes is a key factor in this failure. WHO's 2016-2021 targets for viral hepatitis have already been missed (with the exception of the target on hepatitis B prevalence in children under five years old, which was achieved), and more systematic efforts are needed to achieve global hepatitis targets.[1,2] Yet 80% of high-income countries are not on track to meet the WHO's 2030 targets, and 67% are projected to be off-track by at least 20 years.[3]

Access to hepatitis C diagnosis, treatment and care for people who use drugs is often hindered by accessibility and affordability. Other factors, such as a lack of safe injecting equipment, violence, human rights abuses, criminalisation, punitive and restrictive policies, gender, ethnicity, and race, also make certain groups most at risk of HIV vulnerable to viral hepatitis. Stigma and discrimination continue to stop people most at risk of hepatitis C from getting tested or seeking treatment. The stigma people who inject drugs experience in formal healthcare settings often makes people feel negatively about seeking healthcare in the future.[4,5]

Almost 4 in 10 people who inject drugs have active hepatitis C and 1 in 12 have active hepatitis B, according to a global systematic evidence review.[6] Transmission of blood-borne viruses, including HIV and hepatitis C and B, which can happen when people share unsterile injecting equipment, are a leading contributor to illness and death among people who inject drugs. Eastern Europe and Latin America are the regions with the highest current hepatitis C prevalence among people who inject drugs.[6]

Almost 4 in 10 people who inject drugs have active hepatitis C

1 in 12 people who inject drugs have active hepatitis B

HEPATITIS C SERVICES: ISSUES AND CHALLENGES

Although updated international guidance calls for decentralised, integrated services for hepatitis C diagnosis, treatment and care, this is still not the norm in most countries.[7]

EURASIA

In Eastern Europe and Central Asia, nearly half (49.1%) of people who inject drugs are living with hepatitis C.[6] The main barriers to accessing hepatitis diagnosis and treatment in the region include poor coverage of harm reduction services, poor access to cost-effective harm reduction services, low hepatitis C testing, linkage to care and treatment, restrictions for accessing direct-acting antivirals (DAAs), and a lack of national strategies and government investment to support WHO elimination goals.[8,9] Many of these barriers are common in regions across the world.

EASTERN AND SOUTHERN AFRICA AND WEST AND CENTRAL AFRICA

In Eastern and Southern Africa and West and Central Africa, barriers to accessing hepatitis C diagnosis and treatment remain an issue, as the costs of both services are mainly borne by the person living with hepatitis. The only country in both regions to fund testing and treatment is Rwanda, where treatment costs are covered by private sector fundraising. Treatment is still not readily available in Malawi.[10] Reliable data on hepatitis C among people who inject drugs remains scarce in both regions.

In Kenya, an estimated 16% of people who inject drugs have been diagnosed with hepatitis C, however only 20% of people diagnosed receive treatment, indicating issues with linking people to treatment and care.[11] Access to DAAs has also been a challenge in Kenya due to pharmaceutical costs.[12] Resources for hepatitis C prevention are low and this is reflected by a lack of evidence on current knowledge and perceptions of hepatitis C among people who inject drugs. Increasing hepatitis C care and access to prevention resources is likely to provide opportunities to improve uptake of services. A recent study suggests that hepatitis C prevalence among the sexual and injecting partners of people who inject drugs is more than 12 times higher than among Kenya's general population where hepatitis C prevalence is less than 1%. More efforts are needed to ensure sexual and injecting partners are included in outreach for people who inject drugs.[13]

NORTH AMERICA

In Canada, hepatitis C prevalence is high among people who inject drugs in some areas, however, there are important service gaps relating to linkage to treatment and care. A national survey found that continued access to hepatitis C testing and prevention services, targeted strategies to address barriers to accessing HIV and hepatitis C treatment and care, and improvements in ongoing support for housing and mental health are needed.[14]

OCEANIA

In Aotearoa New Zealand, the stigmatising attitudes of some health professionals means people who use drugs are more likely to access hepatitis C treatment via the New Zealand Needle Exchange Program (NZNEP). Funded by the Ministry of Health, NZNEP is peer-led and peer-based, and it is committed to providing a health and human rights-based service for people who use drugs. Aotearoa New Zealand has a national hepatitis C action plan, which includes people who inject drugs as a priority population. However, it is unlikely that the country will meet the WHO targets for elimination by 2030. Sterile injecting equipment, hepatitis C testing and treatment and harm reduction information is generally available. Māori people are disproportionately affected by hepatitis C. In 2019, 26% of hepatitis C infections among people with hepatocellular carcinoma (liver cancer) were Māori, despite Māori people only making up 14% of the country's population.[15] Future national planning in New Zealand must place a greater emphasis on initiatives to improve awareness, testing and treatment of hepatitis

C among Māori people, and improve access to services for this population group; a lesson for other countries where Indigenous people who inject drugs are at disproportionately higher risk of hepatitis C.[16]

Australian Aboriginal and Torres Strait Islander people are also disproportionately affected by hepatitis C. At the end of 2020, 18% of Australian Aboriginal and Torres Strait Islander people were living with active hepatitis C, despite making up just 3% of the Australian population.[17] Injection drug use with unsterile injecting equipment is the primary route of transmission of hepatitis C. Data also suggests that, between 2014 and 2020, the proportion of syringe sharing was consistently higher among Aboriginal and Torres Strait Islander people than among non-Indigenous people.[17] Aboriginal and Torres Strait Islander people experience racism and discrimination in all aspects of daily life as well as within the healthcare sector. Between 2019-2021, 54% of Aboriginal and Torres Strait Islander people attending drug treatment clinics or needle and syringe programmes (NSPs) reported experiences of stigma and discrimination in relation to their drug use, and 63% reported stigma and discrimination in relation to their hepatitis C diagnosis.[17] As a result, a key recommendation is for Aboriginal-controlled health services to expand and include harm reduction services, such as NSPs.

EURASIA AND WESTERN EUROPE

In some European countries, people who use drugs must be enrolled in an opioid agonist therapy (OAT) programme or an abstinence-oriented programme to receive hepatitis C treatment. In Romania, for example, people living with both HIV and hepatitis C, must have a negative drug test result before starting DAA treatment. If someone is not enrolled in one of these programmes, additional steps and approvals from public authorities are required before being able to access treatment.[18] In Croatia, Bulgaria, Hungary, Poland, Romania and Slovakia, national treatment guidelines penalise people who are actively using drugs and deny them access to hepatitis C treatment. Cost is another major barrier, if borne by the client. In some countries, such as Belgium, Poland and Romania, DAA is only reimbursable if someone has social security or health insurance. This works for citizens, but not for non-citizens. In Slovakia, hepatitis C treatment is only paid for if people can prove they have not used drugs for a year, with corroborating toxicology results every three months.[18]

"People who inject drugs are often excluded from treatment due to restrictive guidelines, have poor access to health services or experience stigma when disclosing their status as a person who uses drugs, all of which stop people from using hepatitis care"

Another barrier comes from medical staff and doctors who are reluctant to provide hepatitis C treatment to people who use drugs due to unfounded adherence and reinfection concerns. Evidence shows that this perception is false. In a recent study, despite study participants using both alcohol and drugs, the median adherence for hepatitis C drugs ledipasvir/sofosbuvir was 96%.[19]

An assessment of hepatitis C services in 35 European countries suggests that regional and national hepatitis care varies substantially and is often below WHO targets, with fewer than 1% of people who inject drugs living in countries with high provision of hepatitis C services.[20] Even in places where such services exist, people who inject drugs face many difficulties in accessing hepatitis care. People who inject drugs are often excluded from treatment due to restrictive guidelines, have poor access to health services or experience stigma when disclosing their status as a person who uses drugs, all of which stop people from using hepatitis care.

The COVID-19 pandemic has had an impact on all stages of the hepatitis C care cascade and has reduced access to essential medical services among people most affected by HIV, including people who use drugs. Populations that are marginalised have also struggled to maintain access to harm reduction and drug treatment services.[21]

PROGRESS IN SCALING UP HEPATITIS C TESTING AND TREATMENT FOR PEOPLE WHO USE DRUGS

Some countries have made progress in synergizing national responses to harm reduction and hepatitis C programming for people who inject drugs. One thing many of the more successful programmes have in common is that they are decentralised, community-based and/or community-led. Those programmes that have expanded hepatitis C testing and treatment services at the same site within primary healthcare and harm reduction facilities have achieved great success in reaching and treating people.

ASIA

In India, a community driven test-and-treat pilot (CONE Manipur) has the potential to improve hepatitis C services for people who inject drugs.[22] This community-led, comprehensive, simplified hepatitis care model, which aims to expand access to care for chronic hepatitis, includes same-day hepatitis C testing and treatment initiation at drug rehabilitation centres in Manipur.[23] An assessment of the pilot found 95% of eligible clients were screened for hepatitis B and C, 40% of whom tested positive for hepatitis C antibodies. All of those testing positive for hepatitis C antibodies received a hepatitis C RNA viral load test[24]; 61.5% tested positive for hepatitis C (RNA), of whom 96% had viremia and began standard treatment (sofosbuvir and daclastasvir) that day. The median time from screening to hepatitis C treatment initiation was around eight hours.[24] To address low hepatitis C treatment uptake, this successful model should be replicated and scaled up through India's National Viral Hepatitis Control Programme.

In Thailand, C-FREE is another community-based testing and treatment programme for HIV and hepatitis that has achieved high hepatitis C cure rates. C-FREE was implemented in six drop-in centres for people who use drugs and their partners; harm reduction services were provided alongside testing for HIV, hepatitis B and hepatitis C every three months. This model of care is designed to eliminate the barriers to treatment people who use drugs and their partners commonly face by providing services in settings where people feel comfortable. Of the clients who met the programme's hepatitis C treatment eligibility criteria, 87.9% started sofosbuvir/velpatasvir and 73.3% completed treatment. Of these, 61.6% reached a sustained virological response. This shows that community-based hepatitis treatment for people who use drugs is safe and highly effective. National programmes should urgently integrate community-based HIV and hepatitis B and C test-and-treat services as the standard of care for people who use drugs to decrease deaths and prevent onward transmission of these infections.[25]

Vietnam has increasingly integrated hepatitis B and C care for people who inject drugs, gay men and other men who have sex with men and other groups most affected by HIV within the framework of harm reduction, PrEP and other programmes for at-risk populations. Vietnam successfully reached its target when it initiated 16,000 people with hepatitis C on treatment. The HIV/hepatitis C coinfection programme's technical working group advocated to Vietnam's national HIV programme and the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) to expand reach, moving from the initial target population of people living with HIV and hepatitis C to include people with hepatitis C who were receiving methadone and people in prisons. This enabled the programme to utilise all 16,000 Global Fund-supported DAA treatment courses and broaden access to hepatitis C care to include people who are at risk of HIV and hepatitis C.[26] Building on its success, the programme will continue to leverage the Global Fund grant to procure additional DAAs to treat another 5,000 people in 2022-2023. Treatment will be for people living with HIV and hepatitis C and people accessing methadone.[27]

In 2019, Malaysia decentralised hepatitis C care by enabling primary healthcare facilities to test and treat hepatitis C. Now the country is focusing on improving hepatitis C care for populations most affected by HIV and people in prison. To address co-infections, policies are now in place for the integration of hepatitis B and C screening, treatment

and care in HIV clinics.[28] In 2021, the Malaysian government announced it would conduct a study on the impact of using hepatitis C self-testing as part of its commitment to eliminate hepatitis C by 2030.[29]

"Community-based hepatitis treatment for people who use drugs is safe and highly effective. National programmes should urgently integrate community-based HIV and hepatitis B and C test-and-treat services as the standard of care for people who use drugs to decrease deaths and prevent onward transmission of these infections"

EURASIA

Georgia has improved health services for people who use drugs by taking an evidence-based approach to hepatitis C elimination. Since the beginning of the Georgia Hepatitis C Elimination Program in 2015, the proportion of people who use drugs living with chronic hepatitis C infection has fallen from 51.1% to 17.8%.[33] Under this programme, harm reduction services have been expanded considerably in both scope and scale. Service delivery locations have been increased, for example, by providing hepatitis C and B antibody screening at NSP sites and through mobile services.[33] These screening efforts have substantially increased the number of people who inject drugs in Georgia who are aware of their hepatitis C infection status, from 17,103 in 2016 to 27,967 in 2021. Hepatitis C treatment services have also been integrated into three NSP sites (in Tbilisi, Batumi, and Zugdidi) and one OAT site. At harm reduction integrated sites, 997 people who inject drugs were enrolled in hepatitis C treatment, including 173 people during 2021. These harm reduction services are maintained with support from the Global Fund and the Georgian government's HIV and Drug Addiction Prevention Programs. The share of state funding for NSP services increased from 14% to 30% between 2020 and 2021.[34] A hepatitis C self-testing programme is also being explored through a feasibility and acceptability study with people who inject drugs, gay men and other men who have sex with men in Tbilisi. Around 82% of people who inject drugs in the study were able to complete a self-test correctly.[33]

MIDDLE EAST AND NORTH AFRICA

In Egypt, the government has reintroduced and scaled up NSPs and introduced OAT within the framework of hepatitis C elimination. Its harm reduction programme for people who inject drugs now includes syringe distribution, plus hepatitis B and C rescreening and treatment for at-risk individuals who missed the national screening programme, including people who inject drugs and people in prison.[32] This national programme shows that community-based hepatitis C screening is possible.

WEST AND CENTRAL AFRICA

In Nigeria, the new *National Strategic Framework for Viral Hepatitis (2022-2026)* has expanded the definition for key populations to include people who inject drugs, people in correctional centres and people in closed settings – a positive shift in policy. It also includes targets and objectives for harm reduction coverage as well as hepatitis C testing and treatment for people who inject drugs. However, there is a need for integrated, targeted and context-specific interventions to address Nigeria's high prevalence of viral hepatitis.

WESTERN EUROPE

In Iceland, injecting drug use has been a key driver of hepatitis C transmission. In 2016, the country initiated a nationwide hepatitis C elimination programme called TraP HepC. By 2020, the country had already met the WHO goals of diagnosing 90% of infections and treating 80% of diagnosed infections by 2030. This was achieved by establishing new models of care for marginalised people, including good access to sterile needles and syringes, and prompt re-treatment without stigma for people who get reinfected.[30,31]

WAYS TO IMPROVE SERVICE DELIVERY

Poor access to services is a major issue in addressing hepatitis C and B among people who use drugs. Integrated, person-centred service delivery and prioritising key populations in every setting will improve accessibility. As seen in the examples of progress given above, the role of community-led and community-based services, as well as peer navigators to guide people through health services, is critical.

Interventions such as hepatitis C self-testing – whereby a person collects their own specimen (oral fluid or blood) then performs the test and interprets the result, often in a private setting, either alone or with someone they trust – can complement existing testing services. WHO guidelines now recommend easy access to hepatitis C self-testing, but there is little uptake from programmes. Hepatitis C self-testing is easy and can be done anywhere, which enables programmes to reach vulnerable and stigmatised populations such as people who use drugs, people who sell sex, LGBTQI+ people and men who have sex with men.

Another way to improve the quality of services is to improve data, including monitoring data relating to viral hepatitis among people who inject drugs. Accurate and reliable hepatitis prevalence data (disaggregated by gender), population-based studies, and estimates of the diagnosed and treated proportion of a population, are lacking. This undermines the development of strategies and allocation of budget to eliminate viral hepatitis, as seen in Eastern and Southern Africa. However, this should not be a reason for delaying viral hepatitis screening, detection and linkage to care.[35] Instead, the focus should be on increasing political will and securing sustainable funding to implement programmes.

POLICY DEVELOPMENTS

Since 2020, new global goals, strategies and commitments have provided a guiding framework for national strategic planning for viral hepatitis. The WHO's global health sector strategies, The Joint United Nations Programme on HIV/AIDS (UNAIDS)' Global AIDS Strategy 2021-2026, and the United Nations General Assembly's 2021 Political Declaration on HIV and AIDS, if implemented, will all contribute to the elimination of hepatitis.

In 2022, the WHO published Global Health Sector Strategies on HIV, Viral Hepatitis and Sexually Transmitted Infections for the period 2022-2030 to guide the health sector to end these epidemics by 2030.[36] The new strategies call for countries to actively prioritise populations most affected by HIV in all settings. They also provide guidance on the frequency of hepatitis C testing for people at ongoing risk of infection and the provision of treatment, without delay, to people who have recently acquired hepatitis C and those at ongoing risk.

If the 2030 targets are achieved, the number of new annual HIV and viral hepatitis infections could drop from 4.5 million in 2020 to less than 500,000 in 2030, and the number of deaths could reduce from 2.3 million to less than 1 million over the same period. The number of new cases of cancer due to HIV, viral hepatitis and STIs could drop from 1.2 million to less than 700,000.[36]

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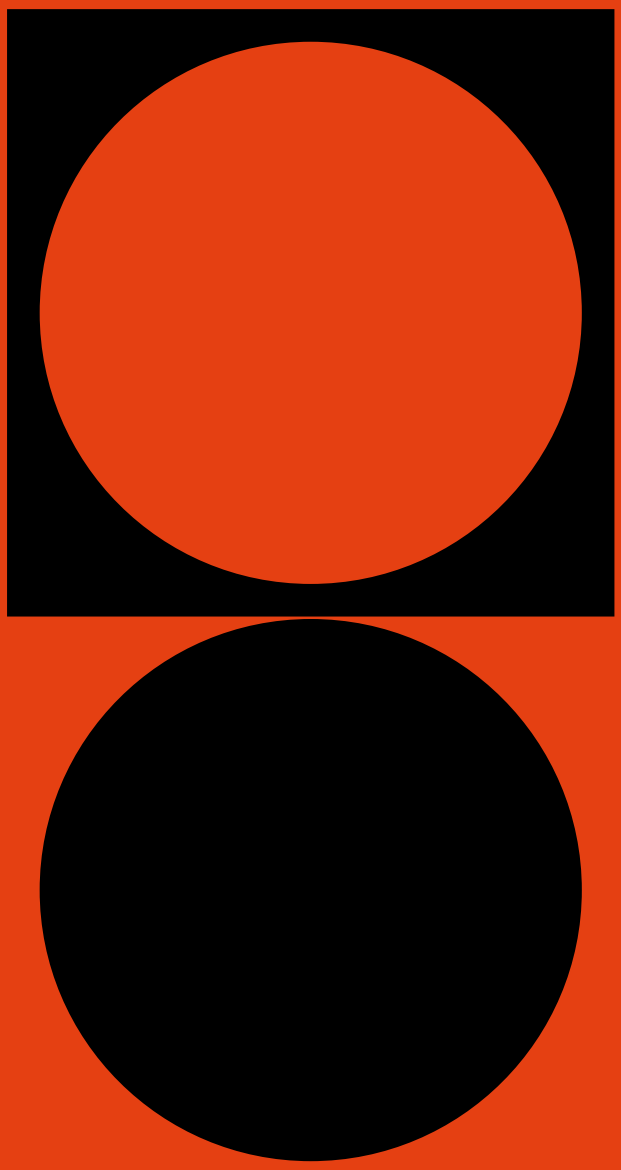
REGIONAL OVERVIEW: ASIA



THE GLOBAL STATE
OF HARM REDUCTION 2022

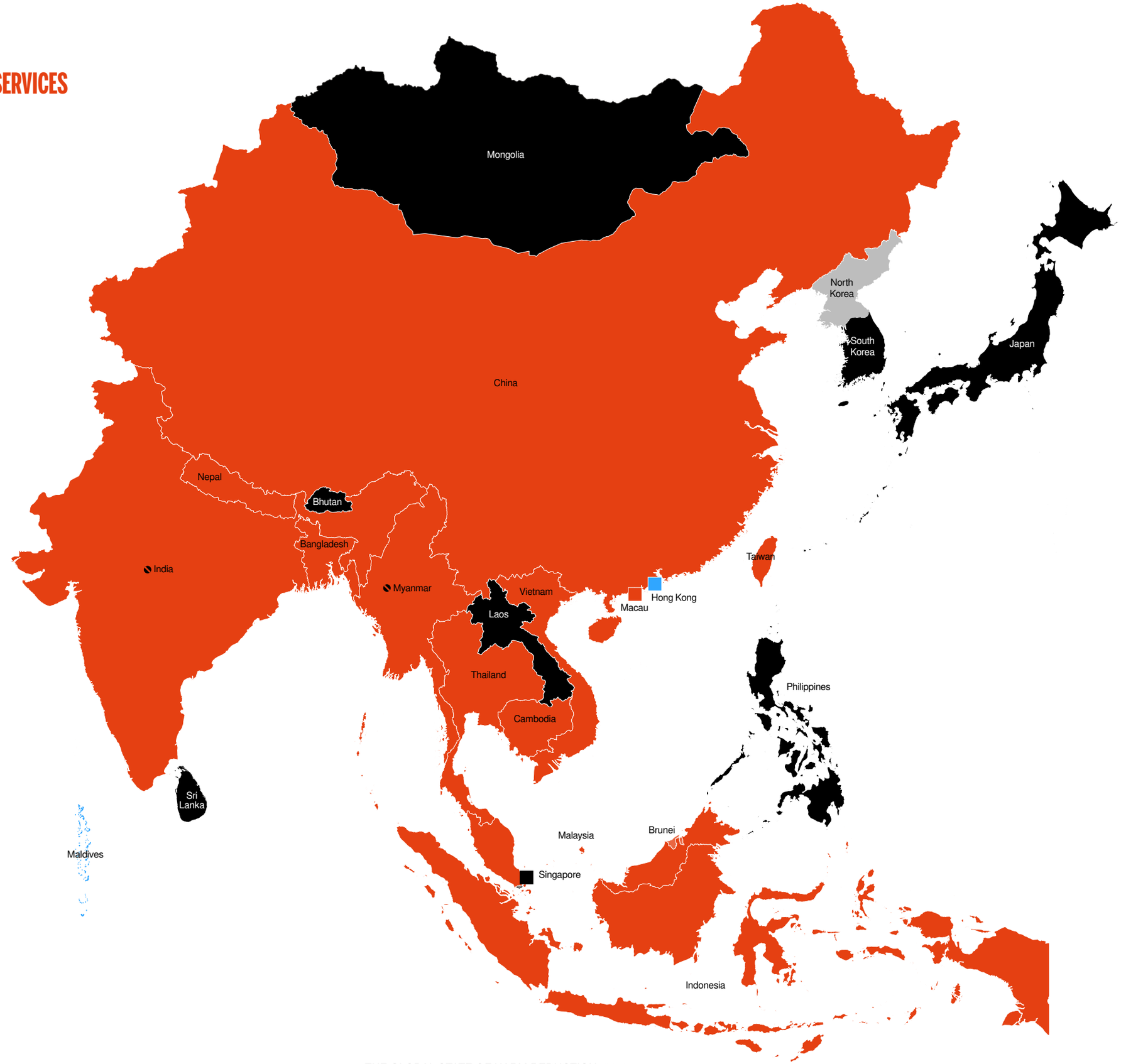
HARM REDUCTION INTERNATIONAL

TABLE 2 EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN ASIA

Country/territory	People who inject drugs[a]	HIV prevalence among people who inject drugs (%)[a]	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[a]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[a]	Harm reduction responses				
					NSP[b]	OAT[c]	Peer distribution of naloxone[d]	DCR[e]	Safer smoking equipment[f]
Bangladesh	33,067[2]	2.5	31	7	✓ 21[3]	✓ M[3]	×	×	×
Bhutan	nd	nd	nd	nd	×	×	×	×	×
Brunei Darussalam	nd	nd	nd	nd	×	×	×	×	×
Cambodia	4,500	8	29.2	nd	✓ 5[4]	✓ M[4]	×	×	×
China	556,000[5]	5[6]	49	18.3	✓[7]	✓ M[7]	×	×	×
Hong Kong	861[8]	<1[9]	83.5	nd	×	✓ M[10]	×	×	×
India	878,000	9[11]	49.5	6.4	✓ 266[12]	✓ B M[11]	✓ [13]	×	×
Indonesia	204,000	39.1	89.2	nd	✓ 216[12]	✓ M[14]	×	×	✓ [15]
Japan	351,000	nd	64.8	3.2	×	×	×	×	×
Laos	nd	17.4	nd	nd	×	×	×	×	×
Macau	<100[16]	3[17]	40[17]	9[17]	✓ 1[18]	✓ B M[18]	×	×	×
Malaysia	75,000[19]	14.1	49.5	nd	✓ 477[20]	✓ M[20]	×	×	×
Maldives	2,500	nd	0.7	0.2	×	✓ B M[21]	×	×	×
Mongolia	nd	nd	nd	nd	×	×	×	×	×
Myanmar	96,000	26.4	75.6	7.7[22]	✓ 51[12]	✓ M[23]	✓	×	×
Nepal	38,000	2.8[24]	21.8	1	✓ 60[12]	✓ M[25]	×	×	×
North Korea	nd	nd	nd	nd	nd	nd	nd	×	×
Philippines	7,200[26]	29[26]	36	7.1[27]	×	×	×	×	×
Singapore	2,285[28]	nd	42.5	8.5	×	×	×	×	×
South Korea	nd	nd	50.6	nd	×	×	×	×	×
Sri Lanka	2,500	0	5.6	0.3	×	×	×	×	×
Taiwan	60,000[29]	13.4	91.9	18.1	✓ 1,254[30]	✓ M[30]	×	×	×
Thailand	46,233[31]	22.2	72.4[32]	4.8[32]	✓ 30[33]	✓ M[33]	×	×	×
Vietnam	214,000	22.5	72.5[34]	17[34]	✓ 56[35]	✓ M[35]	×	×	×

a Unless otherwise stated, data is from Degenhardt et al (under review).[1]
b At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available)
c At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, M=methadon.
d At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training, and facilitates secondary distribution of naloxone between peers.
e At least on drug consumption room (also known as safe consumption sites among other names) operational in the country or territory, and the number of facilities.
f At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.

AVAILABILITY OF HARM REDUCTION SERVICES



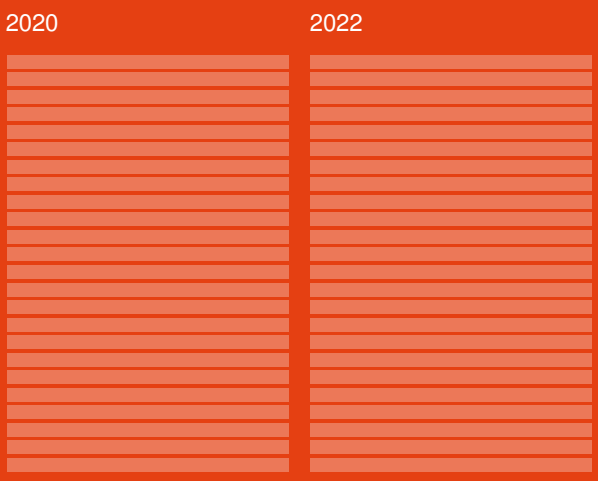
NSP, OAT AND DCRs

12 countries (50%) in Asia provide **needle and syringe programmes** (no change from 2020)

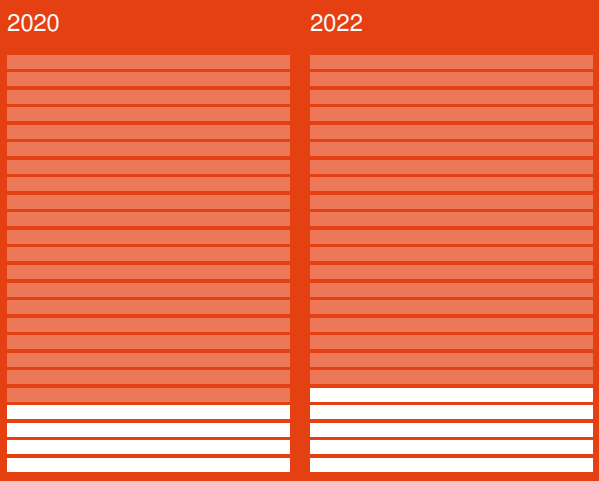
14 countries (58%) in Asia provide **opioid agonist therapy** (no change from 2020)

No country in Asia provides **drug consumptions rooms** (no change from 2020)

HARM REDUCTION IN PRISONS



No country in Asia provides **needle and syringe programmes** in prisons (no change from 2020)



5 countries in Asia provide **opioid agonist therapy** in prisons (+1 since 2020, Macau)

INDONESIA IS THE ONLY COUNTRY IN ASIA WITH A SAFER SMOKING EQUIPMENT PROGRAMME

REGIONAL OVERVIEW

AUTHOR:
GIDEON LASCO

INTRODUCTION

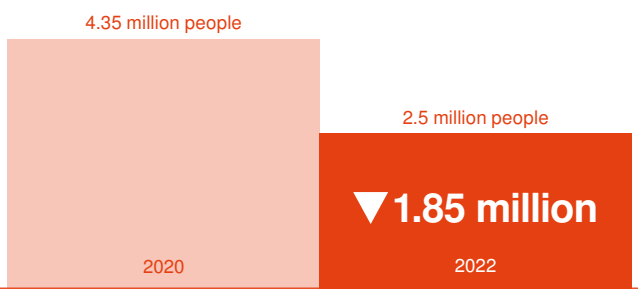
There are over 2.5 million people who inject drugs in Asia (see Table 2, page 50) and many others use drugs via other methods.

Drug use and policy contexts vary across the region's 24 countries. However, there are several observable trends, one of which is the continuing shift in the drug of choice (and/or of concern) in various countries from heroin and other opioids to methamphetamine.[36] In China, the government now reports that a majority of people who use drugs use methamphetamine,[5] leading to a revised official estimate (see Table 2, page 50) of 556,000 people who inject drugs. Academic studies have identified various factors that are causing this shift, including the wider availability and accessibility of methamphetamine and the widespread perception of its relative safety compared to heroin (public health campaigns have focused on the harms of using heroin).[37]

The new regional estimate of over 2.5 million people who inject drugs reflects the shift toward methamphetamine, as it is around 2 million fewer people than the estimate of 4.35 million reported in the *Global State of Harm Reduction 2020*.[38] It is worth noting that the updated figure is partly based on incomplete data and country population estimates that have not been revised since the *Global State of Harm Reduction 2020*. Nonetheless, this indicates a changing regional picture of drug use that is corroborated by global and national reports. For instance, the United Nations Office on Drugs and Crime (UNODC) describes 2021 as a record year for methamphetamine seizures in the region, totalling 171.5 tons.[39] The general price of methamphetamine has continued to decrease, making it more widely accessible and available—trends that have been attributed primarily to the shift of methamphetamine production to tablet form and the use of non-controlled substances in the lower Mekong sub-region in Southeast Asia.[39]

"The drug of choice and/or concern is shifting from heroin and other opioids to methamphetamine in many Asian countries"

Estimate of the number of people who inject drugs in Asia



The rise in methamphetamine use has created new harm reduction needs. Some organisations have already pioneered interventions. In Jakarta and Makassar, Karisma Foundation's outreach programme involving the distribution of *cangklong* (glass pipes) as part of safer smoking kits reported considerable success in terms of engagement and awareness.[40] Likewise, in Hanoi and Ho Chi Minh City, the Centre for Supporting Community Development Initiatives (SCDI) piloted a methamphetamine-focused outreach programme that offered harm reduction counselling, mental health screening and referrals to other services.[41] Although limited in scope and highly controversial within their political contexts, such programmes can nonetheless lead to scaled-up responses in the future.

Since 2020, Asia has experienced drastic natural disasters and climate crises. Cyclones, earthquakes, heatwaves, drought, forest fires, flooding, landslides and tropical storms have resulted in death, disease and poverty. Existing health and social care systems are unprepared, and ill equipped in most cases, to effectively respond to and manage these crises, leaving people who have been marginalised the most – including people who use drugs – to fend for themselves.[42,43,44] Political and economic crises have also had a significant negative impact on harm reduction. Sri Lanka's ongoing economic crisis has put health services under immense pressure,[45] while the 2021 military coup in Myanmar disrupted the implementation of harm reduction services and may have put the future of such services at risk.[46,47]

COVID-19, NEEDLE AND SYRINGE PROGRAMMES (NSP) AND OPIOID AGONIST THERAPY (OAT)

Since the *Global State of Harm Reduction 2020*, no country in Asia has made major changes in the availability of needle and syringe programmes (NSPs) or opioid agonist treatment (OAT). However, sociopolitical opposition has either held back or scaled down harm reduction programmes,[48,49] in Myanmar and Thailand, while Malaysia officially attributes its decrease in NSP sites to the decreased demand for those services. Yet "the continued significance of injecting drug use is reflected by the region's epidemiological picture: HIV infections continues to rise in countries such as the Philippines and Malaysia, despite a global decline,[50,51] while hepatitis C (HCV) prevalence remains high among people who inject drugs (e.g. 80% of men who inject drugs in Cebu City, Philippines are living with hepatitis C[52])."

"The continued significance of injecting drug use is reflected by the region's epidemiological picture: HIV infections continues to rise in countries such as the Philippines and Malaysia, despite a global decline, while hepatitis C (HCV) prevalence remains high among people who inject drugs"

The COVID-19 pandemic appears to have had little impact on drug supply and demand in the region.[36] However, the resulting diversion of health resources and social services toward COVID-19-related programmes has hampered harm reduction efforts in some countries (see Asia paragraph of COVID-19 chapter, page 34). In parallel, the COVID-19 pandemic has also accelerated reforms in some harm reduction initiatives, such as the provision of take-home methadone in India, Myanmar and Vietnam[53] and the initiation of online counselling and outreach in Japan and Macau.[54,55] Alongside programmes intended specifically for chemsex (see Spotlight: Chemsex, page 56), these represent some positive developments since 2020.

POLICY DEVELOPMENTS

In terms of overall policy, much of the region continues to subscribe to hardline approaches and 'drug-free' paradigms. In the Philippines, President Rodrigo Duterte's 'war on drugs' persisted up to the end of his term, and the country's political climate remains tilted towards punitive approaches under President Ferdinand Marcos Jr., including efforts to restore the death penalty for drug offences.[56] In Japan, under its zero-tolerance drug regime, the government has proposed amendments to existing laws that would criminalise the personal consumption of cannabis.[57] In Bangladesh, an association has been made between drugs and the Rohingya crisis, which has contributed to negative attitudes and punitive responses towards Rohingya refugees. In June 2022, a 28-year-old Rohingya man was sentenced to death for the possession and smuggling of methamphetamine tablets, for example.[58] Bangladesh has seen a rise in extrajudicial killings of people associated with the drug trade, and the country's drug policy has become increasingly militarised.[46,59,60] "Despite vocal opposition from civil society and the United Nations Office of the High Commissioner for Human Rights, Singapore has resumed executions of people convicted of drug trafficking,[61] cementing its classification—alongside China, Malaysia, Indonesia, North Korea and Vietnam—as a 'high application state' in imposing the death penalty for drug offences."[62]

Punitive approaches to drugs have also translated to poor conditions in prisons, resulting in a vast number of people who use drugs being deprived not only of their liberty, but of access to basic harm reduction services.[63] Forced rehabilitation programmes are often no different from prisons. As a 2020 United Nations joint statement asserts, such programmes are rife with 'human rights violations, including lack of due process, forced labour, inadequate nutrition, physical and sexual violence... and denial of evidence-based drug dependence treatment and basic health-care services' toward detainees.[64] Only two countries in the region (Myanmar and India) are known to offer take-home naloxone and/or peer distribution of naloxone, and this is on a very limited basis.[65,66] No country is known to offer drug consumption rooms.

Some countries have undertaken efforts to depart from punitive approaches. For example, Thailand legalised kratom, a plant that has stimulant properties, resulting in the release of thousands of people jailed for related offences and the expungement of their records.[67] In 2022, the country became the first in Asia to legalise cannabis, including consumption, possession, sale, cultivation and importation.[46] Thailand's latest report shows that NSPs have been managed exclusively by civil society organisations (not the government) due to what it describes as 'controversy within the public sector about needle exchange.'[49] In June 2022, Malaysia announced its intent to abolish mandatory death penalty sentencing, which has been disproportionately meted out to people charged with drug offences.[68] However, indicating this intention does not necessarily signify progress in overall policy reform.

"Despite vocal opposition from civil society and the United Nations Office of the High Commissioner for Human Rights, Singapore has resumed executions of people convicted of drug trafficking, cementing its classification as a 'high application state' in imposing the death penalty for drug offences"

SPOTLIGHT:

CHEMSEX IN ASIA

Chemsex, the practice among gay men and other men who have sex with men of using specific drugs to enhance and prolong sex (often involving group sex), is on the rise in Asia. In 2021, estimates from nine countries in the region suggest that between 3 to 31% of gay men and other men who have sex with men engaged in chemsex in the past year.[69] These statistics indicate that a robust response is required because people who engage in chemsex are at higher risk of contracting HIV than the general population, according to studies from Malaysia,[70] Hong Kong,[71] Thailand,[72] and China.[73] Common drugs used by people engaged in chemsex in the region, typically in a polydrug-use context, include methamphetamine, ecstasy (MDMA), poppers (alkyl nitrites), ketamine and gamma-hydroxybutyrate or gamma-butyrolactone (GHB/GBL),[74,75,76] and will often use more than one type of drug during their chemsex sessions.

In approaching chemsex as a distinct practice and context of drug use, scholars, advocates and people from the chemsex community acknowledge that "traditional harm reduction services are [often] not appropriate for [the] needs" of people who engage in chemsex.[77] For instance, while certain chemsex settings may involve injecting drugs, meaning some risks can be mitigated by NSPs, many others, such as the risks arising from orally-consumed drugs like MDMA, require tailored interventions that pre-existing programmes do not cover. There is, in other words, a need to innovate and tailor programmes to meet the specific needs of the communities in question. Fortunately, in recent years, a number of organisations and initiatives in the region have paved the way for such contextualised interventions.

For Lighthouse, a Hanoi-based organisation that caters specifically to gay men and other men who have sex with men, community engagement is fundamental. In addition to providing accessible peer support, harm reduction packages, sexually transmitted infection (STI) prevention services such as pre-exposure prophylaxis (PrEP) and specialist referrals, the organisation's advisory board consists of gay men and other men who have sex with men. By taking this community-centred approach, the organisation is able to ensure that its efforts reflect the realities of the communities it supports.[69]

In Thailand, APCOM Foundation has made progress in chemsex-related interventions by harnessing digital landscapes. Its HIV-testing campaign, *TestXXX*, started as a Bangkok-based initiative in 2014 (as *TestBKK*), but has since partnered with civil society organisations from neighbouring Southeast Asian countries to create branches in Ho Chi Minh City, Manila and Jakarta. These community-led initiatives encourage gay men – particularly those who engage in chemsex – to access HIV services and provide them with online information on sexual health, harm reduction and living with HIV.[78]

In Taiwan, Min-Sheng Hospital in Kaoshiung City supports the HERO (Healing, Empowerment, Recovery of chemsex) clinic, which uses an integrated health service model to create a one-stop health and social service designed to address the needs of gay men and other men who have sex with men who engage in chemsex.[69] The clinic uses digital technologies to make the service easy to access, and centralises the diagnosis, treatment and prevention of STIs and mental health issues, including access to counselling and specialist care with an emphasis on tailoring care according to an individual's self-assessed needs.[69,79]

Researchers have documented the ways in which individuals and communities can limit the harms of chemsex, particularly in places with little or no policy support. In the Philippines, people engaging in chemsex have been found to actively bring their own syringes to 'party'n'play' sessions to reduce the possibility of sharing syringes, to pay for PrEP and STI tests and medicines where available, and limit polydrug use.[80]

All of the above illustrates the need to broaden the availability, accessibility and acceptability of harm reduction services, and to tailor services for chemsex, as well as other drug-use practices, based on local and regional contexts.

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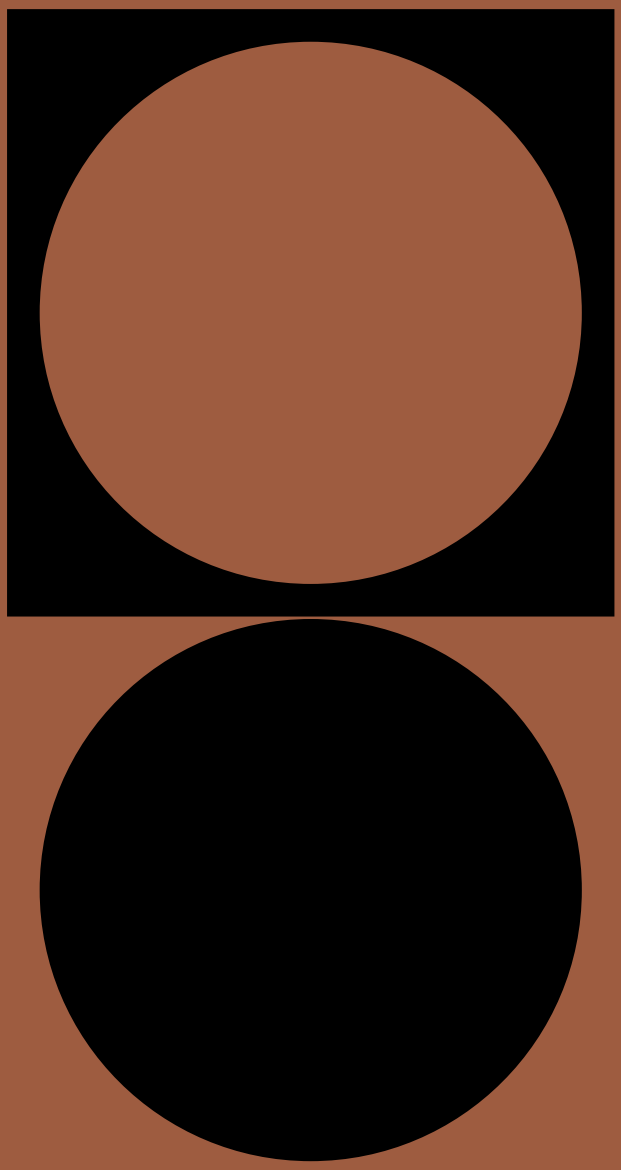
REGIONAL OVERVIEW: EASTERN AND SOUTHERN AFRICA



THE GLOBAL STATE
OF HARM REDUCTION 2022

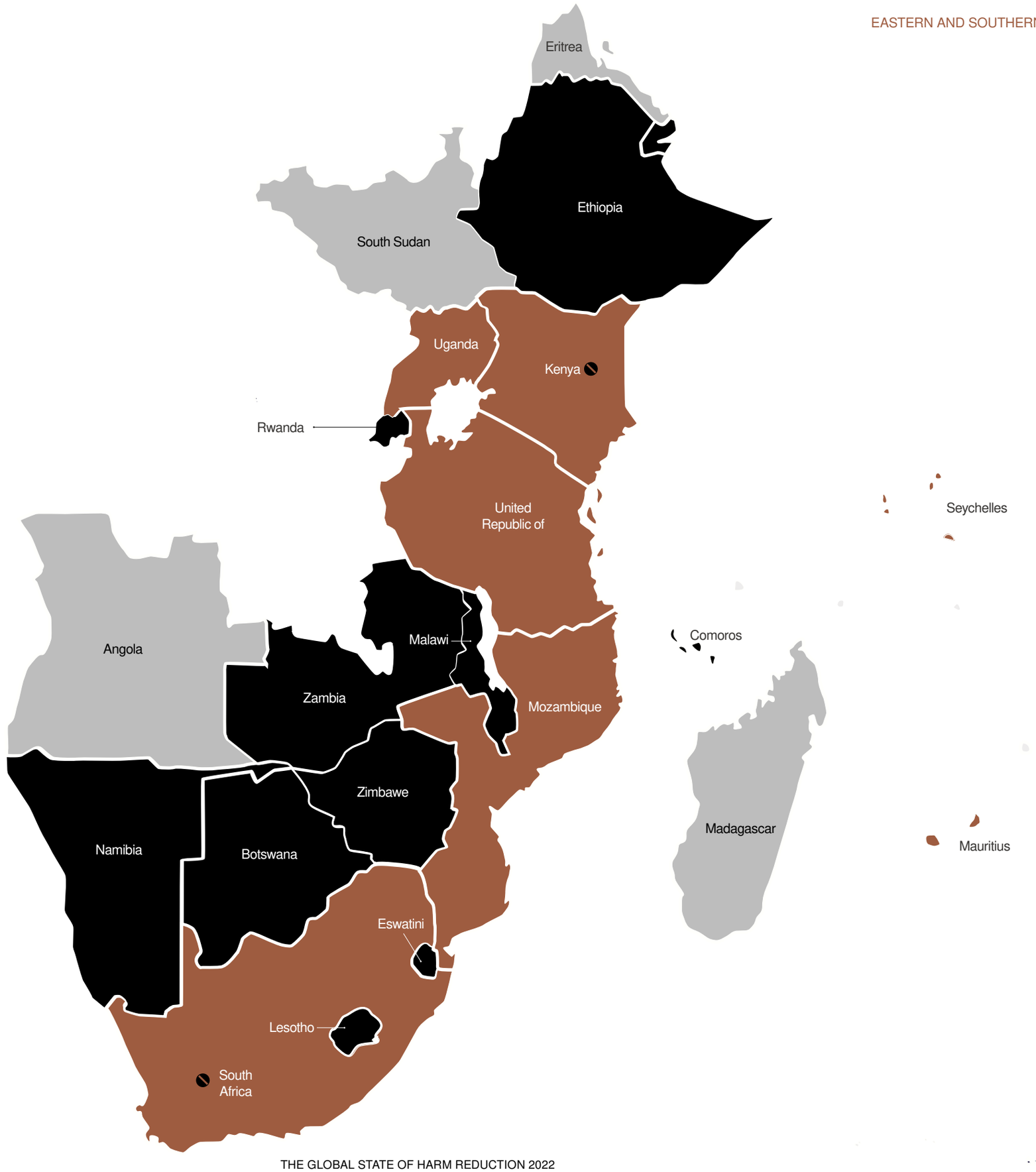
HARM REDUCTION INTERNATIONAL

TABLE 3 EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN EASTERN AND SOUTHERN AFRICA

Country/territory	People who inject drugs[a]	HIV prevalence among people who inject drugs (%)[a]	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[a]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[a]	Harm reduction responses[b]				
					NSP[c]	OAT[d]	Peer distribution of naloxone[e]	DCR[f]	Safer smoking equipment[g]
Angola	nd	nd	nd	nd	nd	nd	nd	×	nd
Botswana	nd	5.1	nd	nd	×	×	×	×	×
Comoros	nd	nd	nd	nd	nd	nd	nd	×	nd
Eritrea	nd	nd	nd	nd	nd	nd	nd	×	nd
Eswatini	1,279[2]	nd	nd	nd	×	×	×	×	×
Ethiopia	139,500	6.3	3.4	5.1	×	×	×	×	×
Kenya	36,000	11.3	20	3.9	✓	✓ M B	✓	×	×
Lesotho	1,279	nd	nd	nd	×	×	×	×	×
Madagascar	18,500	4.5	5.6	5.3	nd	nd	nd	×	nd
Malawi	nd	nd	nd	nd	×	×	×	×	×
Mauritius	12,000	32.3	90	3.5	✓	✓ M	×	×	×
Mozambique	33,000	35.5	43.6	24.2	✓[3]	✓ M	×	×	×
Namibia	nd	nd	nd	nd	×	×	×	×	×
Rwanda	2,000	9.4	nd	nd	×	×	×	×	×
Seychelles	2,000	12.6	79.1	0.3	✓[4]	✓ M	×	×	×
South Africa	82,000	17.9	54.7	5	✓	✓ M	✓	×	×
South Sudan	nd	nd	nd	nd	nd	nd	nd	×	nd
Uganda	9,500	17[5]	2[6]	8.4[5]	✓	✓ M B	×	×	×
United Republic of Tanzania	30,000[7]	35[7]	23.1	6.9	✓	✓ M	×	×	×
Zambia	26,840	24[8]	nd	nd	×	×	×	×	×
Zimbabwe	nd	nd	nd	nd	×	×	×	×	×

a Unless otherwise stated, data is from Degenhardt et al (under review).[1]
b Data sourced in *Global State of Harm Reduction* survey responses, unless otherwise stated.
c At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available)
d At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, M=methadon.
e At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training, and facilitates secondary distribution of naloxone between peers.
f At least one drug consumption room (also known as safe consumption sites among other names) operational in the country or territory, and the number of facilities.
g At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.

AVAILABILITY OF HARM REDUCTION SERVICES



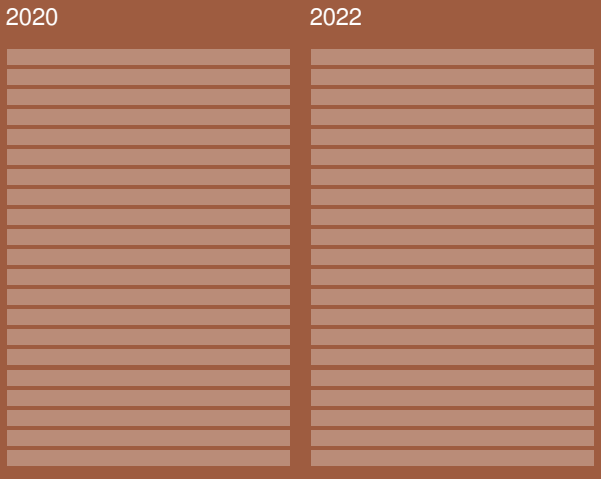
NSPs, OAT AND DCRs SINCE 2020

7 countries (33%) in Eastern and Southern Africa provide **needle and syringe programmes** (+2 since 2020, Uganda and Seychelles)

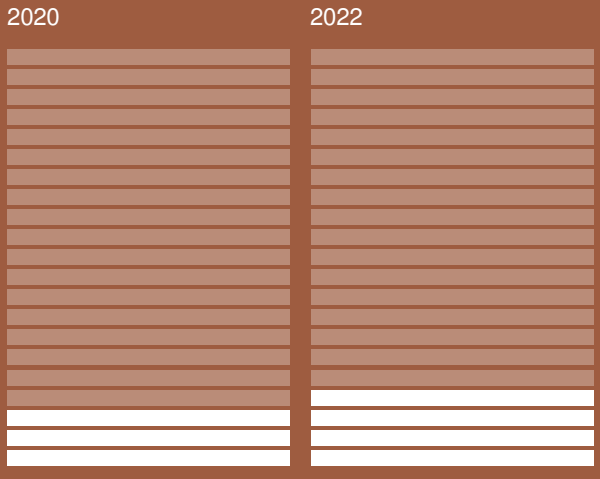
7 countries (33%) in Eastern and Southern Africa provide **opioid agonist therapy** (no change from 2020)

No country in Eastern and Southern Africa provides **drug consumptions rooms** (no change from 2020)

HARM REDUCTION IN PRISONS



No country in Eastern and Southern Africa **provides needle and syringe programmes** in prisons (no change from 2020)



4 countries (19%) in Eastern and Southern Africa provide **opioid agonist therapy** in prisons (+1 since 2020, Tanzania)

THERE ARE NO FORMAL HARM REDUCTION PROGRAMMES FOR STIMULANTS OR NEW PSYCHOACTIVE SUBSTANCES IN EASTERN AND SOUTHERN AFRICA

REGIONAL OVERVIEW

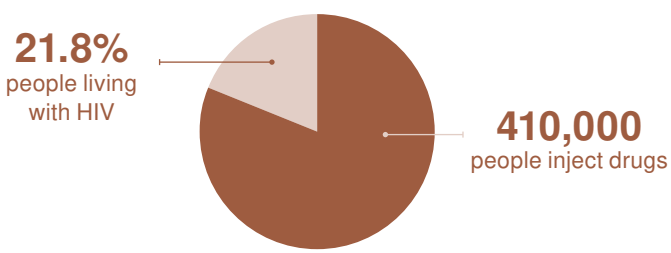
AUTHOR:
WANGARI KIMEMIA

INTRODUCTION

A rough estimate from incomplete surveys indicates there are about 410,000 people who inject drugs in Eastern and Southern Africa, 21.8% of whom are living with HIV.[9,10] In recent years, available data from the region shows an increase in heroin use,[11,12] injecting drug use, and increased HIV and hepatitis infections among people who inject drugs.[13] Eastern and Southern Africa is characterised by repressive criminal laws, high estimated transmission rates of HIV and viral hepatitis among people who inject drugs,[14] and an absence of essential health services.[3,13,15] Punitive policies, minimal data, lack of political will, limited funding, stigma, and discrimination are among the main challenges hampering the implementation of harm reduction services in the region.

Generally, poor data is damaging to countries' abilities to make good policies and data-driven decisions.[16] One of the challenges that researchers encounter when conducting studies in Eastern and Southern Africa is that data on HIV and drug use is poor: it either does not exist or it lacks validity and reliability.[17] In large part, this is driven by the criminalisation and stigmatisation of drug use, which pushes people who use drugs into hidden spaces and discourages people from disclosing their drug use to researchers and healthcare providers.[9] As long as such punitive laws and policies persist, it will be difficult to obtain accurate national estimates of drug use patterns. Evidence from other countries on the effectiveness and cost-effectiveness of harm reduction, alongside co-operation and information sharing between countries and rapid, localised assessments of needs, can provide a reliable basis for the implementation of essential harm reduction services in Eastern and Southern Africa.[18]

More than 1 in 5 people who inject drugs in Eastern and Southern Africa are living with HIV



"One of the challenges that researchers encounter when conducting studies in Eastern and Southern Africa is that data on HIV and drug use is poor: it either does not exist or it lacks validity and reliability. In large part, this is driven by the criminalisation and stigmatisation of drug use, which pushes people who use drugs into hidden spaces and discourages people from disclosing their drug use to researchers and healthcare providers"

NEEDLE AND SYRINGE PROGRAMMES (NSPs)

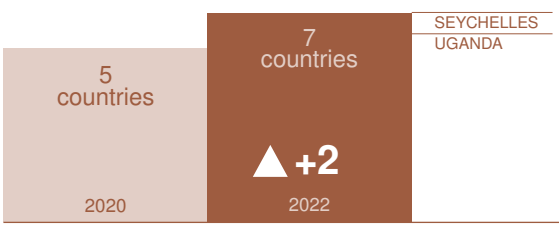
Of the 20 countries in the region, NSPs are operational in only 7 (Kenya, Mauritius, Mozambique, Seychelles, South Africa, Tanzania, and Uganda). This marks an increase of two countries since 2020 (Seychelles[a4] and Uganda, which initiated an NSP in 2018 and ended the programme in 2019, then resumed it in 2021[19]). Even in countries where NSPs exist, they are insufficiently accessible to the people that need them and are often disrupted.[3]

OPIOID AGONIST THERAPY (OAT)

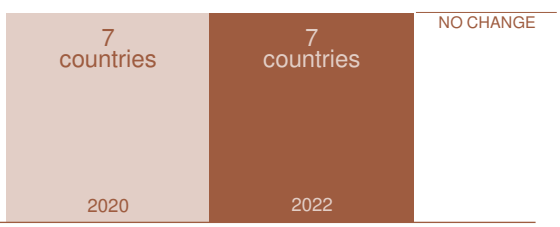
OAT remains limited in the region, with programmes in only seven countries (Kenya, Mauritius, Mozambique, Seychelles, South Africa, Tanzania, and Uganda). This is an increase of two countries since 2020 (Mozambique[3] and Uganda[19] – Uganda opened its first OAT programme in October 2020[20]). Methadone is used in all seven countries, while buprenorphine is also used in Kenya, Mauritius, South Africa, Tanzania and in clinical trials in Uganda.[19] Zambia does not implement OAT, and methadone is not registered or available.[21] In South Africa, advocacy efforts led to methadone being added to the essential medicines list, but the high price of methadone limits access to OAT.[22] In August 2022, after sustained civil society advocacy, pharmaceuticals company Umsebe Healthcare announced a significant reduction in the price of methadone for healthcare providers from late 2022[23] (not yet implemented at the time of this report).[24]

The approach to OAT is broadly regimented and has taken place primarily within medical settings,[25] generally administered as directly observed therapy (DOT).[26] The DOT approach has been associated with high, avoidable costs. For example, in Kenya the actual cost of acquiring methadone comprises only 10% of the total cost; 86.4% funds personnel costs, and the remaining 4% funds recurrent, non-personnel costs, mainly dispensing cups.[27]

Needle and Syringe Programmes (NSPs)



Opioid Agonist Therapy (OAT)



a In Seychelles, NSPs have been available since 2016, but this was unreported in previous editions of the *Global State of Harm Reduction*.

DOT is associated with reduced retention of clients on treatment[28] and increased vulnerability of people who use drugs to COVID-19 in high prevalence areas, for example, because people have to leave their houses to travel to receive it.[29]

The COVID-19 pandemic has led to alternatives to DOT being explored. For example, Kenya introduced take-home doses, mobile van dispensing and buprenorphine.[30] During Ramadan, organisations in Kenya moved to 'moonlight dispensing' so people who were fasting during the day could still access OAT.[30] Tanzania and Uganda have also introduced initiatives for take-home doses.[28,30,31]

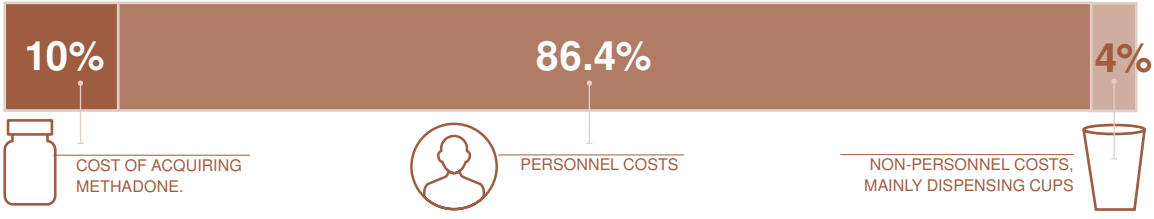
STIMULANTS AND NEW PSYCHOACTIVE SUBSTANCES (NPS)

Cocaine and methamphetamine use have increased in the region since 2020.[11,32] South Africa is now estimated to be one of the largest methamphetamine consumer markets in the world[3], and significant methamphetamine markets also exist in Botswana, Eswatini, Kenya, Lesotho, Malawi, Mozambique, Uganda, Zambia and Zimbabwe.[33] Civil society in Zimbabwe reports increased popularity of crystal methamphetamine.[3] Mauritius is experiencing an increase in the use of NPS, notably synthetic cannabinoids and synthetic cathinones.[34] No civil society informants reported formal harm reduction programming for stimulants or NPS (for example, no stimulants prescription programmes or the distribution of safer smoking kits), although civil society organisations in South Africa have been distributing safer stimulant kits since 2020 on an ad hoc basis.[35]

OVERDOSE, OVERDOSE RESPONSE AND DRUG CONSUMPTION ROOMS (DCRs)

There is a lack of data on overdose and drug-related deaths in Eastern and Southern Africa, and no country has national data on either issue.[3,36] One small study in Dar-es-Salaam, Tanzania found that 34% of a sample of women who use drugs had experienced an overdose.[37] Two countries in the region have at least one naloxone peer distribution programme: Kenya and South Africa.[22,38,39,40,41] However, these are all small programmes with minimal reach and accessibility. For example, although a peer-run outreach programme has distributed a small number of intramuscular naloxone in South Africa, it remains a prescription-only medication and no nasal naloxone is available in the country.[42] No country in the region reported having a drug consumption room.

The cost of directly observed therapy for OAT in Kenya



HIV AND ANTIRETROVIRAL THERAPY (ART)

Eastern and Southern Africa is still heavily affected by HIV, and is home to approximately 54% of all people living with HIV in the world.[10] New HIV infections declined by 44% from 2010 to 2021 in the general population, but HIV prevalence among people who inject drugs is estimated at 21.8%, compared with 6.2% among the general population.[10] Criminal laws undermine efforts to reach and engage people who use drugs in national HIV responses.[10] Indeed, civil society actors and researchers report that stigma and discrimination is a major barrier for people who use drugs when it comes to accessing HIV-related services.[40,41,43,44,45,46,47] Other barriers to HIV care include a lack of facilities in rural areas, which means people have to travel long distances to access treatment, which is time-consuming and expensive.[42] People who are experiencing homelessness also struggle to store medication safely.[48]

"Eastern and Southern Africa is still heavily affected by HIV, and is home to approximately 54% of all people living with HIV in the world. New HIV infections declined by 44% from 2010 to 2021 in the general population, but HIV prevalence among people who inject drugs is estimated at 21.8%, compared with 6.2% among the general population"

HARM REDUCTION IN PRISONS

NSPs are not available in any prison in the region, and only five countries (Eswatini,[47] Kenya,[49] Mauritius,[50] Seychelles and Tanzania) provide OAT in prisons. All countries reportedly provide HIV testing and treatment inside prisons, although there are many documented barriers to access, particularly for women who use drugs, including humiliating and punitive treatment.[51] Viral hepatitis testing and treatment is largely unavailable, and no country has data on drug-related deaths in prisons. Moreover, no country provides naloxone in prison or has a naloxone-on-release programme.

WOMEN WHO USE DRUGS

Women who use drugs are still largely left out of research and service delivery.[51,52,53] In Mozambique, data on women who use drugs is virtually non-existent; a 2015 report indicated that women who use drugs are extremely vulnerable and lack access to healthcare, legal support, and sexual reproductive health rights and services.[3] This is despite the fact that women who use drugs in the region may be more vulnerable to HIV, for example through involvement in the sex industry.[54,55]

Research in South Africa has found that women who use drugs face many additional barriers to accessing harm reduction services, including stigma, sexual and physical violence, harassment from law enforcement and a lack of tailored services.[51,53,56] New programmes supported by the Dutch Ministry of Foreign Affairs' Love Alliance grant and the United Nations Office on Drugs and Crime are being implemented in the country to improve access to HIV and sexual and reproductive health services for women who use drugs through the training of community healthcare workers.[42]

PUNITIVE DRUG POLICIES AND LIMITED FUNDING

Ten countries in Eastern and Southern Africa make explicit, supportive reference to harm reduction in national policy documents (see Table 3, page 60). The East African Community Regional Policy on Alcohol, Drugs and Substance Abuse aims to scale up harm reduction programmes in the East African Community states (Burundi, Democratic Republic of the Congo, Kenya, Rwanda, South Sudan, Tanzania and Uganda).[57] In South Africa, NSPs are included in the *South African National Strategic Plan on HIV, Tuberculosis and STIs 2017-2022*, and activists, including the South African Network of People who Use Drugs, are providing input into the renewed plan for 2023 to 2025.[35,58]

In Mauritius, the provision of sterile needles and syringes is explicitly permitted by the HIV and AIDS Act of 2006.[59] Research from Kenya suggests that the lack of a legal framework for harm reduction results in de-prioritisation of harm reduction programmes in domestic budgets.[60]

POSITIVE DEVELOPMENTS

For the first time, Uganda has included people who inject drugs as a key population in the National HIV *Strategic Plan 2020/21 to 2024/25*.[61] Guidelines for access to HIV services for people who use drugs and a draft standard operating procedure for police on interacting with people who use drugs have also been developed.[19] A diversion strategy for people who use drugs has been adopted by the police, and 85 law enforcement officers had been trained on its implementation by March 2022.[62]

In 2020, Kenya revised its OAT guidelines to include take-home doses and buprenorphine.[30] Moreover, Kenya amended its Narcotics, Drugs and Psychotropic Substances Act to decriminalise drug paraphernalia, differentiate in law between amounts for use and amounts for trafficking, reduce imprisonment for personal cannabis possession from 10 years to no more than 5 years, and introduce an option of a fine of not more than 100,000 Kenya Shillings (about USD 850) for personal cannabis possession.[63]

NEGATIVE DEVELOPMENTS

Governments in the region continue to promote policies associated with a failed prohibitionist approach to drugs.[64] Kenya has introduced penalties for law enforcement officers who aid offences through 'concealing the commission of any offence' and has also made it mandatory to disclose information about offences.[63] Civil society in Kenya fear that the amendments will be exploited by law enforcement to target people charged with low-level drug crimes.[65] Zimbabwe's public health policies do not take into account drug use or identify people who use drugs as a key population.[3] In Mozambique, 'inciting drug use' and 'abandoning drug use paraphernalia in a public place' are crimes. In March 2022, the local government in Maputo, Mozambique banned syringe distribution in the community, motivated by complaints about syringes being left in public spaces, though the ban was lifted in mid-2022.[3] In South Africa, drug testing in schools is permitted by law; drug testing is permitted in work places when it is referenced in employment contracts or in a substance use policy.[3,42]

FUNDING GAP

There is strong political commitment across the region to address HIV, and most countries have adopted ambitious targets to expand HIV programmes and increase domestic funding for these programmes.[10] But adequate funding for harm reduction remains a major challenge, and countries still rely on international donors.[60] PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) are the main harm reduction donors in the region.

Domestic funding for harm reduction varies across the region. The governments of Seychelles and Mauritius fund national OAT programmes.[66] In Kenya, during the 2016-2017 financial year, the government contributed 25% of the total spending on HIV but only 8% of this funding went toward HIV prevention (including, but not limited to, harm reduction).[15] In South Africa, apart from one programme in the city of Tshwane, no other harm reduction services are funded by the national government.[3,67] In Uganda, no domestic funding was provided for harm reduction in 2017, 2018 and 2019; all services were funded by international donors.[68] The sustainability of harm reduction programmes in Tanzania also depends on international funding.[69]

Civil society reports that these funding gaps greatly hamper the scale up of harm reduction in the region.[19,24,40,44]

Support don't Punish in front of a prison in Mauritius. L'Initiative sida, tuberculose and paludisme.

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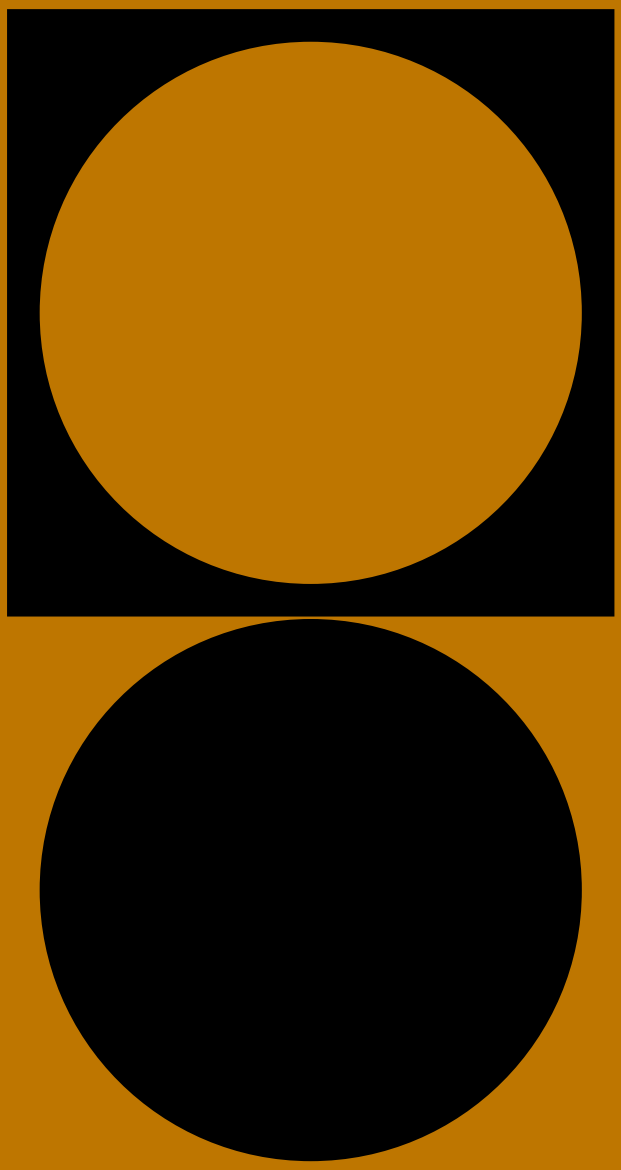
REGIONAL OVERVIEW: EURASIA



THE GLOBAL STATE
OF HARM REDUCTION 2022

HARM REDUCTION INTERNATIONAL

TABLE 4 EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN EURASIA

Country/territory	People who inject drugs[a]	HIV prevalence among people who inject drugs (%)[a]	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[a]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[a]	Harm reduction responses[b]				
					NSP[c]	OAT[d]	Peer distribution of naloxone[e]	DCR[f]	Safer smoking equipment[g]
Albania	7,000	0.5	34	20.2	✓ 2	✓ M B	×	×	×
Armenia	9,000	1.1	49.2	nd	✓ 12	✓ M	×	×	×
Azerbaijan	60,300[22]	9.8	59.3	7.9	✓ 17	✓ M	×	×	×
Belarus	79,500	25.2	59	9.6	✓ 34	✓ M B	×	×	×
Bosnia and Herzegovina	10,500	0.1	39.5	0.2	✓ 2	✓ M	×	×	×
Bulgaria	17,000	4.4	67.8	6	×	✓ M B O	×	×	×
Croatia	6,000	0.4	36.7	1	✓ 137	✓ M B O	×	×	×
Czechia	40,500	0.3	17.4	15.1	✓ 111	✓ M B	×	×	✓
Estonia	7,000	51.4	79.2	4.8	✓ 23	✓ B	×	×	✓
Georgia	52,500	1.6	62.4	7.2	✓ 14	✓ M B	✓	×	×
Hungary	6,500	0	35.9	1	✓ 31	✓ M B	×	×	×
Kazakhstan	113,000	9.2	58.8	7.9	✓ 125	✓ M	×	×	×
Kosovo	4,600[23]	0[23]	23.8[23]	0.1[23]	✓	✓ M	×	×	×
Kyrgyzstan	28,000	12.4	43.9	11.3[22]	✓ 40	✓ M	✓	×	×
Latvia	7,000	16.2	69.2	2	✓ 20	✓ M	×	×	×
Lithuania	8,000	8.3	65.6	10.5	✓ 11	✓ M B	×	×	×
Moldova	27,500[22]	28.3	50	4.8	✓ 28	✓ M B	×	×	✓
Montenegro	2,300	0.1	44.2	0	✓ 2	✓ M B	×	×	×
North Macedonia	6,500	0	65.4	nd	✓ 16	✓ M B	×	×	×
Poland	14,664[24]	15.4	58.7	3.9	✓ 7	✓ M B	×	×	×
Romania	17,024[25]	19.4[25]	72.7[25]	3.2[25]	✓ 2	✓ M B	×	×	×
Russia	1,274,000	49.8	72.5	9	✓	×	×	×	×
Serbia	28,500	0	42.6	10.5	✓ 2	✓ M B	X	×	×
Slovakia	18,000	0	38.5	2.7	✓ 19	✓ M B	X	×	✓
Slovenia	5,500	0.3	28.6	3.4	✓ 139	✓ M B O	✓	×	✓
Tajikistan	26,000	18	61.3	2[26]	✓ 48	✓ M	✓	×	×
Turkmenistan	nd	nd	nd	nd	×	×	×	×	×
Ukraine	296,000	20.4	60.6	4.6	✓ 2,380	✓ M B	×	× [h]	×
Uzbekistan	54,500	7.3	51.7	nd	✓ 230	×	×	×	×

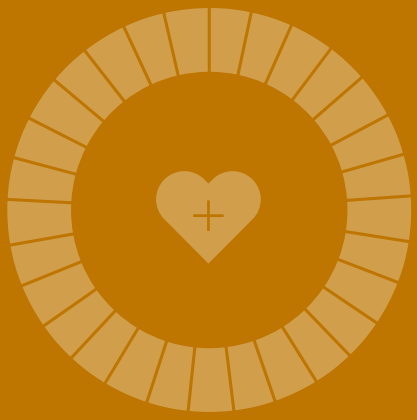
a Unless otherwise stated, data is from Degenhardt et al (under review).[1]
b Data sourced in Global State of Harm Reduction survey responses, unless otherwise stated.[2–21]
c At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available)
d At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, M=methadone.
e At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training, and facilitates secondary distribution of naloxone between peers.
f At least one drug consumption room (also known as safe consumption sites among other names) operational in the country or territory, and the number of facilities.
g At least one programme in the country or territory distributing safer smoking equipment to people who use drugs
h Although one harm reduction facility in Ukraine permits drug use on site, it is not officially sanctioned by local or national government.

AVAILABILITY OF HARM REDUCTION SERVICES

NSPs, OAT AND DCRs SINCE 2020

27 countries (93%) in Eurasia provide **needle and syringe programmes** (no change from 2020)

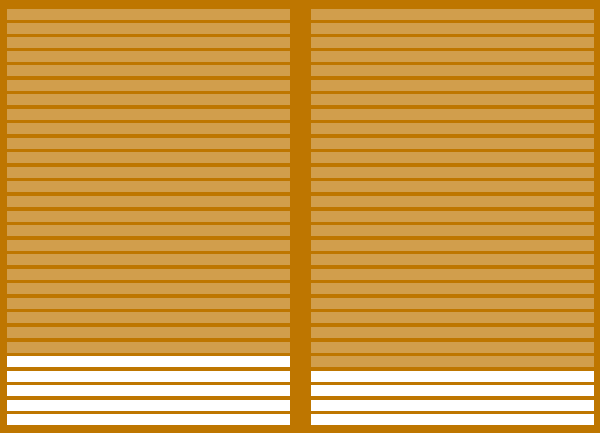
26 countries (90%) in Eurasia provide **opioid agonist therapy** (no change from 2020)



No country in Eurasia provides **officially sanctioned drug consumption rooms** (no change from 2020)

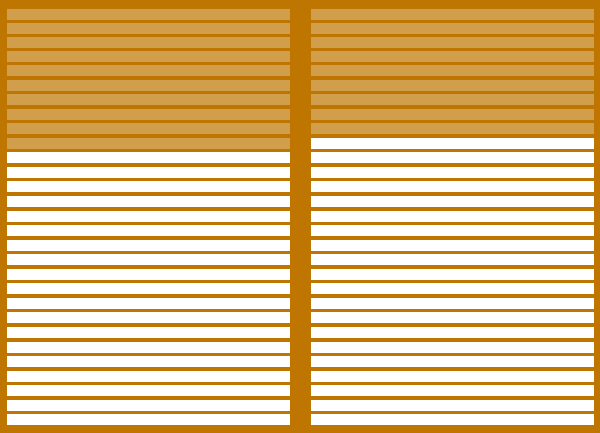
HARM REDUCTION IN PRISONS

2020 2022



4 countries in Eurasia **provide needle and syringe programmes** in prisons.[a]

2020 2022



20 countries in Eurasia provide **opioid agonist therapy** in prisons (+1 since 2020: Kosovo introduced prison OAT, while reports suggest it is no longer available in Georgia and Hungary)

SAFER SMOKING KITS ARE NOW AVAILABLE IN CZECHIA, ESTONIA, SLOVAKIA AND SLOVENIA

a In 2018 and 2020, the *Global State of Harm Reduction* reported the existence of prison NSP in North Macedonia. However, new reports from national civil society organisations show that prison NSP has never been meaningfully implemented in the country.

REGIONAL OVERVIEW

AUTHOR:
MARIA PLOTKO

INTRODUCTION

Harm reduction is included in national government policies in 25 of the 29 countries in Eurasia. Despite this, in the majority of countries in the region, the policy environment is dominated by punitive approaches focused on supply reduction and criminalisation. People who use drugs are vulnerable to stigma, discrimination, arbitrary arrest, and ill-treatment by police, health professionals, social services and society at large.[27,28,29] According to HIV Justice Worldwide, Eastern Europe and Central Asia has the second highest number of laws criminalising HIV exposure, non-disclosure and transmission, with Belarus, Russia and Uzbekistan having particularly high numbers of criminal cases related to these laws.[30]

Approximately 2.2 million people inject drugs in Eurasia (see Table 4, page 72). However, there is no data from Turkmenistan, and many countries in Eurasia do not collect regular data on the number of people who use drugs. When they do collect data, it frequently lacks even basic disaggregation by gender. This negatively impacts advocacy and the expansion and introduction of new harm reduction services.

According to national experts, injecting drug use has reduced over recent years, but it is still common, particularly in Belarus, Estonia, Georgia, Russia and Ukraine.[2–21,26] Cannabis remains the most commonly used drug, followed by opioids (illicit methadone, fentanyl and heroin) in the eastern part of the region, and stimulants (primarily methamphetamine and cocaine) in the western part, in countries such as in Czechia and Hungary.[31] Amphetamine-type stimulants are reported to be the most popular injected substances in Czechia, Slovakia and Hungary.[32,33,34]

New psychoactive substances (NPS) are becoming increasingly popular in the post-Soviet part of the region due to their low price and high availability.[35] A recent study in Moldova provided evidence of a significant increase in the use of synthetic cathinones and synthetic cannabinoids.[36] The use of NPS is associated with increased risk of HIV due to multiple injections and an increased number of sexual contacts.[37,38] There are also reports of an association between the use of NPS and mental health issues.[38]

"Eastern Europe and Central Asia has the second highest number of laws criminalising HIV exposure non-disclosure and transmission, with Belarus, Russia and Uzbekistan having particularly high numbers of criminal cases related to these laws"

HIV AND TUBERCULOSIS

According to The Joint United Nations Programme on HIV/AIDS (UNAIDS), Eastern Europe and Central Asia has the fastest growing HIV epidemic in the world with 43% of new cases attributed to injecting drug use.[22] For example, HIV self-testing is approved in national policy in Albania, Armenia, Belarus, Bosnia and Herzegovina, Georgia, Kyrgyzstan, Latvia, Republic of Moldova, Poland, Romania, Russia, Tajikistan, Ukraine, Uzbekistan and is available at harm reduction sites in Ukraine, Estonia, Lithuania, Latvia, Moldova, Poland and Russia. In Poland, Projekt Test runs an HIV helpline that assists with home self-testing.[39]

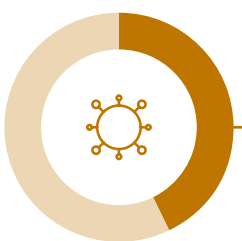
A high prevalence of HIV and criminalisation make people who use drugs vulnerable to tuberculosis.[40] People in prison are more likely to acquire tuberculosis, and tuberculosis services both in prisons and in the community are rarely tailored to the needs of people who use drugs.[41] As a result, interruptions to tuberculosis treatment are common, resulting in high prevalence of multi-drug resistant tuberculosis.[42] Low access to testing and treatment services often means that people who use drugs come in contact with the health system at late stages of the disease.[42]

NEEDLE AND SYRINGE PROGRAMMES (NSPs)

As of 2022, NSPs were available in 27 out of 29 countries in Eurasia. The two exceptions are Turkmenistan, where there have never been NSPs, and Bulgaria where services closed in 2020 following the withdrawal of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund). NSP facilities are mainly located in big cities. In Uzbekistan, NSPs are only available through general primary healthcare facilities, making them less acceptable to clients due to the stigma, discrimination and criminalisation they experience. Syringes are accessible via vending machines in Czechia, Hungary, and Georgia, and there are plans to introduce them in Moldova in late 2022.[5,16,17,20,43]

However, in most countries in the region, NSPs are operated by community organisations, which integrate services with HIV and hepatitis C testing, mental health consultations, legal assistance, support from social workers and referrals to other health and social services.[2–21] Across the region during the COVID-19 pandemic, the social component of NSPs (personal interaction between clients, peers and service providers) went online, expanding the pool of clients and making services more accessible.[44]

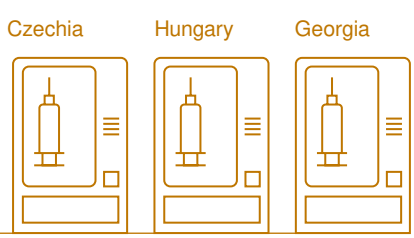
Injecting drug use is the leading cause of new HIV infections in Eastern Europe and Central Asia



43%

43% of new HIV cases in Eurasia are attributed to injecting drug use

Syringe dispensing machines are available in at least three countries



"In most countries in the region, NSPs are operated by community organisations, which integrate services with HIV and hepatitis C testing, mental health consultations, legal assistance, support from social workers and referrals to other health and social services."

OPIOID AGONIST THERAPY (OAT)

As of 2020, OAT was available in 26 countries, but remains prohibited in Russia, Turkmenistan, and Uzbekistan. Coverage varies considerably and is extremely low in some states. There are only six countries in which more than 20% of people who primarily inject opioids receive OAT (Croatia, Estonia, Hungary, Montenegro, North Macedonia and Slovenia).[45] The Eurasian Harm Reduction Association reports that services are of poor quality, as most OAT services do not operate according to person-centred and gender-sensitive principles.[46] Additional services provided by OAT programmes, such as psychosocial support and training for health workers, are the two areas that have suffered the most during the transition to national funding after the withdrawal of the Global Fund, including in Belarus and Moldova.[47] Some countries have private OAT sites, for example, Ukraine and Romania.[3,7,15]

Heroin-assisted therapy (HAT) as a form of OAT remains unavailable throughout the region.

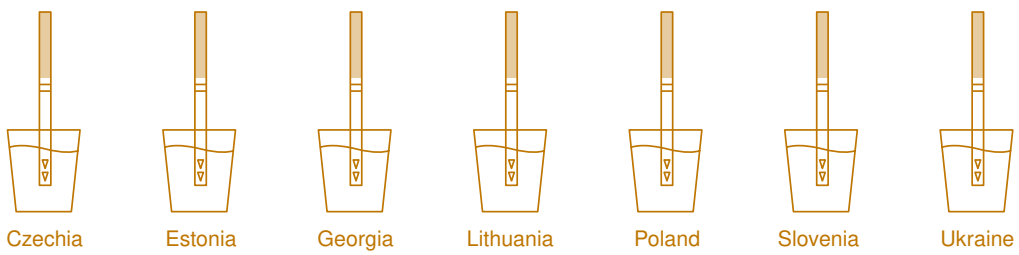
Significant barriers to OAT remain. These include a repressive policy and legal environment, unequal coverage between rural and urban areas, stigma, a lack of take-home dosing (notably in Azerbaijan, Belarus and Kazakhstan), opposition by law enforcement officials, a lack of trust between service providers and clients, and abstinence-based approaches.[2–21] Using opioids with other drugs can lead to people being excluded from OAT programmes in Azerbaijan, Belarus, Kazakhstan, Montenegro, Poland and Ukraine.[14,15,21,24]

During the COVID-19 pandemic, all countries with OAT programmes introduced take-home dosing for all clients. Unfortunately, some (for example Azerbaijan and Georgia) stopped this practice as soon as COVID-19 infection levels decreased.[17,44] Civil society efforts have helped to reinstate, and will work to maintain, take-home dosing in Georgia to ensure higher levels of accessibility.[44]

SAFER SMOKING KITS, STIMULANT PRESCRIBING AND DRUG CHECKING

Safer smoking kits are now available in Czechia, Estonia, Slovakia and Slovenia.[4,9,11,18–20] In Moldova, thanks to civil society's efforts, a new package containing pipes, saline solution, calcium, lip balm, and over-the-counter medications for heart

Drug checking is available in at least seven countries



palpitations, pain and anxiety has been introduced for people who use NSPs.[5,6,16]

In 2020, Czechia introduced a stimulant prescription programme for people who use stimulants, following similar principles to OAT.[20,48] Psychiatrists are now able to prescribe methylphenidate (also known as Ritalin) to people who use methamphetamines, whereas previously methylphenidate could only be formally prescribed for hyperactivity and sleep disorders.[48,49]

Drug checking is mostly provided through the distribution of reagent test kits at festivals and in nightlife settings in Czechia, Estonia, Georgia, Lithuania, Poland, Slovenia and Ukraine.[49,50,51,52] In Slovenia, a civil society organisation called DrogArt accepts samples of substances on a regular basis and provides data to the national early warning system, making it possible to issue alerts about potentially dangerous batches of drugs.[50,53] There are still no licensed drug consumption rooms (DCRs) in the region, although the first harm reduction site that allows drug use on its premises was opened in Sumy, Ukraine in 2019 and continues to be operational as of September 2022.[a] DCRs continue to be on the advocacy agenda for civil society organisations in Czechia, Estonia, Moldova, Montenegro, Poland and Slovenia.[2,9,11,18–20]

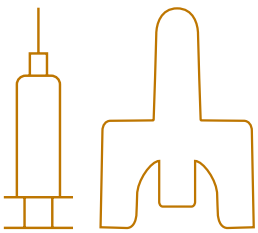
HARM REDUCTION IN PRISONS

Twenty-one countries in Eurasia provide OAT for maintenance in prisons. There are reports that Kosovo now implements OAT in prisons, but in Georgia OAT is only available for short detoxification rather than long-term maintenance treatment, and in Hungary prison OAT is virtually inaccessible in practice.[54] Even where it is implemented, OAT in prisons is not widely accessible. In Albania, Latvia, Montenegro and Serbia, people cannot start OAT while in prison, but it is available if people were on OAT before being incarcerated.

As of 2022, only four countries had NSPs in prisons (Armenia, Kyrgyzstan, Moldova, and Tajikistan). Research in Moldova in 2021 found some concerns around the accessibility of NSPs in the country's prisons, including issues related to confidentiality and discrimination when accessing other health services.[55] No programmes providing naloxone on release from prison were reported in the region.[56]

Naloxone availability in Eurasia

Take-home naloxone programmes: Albania, Czechia, Estonia, Georgia, Kyrgyzstan, Lithuania, Moldova, Slovenia, Tajikistan and Ukraine



Naloxone peer-distribution programmes: Georgia, Kyrgyzstan, Slovenia and Tajikistan.

a While this service has some support from a government narcological clinic, it does not have the formal endorsement of local government. For this reason, it is not included in the *Global State of Harm Reduction* global figures on DCRs. In 2018 and 2020, the *Global State of Harm Reduction* reported the existence of prison NSP in North Macedonia. However, new reports from national civil society organisations show that prison NSP has never been meaningfully implemented in the country.

OVERDOSE AND NALOXONE PROGRAMMES

The proportion of deaths due to overdose in Eurasia is likely to be underestimated, in part due to the stigma related to drug use. In many cases, overdose goes unreported on death certificates; anecdotal evidence suggests families often request that the cause of death be recorded as a heart-related condition.[2–21]

Although emergency medical staff have access to naloxone in all countries, for those most likely to witness an overdose (such as people who use drugs and their friends and family), access is extremely limited. In many countries in the region, naloxone is only available via prescription. Nevertheless, naloxone and overdose prevention education is explicitly stated as part of the harm reduction programmes for people who use drugs in Georgia, Kyrgyzstan, Moldova, Tajikistan and Uzbekistan.[56]

Naloxone peer-distribution programmes exist in four countries in the region (Georgia, Kyrgyzstan, Slovenia and Tajikistan), while other forms of take-home naloxone programmes operate in a further six countries (Albania, Czechia, Estonia, Lithuania, Moldova and Ukraine).[6,7,9,11,12,15–20,36]

WOMEN WHO USE DRUGS AND PARENTAL RIGHTS

There are insufficient services tailored to the needs of specific populations in Eurasia, notably sex workers, gay men and other men who have sex with men, LGBTQI+ people, and young people who use drugs. In particular, there is a lack of gender-sensitive services for women who use drugs.[2–21]

There is little data on the number of women who use drugs in the region, and OAT is frequently inaccessible to pregnant and parenting people who use drugs.

A particular issue in the region is the deprivation of parental rights based solely on drug use. One of the most extreme situations is in Belarus, where children are deemed to be in a 'socially dangerous situation' if they are parented by a woman who either uses drugs or is on OAT.[21] If the state recognises a child as being in a socially dangerous situation, a mark is put in the parent's passport and medical record, increasing stigma and discrimination. In addition, social services can take the child away from the family. In such cases, parents must pay monthly fees to the state. Conditions for returning a child to the mother often include providing what the state deems to be adequate housing and a sufficient income. Civil society organisations report that many people have difficulties complying with these conditions while paying the monthly fees to the state.[21]

In November 2021, the United Nations Committee on the Elimination of Discrimination Against Women urged Kyrgyzstan to amend a law which provides for the deprivation of parental rights based on parental drug dependence, and to improve access for women who use drugs to harm reduction services.[57]

FUNDING FOR HARM REDUCTION

In almost all the region's countries, due to criminalisation (de facto and de jure), harm reduction and other health services are severely underfunded and depend on international donors. Withdrawal of international funding from the region has left gaps in service provision which governments are reluctant to fill.

SPOTLIGHT

UKRAINE

Since 24 February 2022, the Russian invasion of Ukraine has destroyed lives, cities and essential supply chains. Millions of Ukrainians have been forced to leave their homes. As of September 2022, more than 14 million Ukrainians had been displaced, either within Ukraine or to other European countries.

Inside Ukraine

Civil society has led the response to the humanitarian crisis. In the first few weeks of the war, regional and national organisations launched weekly coordination calls, which also included the Center for Public Health at the Ministry of Health in Ukraine and international donors.

Community-led and civil society organisations in Ukraine, such as the All-Ukrainian Association of People who Use Drugs (VOLNA), Light of Hope and Convictus, have provided shelter and delivered food, medication and harm reduction supplies to the Ukrainian regions that were cut off from supply chains or where people could not leave their homes. The Eurasian Harm Reduction Network (EHRA) provided funds for VOLNA to evacuate people who use drugs from Donetsk and Luhansk; areas at the centre of the conflict. Support from Médecins du Monde ensured that civil society organisation Club Svitanok could continue providing harm reduction services in Donetsk, while MADRE funded the evacuation of some of Club Svitanok's staff from the region.

Early in the war, VOLNA and the Ukrainian Network of Women who Use Drugs (VONA) successfully advocated for changing national OAT protocols, allowing people to receive take-home doses. Initially, 15-day take-home doses were provided; later this was extended to 30 days. VOLNA and VONA also pushed to secure an uninterrupted supply of OAT across the Ukrainian regions most affected by war and violence. In the Donetsk region, as of September 2022, only the OAT site in Bakhmut has closed, while sites in Kramatorsk, Slavyansk, Pokrovsk and Druzhkovka continue to operate. In addition, policy changes now mean that people are no longer required to be registered in a city to receive OAT.

Service delivery is impeded by the fact that harm reduction organisations have not received funding from the Ministry of Health since March 2022. It is not known when committed funds will reach these organisations.

Experiences in neighbouring countries

Due to stigma around drug use and HIV, upon arrival in new countries people tried to hide their status, avoid the public health system, and buy drugs through illicit channels rather than acquiring them through OAT programmes. Nevertheless, the governments of Hungary, Moldova, Poland, Romania, and Slovakia (all five border countries) issued special decrees ensuring continuation of treatment and access to medicines for refugees from Ukraine. For example, after 24 February 2022, everyone who arrived in Poland with a Ukrainian passport and PESEL identification number[a] could receive OAT and antiretroviral therapy (ART) free of charge. Most people with this documentation promptly received take-home OAT, either for a week or two weeks. In Slovakia, Ukrainian refugees do not need to have mandatory health insurance to receive OAT free of charge. This includes buprenorphine, a medicine which is limited in stock and not usually covered under the state's insurance programme.

Photos from Ukrainian organisation Light of Hope (LoH).

Local civil society organisations helped newly arrived clients navigate the system and get medication faster. They also assisted with translation, which is one of the main barriers for accessing services. These activities are mostly supported by international donors or operate without any funding at all, making sustainability a significant challenge.

The sudden influx of new clients has highlighted deficiencies in existing HIV and harm reduction services. In Slovakia, for example, people needed additional approval from the Ministry of Health to start ART. In Romania, the additional clients exposed the precariously low funding for OAT programmes. More generally, the refugee crisis highlighted the absence or limited availability of social and psychological support services and shelters open to people who use drugs across the region. The fact that clients of private OAT clinics are not registered in the Ukrainian OAT database also complicated the process of getting the medication to all who needed it.

In Romania, due to insufficient funding, the state OAT programme was unable to procure more medication, and instead referred new clients to the civil society organisation ARAS.[3] In Moldova, when people did not have their prescription with them, local community organisation Community Centre of Psychological Support for Drug Users (PULS) contacted staff at OAT centres in Ukraine to ensure continuity.[6]

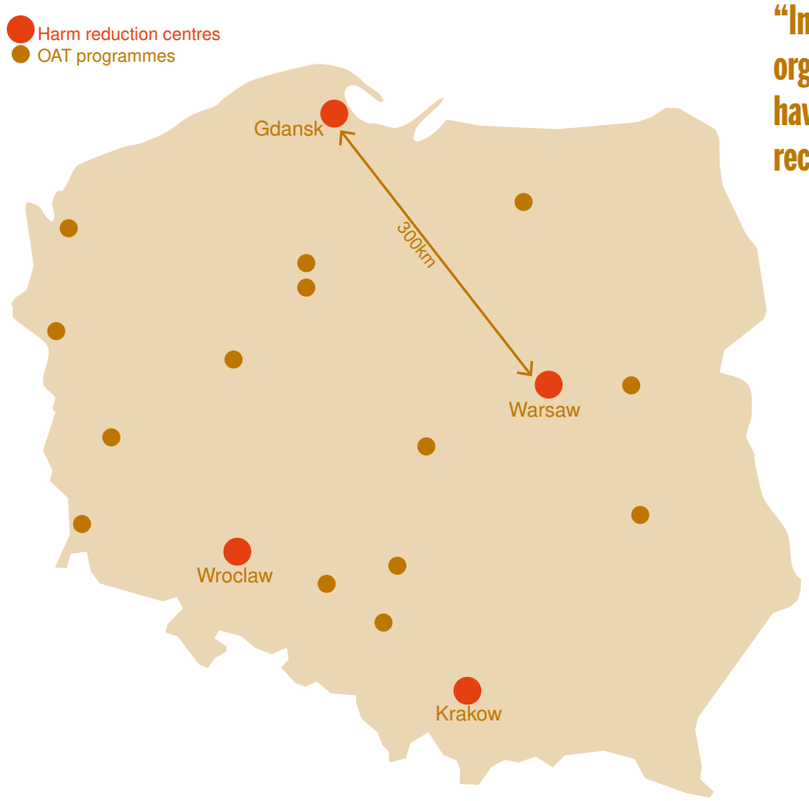
The war intensified needs for psychological support, shelters and food packages. With the help of international donors (such as the Global Fund, which launched emergency grant programmes), these services were established then expanded upon by civil society organisations.

On a positive note, the dire situation has shown that the region's harm reduction systems can work in ways that are more responsive and people-centred. For example, both in Ukraine and neighbouring countries, clients were required to complete fewer documents to enrol in drug treatment and receive take-home OAT. But civil society representatives are not optimistic that these more flexible, person-centred services will continue, not only for people who are refugees but also for the national clients, because funding is linked to the refugee crisis and only applies to those who came from Ukraine after 24 February 2022.[2,3,5,6]

a Powszechny Elektroniczny System Ewidencji Ludności (PESEL), the Universal Electronic Population Registration System, is an 11-digit digital symbol that identifies an individual.'

SPOTLIGHT

WHEN AVAILABILITY DOES NOT MEAN ACCESSIBILITY



"In Poland, civil society organisations report that people have to travel up to 100km to receive OAT"

Harm reduction programmes in Eurasia first developed as HIV prevention interventions among people who inject drugs. Historically, these programmes have served as links to care for the most vulnerable people who use drugs. However, across the region there are barriers to HIV and harm reduction services which, in practice, makes them inaccessible to people who use drugs. Among these are requirements for registration and formal identification and geographic barriers.

The need for ID

OAT programmes in Eurasia are often highly medicalised, high threshold and have strict rules. For example, programmes may require people to have government-issued identity documents (ID), referral from a psychiatrist or other supporting documentation to enrol.[60]

One of the most vivid examples of this is North Macedonia. Here, in order to access any state supported services (except in prison, where people are identified by fingerprints), individuals need to have an ID.[61] But to get an ID, they need to have a residential address. This creates obstacles for certain populations; for example, many houses built and occupied by Roma people are built illegally and therefore cannot be used to register an ID. In addition, landlords are often unwilling to register people in their apartments, especially people who use drugs. People experiencing homelessness do not have an address to register. Even if a person manages to get an ID, they need to find a family doctor, who in turn will be willing to make a referral to a psychiatrist, who can then make a diagnosis and prescribe OAT. But family doctors are often unwilling to take on people who use drugs or Roma people. People who do manage to get a prescription must be able to travel to one of only two OAT centres, both of which are in Skopje, North Macedonia's capital city.[65]

Harm reduction organisations in Eurasia often assist with lost or expired IDs, or when people simply do not have one. In Romania, people without a permanent address can get a temporary ID which can be renewed every two years.[3] In Slovakia, police can issue a temporary ID, and in Moldova, police can provide a certificate that can temporarily be used instead of an ID.[4,6,16,36]

Geographic barriers

Across the region, both NSP and OAT programmes have limited geographical spread and usually operate only in big cities. In Poland, civil society organisations report that people have to travel up to 100km to receive OAT. This journey must be taken daily, until clients meet requirements for take-home doses (these requirements include abstaining from using illicit drugs and attending therapy sessions).[2] This issue is replicated across the region. In Belarus, Kazakhstan and Ukraine, even moving between cities is problematic, as you can receive OAT only where you are registered.[7,14,15,21] Furthermore, within a city there is usually only one OAT service, meaning people may need to travel significant distances. The need to register to access take-home medication exacerbates the problem.[7,14,15,21]

Other issues include opening hours and the physical accessibility of sites. A lot of OAT sites open during work hours, making it difficult for clients who are employed to attend. People living with a disability may also have difficulties accessing OAT sites. For example, in Kazakhstan civil society organisations report that some OAT sites have stairs.[14]

In Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, Moldova, Tajikistan and Ukraine, in order to enrol on OAT or other drug dependence treatment, people are required to register in a 'drug user registry', but registering can limit people's ability to find a job, study and raise children.[14–16,21] This is also the case for people accessing drug treatment in Russia and Uzbekistan. Criminalisation, discrimination and stigma mean that many people who use drugs are not inclined to access such services.

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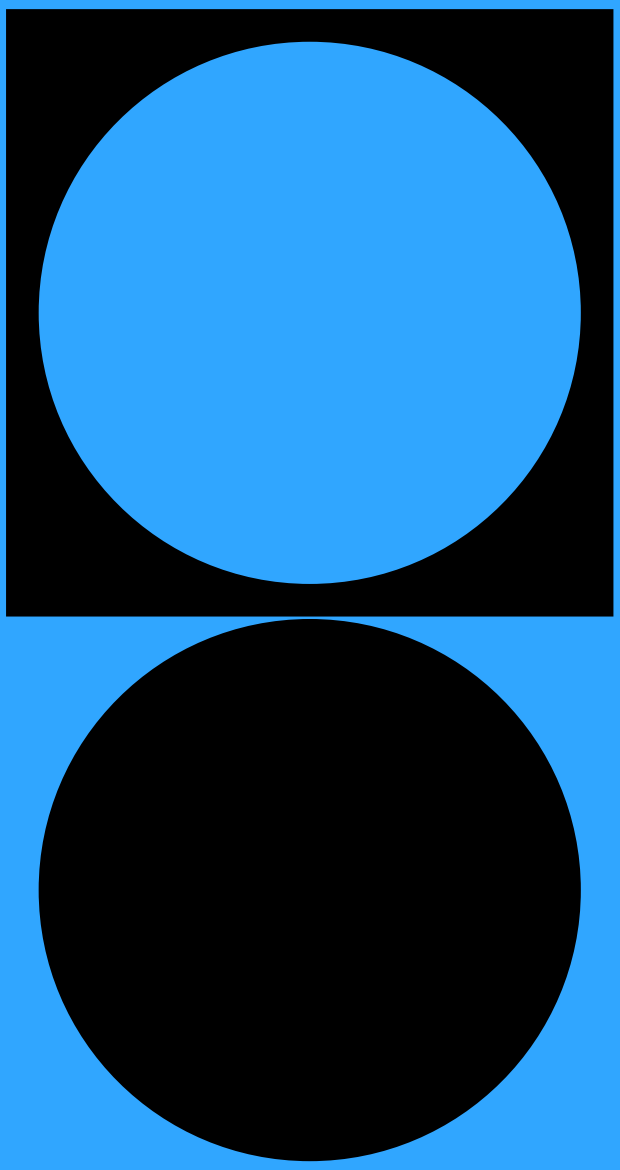
REGIONAL OVERVIEW: LATIN AMERICA AND THE CARIBBEAN



THE GLOBAL STATE
OF HARM REDUCTION 2022

HARM REDUCTION INTERNATIONAL

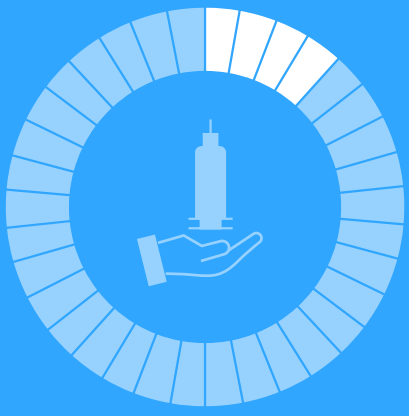
TABLE 5 EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN LATIN AMERICA AND THE CARIBBEAN

Country/territory	People who inject drugs[a]	HIV prevalence among people who inject drugs (%)[a]	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[a]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[a]	Harm reduction responses[b]				
					NSP[c]	OAT[d]	Peer distribution of naloxone[e]	DCR[f]	Safer smoking equipment[g]
Antigua and Barbuda	nd	nd	nd	nd	✗	✗	✗	✗	✗
Argentina	11,500	49.7	54.6	8.6	✗	✓[2]	✗	✗	✗
Bahamas	nd	nd	nd	nd	✗	✗	✗	✗	✗
Barbados	nd	nd	nd	nd	✗	✗	✗	✗	✗
Belize	nd	nd	nd	nd	✗	✗	✗	✗	✗
Bolivia	4,500	nd	nd	nd	✗	✗	✗	✗	✗
Brazil	237,000	48	48.6	2.3	✗	✗	✗	✗	✓[5]
Chile	50,000	nd	nd	nd	✗	✗	✗	✗	✗
Colombia	nd	5.7	30.5	nd	✓[3]	✓[3]	✗	✗	✗
Costa Rica	nd	nd	nd	nd	✗	✗	✗	✗	✗
Cuba	nd	nd	nd	nd	✗	✗	✗	✗	✗
Dominican Republic	nd	nd	nd	nd	✓[1]	✗	✗	✗	✗
Dominica	nd	nd	nd	nd	✗	✗	✗	✗	✗
Ecuador	nd	nd	nd	nd	✗	✗	✗	✗	✗
El Salvador	7,500	nd	nd	nd	✗	✗	✗	✗	✗
Grenada	nd	nd	nd	nd	✗	✗	✗	✗	✗
Guatemala	nd	nd	nd	nd	✗	✗	✗	✗	✗
Guyana	nd	nd	nd	nd	✗	✗	✗	✗	✗
Haiti	nd	nd	nd	nd	✗	✗	✗	✗	✗
Honduras	nd	nd	nd	nd	✗	✗	✗	✗	✗
Jamaica	nd	nd	nd	nd	✗	✗	✗	✗	✗
Mexico	111,500	4.3	95.3	nd	✓[4]	✓[4]	✓[4]	✓[4]	✗
Nicaragua	nd	0	nd	nd	✗	✗	✗	✗	✗
Panama	nd	nd	nd	nd	✗	✗	✗	✗	✗
Paraguay	nd	9.4	9.8	nd	✗	✗	✗	✗	✗
Peru	nd	13	nd	nd	✗	✗	✗	✗	✗
Puerto Rico	21,000	6	78.4	nd	✓[1]	✓[1]	✓	X	X
Saint Kitts and Nevis	nd	nd	nd	nd	✗	✗	✗	✗	✗
Saint Lucia	nd	nd	nd	nd	✗	✗	✗	✗	✗
Saint Vincent and the Grenadines	nd	nd	nd	nd	✗	✗	✗	✗	✗
Suriname	nd	nd	nd	nd	✗	✗	✗	✗	✗
Trinidad and Tobago	nd	nd	nd	nd	✗	✗	✗	✗	✗
Uruguay	6,000	18.5	21.9	4.5	✗	✗	✗	✗	✗
Venezuela	nd	nd	nd	nd	✗	✗	✗	✗	✗

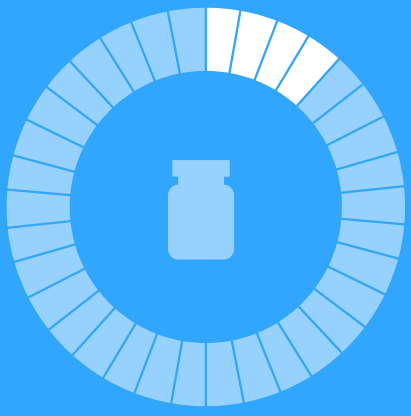
a Unless otherwise stated, data is from Degenhardt et al (under review).[1]
b Data sourced in Global State of Harm Reduction survey responses, unless otherwise stated.
c At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available)
d At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, M=methadone.
e At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training, and facilitates secondary distribution of naloxone between peers.
f At least one drug consumption room (also known as safe consumption sites among other names) operational in the country or territory, and the number of facilities.
g At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.

AVAILABILITY OF HARM REDUCTION SERVICES

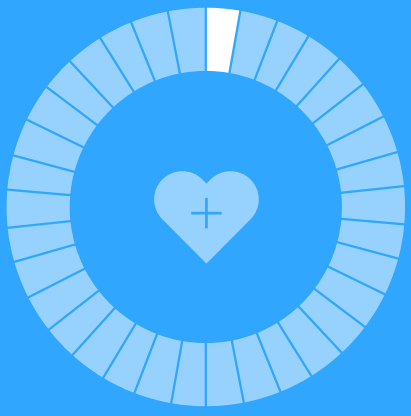
NSPs, OAT AND DCRs SINCE 2020



4 countries (12%) in Latin America and the Caribbean provide **needle and syringe programmes** (no change from 2020)



4 countries (12%) in Latin America and the Caribbean provide **opioid agonist therapy** (no change from 2020)



1 country in Latin America and the Caribbean provides **drug consumptions rooms** (+1 since 2020, Mexico)

HARM REDUCTION IN PRISONS

No country in Latin America and the Caribbean **provides needle and syringe programmes** in prisons (no change from 2020)

No country in Latin America and the Caribbean provides **opioid agonist therapy** in prisons (no change from 2020)

COCAINE AND NON-INJECTED DRUG USE ARE THE HARM REDUCTION PRIORITIES IN MOST OF THE REGION

REGIONAL OVERVIEW

AUTHORS:
CAROLINA AHUMADA and **JORGELINA DI IORIO**

INTRODUCTION

Latin America and the Caribbean is home to many complex and connected social inequalities. Intersectional inequalities, including those relating to class, gender, age, ethnicity, race, place of residence, migratory status and disability, create exclusion and discrimination. The COVID-19 pandemic has greatly exacerbated these inequalities. It is no coincidence that Latin America and the Caribbean has been one of the regions most affected by the COVID-19 pandemic.[1] People who use drugs are one of the most affected populations, in terms of physical, social, economic and legal harms.

Since 2020, the main concern of civil society organisations in the region has been setbacks in drug policy reform by governments in Brazil, Uruguay, Chile, Honduras, El Salvador, Peru, Ecuador and Bolivia. Civil society organisations link these regressive approaches to drug policy to an increase in violence and other human rights violations.[2–13] In contrast, new administrations in Mexico and Colombia have raised hopes of potential reform, particularly regarding cannabis.[11,13]

Cocaine is the drug of greatest health concern in the region. As it tends to be inhaled or smoked,[14] traditional harm reduction services associated with injecting and opioid use, such as needle and syringe programmes (NSPs), access to naloxone and opioid agonist therapy (OAT), are less relevant in the region. Interventions such as distribution of safer smoking kits and drug checking are prioritised. More broadly, civil society organisations report that the harm reduction movement in Latin America characterises itself as a human rights-based, political and humanitarian approach to the social vulnerability of people who use drugs, rather than an approach that focuses on the implementation of health and social interventions.[15]

Decriminalising and regulating adult use of cannabis is the main priority for drug policy reform for civil society in the region.[3–6,16] There has been a lack of approaches that are sensitive to gender and ethnicity, which has highlighted the need to incorporate intersectional approaches to harm reduction programming and policy across governments in the region and civil society.[3,5,6,8,10,12,17,18] In 2016, this led to the Latin American Network of Anti-Prohibitionist Feminists (RENFA) being established. The network was expanded in 2020 and now includes member organisations and people who use drugs from Argentina, Bolivia, Brazil, Ecuador, Mexico, and Uruguay.[5]

“The harm reduction movement in Latin America characterises itself as a human rights-based, political and humanitarian approach to the social vulnerability of people who use drugs, rather than an approach that focuses on the implementation of health and social interventions.”

NEEDLE AND SYRINGE PROGRAMMES (NSPs)

The low prevalence of injected drug use in Latin America means that NSPs are not the highest priority for harm reduction responses in the region.[14] As reported in the *Global State of Harm Reduction 2020*, only Colombia, the Dominican Republic, Puerto Rico and Mexico have NSPs. Since 2020, Colombia and Mexico have opened new NSP sites. Despite the low rate of injection drug use in the region, NSP coverage is still insufficient, and funding has decreased due to the prioritisation of resources to respond to the COVID-19 pandemic. There remain many barriers to accessing services, including geographic and logistic, as services are limited to a few cities and have limited operational capacity.[10,11,13,17]

In Colombia, government-run NSPs have increased, but civil society organisations report that, unlike programmes co-managed with civil society organisations, the engagement of people who use drugs is limited at government-run NSPs. The lack of empathy people experience in state health centres where these NSPs are based negatively affects access.[10,13,17]

In Mexico, NSPs are managed by 12 civil society organisations that form the Mexican Harm Reduction Network (Red Mexicana de Reducción de Daños, REDUMEX). These are all based in the country's northern states where injecting drug use is more prevalent.[11]

OPIOID AGONIST THERAPY (OAT) AND ACCESS TO NALOXONE

The use of opioids is not epidemiologically significant in the region.[14] OAT programmes operate in Colombia, Puerto Rico and Mexico. In all three countries the programmes are implemented by local government. Each programme experienced a lack of supplies during the COVID-19 pandemic.[13] There are geographical and administrative barriers to access, including those relating to health workers' stigmatising and discriminatory attitudes and behaviour towards people who inject drugs.[10,13,17]

Access to naloxone in Colombia, the Dominican Republic and Mexico is limited. It is more widely available through civil society organisations in Puerto Rico, where doses are distributed directly to people likely to witness an overdose. Legal restrictions and the persistence of punitive policies are the main barriers affecting availability.[10,11,13,17] In Mexico, some progress has been made toward the reclassification of naloxone so that it can be directly accessible to people likely to witness an overdose. However, at present, access is possible only through donations to civil society organisations from partners in the United States.[11]

STIMULANTS AND NEW PSYCHOACTIVE SUBSTANCES (NPS)

Health harms linked to smoking cocaine are relatively high in the region, compared with harms from other drugs. Cocaine use is reported as the main reason for entering drug treatment in Argentina, Chile and Uruguay, and as the second most common reason in Brazil (after cannabis), and it also plays a significant role in Peru and Ecuador.[19] In Brazil, E de Lei has pioneered the delivery of kits for the safer use of smokable cocaine.[5] However, there is an information gap, and there is inadequate data to document associations between smokable cocaine and communicable diseases such as HIV, tuberculosis or hepatitis C.[2]

The use of amphetamine-type stimulants in Latin America and the Caribbean, including amphetamines, methamphetamine and pharmaceutical stimulants, is lower than other regions. Nevertheless, Mexico has higher rates of use of amphetamine-type stimulants than other countries in the region.[14] Some NPS appear to be

unique to the region. For example, a substance known as H is reportedly commonly used in Guayaquil, Ecuador, predominantly among people with low incomes. This substance, reported to contain heroin, diltiazem (a heart medication) and caffeine, was first observed in prisons and then moved to the streets. It is smoked and is extremely cheap.[12] Another example is 'tusi' (also known as 'tuci' or 'pink cocaine') popular in Argentina, Chile, Colombia, Costa Rica and Peru.[20] Tusi is often thought by people who use it to be the NPS 2CB (hence its name), but drug checking services have found it to be a combination of MDMA, ketamine and caffeine.[21,22]

There have been reports of carfentanyl being used as a cutting agent in cocaine. In February 2022, 24 young men died in the Puerta 8 neighbourhood of Buenos Aires after using cocaine contaminated with carfentanyl.[23] In Chile, through testing with fentanyl strips, fentanyl has been detected in samples of ketamine.[24]

In response to these challenges, implementation of drug checking has increased in the region since 2020. Argentina, Colombia, Chile, Peru, Mexico and Brazil are carrying out drug checking using colorimetric reagents through their harm reduction programmes, making it available at parties and mass events.[25] But drug checking services are not operating at the scale required to meet need.

DRUG CONSUMPTION ROOMS (DCR)

La Sala in Mexicali, Mexico run by Verter AC is the only DCR in the region, and this is exclusively for women who inject drugs.[11] The space has operated with interruptions since 2018. While it previously operated in defiance of the local government, the space now has tacit government endorsement. La Sala offers other harm reduction services, such as reproductive and sexual health services, legal support, peer counselling, drug checking, overdose prevention, HIV and hepatitis C prevention programmes and naloxone distribution. However, this single facility is insufficient for the more than 100,000 people who inject drugs in Mexico. This results in the existence of informal facilities (known as 'picaderos'). Some of these are run by civil society organisations and receive outreach visits, others are entirely closed off to harm reduction services.

No other licensed DCRs operate in the region. However, in Bogotá, Colombia, planning is at an advanced stage for a DCR for injected drug use, to be operated by Acción Técnica Social.[13] Despite the severe lack of official DCRs, harm reduction organisations often function as unofficial drug consumption rooms, sheltering clients from criminalisation, stigmatisation and violence.[5] Such organisations, for example É de Lei in Brazil, also connect clients with other health and social services.[26]

Mexico has the only drug consumption room (DCR) in the region, and this is exclusively for women who inject drugs.

CHEMSEX

Although sexualised drug use, with the intention of increasing pleasure, is widespread in the region, its identification with the international term 'chemsex' is relatively new.[27] Organisations in Argentina, Brazil and Colombia are currently carrying out exploratory studies to characterise sexualised drug use in the region, with the intention of designing harm reduction services.[5,13,28]

VIRAL HEPATITIS, HIV AND ANTIRETROVIRAL THERAPY (ART)

In Latin America, integrated services for viral hepatitis and HIV services are common for the general population, although access to testing and treatment varies between countries.[2,8–11,17,29] Although the use of smokable cocaine and other stimulants is associated with HIV and viral hepatitis risk behaviours, there are few services specifically for people who smoke cocaine.[30]

HARM REDUCTION IN PRISONS

Healthcare in prisons is lacking in Latin America and the Caribbean. Civil society organisations consider prison harm reduction programmes to be necessary, but it is not part of the political agenda in the region. No prison in the region provides OAT, NSP or naloxone.[2–4,8,10–13] One programme in Bolivia, run by Acción Andina, provides support rooted in a harm reduction approach for people after they have been released from prison if they have been diagnosed with drug dependence.[3]

Antiretroviral medication and testing for HIV and tuberculosis is officially available free of charge in all prisons in the region, although accessibility remains an issue (as reported in Argentina).[2]

POLICY DEVELOPMENTS FOR HARM REDUCTION

Despite some reforms, drug policies in the region are still based on the principles of the 'war on drugs'; namely, the criminalisation of the production, sale and use of illegal substances, plus abstinence-based treatment. This punitive approach results in violence and human rights violations.[31]

The governments in Colombia and Mexico have recently taken an alternative approach, presenting new opportunities for drug policy reform.[11,13] The Mexican government is currently discussing comprehensive regulation of cannabis use (medicinal and adult use), and the Colombian government is discussing the regulation of cocaine.[32]

In Brazil, Costa Rica and Uruguay, where harm reduction is supported in national policies, government funding for harm reduction services has been cut, forcing services to decrease their coverage.[4,6,8,18] Both in Brazil and Uruguay, civil society organisations warn of the increase in compulsory hospitalisation of people who use drugs as well as the increase in funding for abstinence-based treatment services.[5] In Brazil, the Bolsonaro administration has continued its dramatic shift away from promoting harm reduction to exclusively supporting abstinence-based programmes.[5] This has been accompanied by the administration's political persecution of academics, researchers and activists who are supportive of harm reduction.[4]

"The governments in Colombia and Mexico have recently taken an alternative approach, presenting new opportunities for drug policy reform. The Mexican government is currently discussing comprehensive regulation of cannabis use (medicinal and adult use), and the Colombian government is discussing the regulation of cocaine."

FUNDING DEVELOPMENTS

Civil society has observed an ongoing reduction in international funding for harm reduction in the region.[4,11,13,16] The Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) is currently funding two projects relating to harm reduction the region. One is in Colombia, which includes funding for NSP,[17] the other is the Positive Leadership Alliance and Key Populations programme (Alianza Liderazgo en Positivo y Poblaciones Clave; ALEP-PC), a multi-country project focusing on HIV and populations most affected by HIV, including people who use drugs.[12] In 2022, Costa Rica became the first country to include a representative of the community of people who use drugs on its Global Fund country co-ordinating mechanism (CCM), the national committee that oversees Global Fund grants. According to research by the Latin American Network of People who Use Drugs (LANPUD) and Harm Reduction International, no other country in the region has a representative from the community of people who use drugs on its CCM. This is despite the fact that the Global Fund indicates that people who use drugs are a key population and should therefore be represented,[33] and LANPUD has member organisations in ten countries in the region, meaning these representatives exist.[15,33]

Since 2020, both national and international funding has focused on the COVID-19 response. This has led to particularly significant decreases in national government budgets for mental health services and drug use in Argentina, Bolivia, Brazil, Colombia, Mexico and Peru.[4,11,13,16]

SPOTLIGHT

COVID-19, SMOKABLE COCAINE AND SOCIAL VULNERABILITY

Interventions from E de Lei providing COVID 19 prevention and care during pandemic

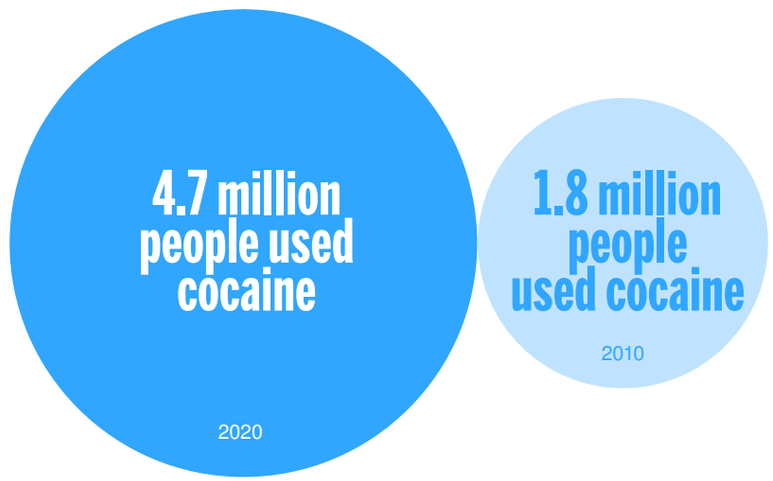
Cocaine is the most commonly used stimulant in the region, and smokable cocaine is the most commonly used drug among people experiencing homelessness.[2,5,8,14] Cocaine is produced, trafficked, and used in South America, where it is estimated that, in 2020, 1.6% of the population aged 15-64, or 4.7 million people, had used cocaine derivatives in the previous year. This estimate is more than double the estimate for 2010 (0.7%, 1.8 million people).[14]

Since the beginning of the COVID-19 pandemic, health inequalities have deepened. For example, people who are homeless and use drugs have less access to drug and harm reduction services than other people who use drugs, despite having a higher level of smokable cocaine use. Civil society organisations across the region report an increase in criminalisation and institutional violence against people with experience of homelessness, contributing to increased physical, psychological, legal, social and interpersonal risks associated with drug use.[2,4,5,5,8,11–14,16,29]

Harm reduction civil society organisations have been providing food, face masks, sanitising gel and access to drinking water as measures to prevent transmission of COVID-19 among people with experience of homelessness, as reported in Argentina, Brazil, Colombia, Ecuador and Uruguay.[2,4,5,5,8,11–13,16]

The use of smokable cocaine is highly stigmatised in the region. The increase in smoking cocaine, associated with growing poverty in the region,[14,19] generates challenges in the way harm reduction services are designed and implemented to reach people living on the streets. Harm reduction services also face the challenge of mitigating the stigma and discrimination associated with homelessness and smokable cocaine use.[34–36] Civil society and government-supported organisations in Argentina, Brazil and Colombia take a harm reduction approach to services for people with experience of homelessness. But, problematically, in Uruguay the government is proposing a law that would enable compulsory internment of people living on the streets.[8]

"In 2020, 1.6% of the population aged 15-64, or 4.7 million people, had used cocaine derivatives in the previous year. This estimate is more than double the estimate for 2010 (0.7%, 1.8 million people)"



SPOTLIGHT

TOWARDS REGULATED MARKETS FOR CANNABIS AND COCAINE

Cannabis and cocaine are the two most produced, trafficked and consumed illicit substances in the region.[14] Moving towards market regulation of both is a public health strategy.

Debates on the regulation of cannabis as a way to overcome criminal control of the drug market are progressing across Latin America and the Caribbean. But these developments, including national legislation,[37] coexist with prohibitionist discourses and punitive policies to control the supply of other illicit substances (e.g. in Colombia, Peru and Bolivia). This leads to criminalisation of and stigma towards people who use drugs, growers and small-scale sellers as well as an increase in violence linked to the illegal market.[38]

Uruguay is the only country in the region that has a comprehensive law regulating all cannabis use. It is also the first country in the world to legalise the cannabis market with strong state control.[37] Mexico and Colombia are moving towards comprehensive regulation of cannabis and have judicial rulings that guarantee access and production of cannabis.[37] Argentina, Brazil, Chile, Costa Rica, Ecuador, Paraguay, Panama, Peru and Puerto Rico have legislation on the medical use of cannabis. In all of these countries, except Puerto Rico, cannabis access is restricted to a medical-pharmaceutical approach.[15,37] Cuba, Bolivia, El Salvador, Guatemala, Honduras, Nicaragua and Venezuela maintain a strong prohibitionist position on cannabis.[37]

In Colombia, unlike Bolivia and Peru (the other major coca producers), progress has been made towards regulating the cocaine market. President Gustavo Petro took office in August 2022, and his administration has made clear its opposition to a 'war on drugs' approach and halted the forced eradication of coca crops.[37]

Prejudice and stigma continue to be major obstacles to drug policy reform and the redesign of drug policies based on human rights.[3,5,6,8,9,11–13,16] Civil society organisations are also concerned that cannabis legislation in the region has given significant economic opportunities – after long-term political lobbying – to the international cannabis industry.[15] This reflects a continuation of neo-colonial control of the region's agricultural and natural resources.[15] To address this, any further movement towards regulated markets in cannabis and cocaine must promote and protect the interests of local and national producers.

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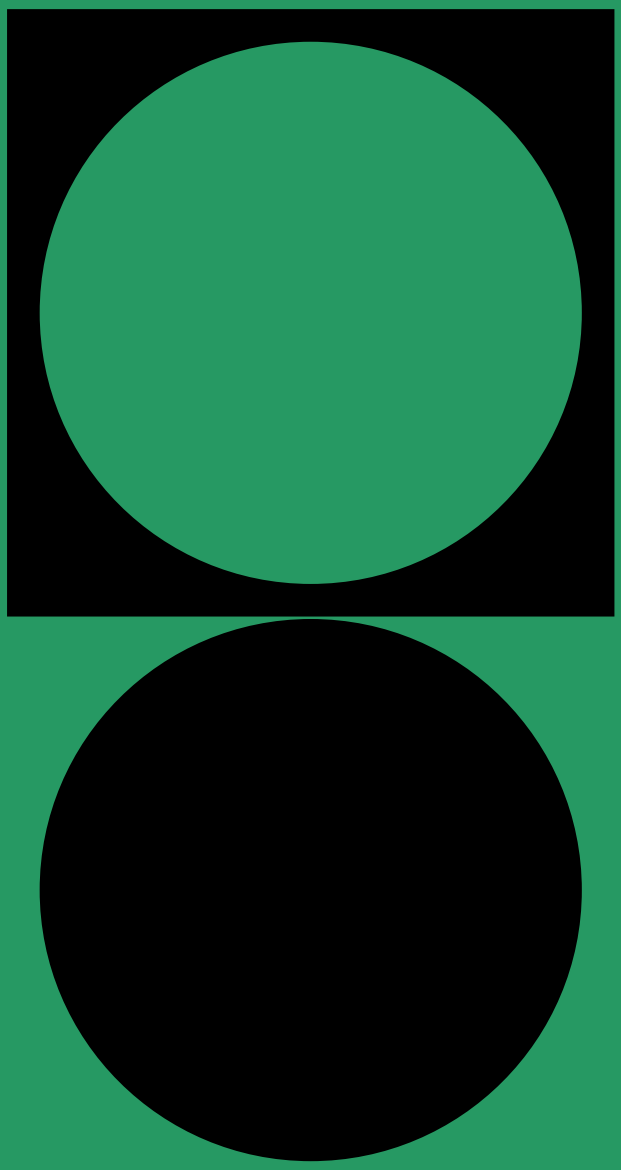
REGIONAL OVERVIEW: MIDDLE EAST AND NORTH AFRICA



THE GLOBAL STATE
OF HARM REDUCTION 2022

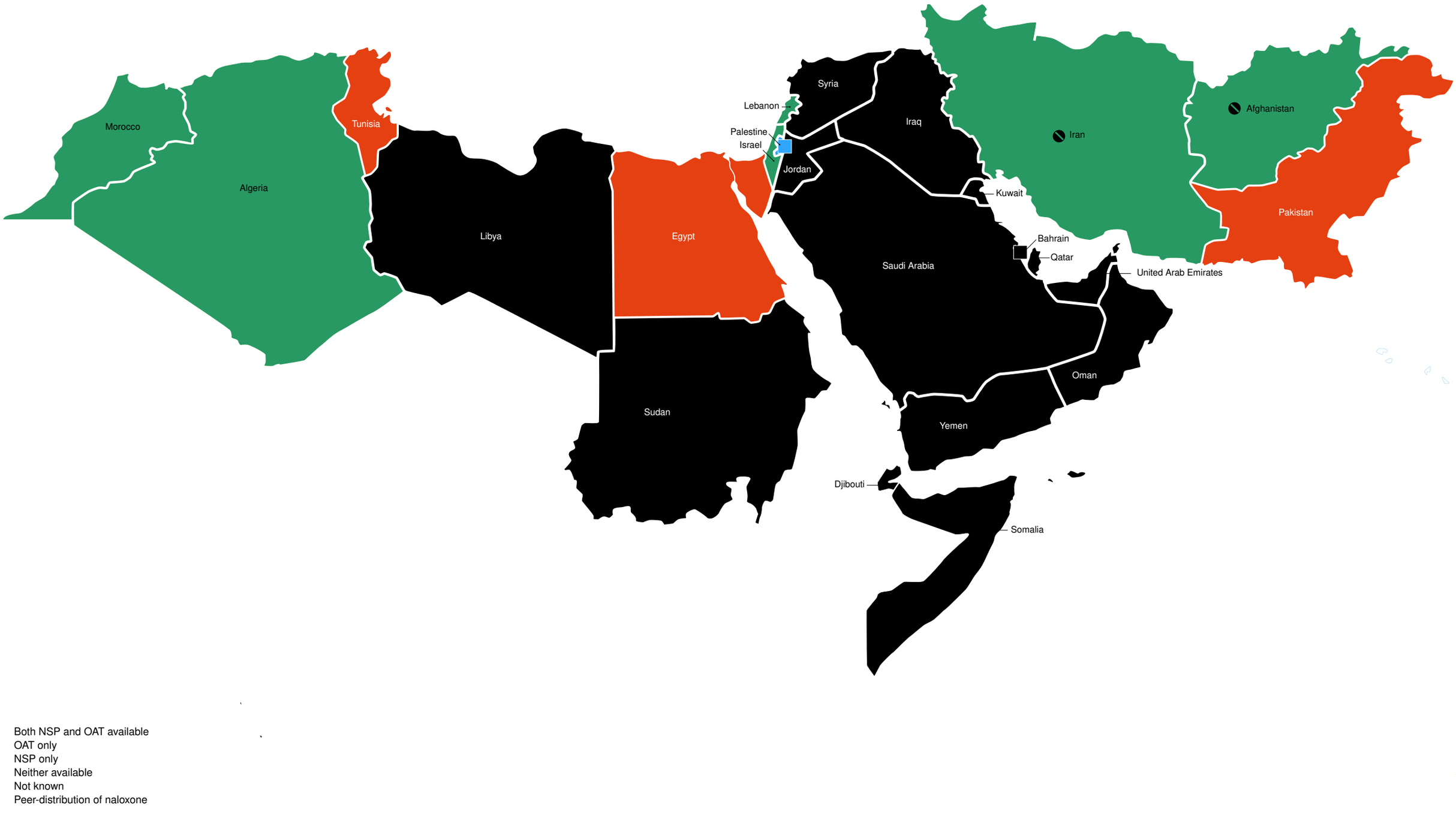
HARM REDUCTION INTERNATIONAL

TABLE 6 EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN THE MIDDLE EAST AND NORTH AFRICA

Country/territory	People who inject drugs[a]	HIV prevalence among people who inject drugs (%)[a]	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[a]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[a]	Harm reduction responses[b]				
					NSP[c]	OAT[d]	Peer distribution of naloxone[e]	DCR[f]	Safer smoking equipment[g]
Afghanistan[h]	57,207	3.1[3]	37.3[3]	3.7[3]	✓	✓	✓	×	×
Algeria	17,000	1.1	nd	nd	✓	✓ M	×	×	×
Bahrain	nd	4.6	nd	nd	×	×	×	×	×
Djibouti	nd	nd	nd	nd	×	×	×	×	×
Egypt	nd	3.8	49.5	13.5	✓	×	×	×	×
Iran	177,000	4.3	39.4	5.9	✓	✓ M B	✓[i]	×	×
Iraq	nd	nd	nd	nd	×	×	×	×	×
Israel	nd	nd	nd	nd	✓[1]	✓[1]	×	×	×
Jordan	nd	nd	nd	nd	×	×	×	×	×
Kuwait	nd	0.8	12.3	0.4	×	×	×	×	×
Lebanon	9,500	0.3	22	1.6	✓	✓ B	×	×	×
Libya	2,000	89.6	86.1	nd	×	×	×	×	×
Morocco	31,500	6.4	38.1	nd	✓	✓ M	×	×	×
Oman	nd	11.8	75.5	nd	×	×	×	×	×
Pakistan	497,000	30.9	54.5	7.9	✓	×	×	×	×
Palestine	nd	0	41.7	6.3	×	✓ M	×	×	×
Qatar	nd	nd	nd	nd	×	×	×	×	×
Saudi Arabia	nd	9.8	63	7.7	×	×	×	×	×
Somalia	nd	nd	nd	nd	×	×	×	×	×
Sudan	nd	0	nd	nd	×	×	×	×	×
Syria	nd	0	3.3	0.5	×	×	×	×	×
Tunisia	nd	3.1	17.2	2.7	✓	×	×	×	×
United Arab Emirates	nd	nd	nd	nd	×	×	×	×	×
Yemen	nd	nd	nd	nd	×	×	×	×	×

a Unless otherwise stated, data is from Degenhardt et al (under review).[1]
b Data sourced in Global State of Harm Reduction survey responses, unless otherwise stated.[2]
c At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available)
d At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, M=methadone.
e At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training, and facilitates secondary distribution of naloxone between peers.
f At least one drug consumption room (also known as safe consumption sites among other names) operational in the country or territory, and the number of facilities.
g At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.
h Data on harm reduction service availability, which already represents a decline from previous reports, has been disputed by other sources, some of which report a collapse of harm reduction services in many parts of Afghanistan.
i While these services are reportedly available, civil society organisations report that they may be inaccessible in practice.

AVAILABILITY OF HARM REDUCTION SERVICES



NSPs, OAT AND DCRs SINCE 2020

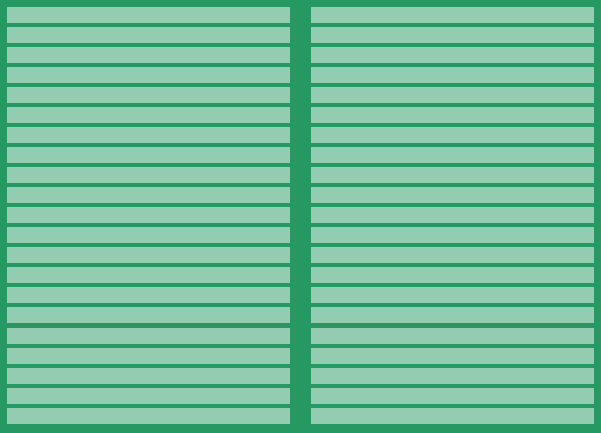
9 countries (38%) in the Middle East and North Africa provide **needle and syringe programmes** (no change from 2020)

7 countries (29%) in the Middle East and North Africa provide **opioid agonist therapy** (+1 since 2020, Algeria)

No country in the Middle East and North Africa provides **drug consumptions rooms** (no change from 2020)

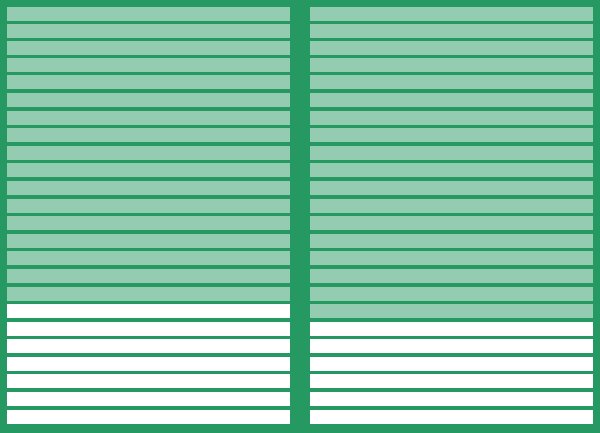
HARM REDUCTION IN PRISONS

2020 2022



No country in the Middle East and North Africa provides **needle and syringe programmes** in prisons (no change from 2020)

2020 2022



6 countries in the Middle East and North Africa provide **opioid agonist therapy** in prisons (-1 since 2020, Jordan)

ECONOMIC, HUMANITARIAN AND POLITICAL CRISES HAVE NEGATIVELY IMPACTED HARM REDUCTION IN THE MIDDLE EAST AND NORTH AFRICA

REGIONAL OVERVIEW

AUTHORS:
SANDRA HAJAL and **ELIE AARAJ**

INTRODUCTION

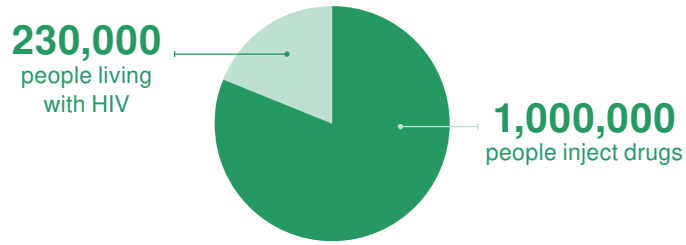
The Middle East and North Africa (MENA) region continues to experience conflicts, crisis, economic disturbances, political unrest, and the movement of refugees from Iraq, Palestine, Syria and Yemen.[4] All these factors have increased the general burden on public health systems, and affected drug use, HIV and harm reduction programmes in particular.[5,6] Environmental disasters related to the climate crisis, including the flooding in Pakistan in September 2022, have also put significant pressure on health services, including harm reduction.[7,8]

The latest data shows that around one million people in MENA inject drugs and 230,000 people are living with HIV.[2,9] On average, around 16,000 people are diagnosed with HIV every year in the region.[9] But only 43% of people living with HIV are on antiretroviral therapy (ART), and only 25% of pregnant women have access to antiretroviral medicines to protect their health and prevent mother-to-child transmission of HIV.[9] Despite evidence of the effectiveness of harm reduction interventions in promoting the health and rights of people who use drugs, these interventions remain limited in MENA region due to social, cultural, legal and economic challenges. In addition, data on drug use remains scarce in the majority of countries.[2] In some countries, research on drugs, populations most affected by HIV, HIV prevalence and many other important indicators are either non-existent or not comparable with other data because of a lack of research methods standardisation. In addition, most countries in the region lack human and financial resources to conduct regular research activities.[2]

NEEDLE AND SYRINGE PROGRAMMES (NSPs)

NSPs continue to be available in Afghanistan, Algeria, Egypt, Iran, Israel, Lebanon, Morocco, Pakistan and Tunisia. No countries in the region

More than 1 in 5 people who inject drugs in Middle East and North Africa are living with HIV



have newly implemented or closed programmes since 2020.[2,10–19]

Since 2020, Algeria has initiated OAT with methadone, operated by civil society organisations with government funding. With the support of the United Nations Office on Drugs and Crime (UNODC) and the Middle East and North Africa Harm Reduction Association (MENAHRA), Egypt and Pakistan have also been able to start the preparation and implementation of OAT, although these programmes are not yet fully operational. The preparatory work has included drafting standard operating procedures and protocols, training service providers, setting up a reporting system and importing the needed medication.[7,10–15,20] OAT continues to be available in Afghanistan,[j] Iran, Lebanon, Morocco and Palestine. But Lebanon is facing major challenges in providing OAT due to the country's ongoing economic and financial crisis (exacerbated by the COVID-19 pandemic and the Port of Beirut explosion in August 2020 – see Spotlight: Lebanon's OAT Shortage, page 103).[2,10,11,16–19] Since 2019, Lebanon has experienced a dramatic collapse in the most basic of services, including period health. There have been shortages of most medications in pharmacies and hospitals and prices have increased considerably.[21] As of 2020, OAT was available to people in prisons in Afghanistan, Iran, Lebanon, Palestine and Morocco.[2,11,16–19] However, in Lebanon it is only available for people who began treatment before incarcertion.[1]

Lockdowns related to the COVID-19 pandemic hindered the accessibility of both NSPs and OAT. Healthcare providers and clients were forced to stay at home, and service delivery centres were closed for periods of time before re-opening, progressively increasing their working hours to return to their previous schedules.[11] Flexibility and innovative service delivery methods (for example, home deliveries, increased take-home doses and outreach deliveries) have all been implemented in Afghanistan, Egypt, Lebanon, Morocco and Tunisia. A World Health Organization rapid assessment, published in late 2020, found almost all countries in the region included substance use programmes as part of their considerations in response to the COVID-19 pandemic, but only around half of all substance use programmes were classified as essential services. Only in Bahrain and Iran were psychosocial services for substance use reported as being fully funded during the COVID-19 pandemic.[22]

No drug consumption rooms (DCRs) are currently available in the region, and the overall response to drug overdose is highly underdeveloped.

HIV AND VIRAL HEPATITIS

HIV testing and treatment is available in the majority of countries. However, coverage and accessibility remains a challenge, especially for people who inject drugs, LGBTQI+ people, sex workers, people in prisons and people who are refugees.[2,10,13,18] Moreover, budget cuts, the decision by the Global Fund to Fight AIDS, Malaria and Tuberculosis (the Global Fund) to phase out funding in Egypt and Jordan from 2023, and the prioritisation of funding for humanitarian and emergency responses have dramatically affected civil society organisations that provide HIV services to people who inject drugs, resulting in major decreases in service delivery.[2,10,12–19]

"HIV testing and treatment is available in the majority of countries. However, coverage and accessibility remains a challenge, especially for people who inject drugs, LGBTQI+ people, people who sell sex, people in prisons and people who are refugees."

j As mentioned above, data on harm reduction services in Afghanistan is disputed, and the situation remains volatile following the Taliban offensive in spring 2021.

In the past two years, the expansion of HIV programmes in prisons has continued in Egypt, Morocco, Sudan, and Tunisia.[20] Rapid situational assessments of HIV and risk behaviours (including drug use) were carried out in prisons in Egypt, Sudan and Tunisia, a prison health strategy was launched in Morocco, and the first prison HIV programme was initiated in five prisons in Sudan.[20]

People who use drugs are at heightened risk of HIV and hepatitis C due to injecting drug use, sexual risk behaviours, inequalities, displacement and stigma. Approximately 30.5% of people who inject drugs in MENA are estimated to be living with current hepatitis C infection, and 4.1% are estimated to be living with HIV.[1]

WOMEN WHO USE DRUGS

Women still experience major gaps in access to harm reduction and treatment services.[2,10] This also applies to women who are partners of men who inject drugs, who need additional services to prevent and treat HIV and viral hepatitis.[23] In countries where harm reduction centres are concentrated in urban areas, some women find it hard to access these centres due to limited mobility or child care responsibilities that conflict with opening hours, and also face the barrier of stigma.[11] Iran and Tunisia currently offer gender-sensitive harm reduction programmes, with services tailored to the needs of women who use drugs and their children, although in Iran there are reports that these services are under threat from conservative actors and funding cuts, leading to two such services closing since 2020.[7,11] Tunisia has established Jasmin Space, a centre exclusively for women who inject drugs and their children, which offers tailored services.[11] Sex workers, LGBTQI+ people and refugees also face challenges in accessing harm reduction programmes due to discriminatory policies and stigmatisation from the general community and healthcare providers.[11]

CIVIL SOCIETY IN MENA

The Middle East and North Africa Network of/for People who Use Drugs (MENANPUD) was established in 2011. It is a community-led network of people who use drugs in MENA whose mission is to support peers, promote the health and wellbeing of people who use drugs, defend the rights of people who use drugs, reduce stigma, discrimination and criminalisation and promote harm reduction services. Since it began, MENANPUD has been supported, financially and technically by MENAHRA.[10,11] In 2021, MENANPUD started the process of officially registering as a non-governmental organisation in Lebanon and launched its first five-year strategy. Members received training to support them in NGO governance, proposal writing, social media, communications, advocacy and many other topics. Members have organised several awareness and advocacy campaigns in their respective countries and through the global *Support. Don't punish* campaign.[10,11]

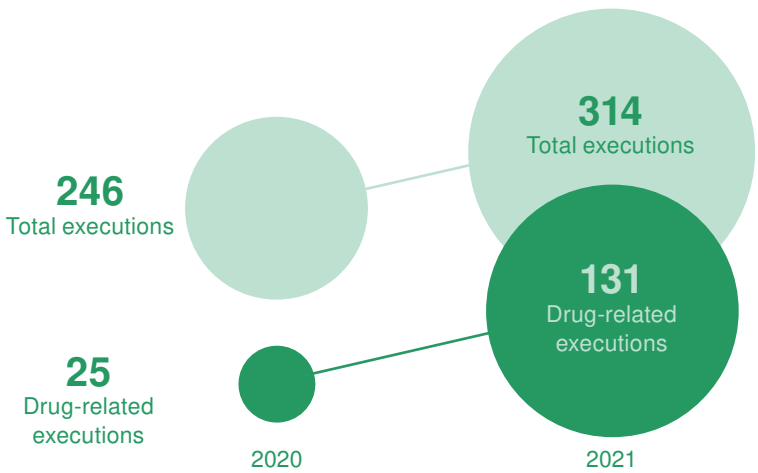
POLICY AND FUNDING DEVELOPMENTS

Drug use remains criminalised in most countries in the region, and eight states retain the death penalty for certain drug offences (Bahrain, Egypt, Iran, Iraq, Kuwait, Palestine, Saudi Arabia and the United Arab Emirates). In Iran, at least 131 people were executed for drug-related offences in 2021, a 42% increase from 2020. The criminalisation of drugs continues to contribute to overcrowding in the region's prisons, with an attendant increased risk of health issues.[7,24]

There is limited domestic funding for harm reduction, which means services are not scaled up and there is limited availability of medication, commodities and other needed materials. Civil society organisations lead advocacy efforts to push for harm reduction approaches, programme implementation[2,10] and increased domestic and international funding. Civil society organisations also conduct local advocacy to initiate new programmes or bring about legal reforms.

Harm reduction for people who inject drugs is explicitly mentioned in the national policies of 14 out of 24 countries (Afghanistan, Algeria, Bahrain, Egypt, Iran, Jordan, Lebanon, Libya, Morocco, Oman, Pakistan, Palestine, Syria and Tunisia).[2,10–20] However, in many countries the political support for harm reduction remains limited. Many governments do not consider HIV and harm reduction to be high priorities, which makes it difficult to adopt an evidence-based, health-based response to drugs.

In Iran, at least 131 people were executed for drug-related offences in 2021, a 42% increase from 2020.



SPOTLIGHT

LEBANON'S OAT SHORTAGE

Since 2019, Lebanon has witnessed a dramatic financial crisis exacerbated by the increased economic strain of the COVID-19 pandemic and worsened by the massive explosion in Beirut port in August 2020. Human Rights Watch reported that in 2021, 80% of people in Lebanon did not have access to basic human rights and a decent standard of living, including health, education, adequate housing and electricity.[27] Since 2019, the Lebanese pound was devalued against the US dollar, resulting in increased prices and a shortage of basic goods. In addition, the Lebanese authorities and Bank of Lebanon ended subsidies for many essential items, including medication, which led to shortages and a significant increase in prices. The crisis also affected the country's OAT programme. The programme began in 2012 and sits in the Ministry of Public Health (MoPH). People who need OAT are usually prescribed buprenorphine by a psychiatrist in a private setting or by a civil society organisation. The medication is dispensed in three government hospitals pharmacies in three regions in Lebanon.

In September 2021, without prior notice, the MoPH informed all civil society organisations and psychiatrists of an imminent buprenorphine stock-out, with a maximum of one month of supply left. Service providers were urged to decrease clients' dosages to 8mg per day to buy time to find a solution. They were also asked to stop enrolling people to the OAT programme.

Stakeholders involved in the implementation of OAT programmes (civil society organisations AJEM, SIDC and Skoun; private psychiatrist and clinic organisation Reset; the Lebanese Psychiatric Society; the National Mental Health Programme; MENANPUD and MENAHRA) launched an emergency action plan to address the situation. The action plan included:

- Revising the dosages of around 1,200 clients and limiting the intake of new clients to extend limited supplies of OAT medications and avoid abrupt cessation for current clients.
- Securing and receiving authorisation from the Lebanese Psychiatric Society to use an expired stock of medication for the next three months.
- Dedicating a small fund (secured by Skoun) to support services for people willing to undergo detoxification.
- Advocating with international donors to receive funds to buy new stocks of medication (secured by MENAHRA and Skoun).
- Advocating with the Minister of Health and the Bank of Lebanon to secure subsidies to import OAT medication.
- Developing an overdose prevention action plan and securing 2,600 doses of naloxone.

The action plan was implemented, and MENAHRA and Skoun were able to mobilise funds to secure around eight months of medication. The Bank of Lebanon provided approval to continue partial support for OAT medication. This allowed new clients to be enrolled and existing clients to resume the dose on which they were stable. In addition, MENAHRA and partners liaised with Harm Reduction International and engaged Ethypharm, a UK-based pharmaceutical company and producer of buprenorphine, to donate a supply of buprenorphine to mitigate the impact of low stocks. Following extended negotiations and procedures, Ethypharm and MENAHRA were able to successfully import a donation of 6,946 packs of buprenorphine tablets in May 2022.[28] Notwithstanding these wins, the current stock is unsustainable and NGOs are not receiving regular updates from the MoPH regarding stock availability. Civil society organisations that deliver OAT report a risk of further shortages.[10,16]

Civil society organisations that provide OAT report that this instability has led to:

- people on OAT experiencing withdrawals and in some cases using illicit drugs;
- increased overdoses;
- increased mental health problems;
- and stress for clients, caregivers and families.

Civil society responded by increasing support and counselling sessions for people who use drugs. They also increased services so they could see clients more frequently and monitor people's mental health and any high-risk behaviours. Staff in civil society organisations experienced increased burnout due to the stressful nature of the situation.

The collaboration, fast response and pooling of donations and support among civil society organisations engaged in harm reduction secured the OAT medication needed to avert a significant crisis.

The Lebanese government must prioritise OAT as an essential medication to ensure the sustainability of programmes and reduce the country's reliance on international donors. It also needs to increase domestic funding and support for civil society organisations working in the fields of drug use and harm reduction. These organisations tend to be excluded from humanitarian, emergency and domestic funding, yet they are supporting some of the most vulnerable people in Lebanon who are unable to access or afford medication.

SPOTLIGHT

L'ESPACE LES JASMINS: A SPACE OF OUR OWN

According to limited available data, around one in five (19%) people who inject drugs in the world are women.[1] In Tunisia, the number of women who inject or use drugs has grown over recent years. Women who use drugs are greatly underserved by the Tunisian state, and tend to be even more overlooked than their male counterparts in terms of services, research, support programmes and access to harm reduction.[29] In 2015, during community meetings organised by the Tunisian Association against Sexually Transmitted Diseases and AIDS, women who inject drugs called for their own exclusive space as well as tailored social assistance and support for their children.

In response, civil society actors renewed their focus on gender-responsive harm reduction services. L'Espace les Jasmins, a space exclusively for women who inject drugs and their children, was launched on International Women's Day in March 2016. It offers a range of services for women in vulnerable situations and forms part of the harm reduction response to hepatitis C and HIV among women who inject drugs. Women who inject drugs – who are often experiencing the double stigma of being a woman who uses drugs as well as marginalisation and rejection from family and wider society – use the space for socialising and sharing experiences. The centre's goal is to improve the availability, accessibility, acceptability and quality of combined prevention, health, social and legal services for women who inject drugs.

The services the centre provides are high quality, relevant, targeted and continuous. These services include:

- distribution of kits that include condoms, lubricants and syringes;
- distribution of hygiene kits that include shampoo, wipes, towels, toothbrush and toothpaste, underwear, socks and soap;
- anonymous and free HIV, hepatitis C and syphilis screening;
- psychological and psychiatric support;
- support from an addiction specialist doctor, available weekly;
- legal support and advice;
- support for income-generating activities;
- hairdressing and other free beauty services;
- space for children, with educational games, swings and painting;
- and educational support for children, including private lessons, day-care and school supplies.

L'Espace les Jasmins now receives 368 women and 90 children every month. The centre's main source of funding comes from the Solidarité SIDA programme of the Mayoralty of Paris.

The main challenges L'Espace les Jasmins encounters are:

- advocacy for a comprehensive, holistic and integrated approach to harm reduction services, taking into consideration the role of gender;
- support for minors and provision of legal support;
- legal support for staff (for example, if they are arrested for carrying drug paraphernalia);
- advocacy with decision-makers for a better legal framework to support women who inject drugs;
- and introduction of an OAT programme for women who inject drugs.

L'Espace les Jasmins remains one the few centres that provides harm reduction services for women who use drugs in MENA.

SPOTLIGHT

THE RISE AND FALL OF HARM REDUCTION IN AFGHANISTAN

Afghanistan remains the world's leading supplier of opium; and the drug has been consumed there since ancient times.[30] Driven by decades of armed conflict, deterioration of security, economic stagnation and unsterile injection drug use, Afghanistan is vulnerable to increasing HIV infections and other blood-borne infections.[31]

Despite the violence, disorder and insurgency that marks the country's sociopolitical landscape, as well as the 'drug-free' paradigm that characterises its overall drug strategy, Afghanistan has been a rare example in the region of successful harm reduction implementation. Harm reduction programmes were implemented in the country following the fall of the Taliban in 2001, with support from donors and civil society organisations. By 2010, up to 28 NSP sites were operational.[32] In February 2010, the first methadone programme was launched, initially supporting 71 people.[33] In fact, such was the optimism toward the continued success of harm reduction interventions, one proponent from a harm reduction programme in Kabul declared: "Let us make a bet [that] Afghanistan could be a place of positive concern and interest in the future for the next generation of harm reduction!"[31]

This optimism would seem to have been vindicated during the following decade, which saw the scaling up of various harm reduction programmes, albeit largely due to international support. By 2012, there were a reported 19 NSPs in the country as well as one OAT site.[34] By 2020, there were 24 NSP sites and 8 OAT sites, and the country had become one of very few that implemented peer distribution of naloxone.[35] During the COVID-19 pandemic, the government and NGOs adjusted their responses to include provisions for take-home methadone and distributed harm reduction kits containing sterile needles, syringes, condoms, and medicines for sexually transmitted infections, among other products.[36]

But progress stopped when the Taliban returned to power in August 2021. In April 2022, the Taliban banned all forms of drug production and consumption, including that of opium, despite the drug's lucrative contribution to the national economy.[37] Reports from Kabul describe the collapse of harm reduction services in five provinces that previously relied on government funding to provide such services, resulting in staff going unpaid, a lack of harm reduction kits, a shortage of medicines and other medical equipment, and the shutdown of HIV prevention services.[38] As of August 2022, only eight NSP sites were operational and nine OAT sites (including four in prison).[39,42] Moreover, the Taliban has enabled the arbitrary arrest, detention and violent treatment of people associated with drugs[38]—in many ways mirroring what transpired during the previous Taliban regime, under which responses included 'maiming' the hands of people who use drugs.[40]

Left without a source of income from the opium trade, journalists report that "millions have joined the ranks of the impoverished," and people who use drugs can now be seen "living in parks and sewage drains, under bridges and on open hillsides" of Kabul.[41] The case of Afghanistan suggests political stability is a necessary precondition for the sustainability of harm reduction efforts, and that progress in any form should not be taken for granted, given its contingency on whoever is in power.

k This section was researched and written by Gideon Lasco.

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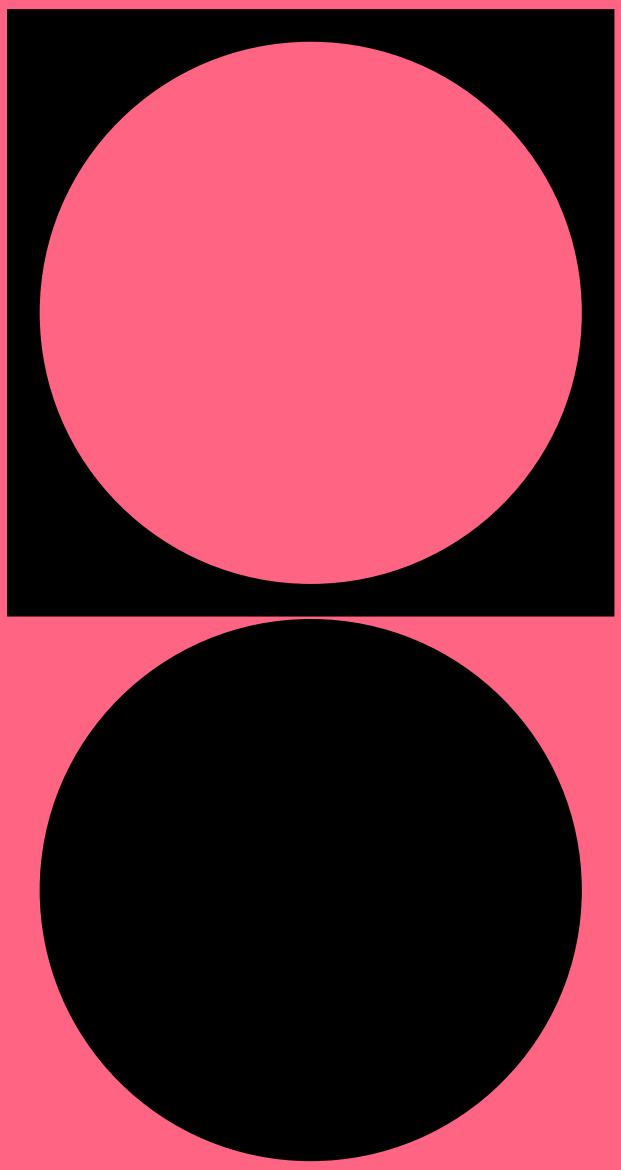
42. Another correspondent working in harm reduction provided slightly different figures: 14 NSP sites and eight OST sites (the same number from the GSHR 2020). It is worth noting that the correspondence from ANPASH qualified that, apart from the eight operational NSP sites, six more were supposedly awaiting funding from The Global Fund for reprogramming; however, it is unclear whether those six sites had already been restarted at the time of writing.

REGIONAL OVERVIEW: NORTH AMERICA



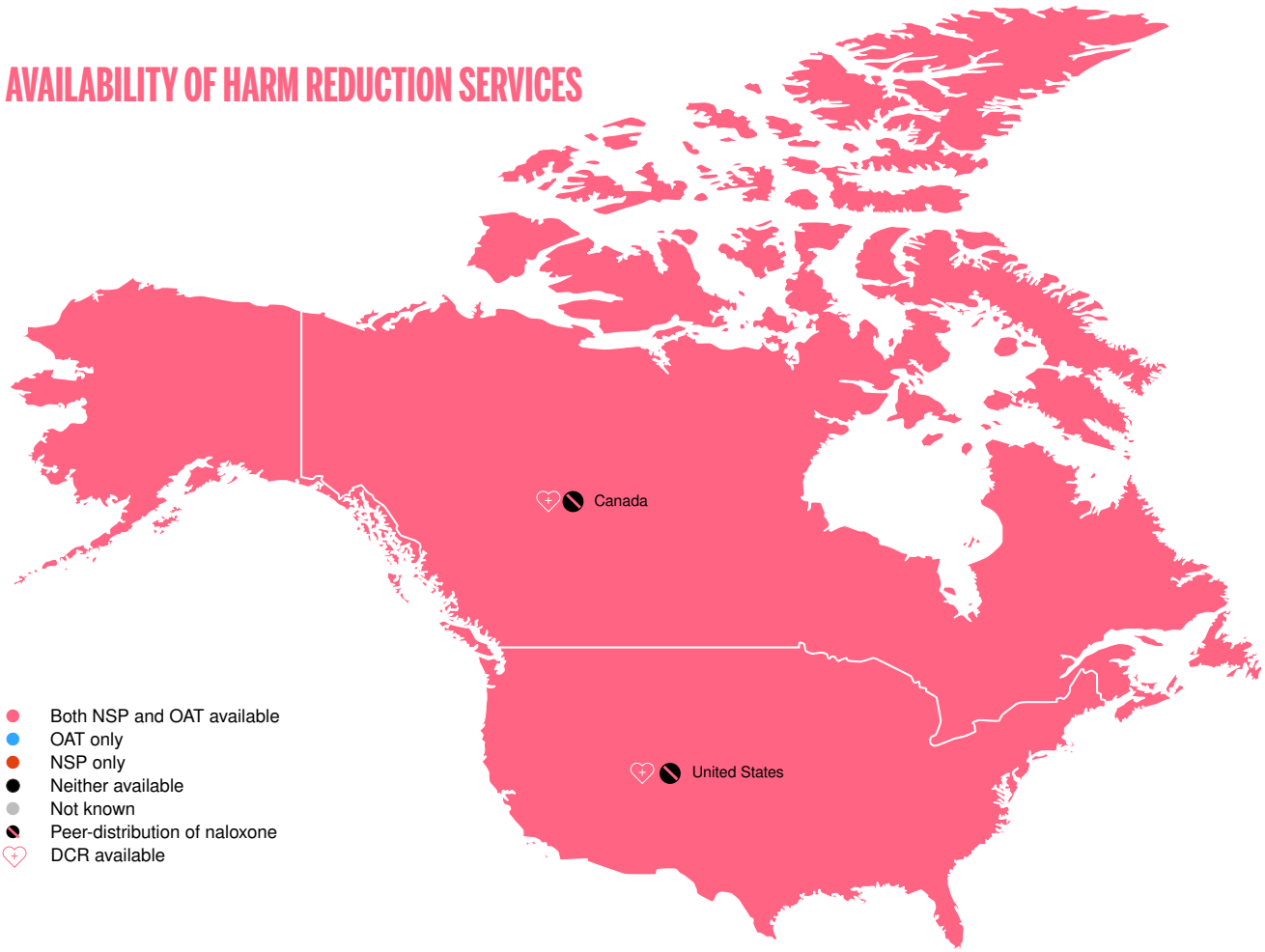
THE GLOBAL STATE
OF HARM REDUCTION 2022

HARM REDUCTION INTERNATIONAL

TABLE 7 EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN NORTH AMERICA

Country/territory	People who inject drugs[a]	HIV prevalence among people who inject drugs (%)[a]	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[a]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[a]	Harm reduction responses				
					NSP[b]	OAT[c]	Peer distribution of naloxone[d]	DCR[e]	Safer smoking equipment[f]
Canada	130,000[2]	5.8	38.6	nd	✓[3]	✓ B F H M[3]	✓[3]	✓40[g4]	✓[3]
United States of America	3,694,500[5]	6.1	53.5	4.8	✓ >433[6]	✓ M B[7]	✓[7]	✓2[7]	✓[7]

AVAILABILITY OF HARM REDUCTION SERVICES



a Unless otherwise stated, data is from Degenhardt et al (under review).[1]
b At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available)
c At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, F=fentanyl, H=heroin/diamorphine, M=methadone.
d At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training, and facilitates secondary distribution of naloxone between peers.
e At least one drug consumption room (DCR) (also known as safe consumption sites among other names) operational in the country or territory, and the number of facilities.
f At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.
g This includes one prison DCR in Drumheller, Alberta.

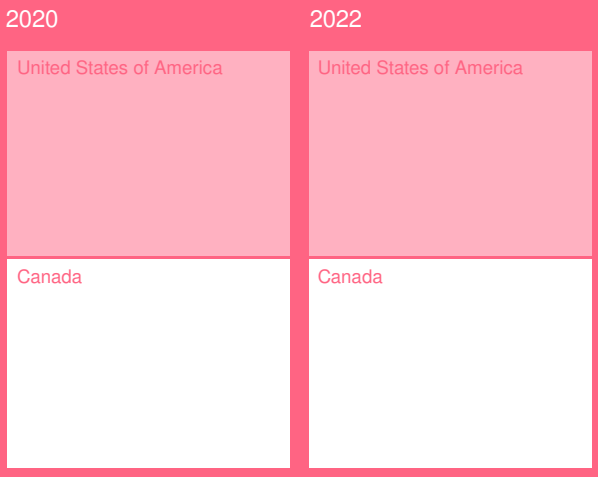
NSPs, OAT AND DCRs SINCE 2020

2 countries (100%) in North America provide **needle and syringe programmes** (no change from 2020)

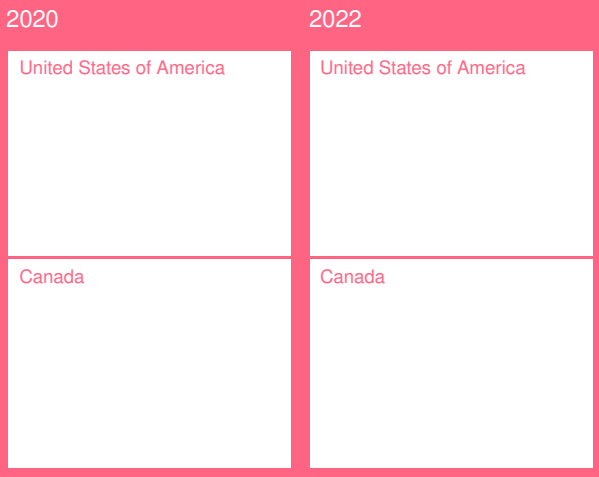
2 countries (100%) in North America provide **opioid agonist therapy** (no change from 2020)

2 countries in North America provides **drug consumption rooms** (+1 since 2020, United States)

HARM REDUCTION IN PRISONS



1 country in North America **provides needle and syringe programmes** in prisons (no change from 2020)



Both countries in North America **provide opioid agonist therapy** in prisons (no change from 2020)

IN THE UNITED STATES, 107,270 PEOPLE DIED FROM DRUG OVERDOSES IN 2021.

REGIONAL OVERVIEW

AUTHORS:
DEREK FRASURE and **SAM SHIRLEY-BEAVAN**

INTRODUCTION

Developments in North America have, once again, taken place in the context of record-breaking drug overdose deaths in both Canada and the United States.

In the United States, 107,270 people died from a drug overdose in 2021, an increase of 60% compared with 2018 (when 67,367 people died).[8] Of these deaths, 75% (80,725) involved opioids, and 88% of those involved synthetic opioids such as fentanyl.[8] Almost a quarter of deaths (23%; 24,605) involved cocaine.[8] More than one million Americans have now died from drug overdoses since 1999.[8] In Canada, in the first year of the COVID-19 pandemic (April 2020 to March 2021), overdose deaths almost doubled compared with the previous 12 months (from 3,747 to 7,362).[9]

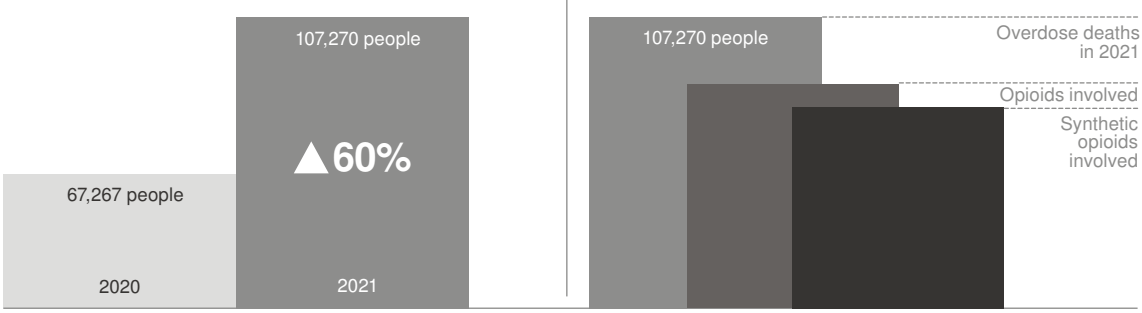
Since 2020, this has contributed to an acceleration of harm reduction programmes.

In the United States, President Biden and the U.S. Office of National Drug Control Policy both named harm reduction as a priority— a first in the country. The Biden administration also committed to an investment of USD 30 million over 3 years from 2022 to 2025.[10] While funding awards have gone primarily to organisations on the East and West Coasts, and to some groups with little harm reduction experience, this is a significant boost to harm reduction programming.[7,11–25]

Another concrete example of this new era in the United States is the opening of the country's first two government-authorised drug consumption rooms (DCRs) in November 2021, both in New York City (operated by OnPoint NYC, and known officially as Overdose Prevention Centers), and the passing of legislation authorising a DCR in Rhode Island.[7,12,13,25–30]

In Canada, civil society actors report the increase in the availability of 'safer supply', which is a significant

Overdose deaths in the United States



positive development.[31–39] Since 2021, Canada's federal government has demonstrated support for this, and the provincial government of British Columbia has provided guidelines for physicians prescribing regulated drugs as an alternative to the illicit supply.[40,41] In British Colombia, fentanyl has been available as a paid prescription since April 2022, although accessibility is limited.[3,35]

In both Canada and the United States, local movements towards decriminalising drugs have gained support. In late 2020, the state of Oregon decriminalised small amounts of all drugs for personal use. Efforts to decriminalise simple drug possession are also underway in other states, provinces and cities in both the United States and Canada.[3,12,29,31,32,35–37,42,43] From January 2023, the province of British Columbia will decriminalise possession of small amounts of drugs for personal use.[44] However, neither country's federal government has formally endorsed decriminalisation. In Canada, a bill that would provide law enforcement options to divert people to services rather than charge them for simple drug possession is in front of the federal parliament at the time of writing (August 2022).[31,45]

Nevertheless, advances in harm reduction in the United States have been met with a significant backlash from conservative figures, who are particularly critical of the possibility that federal funds would be used for the distribution of safer smoking equipment. Some states continue to prevent lawful needle and syringe programmes (NSPs) from operating, despite high levels of HIV infections and overdoses. Other states criminalise drug paraphernalia including syringes and safer smoking and snorting supplies (see Table 7.1, page 112). In California, the governor vetoed a bill permitting overdose prevention sites that was passed in the legislature, falsely asserting that there was no real plan for the efforts.[46] In Canada, areas run by politically conservative parties have substantially less availability of harm reduction services. For example, the provincial government in Alberta withdrew funding from a DCR in Lethbridge, leading to its closure,[3,33,36,40,47] and in Saskatchewan the provincial government continues to refuse to fund Saskatoon's only DCR.[33,39] The site continues to operate, thanks in part to donations from the community.[48,49]

TABLE 7.1 STATE-BY-STATE ACCESS TO HARM REDUCTION IN THE UNITED STATES

State	Needle and syringe programmes[a 6]	Is possession of syringes criminalised by drug paraphernalia laws?[b 91]	Licensed opioid treatment programmes[c 93]	Licensed drug consumption rooms
Alabama	0	Yes	23	0
Alaska	3	No	6	0
Arizona	8	Yes	68	0
Arkansas	2	Yes	6	0
California	65[25]	No[25]	168	0
Colorado	12	Yes, but NSP clients exempt	30	0
Connecticut	10	No	51	0
Delaware	1[94]	Yes, but NSP clients exempt	19	0
Florida	6[93]	Yes, but NSP clients exempt	95	0
Georgia	3	Yes	76	0
Hawaii	1	Yes, but NSP clients exempt	5	0
Idaho	4	Yes	6	0
Illinois	11	Yes, but NSP clients exempt	89	0
Indiana	10	No	24	0
Iowa	2	Yes	8	0
Kansas	0	Yes	9	0
Kentucky	32	Yes, but NSP clients exempt	31	0
Louisiana	5	Yes	10	0
Maine	6	Yes, but NSP clients exempt	12	0
Maryland	6	Yes, but NSP clients exempt	97	0
Massachusetts	15	No	106	0
Michigan	24	No	50	0
Minnesota	12	No	17	0
Mississippi	0	Yes	4	0
Missouri	2	Yes	18	0
Montana	6	Yes	4	0
Nebraska	0	Yes	3	0
Nevada	2	No	16	0
New Hampshire	9	No	11	0
New Jersey	3	Yes, but NSP clients exempt	63	0
New Mexico	2	Yes, but NSP clients exempt	21	0
New York	28[24]	Yes, but NSP clients exempt	131	2[30]
North Carolina	48[94]	Yes, but NSP clients exempt	86	0
North Dakota	4	Yes, but NSP clients exempt	4	0
Ohio	17	Yes, but NSP clients exempt	112	0
Oklahoma	2	Yes	21	0
Oregon	14	No	24	0

a This is the number of NSPs registered with the North American Syringe Exchange Network (except where noted otherwise). This directory is not intended to be exhaustive but gives an indication of the level of service availability in each state.
b Decriminalisation of syringe possession does not always protect people from prosecution for drug residues found in those syringes.
c These are the only programmes licensed to dispense methadone in the United States. People may also be able to access buprenorphine through a prescribing physician.

State	Needle and syringe programmes[a 6]	Is possession of syringes criminalised by drug paraphernalia laws?[b 91]	Licensed opioid treatment programmes[c 93]	Licensed drug consumption rooms
Pennsylvania	7	Yes	105	0
Rhode Island	2	No	22	0
South Carolina	4	No	27	0
South Dakota	0	Yes	1	0
Tennessee	10	Yes, but NSP clients exempt	23	0
Texas	8	Yes	99	0
Utah	6	Yes, but NSP clients exempt	18	0
Vermont	3	Yes, but NSP clients exempt	7	0
Virginia	6	Yes, but NSP clients exempt	46	0
Washington	30	Yes, but NSP clients exempt	35	0
West Virginia	8	Yes, but NSP clients exempt	9	0
Wisconsin	14	No	24	0
Wyoming	0	Yes	0	0
Washington DC	4	nd	5	0

a This is the number of NSPs registered with the North American Syringe Exchange Network (except where noted otherwise). This directory is not intended to be exhaustive but gives an indication of the level of service availability in each state.
b Decriminalisation of syringe possession does not always protect people from prosecution for drug residues found in those syringes.
c These are the only programmes licensed to dispense methadone in the United States. People may also be able to access buprenorphine through a prescribing physician.

NEEDLE AND SYRINGE PROGRAMMES (NSP), OPIOID AGONIST THERAPY (OAT) AND NALOXONE

Since 2020, community and civil society observers in the United States consider that service availability has generally increased for NSPs, OAT and take-home naloxone programmes. However, this is highly variable by jurisdiction (see Table 7.1, page 112). In July 2021, Oklahoma explicitly provided for NSP in law for the first time, but drug paraphernalia laws that criminalise syringe possession remain in place.[18] In six of the United States, there are no government-sanctioned NSPs at all (Alabama, Kansas, Mississippi, Nebraska, South Dakota and Wyoming; see Table 7.1, page 112). In December 2021, the White House issued a model law on NSPs, with the aim of increasing accessibility. Notably, this recommends that states end the criminalisation of syringes as drug paraphernalia.[55]

In Canada, civil society report a diversification of the organisations implementing harm reduction programmes over the last two years, particularly NSPs. Women's shelters, community hubs, shelters and First Nations organisations are increasingly promoting harm reduction in their own programmes.[31,40,56] Canada continues to have more drug consumption rooms than any other country with 39 federally regulated sites in the community and one site in a federal prison, in addition to numerous Overdose Prevention Sites (low-barrier sites typically set up by volunteers and community-based organisations to operate temporarily to respond to acute crises).[4]

Since December 2020, all Medicaid programmes (government-supported health insurance) in the United States are required to cover methadone, which is greatly increasing access to OAT.[7,12,14,17,26,57,58] However, methadone remains heavily regulated and is only available in licensed opioid treatment programmes (see Table 7.1, page 112).[7,24,28,59,60] Buprenorphine can be prescribed by a doctor, but this relies on finding a physician willing and able to do so.[7] There is a racial divide when it comes to who has access to which treatment, with methadone more available in counties where Black and Brown people are unlikely to interact with white people, while buprenorphine is more available in counties where white residents are unlikely to interact with Black or Brown residents.[61]

Harm reduction services in Canada and the United States have continued to experience disruptions related to the COVID-19 pandemic. Limited hours and the temporary or permanent closure of services have been detrimental to service availability and accessibility. Several service providers report that the loss of physical contact with clients has made human connection more difficult, robbing programmes of an important part of their work.[18,35,38,60] In some cases, harm reduction was deprioritised in favour of the public health response to the COVID-19 pandemic.[17,62] In some jurisdictions, select services were protected as essential health services during lockdowns (such as NSPs in Manitoba, Canada) while others were not, including DCRs in Canada.[63] The COVID-19 pandemic also brought some positive changes to harm reduction services, including the expansion of take-home and mail-order OAT and naloxone in both countries, and initiating buprenorphine treatment based on telephone appointments.[7,23,26,29,53,60] However, some of these COVID-19-related rule changes, particularly around take-home methadone, are already being rolled back by clinics as the COVID-19 pandemic subsides in the region.[52]

Stigma, and the lack of services in some jurisdictions and rural areas, remain significant barriers to all harm reduction services in the region. People who are migrants, women, Black, Brown, Hispanic and Indigenous people are particularly affected by stigma.[7,12,14,16,19,21,23,53,54,60] Even in some urban areas where harm reduction is operational, accessibility is limited. For example, Saskatoon, Canada has just two NSPs for a city of 320,000 people.[38] Evolving patterns of drug use also requires services to adapt to remain relevant to the people they serve. For example, increased use of fentanyl in both countries means previously standard doses of methadone and buprenorphine may not be appropriate or adequate OAT for some clients.[3,63] The fact that people are

using benzodiazepines and opioids together may have an impact on the effectiveness of naloxone as an overdose response because this combination of drugs can stop people becoming fully responsive after receiving naloxone; this makes safer supply efforts even more urgent (see Spotlight: Responding to a Toxic Drug Supply, page 116).[7,63]

In prisons, access to harm reduction services is severely limited in both countries. NSPs are operational in just nine federal prisons in Canada, and none in the United States.[3,12,14,36,54] In both countries, significant opposition from conservative politicians, private interests and prison agencies and unions prevents wider implementation.[3,12,14,24,36,38,43,54,60,63] Even where it is available in Canada, the application to participate in an NSP requires the approval of the prison warden; there is no anonymity for clients and uptake is exceptionally low.[3,35] OAT is available in fewer than 1% of prisons in the United States,[7] and OAT in prison is often excluded from insurance coverage.[12,54] However, the United States Department of Justice recently released guidance detailing how the failure to provide OAT in prisons and jails violates federal law.[64] This, along with several successful lawsuits in various jurisdictions, may lead to more closed settings providing OAT in the near future.[52]

STIMULANTS AND NON-INJECTED DRUG USE

In both Canada and the United States, access to harm reduction for people who use stimulants has increased, but it remains small. Availability of safer smoking equipment has increased, often distributed by NSPs. These services are aimed at the increasing number of people who are smoking fentanyl as well as people who smoke crack cocaine and methamphetamines.[7,12,35,36,40] In the United States, safer smoking equipment became a political lightning rod in early 2022 (see Spotlight: Responding to a Toxic Drug Supply, page 116); unfortunately, a particularly potent and highly racialised stigma exists against people who use crack cocaine. Pipe distribution remains illegal in many areas, and federal money cannot be used to supply crack pipes.[7,12,65] The prescription of stimulants (sometimes known as pharmacotherapy, which follows similar principles to OAT) remains officially unavailable in the United States, although there are some reports that the practice takes place 'off-label'.[24] In Canada, the federal government has indicated support for prescribing stimulants to people who use drugs,[40] but a lack of formalised programmes, and therefore a lack of data on effectiveness, hinders the development of such services.[32,33] Smoking drugs is not permitted in the majority of Canadian DCRs, denying people who smoke drugs access to a key harm reduction programme.

"In both Canada and the United States, access to harm reduction for people who use stimulants has increased, but it remains small. Availability of safer smoking equipment has increased, often distributed by NSPs. These services are aimed at the increasing number of people who are smoking fentanyl as well as people who smoke crack cocaine and methamphetamines."

SPOTLIGHT

RESPONDING TO A TOXIC DRUG SUPPLY

North America has a highly toxic drug supply. Benzodiazepines and synthetic opioids (including carfentanil and fentanyl) are frequently found in samples of both opioids and stimulants where they are not expected. There is a further emerging issue of contamination with xylazine, a tranquiliser which may cause central nervous system depression and skin ulcers.[66] Fentanyl is also increasingly used intentionally, particularly in Canada, requiring adaptation from OAT and overdose response services.[67] This toxic drug supply has had an immense impact on overdose rates in North America. To make matters worse, the COVID-19 pandemic has dramatically escalated a crisis of overdose deaths that has been ongoing in the region since the late 1990s.

Alongside efforts to decriminalise and regulate drugs, harm reductionists have three major tools in the response to this toxic supply. The first is safer supply. This means ensuring that people do not receive contaminated substances in the first place. The second is drug checking, so that people can check if their drugs contain contaminants. The third is an effective overdose response.

Safer supply is increasingly available in Canada, although the practice is concentrated on the safer supply of opioids and not stimulants, despite reports of contaminated stimulant supply. Many service providers report that 'traditional' OAT using methadone or buprenorphine is insufficient for, or does not meet, the needs of clients. Fentanyl is rarely available as OAT in Canada, despite being widely used in the community.[63] In a first-of-its-kind programme in Vancouver, which is based on feedback from the community, PHS Community Services provides fentanyl via prescription.[68] Community activism has also been an important part of safer supply advocacy and implementation. For example, in July 2021 the Drug User Liberation Front (DULF) and Vancouver Area Network of Drug Users (VANDU) held a protest during which they handed out tested heroin, methamphetamine and cocaine to promote the concept of safer supply.[69] Since 2020, the federal government in Canada has indicated support for safer supply programmes.[70] However, this support has been insufficient to achieve widespread access. Still only a few prescribers are willing to prescribe diamorphine (pharmaceutical heroin) or fentanyl to people who use opioids,[3,63] despite clear guidelines endorsed by the federal government.[71,72]

Drug checking, where drug samples are tested with portable or laboratory machinery to determine what they contain, is available in both countries as onsite, walk-in and mail-in services. Checking in real time is rarely available, and access remains limited, despite an increase in provision since 2020. Legal and funding barriers often make it difficult to expand access. For example, in Canada, for drug checking services to operate without the threat of criminal charges, they are required to apply for exemption from federal drug laws, which is a slow and bureaucratic process.[3,40,63] However, drug checking is increasingly present in Canadian DCRs (which already have the necessary exemptions to handle illicit substances), particularly in British Columbia.

To combat the specific challenge of fentanyl contamination, many harm reduction organisations in the region provide testing strips capable of identifying the presence of fentanyl in a sample. In Canada, fentanyl testing strips are widely available in DCRs and drug checking facilities. In the United States, federal funds can now be used to purchase fentanyl testing strips. In both countries, fentanyl testing strips are highly acceptable to people who use drugs and can play an important role in reducing harms, particularly for people who use stimulants[73,74], although their usefulness is limited in contexts where fentanyl is the predominant opioid of choice or where virtually all opioids purchased contain fentanyl or an analogue.

Naloxone remains a primary tool in overdose response. Take-home naloxone, as well as peer-led distribution programmes, operate in both countries with support from the federal government and private donors. In Canada, there is concern from civil society that the federal government may overemphasise naloxone accessibility as a panacea for the overdose crisis at the expense of other parts of the response.[38] Even so, while access is high in many cities, rural areas are underserved.[40] Reaching all relevant populations can also be a challenge for naloxone distribution. Civil society actors report that some people, notably those who only use cocaine, believe they do not need naloxone, despite the documented presence of opioid contaminants in the cocaine supply.[31] This may be associated with stigma towards people who inject opioids.

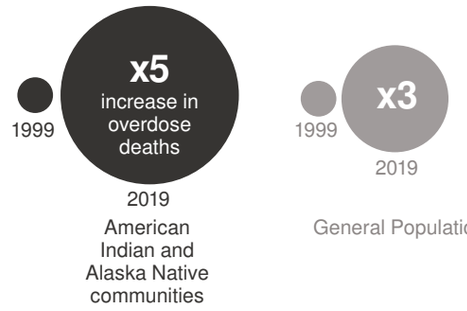
In the United States, naloxone accessibility has also increased since 2020. A broad consensus on the need for naloxone has led to more political and financial support from both state and federal governments.[23,53] However, supply chain shortages in 2021 have caused higher prices, reduced availability, and increased overdose deaths.[21,23,29,59,75] In response, in autumn 2021 civil society organisation Remedy Alliance: For the People negotiated the supply of low cost naloxone with pharmaceutical manufacturers, and is making the medication available to harm reduction organisations across the country.[75] However, naloxone provision in the United States still does not come close to saturation, as no states currently meet need.[76]

Naloxone is not the only response in cases of overdose. Harm reductionists have long advocated 'never using alone' as a mitigation against overdose, and as a way of ensuring medical attention can be sought. DCRs are a way to ensure use happens in the presence of medical professionals. More recently, the COVID-19 pandemic resulted in an increase in the practice of 'virtual spotting', whereby people who use drugs can be in touch with a virtual companion (either by phone or online) while using, who can alert emergency services if the person becomes unresponsive.[77] One such programme is the Never Use Alone hotline, which operates 24/7 from the United States.[7,78] While these programmes work well for many people, their effectiveness is still limited by the criminalisation of drugs, as some people may not want any contact with emergency services.

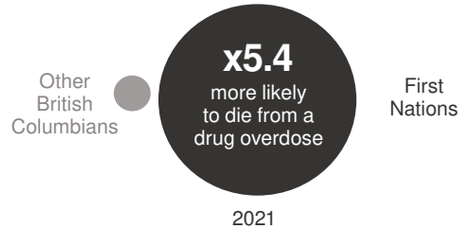
SPOTLIGHT

RACISM, DRUG CONTROL AND HARM REDUCTION

From 1999 to 2019, overdose deaths increased five-fold among American Indian and Alaska Native communities in the United States



In 2021, First Nations people were 5.4 times more likely to die from a drug overdose than other British Columbians



Drug control in North America, as around the world, has long been associated with attempts to control and repress Black, Brown and Indigenous people.[79] Structural racism continues to have a major impact on the accessibility of harm reduction for these groups in both Canada and the United States.[7,16,19,23,54]

Civil society and academic observers in the United States note that, in some areas, there is a tendency for harm reduction services to be concentrated in predominantly white neighbourhoods[24,26,80], as is the case in Phoenix, Arizona, for example[53]. This is despite the fact that overdoses are now increasing fastest among Black Americans, rather than white Americans. Black people make up 12% of the United States' population, but represented 17% of overdose deaths in 2020.[81,82] Some data suggests that the overdose crisis may worsen among Black Americans, even as figures among white Americans improve. In Maryland from 2017 to 2020, for example, overdose deaths among white people decreased by 14%, but they increased by more than 40% among Black people.[83]

"From 1999 to 2019, overdose deaths increased five-fold among American Indian and Alaska Native communities in the United States, while increasing three-fold in the general population. In 2021 in British Columbia, First Nations people made up 15% of drug overdose deaths but only represent 3.3% of the population."

In January 2021, the Biden administration issued an executive order requiring federal agencies to increase efforts to improve services for 'underserved communities', including 'Black, Latino, and Indigenous and Native American' people.[84] In alignment with this order, the federal Harm Reduction Program Grant introduced in 2022 commits to funding projects and programmes that seek to address drug-related health disparities between racial groups (as well as other groups that have been marginalised, such as LGBTQI+ communities).[10] It remains to be seen if this explicit aim will have a significant impact on the accessibility of harm reduction services for these groups.

In Canada and the United States, First Nations and Indigenous people are also disproportionately impacted by drug overdose deaths. From 1999 to 2019, overdose deaths increased five-fold among American Indian and Alaska Native communities in the United States, while increasing three-fold in the general population.[85] In 2021 in British Columbia – the province with the greatest availability of harm reduction services – First Nations people made up 15% of drug overdose deaths but only represent 3.3% of the population.[86] First Nations people were 5.4 times more likely to die from a drug overdose than other British Columbians. The situation is particularly grave among First Nations women. Among the general population, 19% of people who died from an overdose in 2021 were women, but among First Nations people, women made up almost double the proportion of overdose deaths (36%).[86]

To address this, the First Nations Health Alliance has an active harm reduction programme, distributing more than 40,000 doses of naloxone in 2021, including bulk orders sent directly to 106 First Nations communities and organisations in Canada.[86] It also works closely with partners in the health system to foster more culturally safe care for people from First Nations communities and to combat anti-Indigenous racism in health services.[86] In the United States in July 2021, the Substance Abuse and Mental Health Services Administration expanded substance use grants for Indigenous communities, allowing harm reduction supplies to be purchased with funds.[87] As a result, more communities have expanded into harm reduction work, including naloxone distribution and substance use education.[88] One civil society actor estimated there now may be as many as 150 tribal-led NSPs in the United States.[88]

People who have migrated to the United States, primarily from Asia and Latin America, also face severe challenges in accessing harm reduction services. Not only are services rarely located in areas where migrants live, people who are undocumented also face severe consequences related to drug criminalisation. In the 2020 fiscal year, United States Immigration and Customs Enforcement made 51,912 non-trafficking drug arrests: a rate of 1 every 9 minutes.[7,89] Of these arrests, 36,647 led to a criminal conviction.[89] Non-citizens with drug-related convictions may face detainment without hearing in immigration detention facilities while waiting for potential deportation.[90] They can also face disqualification from citizenship, visas and permanent residency ('green cards').[7,14] Civil society actors report that people who are migrants may avoid engaging with harm reduction services for fear of being handed over to immigration authorities and subjected to the compounded consequences of criminalisation.[14,60]

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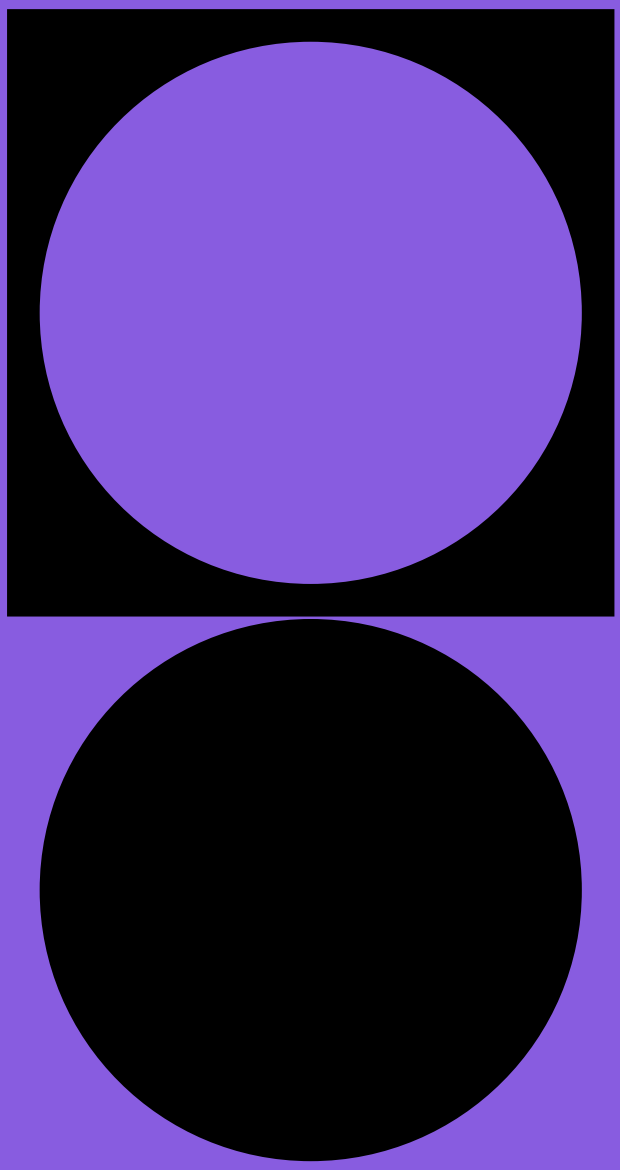
REGIONAL OVERVIEW: OCEANIA



THE GLOBAL STATE
OF HARM REDUCTION 2022

HARM REDUCTION INTERNATIONAL

TABLE 8 EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN OCEANIA

Country/territory	People who inject drugs[a]	HIV prevalence among people who inject drugs (%)[a]	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[a]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[a]	Harm reduction responses[b]				
					NSP[c]	OAT[d]	Peer distribution of naloxone[e]	DCR[f]	Safer smoking equipment[g]
Aotearoa-New Zealand	22,500	0.1	71	2.8	✓ >200[2]	✓ M B[3]	✓[3]	×	×
Australia	98,500	1.3	53	3.9	✓ 4,218[4]	✓ M B[5]	✓	✓ 2	×
Federated States of Micronesia	nd	nd	nd	nd	×	×	×	×	×
Fiji	nd	nd	nd	nd	×	×	×	×	×
Kiribati	nd	nd	nd	nd	×	×	×	×	×
Marshall Islands	nd	nd	nd	nd	×	×	×	×	×
Nauru	nd	nd	nd	nd	×	×	×	×	×
Palau	nd	nd	nd	nd	×	×	×	×	×
Papua New Guinea	nd	nd	nd	nd	×	×	×	×	×
Samoa	nd	nd	nd	nd	×	×	×	×	×
Solomon Islands	nd	nd	nd	nd	×	×	×	×	×
Timor Leste	<500	nd	nd	nd	×	×	×	×	×
Tonga	nd	nd	nd	nd	×	×	×	×	×
Tuvalu	nd	nd	nd	nd	×	×	×	×	×
Vanuatu	nd	nd	nd	nd	×	×	×	×	×

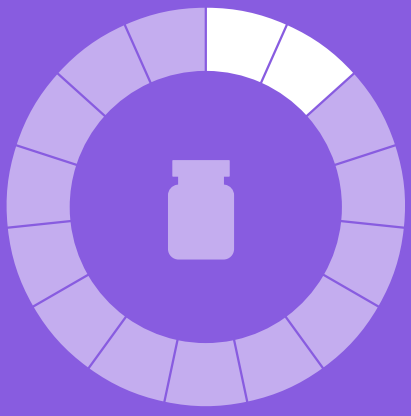
a Unless otherwise stated, data is from Degenhardt et al (under review).[1]
b Data sourced in Global State of Harm Reduction survey responses, unless otherwise stated.
c At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available)
d At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, M=methadone.
e At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training, and facilitates secondary distribution of naloxone between peers.
f At least one drug consumption room (also known as safe consumption sites among other names) operational in the country or territory, and the number of facilities.
g At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.

AVAILABILITY OF HARM REDUCTION SERVICES

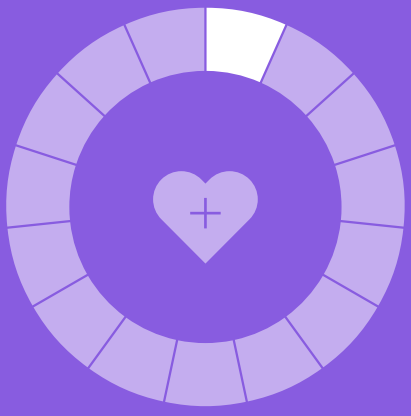
- Both NSP and OAT available
- OAT only
- NSP only
- Neither available
- Not known
- Peer-distribution of naloxone
- DCR available

NSPs, OAT AND DCRs SINCE 2020

2 countries (13%) in Oceania provide **needle and syringe programmes** (no change from 2020)

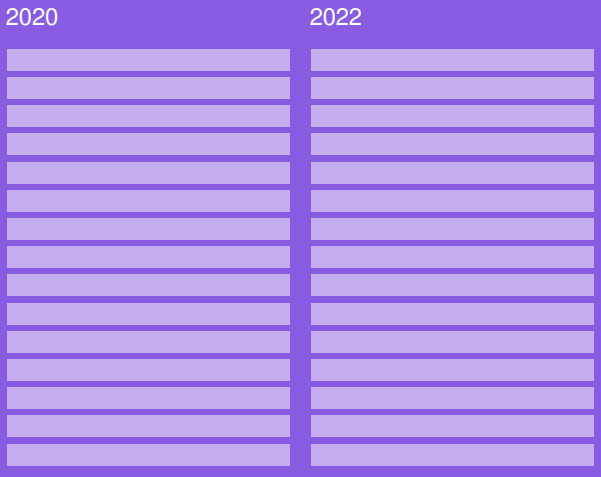


2 countries (13%) in Oceania provide **opioid agonist therapy** (no change from 2020)

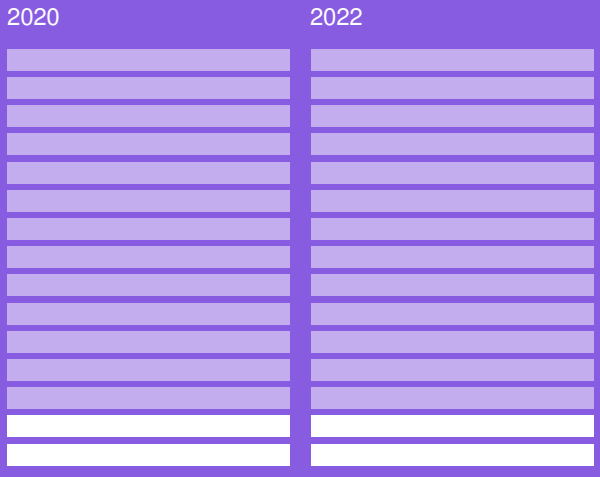


1 country (7%) in Oceania provides **drug consumptions rooms** (no change from 2020)

HARM REDUCTION IN PRISONS



No country in Oceania provides **needle and syringe programmes** in prisons (no change from 2020)



2 countries in Oceania provide **opioid agonist therapy** in prisons (no change from 2020)

MĀORI PEOPLE AND ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE FACE A DISPROPORTIONATE BURDEN OF DRUG-RELATED HARMS

REGIONAL OVERVIEW

AUTHORS:
MICHALA KOWALSKI

INTRODUCTION

There have been a few major developments in harm reduction in Oceania since 2020. In Aotearoa-New Zealand, the government formalised drug checking services and supported the roll out of take-home naloxone. Both Aotearoa-New Zealand and Australia expanded distribution of safer injecting equipment and naloxone via postal services. The COVID-19 pandemic continued to have an impact, notably creating a window of opportunity to advance harm reduction priorities long advocated for by people who use drugs and harm reduction networks. The COVID-19 pandemic disrupted and restricted access to existing services in some cases.[6,7] In Australia, this appears to have stabilised by 2021, with 80% of needle and syringe programme (NSP) clients surveyed reporting that their access to safe injecting equipment was unchanged from early 2020.[8] In 2021, uptake of COVID-19 vaccination among people who inject drugs in Australia was significantly lower than uptake among other people. Research found that women who inject drugs and people who reported daily or more frequent injection were significantly less likely to be vaccinated.[9]

DATA

Data availability in the region remains mixed. In the Pacific Islands Countries and Territories of the Federated States of Micronesia, Fiji, Kiribati, Marshall Islands, Papua New Guinea, Samoa, Solomon Islands, Timor Leste, the Kingdom of Tonga, and Vanuatu, data remains poor.[10,11] Governments do not release reliable numbers regarding population sizes of people who use drugs and injecting behaviours, and there is no indication that any types of formal harm reduction programmes exist in these countries.[11]

Currently, there is an HIV epidemic in Papua New Guinea,[12] and viral hepatitis prevalence is high in Papua New Guinea, Fiji and Kiribati[13], although injecting drug use is not indicated as a factor in either epidemic.[12–14] There are also reports of growing methamphetamine use in the Kingdom of Tonga and Marshall Islands, partly as a result of drug trafficking routes passing through the region.[15,16] Despite this being an indication that providing safer smoking equipment may be necessary, no such programmes exist. The Joint United Nations Programme on HIV/AIDS (UNAIDS)' *Unified Budget, Results and Accountability Framework workplan for 2022 to 2023* includes provision for funding harm reduction programmes in Fiji.[17]

Data from Aotearoa-New Zealand and Australia is better, with reliable estimates of the prevalence of injecting drug use,[18] prevalence of HIV and hepatitis in people who inject drugs,[6,19,20] and the implementation of both formal and informal harm reduction programmes.

DRUG CHECKING

In 2022, Aotearoa-New Zealand made its informal drug checking services an official programme.[21] New legislation has enabled the licensing of four drug checking programmes, including a mix of mobile

and fixed sites, in Auckland, Christchurch, Dunedin and Wellington.[7] Australia's first fixed site drug checking service opened its doors on 18 July 2022 in Canberra.[22] It is currently operating as a six-month pilot[22] (for more information, please see the thematic section on formalising drug checking in the region).

COVID-19

In Aotearoa-New Zealand, take-home naloxone was rolled out for the first time following COVID-19-related lockdowns, provided onsite at harm reduction services.[7,23] As changes were made to the provision of OAT programmes to enable more flexibility, including take-home doses, some OAT service providers had concerns that clients might be at greater risk of overdose.[7] To reduce this risk, the federal government enabled OAT service providers to provide naloxone with take-home OAT doses (i.e. multi-day doses, where clients self-administer).[7] At their discretion, select service providers made naloxone and needle and syringe services available to peer networks to disperse to clients.[7] At present, the provision of naloxone in Aotearoa-New Zealand remains ad hoc, and it is unclear if or when it will be formalised.[7,24,25]

Following a process that began before the COVID-19 pandemic, in July 2022 the Australian government began the roll out a four-year programme of take-home naloxone across the country.[26] Through this new model, currently operational in participating pharmacies, naloxone will be available free of charge without a prescription and dispersed through peer networks, community and hospital-based pharmacies, alcohol and drug treatment centres, NSPs and custodial release programmes.[26] This programme formalises and expands on the pilot take-home naloxone programme the Australian government operated from December 2019 to June 2022 in three states (New South Wales, South Australia and Western Australia).[27]

Since 2020, in response to the COVID-19 pandemic, OAT delivery in both Aotearoa-New Zealand and Australia has placed greater emphasis on reduced in-person supervision, which has resulted in an increase in take-home doses.[7,28] But this has not been rolled out as a uniform measure, and in Australia many clients are back on supervised daily dosing regimens.[29] In Aotearoa-New Zealand, a few select clients who have been 'deemed stable' by their OAT service providers have been able to continue with take-home OAT, reducing the burden of supervision.[7] Another change to the delivery of OAT in Australia is an increase in the prescription of depot buprenorphine[28] (a long-acting injectable formulation of buprenorphine[30]), especially within the prison system.[29] Long-acting injectables can provide people in community settings with more flexibility in their lives, as it removes the logistical burden of attending a clinic for daily dosing and the constant reminder that they are on OAT.[29] However, some harm reduction advocates are concerned that this model of care is over-developed in Australia's prisons and under-developed in community settings.[29] This mismatch between the model of OAT provided in prison and the model of OAT provided in the community has led to a situation in which people are struggling to find a doctor to continue prescribing long-acting injectables upon release from prison.[29] There is limited information available on the choices offered, practices associated with prescribing long-acting buprenorphine to people in prison, and the preferences of people in prison. Broadly, there is a shortage of OAT prescribers, which affects accessibility throughout Australia.[31]

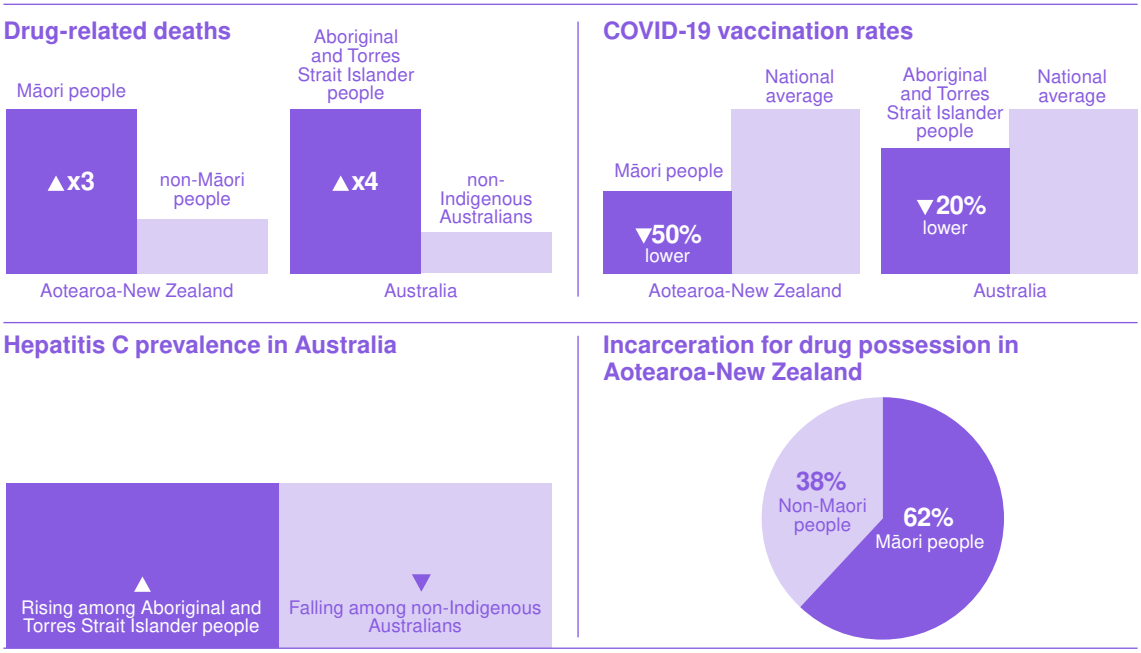
"In July 2022, the Australian government began the roll out a four-year programme of take-home naloxone across the country. Through this new model, currently operational in participating pharmacies, naloxone will be available free of charge without a prescription and dispersed through peer networks, community and hospital-based pharmacies, alcohol and drug treatment centres, NSPs and custodial release programmes."

INEQUITABLE OUTCOMES

Inequitable outcomes of current drug policies and drug use are pervasive in Aotearoa-New Zealand and Australia. Despite longstanding government recognition of the disproportionate burden of drug-related harms faced by Māori people in Aotearoa-New Zealand[32] and Aboriginal and Torres Strait Islander peoples in Australia[33], very little has changed since 2020. This disparity in outcomes includes:

- **Drug-related deaths:** Māori people are three times more likely to die from drug use than non-Māori people in Aotearoa-New Zealand,[34] and Indigenous Australians are four times more likely to die from drug use than non-Indigenous Australians.[35]
- **COVID-19 vaccination rates:** Māori people receiving services for drugs or alcohol had a vaccination rate that was half the national average in 2021,[34] for and the Aboriginal and Torres Strait Islander people vaccination rate was 20-30% lower than the national average vaccination rate in Australia in 2021.[36]
- **Higher and rising hepatitis C prevalence** among Aboriginal and Torres Strait Islander people in Australia; whereas hepatitis C prevalence is dropping among the general population.[37]
- **Incarceration rates:** 62% of people sentenced to prison on drug possession offences were Māori,[34] and Aboriginal and Torres Strait Islander people's rate of imprisonment is 13.3 times higher than the non-Indigenous imprisonment rate in Australia.[38]

Data indicates that, in practice, Aboriginal and Torres Strait Islander peoples[39] and Māori people[40] have been excluded from the benefits of drug law reforms that granted police discretionary powers over whether to press charges for possession of cannabis in Australia and Aotearoa-New Zealand. Culturally safe and appropriate harm reduction services are needed for Aboriginal and Torres Strait Islander people in Australia,[41] and Māori people in Aotearoa-New Zealand.[25,34] Advocates have called for extensive drug law reforms that are inclusive of Indigenous communities.[34,42,43]



POLICY DEVELOPMENTS

There have been small gains in drug law reform in Australia since 2020. In the Australian Capital Territory (ACT), cannabis was decriminalised (sometimes referred to as 'limited legalisation') for personal use, possession and minimal domestic cultivation in January 2020.[31,44] On 9 June 2022, in response to a parliamentary inquiry, the ACT government endorsed a private member's bill to decriminalise possession and use of small amounts of amphetamine, cannabis, cocaine, heroin, LSD, MDMA, methamphetamine and psilocybin.[45] The bill was passed in October 2022 and will come into effect in October 2023.

Setbacks include defeat in a referendum on cannabis legalisation in Aotearoa-New Zealand in 2020.[46] In Australia, the private insurance company that provided public liability insurance for on-site drug checking at festivals in ACT rescinded its coverage in April 2022.[47]

LOOKING AHEAD

There are three processes underway in the region that are likely to have an effect on harm reduction and drug policy. In Aotearoa-New Zealand, the harm reduction community is awaiting the full findings of the review of the 2019 changes to the Misuse of Drugs Act,[48] which were expected to be released in August 2021.[49] In Australia, advocates await the Department of Health's review of opiate dependence medicines, which includes an examination of the barriers to access and future models of care.[50] In New South Wales, Australia's most populous state, the government is yet to respond to the Special Commission of Inquiry into the Drug 'Ice' (methamphetamine).[51] In January 2020, the commission made 109 recommendations, including the decriminalisation of all drugs, the establishment of additional DCRs that include smoking facilities, and removing prohibitions on access to these facilities for young people and pregnant people.[52]

Current priorities for harm reduction advocacy in Aotearoa-New Zealand and Australia include decriminalisation and law reform,[24,24,41,53–55] roll out of naloxone in Aotearoa-New Zealand,[7] broader and more equitable NSP coverage,[25] including in prisons,[53] increasing access to healthcare for people who use drugs,[24,25,55] expanding drug checking services[7,55] and reforming OAT services,[41,56] including injectable OAT and the removal of dispensing fees.[7]

SPOTLIGHT

DRUG CHECKING IN AOTEAROA-NEW ZEALAND

Aotearoa-New Zealand started on the path to formalising drug checking in 2020.[57] This process has formalised services that have been in existence since 2015, when providers began offering informal drug checking services at festivals without legal backing.[58] While a licensing scheme was developed, the country's Director-General of Health was empowered to appoint drug checking service providers on a temporary basis.[57] The formal licensing scheme was introduced in April 2022.[21] Licence terms are for a maximum of three years, and includes stipulation about approved testing methods.[57] To date, four organisations hold licenses to deliver drug checking programmes.[57] These are KnowYourStuffNZ, NZ Drug Foundation, New Zealand Needle Exchange Programme (NZNEP) and the Institute of Environmental Science and Research (EST).[57] These programmes include on site services,[7,24,25] fixed site services,[7,24,25] pop up clinics,[7] mobile services,[24] and a mail-in service for cannabis.[25] Services are funded by the government[7,24] and delivered by community-led organisations.[7,24,25] Peers are meaningfully involved in planning and implementing services.[7,24,25]

However, the programme is still in its infancy,[25] and coverage is insufficient. Most people who need a drug checking programme do not have access to one.[7,24,25] The COVID-19 pandemic response restricted services' ability to run drug checking and had a negative impact on the provision of harm reduction.[7] Moreover, equipment is limited.[24] At the time of writing, there are only four FT-IR spectrometers available for drug checking in Aotearoa-New Zealand.[7] Services are generally available at festivals or in the community on a time limited basis; for example, for three hours on a Tuesday night at a specific location.[7] Service availability is also limited outside of cities.[24] The service is also yet to garner widespread support from the general population.[25]

Organisation	Equipment	Model of Service
KnowYourStuffNZ	Reagents and FT-IR Spectroscopy[58]	On site and fixed site clinics
NZ Drug Foundation	Reagents and FT-IR Spectroscopy[61]	Pop up clinics and fixed site clinics[60]
NZNEP	Reagents and FT-IR Spectroscopy[60]	Fixed site clinics[60]
ESR	Forensic lab	Fixed site confirmatory testing[57,60,62]

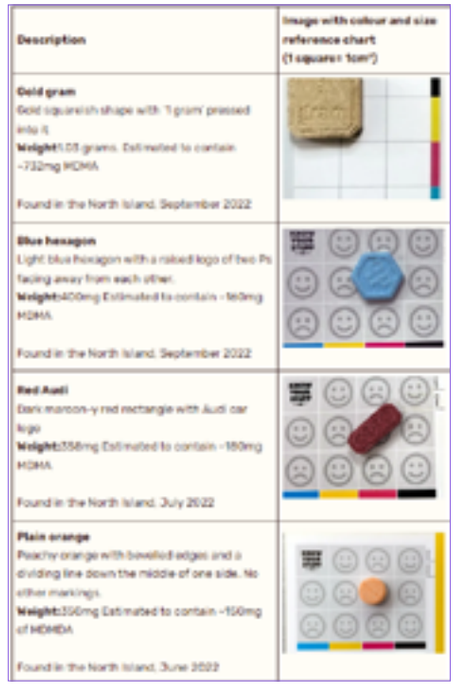
Harm reduction services are currently advocating for drug checking to be made permanently available at community-based outlets, in a similar manner to the local NSPs.[7] Ideally, these services will be located with needle and syringe provider outlets.[7] Drug checking services advertise that drugs, such as MDMA, ketamine, cocaine, methamphetamine, LSD, pharmaceuticals, supplements and other drugs used to enhance performance or image, can all be checked with current processes.[63] Services have also released results from testing during the summer of 2020/2021 to raise awareness among people who use drugs of the true contents of substances sold as MDMA.[63]

In Australia, formal drug checking programmes have operated on a provisional basis. Two on-site drug checking pilots ran in 2018 and 2019,[64] and the ACT government is currently trialling a six-month, fixed-site drug checking service.[22] This service is located within an established harm reduction needle and syringe provider outlet.[29] Results released from the first month of testing indicate that the service has tested samples of ketamine, MDMA, heroin, methamphetamine, cocaine, MDA (3,4-methylenedioxyamphetamine) and a range of psychedelics.[65] All three drug checking pilots have been peer-led, with peer groups working together as part of a consortium of specialists on both the design and implementation of the services.[29]

However, the Australian path to formalisation faced some setbacks in 2022. A third on-site drug checking pilot was cancelled at the last minute in April after a private insurance company rescinded public liability insurance for the service.[47] There is concern among advocates and providers that the insurer's decision will have implications for other drug checking pilots that are in development.[29,66] Of note is the fact that restrictions introduced to mitigate the spread of COVID-19 resulted in the suspension of the festival season for two years. This meant that effective advocacy windows to call for more extensive roll-outs of drug checking services were limited in 2020 and 2021.[67]

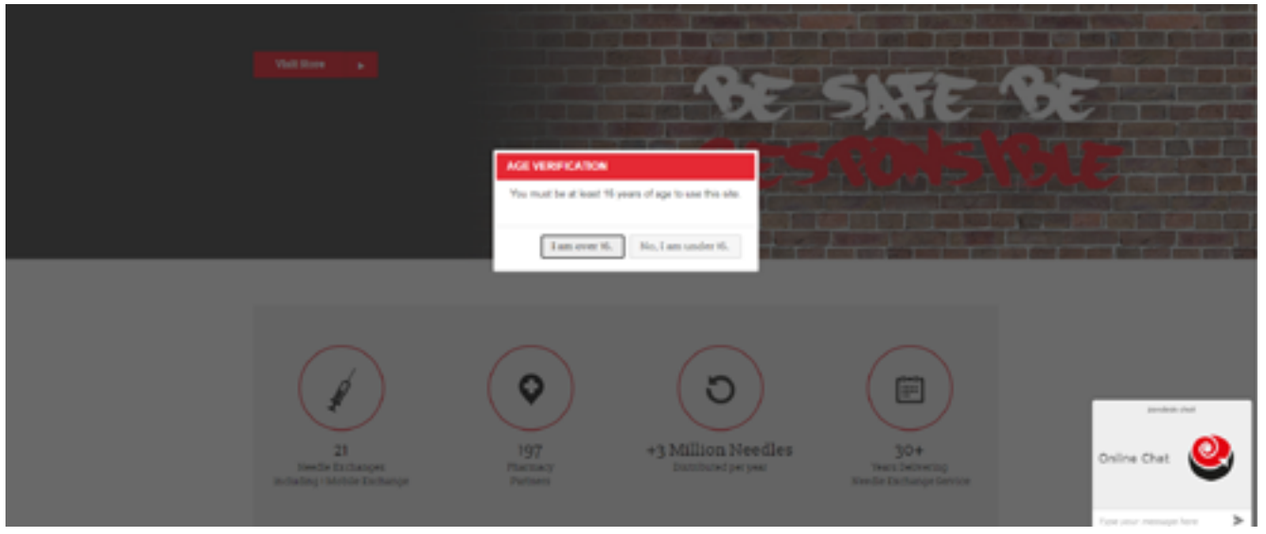
While people who use drugs, advocates, harm reduction organisations and specialists wait for legislative change in Australia, many harm reduction services engage with bottom-up, peer-led strategies to provide (informal) drug checking.[55] As drug checking equipment is legal in Australia, this bottom-up approach involves the distribution of reagent testing kits and fentanyl testing kits at multiple harm reduction service outlets.[55,68] But this operating model does not ensure accurate interpretation of results,[55,68] and the approach to distribution does not necessarily ensure a person receives tailored information and advice. However, these approaches do respond to the significant demand for formalised drug checking services[55,68] and may pave the way for these services to be formal recognised in the future.

Alongside formal and informal drug checking services in Aotearoa-New Zealand and Australia, harm reduction services[69] and government health departments[70,71] in both countries have established early warning systems for drugs.[24,66] These systems are able to send out alerts and notifications about both dangerous adulterants (substances that are added to drugs) and the potency of drugs that are currently in circulation. These early warning systems demonstrate the potential reach of drug checking services that go beyond their individual clients[72] to reduce potential harms for the broader community.



SPOTLIGHT

ONLINE HARM REDUCTION IN OCEANIA



The COVID-19 pandemic created an opportunity for increased digitisation of harm reduction services in Aotearoa-New Zealand and Australia. Peer-led harm reduction organisations[73–75] responded rapidly to lockdowns by turning to online delivery of education[41,73,76] and distribution of sterile injecting equipment via post.[7,41,76] Equipment was mailed to clients via post, including provisions for safe disposal of used equipment.[76] Not only did this pivot to remote distribution of services increase accessibility for clients during COVID-19 restrictions in general,[7] it improved accessibility to harm reduction for rural and remote clients and people who inject drugs other than opioids,[7] and removed some of the points of friction that clients routinely experience while accessing safe injecting equipment (such as travel distance and time commitments).[54,76]

Both Aotearoa-New Zealand and Australia introduced strict lockdown conditions in response to the COVID-19 pandemic in March 2020[77,78] and phased through alternating levels of restrictions throughout 2021.[78,79] Restrictions on mobility and gatherings were lifted in Aotearoa-New Zealand and Australia at the end of 2021.[78,79] Although needle and syringe providers were classified as an essential health service,[25] some outlets restricted their hours of operation.[7] A small number of pharmacy outlets withdrew from the New Zealand Needle Exchange Programme, citing the extra demands placed on them by lockdowns and vaccination programmes.[7] In Australia, 12% of respondents to the 2020 Australian Needle Syringe Program Survey reported that it was more difficult to access equipment during the COVID-19 pandemic.[6]

Notwithstanding the disruption caused by the COVID-19 pandemic, NSP coverage in Australia is classified as high, and NSP coverage in Aotearoa-New Zealand is classified as moderate, according to World Health Organization standards.[18,80] Civil society organisations report that coverage is relatively good in the major cities during daytime hours.[24,29] However, both countries have gaps in NSP coverage in regional and rural areas,[24,29] and after-hours in the cities.[29] Clients resort to filling these gaps with bottom-up strategies, including reusing equipment[54] and sharing equipment, both of which present a greater risk of health harms.[6] The 2020 Australian Needle Syringe Program Survey found that one in six (16%) respondents had shared someone else's injecting equipment in the last month.[6]

At times, the ways NSPs operate in Aotearoa-New Zealand and Australia can be cumbersome and stigmatising. Some services require people to return used equipment to access new equipment.[54] This requirement creates a logistical challenge for some,[54] and increases people's chances of being detected by law enforcement.[29] Clients report that they avoid using after-hours NSPs based in hospitals due to experiencing stigmatising encounters at these services.[29] People have also reported avoiding NSP outlets that are located in OAT sites in both Aotearoa-New Zealand and Australia.[7,29] This is because some OAT programmes take a punitive approach to clients injecting their OAT.[7] According to reports from Aotearoa-New Zealand, clients who are found to be injecting OAT are forced to attend supervised dosing (instead of continuing with take-away doses).[7] Providing these services digitally and by post can overcome these barriers.

As entire sectors transitioned to working online, peer-led harm reduction organisations enhanced their websites[41] and built online shops.[7] Online service integration and distribution models of services differ from one organisation to the next. Some services offer online education, take-home naloxone and sterile injecting equipment free of charge.[73] Others charge a small fee to access sterile injecting equipment.[74,75] Order processing and shipping can take a few days,[73] meaning that this model of access is not on-demand. Civil society organisations report that clients' responses to their online service have been positive.[7]

While the pivot to digitised delivery of harm reduction services has increased accessibility for some people,[7,41,76] it has made services less accessible for others.[7] One concern is that online services will result in clients having fewer points of contact with harm reduction service providers. According to the 2021 *National Data Report on the Needle Syringe Program National Minimum Data Collection*, two in five service interactions at primary NSP outlets involved the provision of health education.[18] One in ten service interactions involved a referral to other harm reduction and healthcare services, either within the service or to an external provider.[18] There may be a need for increased integration of the services that are available online to provide a digital equivalent to the 'no-wrong door' policy that organisations are trying to implement in the physical environment.

To date, the digitisation of some harm reduction services in Aotearoa-New Zealand and Australia has continued, despite the lifting of COVID-19-related restrictions. Peer-led harm reduction organisations have led the way, developing innovative models to provide education, naloxone and safe injecting equipment to clients. The digitisation of services has had a positive effect on the provision of harm reduction; increasing access to services for those located in regional and rural areas, while reducing the barriers people who use drugs face when trying to access harm reduction services.

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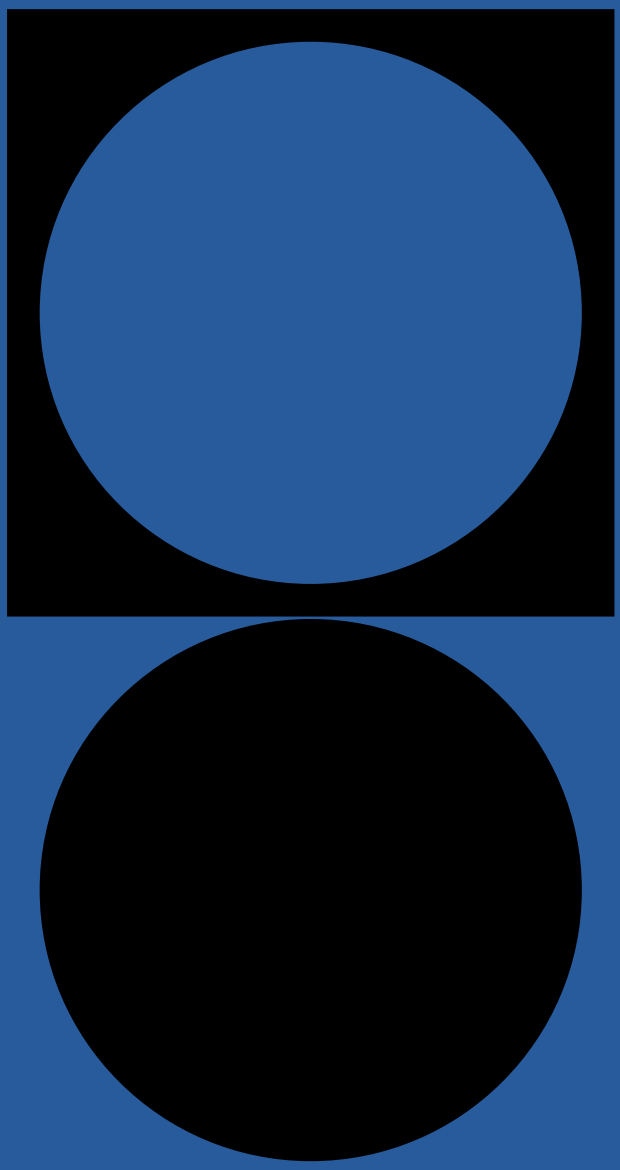
REGIONAL OVERVIEW: WEST AND CENTRAL AFRICA



THE GLOBAL STATE
OF HARM REDUCTION 2022

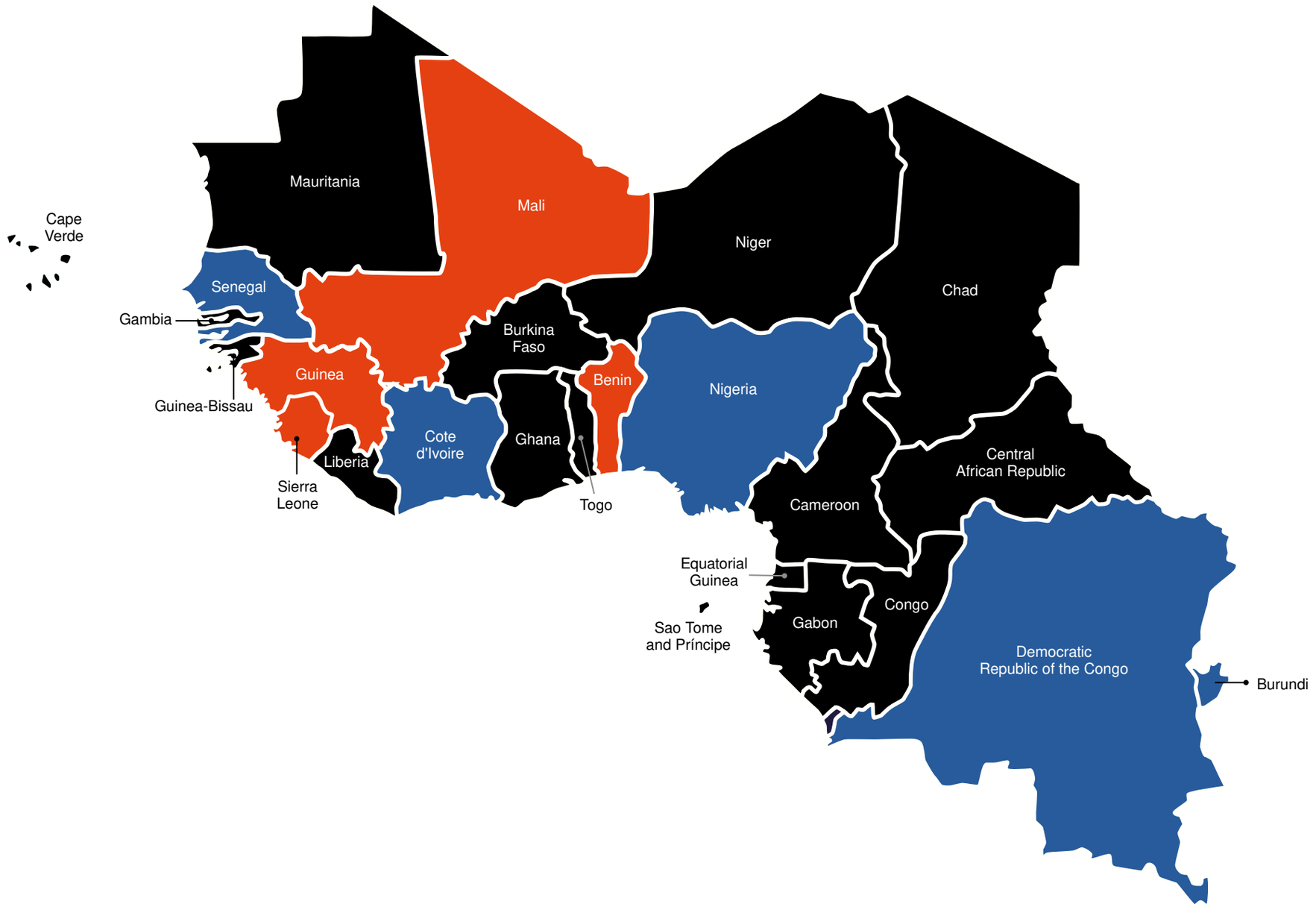
HARM REDUCTION INTERNATIONAL

TABLE 9 EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN WEST AND CENTRAL AFRICA

Country/territory	People who inject drugs[a]	HIV prevalence among people who inject drugs (%)[a]	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[a]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[a]	Harm reduction responses[b]				
					NSP[c]	OAT[d]	Peer distribution of naloxone[e]	DCR[f]	Safer smoking equipment[g]
Benin	nd	5.1	nd	nd	✓	✗	✗	✗	✗
Burkina Faso	nd	nd	nd	nd	✗	✗	✗	✗	✗
Burundi	nd	10.2	5.5	9.4	✓	✓	✗	✗	✗
Cameroon	1,500	nd	nd	nd	✗	✗	✗	✗	✗
Cape Verde	nd	nd	nd	nd	✗	✗	✗	✗	✗
Central African Republic	nd	nd	nd	nd	✗	✗	✗	✗	✗
Chad	nd	nd	nd	nd	✗	✗	✗	✗	✗
Congo	2,500	nd	nd	nd	✗	✗	✗	✗	✗
Côte d'Ivoire	500	5.3	1.8	10.5	✓	✓	✗	✗	✗
Democratic Republic of the Congo	36,500	2.4	nd	nd	✓	✓	✗	✗	✗
Equatorial Guinea	nd	nd	nd	nd	✗	✗	✗	✗	✗
Gabon	nd	nd	nd	nd	✗	✗	✗	✗	✗
Gambia	nd	nd	nd	nd	✗	✗	✗	✗	✗
Ghana	20,000	2.7	2.3	nd	✗	✗	✗	✗	✗
Guinea	nd	nd	nd	nd	✓	✗	✗	✗	✗
Guinea-Bissau	3,500	nd	nd	nd	✗	✗	✗	✗	✗
Liberia	6,000[2]	nd	nd	nd	✗	✗	✗	✗	✗
Mali	6,000	nd	nd	nd	✓	✗	✗	✗	✗
Mauritania	nd	nd	nd	nd	✗	✗	✗	✗	✗
Niger	nd	nd	nd	nd	✗	✗	✗	✗	✗
Nigeria	177,500	3.8	5.8	6.7	✓	✓	✗	✗	✗
Sao Tome and Principe	nd	nd	nd	nd	✗	✗	✗	✗	✗
Senegal	23,000	9.3	39.3	nd	✓	✓	✗	✗	✗
Sierra Leone	2,000	8.5	nd	nd	✓	✗	✗	✗	✗
Togo	2,500	nd	nd	nd	✗	✗	✗	✗	✗

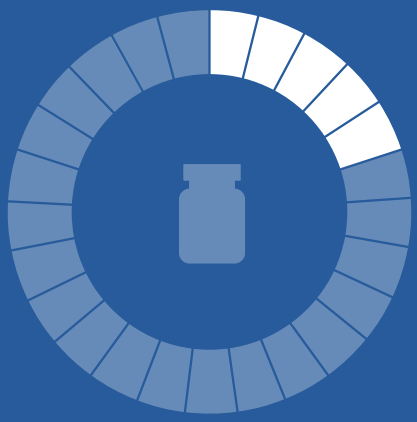
a Unless otherwise stated, data is from Degenhardt et al (under review).[1]
b Data sourced in *Global State of Harm Reduction* survey responses, unless otherwise stated.
c At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available)
d At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, M=methadon.
e At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training, and facilitates secondary distribution of naloxone between peers.
f At least one drug consumption room (also known as safe consumption sites among other names) operational in the country or territory, and the number of facilities.
g At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.

AVAILABILITY OF HARM REDUCTION SERVICES

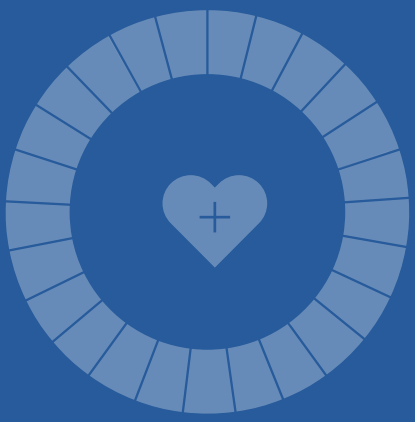


NSPs, OAT AND DCRs SINCE 2020

9 countries (36%) in West and Central Africa provide **needle and syringe programmes** (+4 since 2020, Burundi, Côte d'Ivoire, DRC, Guinea)

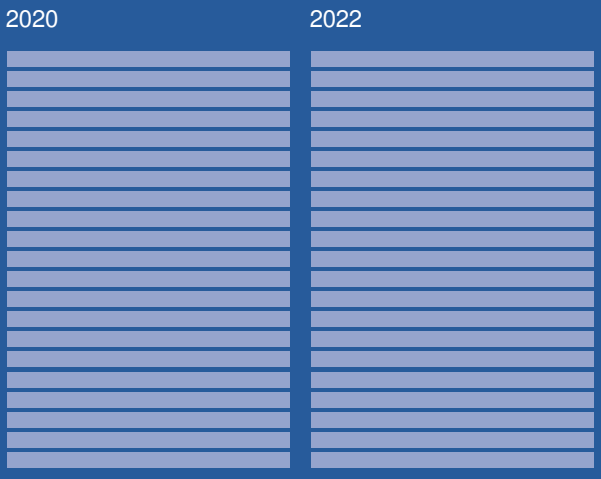


5 countries (20%) in West and Central Africa provide **opioid agonist therapy** (no change from 2020)

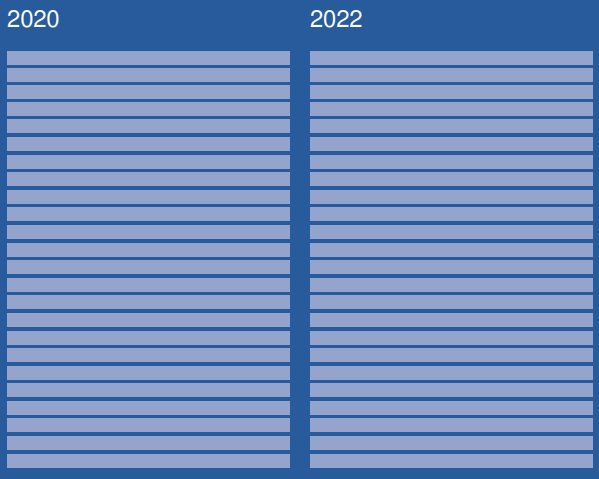


No country in West and Central Africa provides **drug consumptions rooms** (no change from 2020)

HARM REDUCTION IN PRISONS



No country in West and Central Africa provides **needle and syringe programmes** in prisons (no change from 2020)



No country in West and Central Africa provides **opioid agonist therapy** in prisons (no change from 2020)

IN ALL NINE COUNTRIES WHERE THERE ARE NSPS, THEY ARE RUN BY CIVIL SOCIETY ORGANISATIONS

REGIONAL OVERVIEW

AUTHOR:
KUNAL NAIK

INTRODUCTION

Drug policies across West and Central Africa, including drug laws and approaches to drug use, are rooted in prohibitionist interpretations of the international drug conventions and until recently, have remained unchallenged.[3]

The punitive drug policies currently in place hamper progress on harm reduction. Broadly, policy makers still misunderstand harm reduction, linking it to increased drug use rather than seeing it as a public health approach that can benefit their countries and populations.

NEEDLE AND SYRINGE PROGRAMMES (NSPs)

HIV, hepatitis C (HCV) and tuberculosis (TB) remain major concerns for West and Central Africa; for example, HCV prevalence in Nigeria is 8.1%.[4] Yet, despite the urgent need, there is a lack of NSPs in the region. Only nine countries (Benin, Burundi, Cote d'Ivoire, Democratic Republic of Congo/DRC, Guinea, Mali, Nigeria, Senegal and Sierra Leone) out of region's 25 countries have NSPs, all of which are run by non-governmental organisations.[5] Senegal has five operational NSPs, two of which are in the Dakar region, at the Dakar Centre for Integrated Addiction Care (Centre de prise en charge intégrée des addictions de Dakar, CEPIAD) and at a psychiatric hospital.[6]

Since the *Global State of Harm Reduction 2020*, four countries have initiated NSP programmes: Burundi, Côte d'Ivoire, the DRC (limited to Kinshasa only)[7] and Guinea. However, service coverage remains inadequate.[3,8] In August 2020, Nigeria began to pilot NSPs in three states (Oyo, Abia and Gombe), with plans for further scaling up of services underway in 2022.[9,10]

HIV AND VIRAL HEPATITIS

Only five countries in West and Central Africa currently offer OAT, all of which use methadone: Burundi, Cote d'Ivoire, DRC (a pilot project in Kinshasa), Nigeria and Senegal.[5]

The United Nations Office on Drugs and Crime (UNODC) is currently supporting the development of standard operating procedures and protocols for medically-assisted therapy focusing on OAT in Nigeria, and Nigeria's National Drug Control Masterplan 2021-2025 commits to rolling out OAT in three as-yet undefined states.[11,12]

OAT is an integral part of harm reduction in the region. This is reflected in the African Union's (AU) *Plan of Action on Drugs and Crime 2019-2023*. The AU's plan is an important reference point for national advocates who want to see harm reduction integrated into their country's health and drug control strategies.[13]

DRUG CONSUMPTION ROOMS (DCRs)

No countries in West and Central Africa have DCRs or provide drug checking facilities.[5] While HIV testing and treatment is available in most prisons in the region, other harm reduction programmes are not.[5]

Respondents to the *Global State of Harm Reduction* survey report that the drugs used in the region include cannabis, heroin and other opioids (such as pentazocine, tramadol and codeine), cocaine, ketamine, MDMA, methamphetamines, adhesives and local stimulants such as kola nut (*gworo*).[5,14]

FUNDING FOR HARM REDUCTION

There is a substantial funding gap for the HIV response in West and Central Africa, and funding remains unsustainable for harm reduction.[5] According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), the available funding for West Africa's HIV response in 2020 was approximately three quarters of the annual amount that will be needed in 2025, implying a need to increase funding. Total funding for HIV in the region declined by 11% between 2010 and 2020. Domestic funding has increased by 6% during the last decade, but peaked in 2018 then declined by 15% across 2019 and 2020.[8]

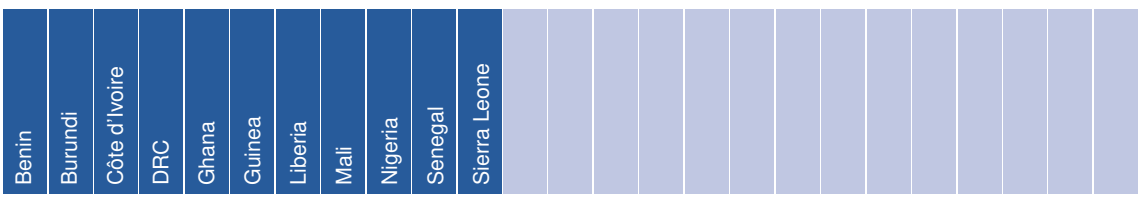
Between 2010 and 2020, the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) increased their contributions to the region by 23% and 85%, respectively, but all other international contributions reduced by 79% overall.[8] Civil society report that the countries in the region where the Global Fund invests in harm reduction include Burkina Faso, Mali, Nigeria, Senegal and Sierra Leone.[5,15]

POLICY DEVELOPMENTS

The COVID-19 pandemic has continued to disrupt service and advocacy since the *Global State of Harm Reduction 2020* report; however, some countries have made progress by incorporating harm reduction in their national plans and moving towards reforming their drug policies.

In 2021, Sierra Leonne conducted an integrated HIV bio-behavioural survey, as well as a law review. A draft bill which includes references to harm reduction, inspired by the Model Drug Law for West Africa,[16] was proposed in the country in the same year.[17] In Liberia, a law supporting the implementation of harm reduction programmes passed the house of legislatives and was awaiting senate approval as of August 2022.[18,19] Ghana has conducted rapid assessment surveys with people who inject drugs, and the data generated will be used to inform a harm reduction strategy, which will be operational on a pilot basis (the Global Fund and the School of Public Health at the University of Ghana support this work).[17] Since 2020, Liberia, Senegal and Sierra Leone have all developed national drug strategies that are supportive of harm

At least 11 countries in West and Central Africa have explicit reference to harm reduction in national policies



reduction for the first time.[20] At least 11 out of the 25 countries in the region now make explicit reference to harm reduction in their national policies (Benin, Burundi, Côte d'Ivoire, DRC, Ghana, Guinea, Liberia, Mali, Nigeria, Senegal and Sierra Leone).

COVID-19

Several countries reported that the COVID-19 pandemic continued to have a negative impact on harm reduction programmes between 2020 and 2022. This is particularly due to restrictions in movement and lockdowns, which stopped people who inject drugs from accessing harm reduction services.[18,21] In some cases, service delivery was stopped, which prevented follow-up with people who were enrolled in harm reduction programmes.[6] But there were some positive outcomes as well, as prevention and protection measures for people who use drugs were strengthened in some countries (including in Côte d'Ivoire). Secondary distribution of injecting equipment through peer networks enabled NSPs to continue in Senegal and Sierra Leone, for example, showing the central value of community-led responses in delivering harm reduction programmes.[15]

One of the key challenges for West and Central Africa is a severe lack of data. Few countries have reliable population size estimates for people who inject drugs (the estimates provided in this chapter are based on regional modelling). Only nine countries mention NSP and OAT in their national strategic plans (Benin, Burkina Faso, Burundi, Côte d'Ivoire, DRC, Guinea, Mali, Nigeria and Senegal); others countries in the region limit their interventions for people who use drugs to providing condoms and antiretroviral treatment for HIV.[3,8]

"One of the key challenges for West and Central Africa is a severe lack of data. Few countries have reliable population size estimates for people who inject drugs"

SPOTLIGHT

DECRIMINALISATION OF DRUG USE AND POSSESSION

Most countries in West and Central Africa still have repressive laws and systems, which criminalise drug possession, drug use and cultivation of small amounts of illicit drugs.[8] As a result of these laws, people who use drugs face stigma, discrimination and human rights violations in the form of physical and psychological harassment, abuse, and violence from the police, coerced drug treatment (programmes lacking an evidence base, therapeutic rationale or benefit), compulsory HIV testing, and the denial of healthcare services, employment and social benefits.

Criminalisation undermines HIV prevention and treatment, progress towards Sustainable Development Goal (SDG) 3 (ensuring healthy lives and promoting well-being for all at all ages), and the realisation of SDG 3.3 (ending the AIDS epidemic by 2030).

When it comes to West and Central Africa, progress has been slow, although there has been some progress towards less punitive drug policies and the decriminalisation of drug use and possession. In March 2020, the Ghanian parliament passed the Narcotics Control Commission Bill into law, which has paved the way for a more humane drug policy and can act as an example for other countries in the region and beyond. One aim of Ghana's new drug law is to treat drug use and drug dependence as a public health issue. Under the new law, drug possession for personal use no longer carries a prison term; instead, people will be fined between GHC 2,400 to 6,000 (USD 240 to 600). This means that people will no longer face up to 10 years in prison for simply possessing drugs for personal use, and will be offered alternatives to incarceration instead. This law represents real progress, but it will have a disproportionate and punitive effect on people who lack resources, and cannot afford the fine.

At the 63rd session of the Commission on Narcotic Drugs, Gambia's representative stated that the Gambian government will soon pass a bill to introduce non-custodial sentencing measures for people who use cannabis. It will also provide a safeguard to stop the drug control law being used in a way that compromises or violates people's rights. The representative of Gambia noted that human rights will remain a cardinal consideration in the country's drug control efforts.

Liberia, supported by the West African Drug Policy Network (WADPN), has presented a bill to amend its Controlled Drug and Substance Act 2014. The bill is progressive and in line with international standards for a comprehensive approach to drug control, even though all drug-related acts remain illegal. The amended law allows people diagnosed with substance use disorders or drug dependence to participate in drug treatment and rehabilitation programmes instead of going to prison. It also dramatically reduces the minimum and maximum sentences for drug use and possession from 5-20 years in prison to 3-18 months, and distinguishes between possession of a prohibited substance for personal use and possession for trafficking.

In April 2022, at the launch of a paper on torture and ill-treatment of people who use drugs in Nigeria, the Ministry of Health and the National Drug Law Enforcement Agency called for collaboration in addressing drug use through a public health and human rights lens, rather than a criminal one.

The adoption in March 2021 of UNAIDS's Global AIDS Strategy 2021-2026 and of the UN's Political Declaration on HIV and AIDS presents new, and ambitious targets, and a unique window of opportunity. The strategy offers a way for countries to move towards more supportive legal environments and provide access to justice for marginalised people, including people who use drugs. Particularly in relation to the '10:10:10' targets,[a] which aim to advance health reforms by 2025. This needs to be central to civil society's advocacy efforts in the region over the next three years to allow communities to lead and drive decriminalisation efforts within their countries.

"Most countries in West and Central Africa still have repressive laws and systems, which criminalise drug possession, drug use and cultivation of small amounts of illicit drugs. As a result of these laws, people who use drugs face stigma, discrimination and human rights violations in the form of physical and psychological harassment, abuse, and violence from the police, coerced drug treatment, compulsory HIV testing, and the denial of healthcare services, employment and social benefits."

a This refers to UNAIDS 'social enabler' targets, which aim for: (1) fewer than 10% of countries to have punitive legal and policy environments that deny or limit access to services; (2) fewer than 10% of people living with HIV and key populations experience stigma and discrimination; and (3) fewer than 10% of women, girls, people living with HIV and key populations experience gender inequality and violence.[38]

SPOTLIGHT

WOMEN WHO USE DRUGS IN WEST AND CENTRAL AFRICA

None of the West and Central African countries that provide harm reduction services have gender-sensitive programmes that cater to the needs of women who use drugs. This is despite the fact that women who use drugs face multiple barriers to accessing harm reduction services. This includes facing more stigma than men who use drugs, both in society and from health workers. Women are also disproportionately affected by gender-based violence and have specific needs related to sexual and reproductive health and childcare. Few harm reduction services in the region respond to the ways in which these different elements interact with drug use. Criminalisation also acutely affects women. It can stop pregnant or parenting people from accessing harm reduction services, and it is associated with physical, sexual and verbal harassment and abuse.[14,30]

While all genders can use drugs and experience mental illness, conflating the two or proposing a causation is inaccurate and stigmatising.31 Equally, it is important to note that sex and gender are regarded as critical structural determinants of mental health and mental illness. Mental illness is a complex phenomenon, and risky behaviour and substance use can occur simultaneously, or subsequently, to one another. A gendered vulnerability in biological, environmental, and behavioural risk factors is associated with the development and escalation of mental illness. As a result, women who use drugs present higher rates of depression and anxiety, suicidal tendencies, isolation and general psychological distress as compared to their male counterparts.[32]

In Africa (including in West and Central Africa), the reality that women use drugs is not yet entirely accepted. Increased criminalisation and stigmatisation of women who use drugs, and poor access to health services can result in women who use drugs engaging in high-risk behaviours related to drug use. Criminalisation drives women who use drugs away from essential services, leading to unsafe practices which, in turn, increases their risk of HIV and HCV infection and that of their sexual partners.

Women are disproportionately impacted by punitive drug control measures in West and Central Africa. Evidence from Côte d'Ivoire, Ghana and Senegal confirms that women who use drugs are particularly vulnerable to health harms, including HIV, sexually transmitted infections and gender-based violence.[33,34,35] Despite this, their access to gender-sensitive harm reduction and treatment services has not improved in the region.[5] Stigma, criminalisation, the fear of losing child custody and other punitive measures deter women from accessing the services that do exist. The proportion of women incarcerated for drug offences remains high, accounting for more than one-third (35%) of all women incarcerated globally.[36]

Despite bold new global targets, currently no countries in West and Central Africa offer harm reduction services specifically for women who use drugs. Decades of evidence and experience, synthesised by UNAIDS in 2020 through a comprehensive evidence review, show that inequalities are a key reason why the 2020 global HIV targets were missed.[29] The region urgently needs non-judgmental services tailored to women who use drugs; services that take into account childcare responsibilities and work to address other barriers to services that women face.

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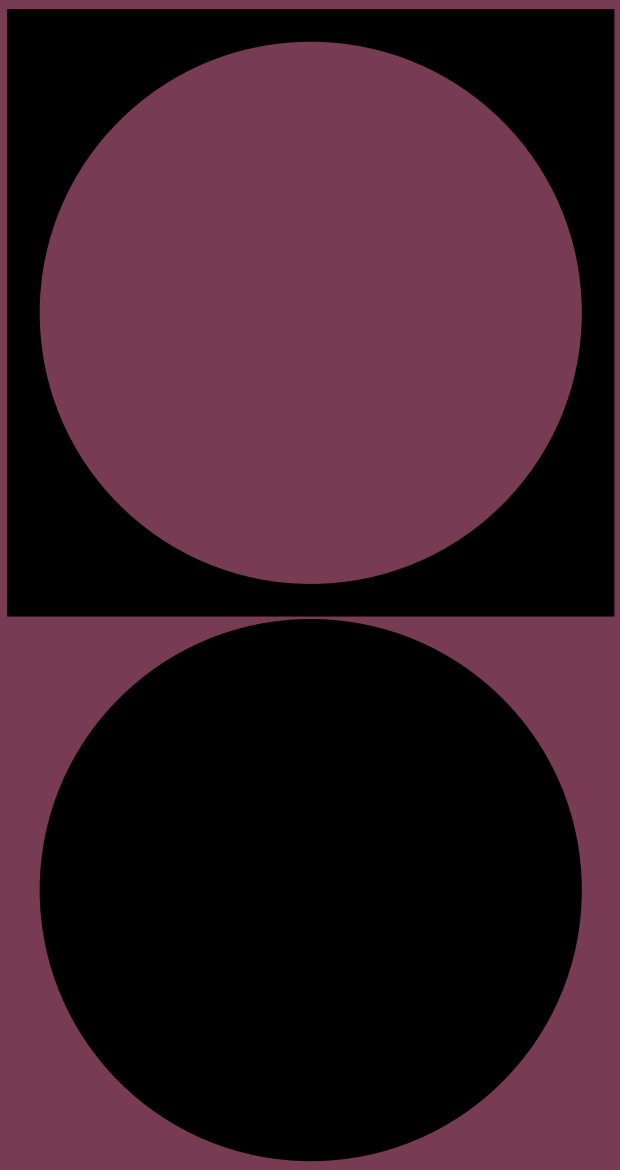
REGIONAL OVERVIEW: WESTERN EUROPE



THE GLOBAL STATE
OF HARM REDUCTION 2022

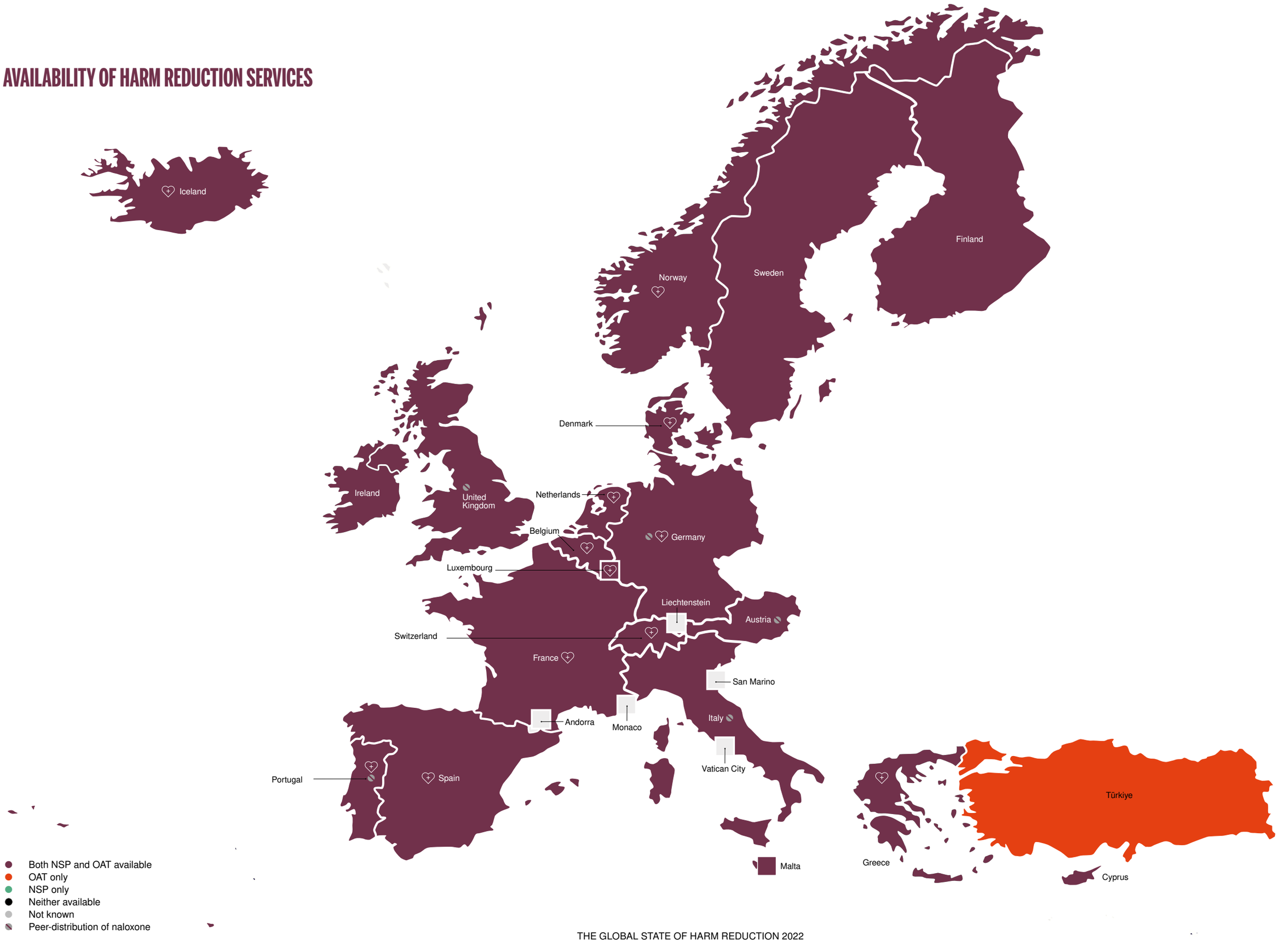
HARM REDUCTION INTERNATIONAL

TABLE 10 EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN WESTERN EUROPE

Country/territory	People who inject drugs[a]	HIV prevalence among people who inject drugs (%)[a]	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[a]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[a]	Harm reduction responses				
					NSP[b]	OAT[c]	Peer distribution of naloxone[d]	DCR[e]	Safer smoking equipment[f]
Andorra	nd	nd	34.0	nd	nd	nd	nd	nd	nd
Austria	15,000	0.4	61.8	4.4	✓ 57	✓ B M	✓[3]	×	✓[3]
Belgium	7,000	4.5	62.5	2.0	✓ 103	✓ B H M	×	✓ 1	✓[4]
Cyprus	<500	1.1	47.7	1.8	✓ 8	✓ B	×	×	nd
Denmark	16,500	1.3	65.6	1.3	✓ 5	✓ B H M	×	✓ 5	nd
Finland	15,500	1.2	73.7	nd	✓ 74	✓ B M	×	×	nd
France	125,500	9.3	54.8	0.8	✓ 610	✓ B M	×	✓ 2	✓[5]
Germany	129,500	4.1	62.9	0.9	✓ 349	✓ B H M	✓[6]	✓ 25	✓[6]
Greece	3,000	3.2	66.8	2.5	✓ 16	✓ B M	×	✓ 1	nd
Iceland	700[7]	5.0[7]	10.0[7]	nd	✓[7]	✓	×	✓ 1	nd
Ireland	8,500	8.3	77.2	0.0	✓ 121	✓ B M	×	×	nd
Italy	320,500	7.7	53.3	5.1	✓ 195	✓ B M	✓[8]	×	nd
Liechtenstein	nd	nd	nd	nd	nd	nd	nd	nd	nd
Luxembourg	2,500	1.9	81.3	0.8	✓ 10	✓ B M	×	✓ 2	nd
Malta	876[9]	0.2	26.9	0.0	✓ 8	✓ B M	✓	×	nd
Monaco	nd	nd	nd	nd	nd	nd	nd	nd	nd
Netherlands	3,000	2.6	61.0	1.0	✓	✓ B H M	×	✓ 25	✓[10]
Norway	8,500	1.0	64.7	1.5	✓ 77	✓ B H M	×	✓ 2	nd
Portugal	12,500	15.6	86.1	4.8	✓ 2,139	✓ B M	✓[11]	✓ 2	✓[11]
San Marino	nd	nd	nd	nd	nd	nd	nd	nd	nd
Spain	9,000	26.5	66.1	5.1	✓ 950	✓ B M	×	✓ 13	✓
Sweden	8,000	5.1	65.2	1.5	✓ 29	✓ B M	×	×	nd
Switzerland	14,000	1.4	74.6	4.0	✓[12]	✓ B H M	×	✓ 13[12]	✓[12]
Türkiye	nd	0.1	53.5	4.4	×	✓ B M	×	×	nd
United Kingdom[g]	223,500	1.1[13]	60.0[13]	12.0[13]	✓ 633	✓ B H M	✓[14]	×	✓[14]

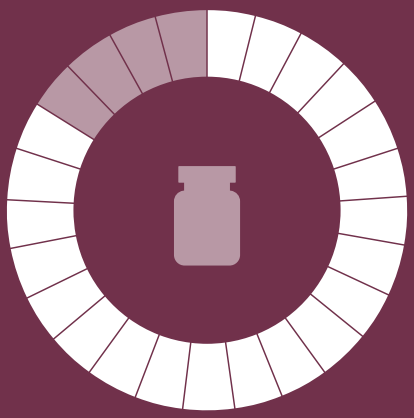
a Unless otherwise stated, data is from Degenhardt et al (under review).[1]
b At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available)
c At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, M=methadone.
d At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training, and facilitates secondary distribution of naloxone between peers.
e At least one drug consumption room (also known as safe consumption sites among other names) operational in the country or territory, and the number of facilities.
f At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.
g The United Kingdom population size estimate for people who inject drugs refers to subnational data from England and Scotland only. The data on HIV and viral hepatitis refers to England, Northern Ireland and Wales only.

AVAILABILITY OF HARM REDUCTION SERVICES

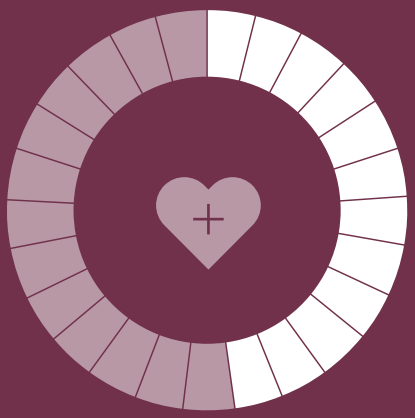


NSPs, OAT AND DCRs SINCE 2020

20 countries (80%) in Western Europe provide **needle and syringe programmes** (no change from 2020)

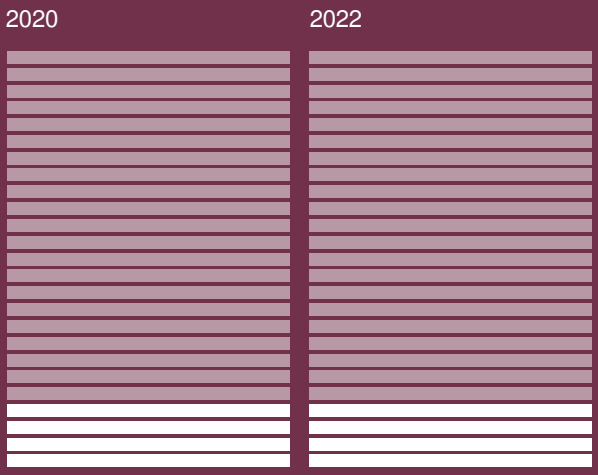


21 countries (84%) in Western Europe provide **opioid agonist therapy** (no change from 2020)

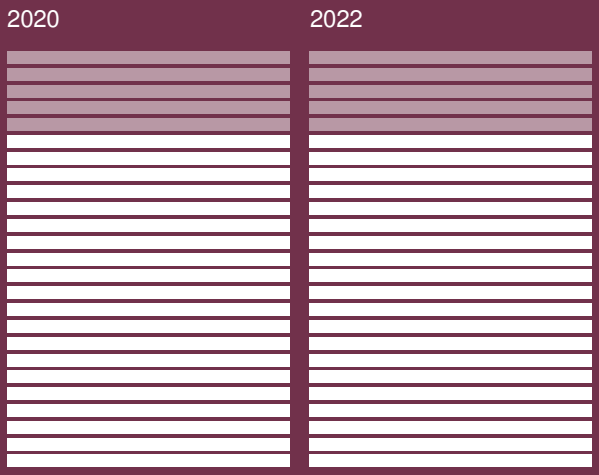


12 countries in Western Europe provide **drug consumptions rooms** (+2 since 2020, Greece, Iceland)

HARM REDUCTION IN PRISONS



4 countries in Western Europe provide **needle and syringe programmes** in prisons (no change from 2020)



20 countries in Western Europe provide **opioid agonist therapy** in prisons (no change from 2020)

HEROIN-ASSISTED TREATMENT IS AVAILABLE IN SEVEN COUNTRIES: DENMARK, GERMANY, LUXEMBOURG, NETHERLANDS, NORWAY, SWITZERLAND, THE UNITED KINGDOM

REGIONAL OVERVIEW

AUTHOR:
ROBERT CSÁK

INTRODUCTION

Western Europe has a long tradition of harm reduction. Countries in the region were among the first to adopt harm reduction services, and harm reduction is in a relatively favourable position, both in terms of policy inclusion and funding, compared to other regions around the world. Needle and syringe programmes (NSP) and opioid agonist therapy (OAT) are available in most Western European countries. However, only Spain, Luxembourg and Norway meet the World Health Organization (WHO) targets of providing at least 200 syringes per person who inject drugs per year and having 40% of people who use opioids on OAT.[15] In Western Europe, one of the most common barriers to accessing harm reduction services is the uneven distribution of services within countries. People who use drugs living in rural areas are particularly underserved in many countries across the region. This is a problem, for example, in Belgium, Ireland, Italy, Germany, Portugal, Scotland, Spain, Sweden, Switzerland and the United Kingdom.[16–27] Unfortunately, there have been no changes in this regard since the *Global State of Harm Reduction 2020*.

The number of countries in Western Europe in which NSPs operate is unchanged since the *Global State of Harm Reduction 2020*, with services available in 20 countries. This equates to all countries in the region with data on this, except Türkiye (there is no data from Andorra, Liechtenstein, Monaco and San Marino).

Although the first months of the COVID-19 pandemic brought serious disruptions to harm reduction services in the region, most Western European countries maintained NSP services throughout the pandemic.[28] Between 2019 and 2020, the number of distributed syringes decreased by more than 10% in 5 countries (Greece, Ireland, Malta, Portugal and the United Kingdom), while there were no changes or slight increases in other countries in the region (such as Austria, Norway and Sweden).[17,26,29] However, COVID-19-related disruptions to harm reduction services had adverse effects on the health of people who use drugs, as COVID-19-related restrictions reduced outreach activities and low threshold harm reduction service capacities in general, leading to reduced HIV and hepatitis C testing availability in the region.[15,20,25,30,31] User groups providing peer-to-peer NSP and outreach services were essential in bridging the gap in harm reduction service coverage during the COVID-19 pandemic.[17]

OAT is the most accepted harm reduction measure in Western Europe, available in all countries including Türkiye (the same as in 2020).[32] But availability does not mean accessibility; there are clear barriers to accessing OAT in the region. In the United Kingdom, half of the people who have died from opioid overdoses have not been in contact with treatment services. Civil society organisations attribute this to high barriers to accessing treatment, such as drug tests, daily or supervised pick up of OAT medicines, and mandatory group therapy.[16] Similar barriers are reported in Italy, where overly rigid protocols and a lack of client involvement in

discussing dosage and therapeutic goals, hinder access.[18] Access to OAT could be improved through low threshold, community-based programmes and the use of mobile outreach settings. For example, in Lisbon a low threshold OAT programme run by Ares do Pinhal experienced a significant increase in its number of clients in 2020, during the first months of COVID-19-related restrictions, as it was able to provide access to OAT when other OAT services were unavailable.[26,33]

"COVID-19-related disruptions to harm reduction services had adverse effects on the health of people who use drugs, as COVID-19-related restrictions reduced outreach activities and low threshold harm reduction service capacities in general, leading to reduced HIV and hepatitis C testing availability."

COVID

The pandemic has shown that it is possible to operate OAT programmes with fewer restrictions, greater autonomy and client choice. Many countries eased OAT regulations during the COVID-19 pandemic, and there was a substantial move towards take-home OAT in the region. For example, in the United Kingdom, most people were moved onto 7 to 14 day prescriptions instead of daily or supervised pick up of OAT medication, and civil society highlights that the vast majority of clients found this improved their treatment experience, as they felt more trusted and more in control of their treatment.[16,17] Civil society in Italy, Spain and Switzerland report similar experiences.[18,19,23,34]

Although the COVID-19 pandemic is still affecting harm reduction services in the region, in 2021 civil society in some cities (London, Copenhagen, Paris, Rome) reported that harm reduction services were no longer disrupted. While services were severely disrupted in the first months of the COVID-19 pandemic (beginning in March 2020), by the start of 2021 these disruptions were much reduced.[25] Nevertheless, reduced opening hours and other limitations in NSPs' capacity affected access to harm reduction commodities like syringes. Harm reduction services made various adaptions to address COVID-19-related disruptions. For example, syringe distribution was expanded in Belgium, Italy, Switzerland and the United Kingdom through an increase in peer-to-peer NSP services or by implementing mail order injecting equipment.[16–18,20,27,35]

In Amsterdam in the Netherlands and Porto in Portugal, civil society organisations report a lack of services tailored to the unique issues faced by women who use drugs during the COVID-19 pandemic.[11]

HARM REDUCTION IN PRISONS

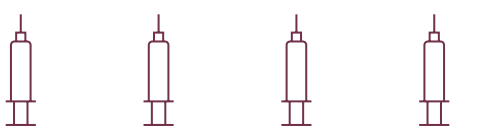
While OAT is available in prisons in most Western European countries, there are serious barriers in access. In many countries, OAT is only available in a small number of prisons, and in some cases it is not possible to start OAT while incarcerated. For example, in Portugal, OAT is available in 49 prisons, but initiation of OAT is only possible in four, thus OAT is predominantly only available to people who started OAT before going to prison.[26] Similarly, in Italy, OAT is made available in all prisons, but bureaucratic barriers make access more difficult for people who were not enrolled on OAT before being in prison.[18] In Belgium, there are bureaucratic barriers to receiving OAT in prisons; it involves a complex process which varies from prison to prison.[27]

NSPs in prison settings are available in four countries in the region (Germany, Luxembourg, Spain, Switzerland). But accessibility is a problem, as it is only implemented in one of two prisons in Luxembourg, in one women's prison in Germany (a syringe-dispensing machine), in 15 prisons in Switzerland (covering one fifth of people in prison in the country), and in a decreasing number of facilities in Spain (47 in 2019).[21–23,36–38]

HEROIN-ASSISTED TREATMENT

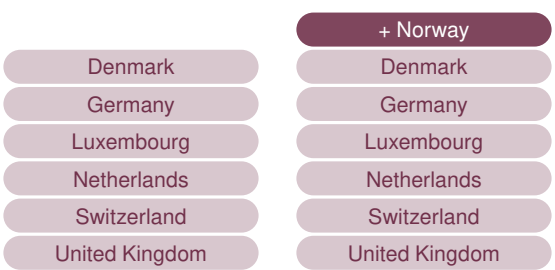
Heroin-assisted treatment (HAT) is available in seven countries, an increase since 2020, with Norway joining the six countries where HAT has been previously available (Denmark, Germany, Luxembourg, the Netherlands, Switzerland, and the United Kingdom). A five-year pilot programme started in Bergen and Oslo in the first half of 2022, available for people who use opioids who have found that other OAT medications do not work for them.[39–41] The Norwegian HAT services open seven days a week, and clients can take heroin in injectable or tablet form with supervised dosing (a take-home policy is not available). As of August 2022, 40 people were enrolled in the programme (of whom at least six were women[42]), although these numbers are expected to rise as the HAT programme's capacity increases.[39–41,43] An evaluation of the United Kingdom's HAT programme found people in the programme experienced positive outcomes, including increased engagement with psychosocial interventions, reductions in consuming street heroin, reductions in risky injecting practices, increased access to secure housing, and reductions in the volume and cost of criminal behaviour.[44] In Switzerland, nasal HAT has been considered as an alternative to injectable or oral pharmaceutical heroin, as it is a suitable treatment option for clients who are unable to inject or mainly use a nasal route of administration.[45] Nasal HAT is an important initiative, as injecting use is in decline among people entering drug treatment programmes for the first time who use heroin as their primary drug, according to 2020 data from the European Union, Norway and Türkiye (only 22% reported injecting as their main route of administration, down from 35% in 2013).[15]

Needle and syringe programmes in prisons



Luxembourg (one prison) | Germany (one prison) | Switzerland (15 prisons) | Spain (49 prisons)

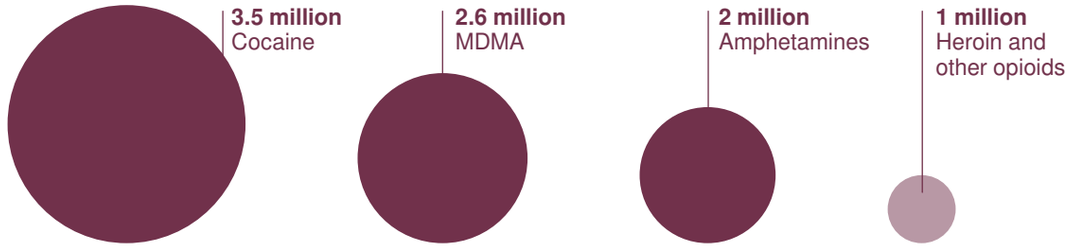
Heroin-assisted therapy in Western Europe



SPOTLIGHT

HARM REDUCTION FOR STIMULANT USE

Drug use in the European Union
The number adults who used each type of drug in 2021



Stimulants are the second most commonly used substances after cannabis in the region. It is estimated that, in the European Union in the last year, 3.5 million adults used cocaine, 2.6 million used MDMA and 2 million used amphetamines, while heroin or other opioids were used by 1 million people.[15] Data suggests that around 25% of people who seek treatment for amphetamine-type substance use are women, compared with 18% of those seeking treatment for opioid use.[15] People who use stimulants need adequate access to harm reduction services for stimulant use, such as safer smoking kits,[a] drug consumption rooms (DCRs) and drug checking. Harm reduction programmes should provide services tailored for the specific needs of people who use stimulants.

Additionally, drug preferences among people who inject drugs are changing, and injecting use of stimulants is on the rise. For example, injection of crack cocaine has increased in England and Wales, and injection of powder cocaine has increased in Scotland.[46] Furthermore, the use of other drugs is widespread among people who inject drugs, with stimulants playing a central role. An analysis of the residual content of used syringes found that 85% of syringes collected in Ireland contained both heroin and cocaine and quarter contained heroin, cocaine and methamphetamine.[47] The syringes collected by the ESCAPE network in eight European cities (Amsterdam, Budapest, Cologne, Helsinki, Lausanne, Oslo, Paris, Vilnius) in 2020-21 showed a similar situation; a third of all syringes contained two or more drugs, with a mix of stimulant and opioid drugs the most frequent combination. [15,48] As stimulant injecting is associated with more frequent injecting, NSPs should consider adjusting their syringe distribution policies to allow for a higher number of syringes while avoiding one-for-one needle exchange schemes.

Smoked cocaine use is on the rise across the region: treatment demand for smoked cocaine issues tripled from 2016 to 2020[15], with increases reported in Belgium, France, Ireland, Italy, Portugal, Spain and the United Kingdom.[15,25,49] Harm reduction services in Brussels, Copenhagen, Lisbon, Paris, parts of Ireland, and Italy have also reported significant increases in smoked cocaine use among clients.[15,25,49] Safer smoking kits can prevent the harms and risks associated with smoking from makeshift pipes or pipe sharing, such as toxin inhalation from repurposed plastic bottles or tin cans, lip cuts and burns, which increases the risk of transmission of HIV, hepatitis C and tuberculosis.[50] Safer smoking kit distribution is available in at least 10 countries in the region (Austria, Belgium, France, Germany, Italy, the Netherlands, Portugal, Spain, Switzerland and the United Kingdom).[18,19,21–23,26,27,35,51] However, it is possible there is a data gap in this area, as safer smoking kit distribution is not part of the routine drug monitoring activities in the region. Inadequate funding is the main barrier to implementation in Italy, Germany, Portugal and Spain.[18,19,21,26] Safer smoking kits are often a 'bottom-up' initiative, led by harm reduction services. For example, in Portugal some harm reduction teams distribute crack cocaine smoking equipment, but the national agency responsible for funding harm reduction programmes does not fund these projects, and the organisations have to identify other resources to buy the kits.[26] In Italy, some harm reduction programmes started distributing safer smoking kits to meet the increased need in the community, but they are not included in the harm reduction commodities paid for by the central public health budget.[18] In the United Kingdom, it is illegal to distribute safer smoking kits under the current drug paraphernalia laws. The only exemption is aluminium foil, so it is the only harm reduction equipment that is distributed for smoking.[16,17,52] This is a problem because stimulant pipes are essential harm reduction equipment, both for engaging people who use stimulants with harm reduction services and reducing transmission risks for HIV, hepatitis C and tuberculosis. Despite the United Kingdom's current paraphernalia laws, a pilot safe inhalation pipe provision programme has started in the country in four areas, with the local police force supporting the intervention, and safer smoking kit distribution will be available in the study's sites for six months in 2023.[16,17,53]

Drug checking services usually target people who use stimulants. Drug checking enables people to have the contents of their drugs analysed. Drug checking services then deliver the results combined with consultation to reduce the risks of drug use. The majority of people who use drug checking services report that they dispose their drug if it contains other substances than expected, leading to reductions in multiple drug use and an increase in people taking smaller doses.[54,55] Another benefit of these services is that they can issue public warnings when high-risk ingredients are found in drugs. Drug checking services have been implemented in at least 11 countries in Western Europe (Austria, Belgium, France, Germany, Italy, Luxembourg, the Netherlands, Portugal, Spain, Switzerland, and the United Kingdom). But coverage is a serious barrier to access; there is only one drug checking service in Belgium, Germany, Portugal and Spain, and there are two services in Austria and the United Kingdom (the first officially licensed, regular drug checking service in the United Kingdom started in Bristol in May 2022).[16,19,22,26,27,56,57] Although drug checking is usually considered a service for people who use stimulants in nightlife and festival settings, this is a service other communities can also benefit from. For example, a pilot drug checking service started in 2022 in Lisbon, Portugal, targeting marginalised people who use drugs on the streets.[26] Between 2020-2021, drug checking services in eight countries[i] identified synthetic cannabinoids in herbal cannabis products in samples submitted by people who experienced serious negative effects after use.[58]

"Stimulant pipes are essential harm reduction equipment, both for engaging people who use stimulants with harm reduction services and reducing transmission risks for HIV, hepatitis C and tuberculosis."

h Safer smoking kits can include metal filters, rubber mouthpieces, push sticks for cleaning pipes and collecting crack residue, and heat-resistant glass pipes. They can also include items like alcohol wipes and hand wipes.

i Synthetic cannabinoids in herbal cannabis were first identified by a drug checking service in Zurich, Switzerland in February 2020, and later in the United Kingdom, France, the Netherlands and Austria in 2020, and Luxembourg, Germany and Italy in 2021.

SPOTLIGHT

DRUG CONSUMPTION ROOMS IN WESTERN EUROPE

The number of countries with DCRs, including mobile drug consumption facilities, has increased since 2020, with Greece and Iceland opening DCRs in 2022, while the first DCR for people who smoke drugs in Portugal opened in 2021 in Lisbon.[26,59,60] An unsanctioned mobile DCR operated in Glasgow, Scotland between September 2020 and May 2021.[61] Currently (as of July 2022), there are 93 official DCRs in 66 cities and 12 countries across Western Europe (Belgium, Denmark, France, Germany, Greece, Iceland, Luxembourg, Netherlands, Norway, Portugal, Spain, Switzerland).[60,62] DCRs usually offer a range of services in addition to supervised consumption spaces; for example, overdose trainings, take-home naloxone, NSP, psychosocial support and referrals to other health and social services.[63–65] DCRs provide a safe environment to use drugs under the supervision of trained professionals, who can intervene in the event of an overdose, and studies have shown that people who inject drugs are highly willing to use these safe spaces.[61,66,67] An illustration of the importance of this initiative is that in Copenhagen, when COVID-19-related restrictions meant people could not enter the DCR facility, some people would use their drugs close by because DCR staff could quickly assist with naloxone in case of an overdose.[25] Available evidence on DCRs shows that they are effective in preventing overdose deaths: there has never been a fatal overdose reported in any DCR around the globe.[68,69]

DCRs are usually associated with opioid use, however, people who use stimulants comprise a significant proportion of DCR clients in the region. For example, non-injecting use of cocaine is prevalent in DCRs in Zurich, the clients of the unsanctioned DCR in Glasgow were predominantly injecting cocaine, and DCRs in Paris and Lisbon report that clients using crack cocaine are dissolving it for injection.[15,25,61,70] The overall trend of decreasing prevalence of injecting use affects the DCRs in the region. In general, more and more people who use DCRs are smoking their drugs. For example, the DCR in Athens reports an increasing trend of people smoking methamphetamine, and in Barcelona civil society actors report an increasing need for a DCR for smoked use.[25,65]

DCRs typically integrate services tailored to local needs. For example, the Lisbon DCR operated by Ares do Pinhal offers two rooms: one space for injecting and one for smoking, plus psychosocial support, a coffee desk, medical consultations and infectious disease screening. To serve the significant proportion of their clients experiencing homelessness, they offer a laundry, bathroom, free clothes, and even a pet-sitting service because many of their clients have pets that they cannot leave elsewhere and this would prevent them from accessing the DCR.[65] The DCR also has a community team which regularly cleans up discarded injecting paraphernalia from the neighbourhood.[65]

Considering the needs of the neighbourhood is an important aspect of a DCR's operation, as the concerns of local residents are a significant barrier to opening, and continuing to implement, DCRs.[71,72] For example, in Zurich, DCRs are open at different times of the day. This ensures that at least one DCR is available in the city throughout the day, while avoiding concerns from residents in any one neighbourhood[70] To decrease visible drug selling in the neighbourhood, 'micro-dealing' (selling small quantities of drugs) is tolerated at the premises (in agreement with the local police) provided that it only happens in the designated place at the facility, no scales are used, it is done discreetly (e.g. money is not visibly transferred) and the 'micro-dealers' are people who use drugs themselves and are clients of the DCR.[70]

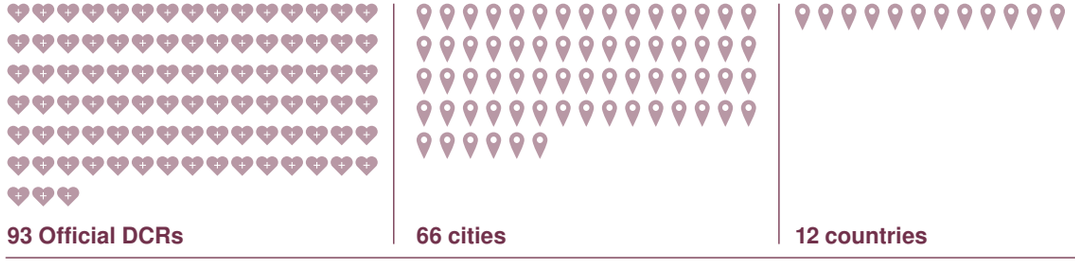
The lack of appropriate legal frameworks and political will seems to be the most prevalent barrier to implementing new DCRs in the region.[16,18–21,27,65,71,72] In Brussels, Belgium the country's second DCR opened in May 2022, but legal issues hinder further expansion.[27] OKANA opened the first DCR in Athens in 2013 as a response to the country's HIV epidemic, but the Greek government then suspended the facility, and it has taken nearly a decade and determined advocacy efforts to open a new DCR in the city.[65,73] Similarly, there has been a decade long advocacy campaign for a DCR in Ireland, but although the appropriate legislation was enacted, a high court challenge has been hindering implementation since 2020.[74,75] In a different legal environment, the unsanctioned DCR in Glasgow was run without an appropriate legal framework. In this case, the DCR closed due to a lack of funding and unsustainable staffing model[j], not because of legal or police action.[61] There is an ongoing initiative to reform the legal framework and introduce DCRs in Finland where a successful citizens' initiative means parliament now has to put the issue on its agenda.[76–78]

Peer involvement is crucial in DCR design and implementation. Engaging potential service users is essential to understand the needs of local communities, while continued participation of people who use drugs in operating and developing the service can help provide a safe place for all clients, ensuring accessibility, use and consumer satisfaction.[79,80] Furthermore, DCR providers should welcome people who still use drugs as staff members.[79] In Portugal, for example, a peer programme with a flexible payment model (where participation is paid by the hour or task) has been implemented. This allows peers to participate in various programme activities run by the mobile DCR, like street outreach, trainings, advocacy events and meetings with residents.[26] In Barcelona, Spain, Metzineres offers low threshold, peer-led harm reduction services for women and nonbinary people who use drugs, including a DCR. Metzineres highlights that community-led organisations can provide adequate services for the most stigmatised and marginalised communities; many programme participants reported that this is the first place they felt safe.[79,81] A significant step forward in the region was reported in Germany, where the first DCR operated by a peer organisation is expected to open in 2023.[21]

"Peer involvement is crucial in drug consumption room design and implementation. Engaging potential service users is essential to understand the needs of local communities, while continued participation of people who use drugs in operating and developing the service can help provide a safe place for all clients, ensuring accessibility, use and consumer satisfaction."

j Volunteers faced risks to their liberty and their earnings from other sources. For example, medical students volunteering were warned that they could be barred from practice if convicted of a criminal offence.[61]

Drug consumption rooms in Western Europe



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